QUEENSLAND PARLIAMENT
COMMITTEES

Coroners (Mining and Resources Coroner) Amendment Bill 2025

Primary Industries and Resources Committee

Report No. 7

58th Parliament, August 2025

Primary Industries and Resources Committee

Chair	Mr Stephen Bennett MP, Member for Burnett
Deputy Chair	Mr James Martin MP, Member for Stretton
Members	Mr Nigel Dalton MP, Member for Mackay
	Mr Robbie Katter MP, Member for Traeger
	Mr Glen Kelly MP, Member for Mirani
	Mr Tom Smith MP, Member for Bundaberg

Committee Secretariat

Telephone	(07) 3553 6621
Email	PIRC@parliament.qld.gov.au
Committee Webpage	https://www.parliament.qld.gov.au/pirc

All references and webpages are current at the time of publishing.

Acknowledgements

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Chair's Foreword

This report presents a summary of the Primary Industries and Resources Committee's examination of the Coroners (Mining and Resources Coroner) Amendment Bill 2025 ('the Bill').

The committee's task was to consider the policy to be achieved by the legislation and the application of fundamental legislative principles - that is, to consider whether the Bill has sufficient regard to the rights and liberties of individuals, and to the institution of Parliament. The committee also examined the Bill for compatibility with human rights in accordance with the Human Rights Act 2019.

During the inquiry, the committee heard the views of many stakeholders and had the opportunity to hear from Resources Safety and Health Queensland (RSHQ), and the Department of Justice regarding the operational functions of the Bill.

Before 2001, inquiries into fatal and serious accidents were carried out by the Mining Warden in the Mining Warden's Court. In March 2001, the Mining Warden's Court ceased inquiries into serious and fatal accidents, and all fatalities on mine and quarry sites were subsequently dealt with by the Coroners Court.

Currently, under the Coroners Act 2003 (Coroners Act), a coroner must investigate a reportable death (which could include a death on a mine site), with discretion for the coroner to conduct a coronial inquest.

Under the current framework, only a small number of mining-related deaths have proceeded to coronial inquest. Since 2022, seven people have lost their lives at Queensland mine sites. From 2014 to 2024, RSHQ has investigated 27 deaths on mines and quarries in Queensland. Coronial inquests have been held for two of these deaths, as well as for two deaths that occurred prior to 2014. The Department of Justice anticipates that, based on existing data, the Mining and Resources Coroner would consider an average of two to four accidental mining-related deaths per year.

The committee held public hearings in Brisbane and received submissions from key stakeholders. While some witnesses expressed concerns about the Bill, the committee considers that the establishment of the Mining and Resources Coroner will provide a sufficient mechanism to investigate and inquire specifically into mining-related deaths.

I also thank our Parliamentary Service staff, the Department of Justice and Resources Safety and Health Queensland.

I commend this report to the House.

Stephen Bennett MP

Chair

Executive Summary

The aim of the Coroners (Mining and Resources Coroner) Amendment Bill 2025 (the Bill) is to 'provide more timely answers and certainty to families that mining related deaths will be investigated and an inquiry conducted to determine the cause of the death', and to prevent similar deaths from happening in the future and keep mining companies accountable.

The Bill would amend the *Coroners Act 2003* to:

- establish a dedicated position of Mining and Resources Coroner (MRC)
- provide that the MRC must undertake mandatory coronial investigations and inquests into all accidental mining-related deaths, including deaths occurring on mines, coal mines, and quarries, as well as certain sites where petroleum and gas works are carried out.

The committee received 5 written submissions and held a public briefing with the Department of Justice and independent regulator Resources Safety and Health Queensland. The committee also held a public hearing with selected stakeholders.

Stakeholders raised concerns in relation to the reforms proposed within the Bill. Some stakeholders suggested that deaths occurring from suicide, from mine dust lung disease, and deaths occurring during travel to work sites should be included as mining related reportable deaths subject to mandatory inquests by the MRC.

The committee made 2 recommendations, found at page vi of this report.

Legislative compliance

The committee's task was to consider the policy to be achieved by the legislation and the application of fundamental legislative principles – that is, to consider whether the Bill has sufficient regard to the rights and liberties of individuals, and to the institution of Parliament. The committee also examined the Bill for compatibility with human rights in accordance with the *Human Rights Act 2019*.

The committee concluded that the Bill was compatible with the *Legislative Standards Act 1992* and the *Human Rights Act 2019*.

Recommendations

The committee recommends that the Bill be passed.

The committee recommends the Department of Justice consider publishing information clarifying how suicide deaths, mine dust lung disease related deaths, and deaths occurring during travel to and from a mining and resources site, would be investigated within the coronial framework and how these investigations intersect with existing regulatory powers.

Glossary

CMSHA	*Coal Mining Safety and Health Act 1999*
Coroners Act	*Coroners Act 2003*
Department	Department of Justice
DNRMMRRD	Department of Natural Resources and Mines, Manufacturing and Regional and Rural Development
FLP	Fundamental Legislative Principle
HRA	*Human Rights Act 2019*
LSA	*Legislative Standards Act 1992*
Magistrates Act	*Magistrates Act 1991*
MQSHA	*Mining and Quarrying Safety and Health Act 1999*
MRA	*Mineral Resources Act 1989*
MRC	Mining and Resources Coroner
RSHQ	Resources Safety and Health Queensland
RSHQ Act	*Resources Safety and Health Queensland Act 2020*

1. Overview of the Bill

On 12 June 2025, the Honourable Deb Frecklington MP, Attorney-General and Minister for Justice and Minister for Integrity, introduced the Coroners (Mining and Resources Coroner) Amendment Bill 2025 (the Bill) into the Queensland Parliament. The Bill was initially referred to the Justice, Integrity and Community and Safety Committee before being re-referred to the Primary Industries and Resources Committee (the committee) for detailed consideration.

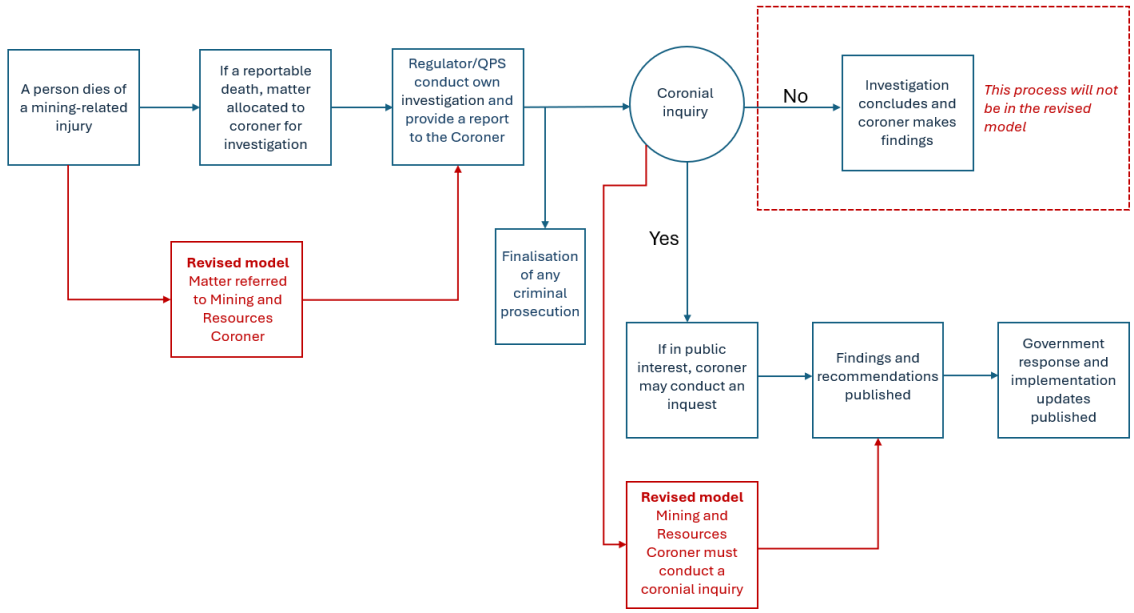
1.1. Aims of the Bill

The Bill would amend the *Coroners Act 2003* (Coroners Act) to:

- establish a dedicated position of Mining and Resources Coroner (MRC)
- provide that the MRC must undertake mandatory coronial investigations and inquests into all accidental mining-related deaths, including deaths occurring on mines, coal mines, and quarries, as well as certain sites where petroleum and gas works are carried out.[1]

The aim of the Bill is to 'provide more timely answers and certainty to family that mining related deaths will be investigated and an inquiry conducted to determine the cause of the death', and to prevent similar deaths from happening in the future and keep mining companies accountable.[2] The Bill is intended to 'complement existing bodies who regulate, educate, and assist the resources industry to meet its obligation to protect the safety and health of its workers, or other agencies who focus their investigations on whether prosecution is warranted'.[3] The proposed changes are shown in red in the figure below.

Figure 1 Differences between the current and proposed model.[4]



[1] Statement of compatibility, p 1.
[2] Explanatory notes, p 1.
[3] Department of Justice, correspondence, 27 June 2025, p 8.
[4] Department of Justice, correspondence, 27 June 2025, p 8.

1.2. Background

Following an election commitment of the current government to reform the how fatal mining accidents are investigated, the government appointed a Mining and Resources Coroner to be based in Mackay after spending 12 months in Brisbane. [5]

1.2.1. Coronial investigations, inquests and reportable deaths

A coronial investigation aims to determine the identity of the person who died, how, when and where they died, and the medical cause of the death. A coronial inquest is an inquisitorial fact-finding process, and is not undertaken to find or attribute liability to anyone. A coroner is specifically prohibited from making any findings or comments that a person is criminally or civilly liable for anything.[6] The purpose of an inquest is to gather information about the cause and circumstances of a death, and to allow a coroner to make comments and recommendations to prevent similar deaths from happening in the future.[7]

Under the current Coroners Act, a coroner must conduct an investigation into a reportable death. Reportable deaths include when the death was violent or otherwise unnatural. Section 8(3) of the current Coroners Act defines a death as a reportable death if:

(a) it is not known who the person is; or

(b) the death was a violent or otherwise unnatural death; or

(c) the death happened in suspicious circumstances; or

(d) the death was a health care related death; or

(e) a cause of death certificate has not been issued, and is not likely to be issued, for the person; or

(f) the death was a death in care; or

(g) the death was a death in custody; or

(h) the death happened in the course of or as a result of police operations.

An unnatural death under section 8(3)(b) includes the death of a person who dies at any time after receiving an injury that caused the death or contributed to the death and without which the person would have died.[8]

1.2.2. Mining deaths in Queensland and coronial investigations and inquests

Under the current framework, very few mining-related deaths have proceeded to coronial inquest. Since 2022, 7 people have lost their lives at Queensland mine sites.[9] From 2014 to 2024, Resources Safety and Health Queensland (RSHQ) have investigated 27 deaths

[5] Hon Dale Last MP & Hon Deb Frecklington MP, 'A Fresh Start for Queensland: Crisafulli Government delivers on election commitment with Mining & Resources Coroner for safety', media release, 8 May 2025.
[6] Coroners Act, ss 45(5), 46(3).
[7] Explanatory notes, p 3.
[8] Coroners Act, s 8(3)(b).
[9] 'Queensland appoints Wayne Pennell as state's first mining and resources coroner', *ABC News*, 8 May 2025.

on mines and quarries in Queensland.[10] Coronial inquests have been held for 2 of these deaths, as well as for 2 deaths that occurred prior to 2014.[11] The last inquest into a mining death in the state was held in 2020 after the 2017 death of Daniel Springer at Goonyella Riverside Mine.[12] According to the Minister, some families have been waiting for several years for answers about a loved one's death. The MRC would immediately oversee outstanding inquests.[13]

The Department of Justice (the department) anticipates that, based on existing data, the MRC would consider an average of 2 to 4 accidental mining related deaths per year if the Bill is passed.[14] Currently, coroners generally handle approximately 200 to 300 cases at any given time. In 2023-24, 6,055 investigations were finalised by the Coroners Court, and 31 inquests were held.[15] The MRC would be able to carry out general coronial work at the same time as undertaking mining-related work. This will assist in reducing the backlog of coronial matters and improving clearance rates.[16]

1.2.3. Former Mining Warden's Court

Before 2001, inquiries into fatal and serious accidents were carried out by the Mining Warden in the Mining Warden's Court. The Mining Warden's Court also had jurisdiction in relation to mining claims, compensations and lease applications. These types of disputes are now heard by the Land Court. In March 2001, the Mining Warden's Court ceased inquiries into serious and fatal accidents, and all fatalities on mine and quarry sites were subsequently dealt with by the Coroners Court.[17]

1.3. Consultation

The explanatory notes state that consultation on the Bill was undertaken with stakeholders from the judiciary, legal, resources, union groups and local government. The department advised that stakeholders were provided with a fact sheet explaining the proposed amendments and outlining the key features of the Bill, along with a consultation draft Bill. Information sessions were held by the Department of Justice, Department of Natural Resources and Mines, Manufacturing and Regional and Rural Development (DNRMMRRD), and RSHQ. Stakeholders were invited to provide written feedback on operational and implementational issues, and feedback received during the consultation process was taken into account in finalising the Bill.[18]

[10] Department of Justice, public briefing transcript, Brisbane, 30 June 2025, p 5.
[11] Hon D Frecklington, Attorney-General and Minister for Justice and Minister for Integrity, Queensland Parliament, Record of Proceedings, 12 June 2025, p 1729.
[12] 'Queensland appoints Wayne Pennell as state's first mining and resources coroner', *ABC News*, 8 May 2025.
[13] 'Queensland appoints Wayne Pennell as state's first mining and resources coroner', *ABC News*, 8 May 2025.
[14] Department of Justice, public briefing transcript, Brisbane, 30 June 2025, p 5.
[15] Department of Justice, correspondence, 27 June 2025, p 4.
[16] Department of Justice, correspondence, 27 June 2025, p 2.
[17] Hon D Frecklington, Attorney-General and Minister for Justice and Minister for Integrity, Queensland Parliament, Record of Proceedings, 12 June 2025, p 1729.
[18] Department of Justice, correspondence, 27 June 2025, p 10.

1.4. Other jurisdictions

What is considered a reportable death varies between jurisdictions, but may include workplace related deaths, including mining related deaths. All jurisdictions have comparable legislation in terms of judicial discretion to hold an inquest unless the death falls within the scope where it is mandatory for an inquest to occur.[19] The department noted that a number of other jurisdictions have provisions relating to the coronial investigation of accidental mining-related deaths, and provided the following examples:

- **Tasmania**: Requires a coroner to hold an inquest for a death if the deceased died at, or as a result of, an accident or injury that occurred at their place of work and the coroner is not satisfied that the death was due to natural causes.
- **Western Australia**: For accidental mining-related deaths, a coroner will conduct an inquiry (similar to a coronial investigation in Queensland) to determine the nature and cause of the death. The coroner may decide to hold an inquest to establish facts surrounding the death, comment on any matter connected to the death and recommend ways to prevent deaths in similar circumstances.
- **Victoria**: For accidental mining deaths, the coroner must investigate the death to determine the identity of the deceased and the cause of death. In addition to the coroner, WorkSafe Victoria and the Earth Resources Regulator will also investigate and prepare investigation reports. The coroner may also hold an inquest into the death, but inquests are not mandatory for mining-related deaths.
- **South Australia**: For any workplace deaths including those occurring within mines, the State Coroner is responsible for ascertaining the cause or circumstances of a reportable death and may in some circumstances conduct an inquest. SafeWork SA will investigate the cause of all reported fatalities within or related to a workplace, inclusive of mines. If a coroner determines that the death is not work-related, SafeWork SA finalises their enquiries.[20]

1.5. Inquiry process

The committee opened its inquiry to submissions on 19 June 2025 and received 5 submissions. The committee conducted a public briefing with officers from the Department of Justice and RSHQ, and held a public hearing with witnesses drawn from submissions.

1.6. Legislative compliance

The committee's deliberations included assessing whether the Bill complies with the requirements for legislation as contained in the *Parliament of Queensland Act 2001*, the *Legislative Standards Act 1992* (LSA), and the *Human Rights Act 2019* (HRA).

[19] Department of Justice, correspondence, 27 June 2025, p 11.
[20] Department of Justice, correspondence, 27 June 2025, pp 10-11.

1.6.1. Legislative Standards Act 1992

Fundamental legislative principles (FLPs) require that legislation has sufficient regard to the rights and liberties of individuals and the institution of Parliament.[21] The committee's assessment of the Bill's compliance with the LSA identified issues with the following FLP, which is analysed in Section 2 of this Report:

- privilege against self-incrimination.

The committee was satisfied that the explanatory notes tabled with the Bill meet the requirements set out in Part 4 of the LSA and include a sufficient level of background information and commentary to facilitate understanding of the Bill's aims and origins.

1.6.2. Human Rights Act 2019

Assessment of the Bill's compatibility with the HRA identified issues with the following, which is analysed further in Section 2 of this Report:

- The right to privacy and reputation.

A statement of compatibility was tabled with the introduction of the Bill as required by section 38 of the HRA. The statement contained a sufficient level of information to facilitate understanding of the Bill in relation to its compatibility with human rights.

1.7. Should the Bill be passed?

The committee is required to determine whether or not to recommend that the Bill be passed.

Recommendation 1

The committee recommends that the Bill be passed.

2. Examination of the Bill

This section discusses key themes which were raised during the committee's examination of the Bill.[22]

2.1. Mining and Resources Coroner, appointment, removal, function, and powers

The Bill would establish the position of MRC, to be appointed by Governor in Council.[23] Before making a recommendation to the Governor in Council about the appointment of the MRC, the Attorney-General, as the responsible Minister, must first consult with the Chief Magistrate and the State Coroner.[24]

Existing provisions of the Coroners Act and the *Magistrates Act 1991* (Magistrates Act) would be used for the appointment of a person as a magistrate and to hold the role of a

[21] LSA, s 4(2).
[22] Note that this section does not discuss all consequential, minor, or technical amendments.
[23] Bill, cl 18, s 82A.
[24] Explanatory notes, p 12; Bill, cl 18, s 82A(2).

local coroner.[25] Existing provisions would also be relied upon to remove the MRC if necessary. The MRC would be able to resign from the position in writing to the Attorney-General; however, this would not prevent the person from being a magistrate or local coroner.[26]

The MRC would be required to conduct investigations and a mandatory inquest for all mining related reportable deaths.[27] The MRC would have the existing functions and powers of a magistrate and a coroner.[28] This would include the power to require witnesses to give self-incriminating evidence.[29] The Coroners Act also provides that a coroner must supply a report on the findings of an investigation to specified persons. Findings relating to the investigation of a reportable death must be published on the State Coroner's website, unless the coroner orders otherwise.[30]

2.1.1. Human rights – right to privacy and reputation

i. Compelling witnesses to give evidence

Provisions that would empower the MRC to compel a witness to provide incriminating evidence may limit an individual's right to privacy because they would require participation in an investigation and involve the disclosure of personal information or evidence to the coroner. The personal information may be that of the witness or, although possessed by the witness, personal to a third party, such as a family member, colleague or associate. Conceivably, the information could be about the deceased person or relating to their death, or about or related to another person. The proposed amendments may compel the giving of evidence or information in instances where disclosure would not otherwise be mandated.

According to the Bill's statement of compatibility, the purpose of the amendments is to ensure the MRC can 'establish a clear and complete understanding of the death and prevent similar deaths from occurring in the future'.[31] The MRC would not be bound by the rules of evidence and will have the power to inform themselves in any way they consider appropriate:

> *The purpose of this power is to place the Mining and Resources Coroner in the best position to acquire all facts relating to the cause of the death, which will assist them to make appropriate comments or recommendations.*[32]

The limitation on the right to privacy would be mitigated by the following existing safeguards under the Coroners Act:

[25] Explanatory notes, p 2.
[26] Explanatory notes, p 2; Bill, cl 18, s 82A.
[27] Explanatory notes, p 2.
[28] Statement of compatibility, p 3; Bill, cl 18, s 82A(3).
[29] Coroners Act, ss 39(1) and (2); Explanatory notes, p 3.
[30] Explanatory notes, p 3.
[31] Statement of compatibility, p 2.
[32] Statement of compatibility, p 3.

- a coroner is not empowered to investigate a death if they are informed that someone is charged with an offence in which the question of whether the accused caused the death may be in issue[33]
- the coroner may only require a witness who refuses to give oral evidence at an inquest because the evidence would tend to incriminate them, to give that evidence if satisfied that it is in the public interest for the witness to do so[34]
- incriminating evidence is not admissible against the witness in any other proceeding, other than a proceeding for perjury[35]
- derivative evidence is not admissible against the witness in a criminal proceeding[36]
- a coroner may make an order prohibiting the publication of information relating to, or arising at, an inquest or pre-inquest conference.[37]

Committee comment

The committee considers the provisions relating to incriminating evidence strike an appropriate balance between an individual's right to privacy and promoting the public interest and the right to life.

The purpose of the power, being to ensure that that mining related deaths are appropriately investigated by empowering the MRC is well-positioned to acquire all of the facts relating to a death is a strong justification for the limitation on the right to privacy.

ii. Reporting and publishing requirements

The Bill's reporting and publishing requirements may limit an individual's right to privacy as the information included in the findings may contain personal information and may not have otherwise been reported or published had an inquest not been undertaken.[38]

Individuals likely to be affected by these provisions, in a privacy sense, may include family members, colleagues or associates of the deceased person, or those who provided information or evidence to the investigation or inquest. Conceivably, information about the deceased person or relating to their death, or about or related to another person, may result in the reporting or publishing of an individual's personal information.

The purpose of the amendments are to promote transparency and accountability of recommendations:

> *… particularly for the entities towards which recommendations have been directed. It is in the public interest that systemic issues that may have been identified by the Mining and Resources Coroner are addressed and monitored,*

[33] Coroners Act, s 29.
[34] Coroners Act, s 39(2).
[35] Coroners Act, s 39(3).
[36] Coroners Act, s 39(4), (5).
[37] Coroners Act, s 41(1), (2).
[38] Statement of compatibility, p 2.

> *so that avoidable causes of deaths occurring within mines, coal mines, quarries and petroleum and gas sites can be prevented.*[39]

This is justification for the limitation on the right to privacy, as it promotes the right to life by seeking to avoid future mining related fatalities. The proposed amendments seek to address matters that may be of significant public interest.

There is a clear and rational connection between the limitation on the right to privacy and its purpose, as the proposed amendments would facilitate public access to information about coronial inquests, which is intended to 'ensure entities are held to account to implement recommendations to reduce the likelihood of similar deaths from occurring in the future'.[40]

Further to publication on the State Coroner's website, the connection between the limitation and its purpose is evident in that the findings, and any comments, relating to the investigation of a mining related reportable death would be given to the Attorney-General, and the RSHQ CEO and Minister. This is because the Attorney-General is responsible for Queensland's legal and justice system, and the purpose of RSHQ is to regulate safety and health in the resources sector.[41]

Committee comment

The committee notes the personal and potentially sensitive and/or incriminating nature of disclosed information, and the impact disclosure may have on third parties, including family members, associates and colleagues of the deceased.

However, the committee considers the proposed reporting and publishing provisions strike an appropriate balance between an individual's right to privacy and promoting the public interest and the right to life.

2.1.2. Fundamental legislative principle - privilege against self-incrimination

As noted in relation to human rights in section 2.1.1 above, the Bill would empower the MRC to compel a witness to provide incriminating evidence. The privilege against self-incrimination as set out in the LSA means that a person cannot be compelled to provide documents or answer questions if those documents or answers may incriminate the person. The privilege exists at common law but can be waived or overturned by statute. For example, it may be justifiable to overturn the privilege against self-incrimination in instances where Parliament considers the public interest is elevated over individual interests, for instance, where it is more important to determine the facts of a matter.[42]

[39] Statement of compatibility, p 3.
[40] Statement of compatibility, p 3.
[41] RSHQ Act, s 4.
[42] Pyneboard Proprietary Limited v Trade Practices Commission [1983] HCA 9.

Removing of the privilege may be justifiable if the matters are peculiarly within the knowledge of the person being questioned and the information obtained is not used against the person in a later proceeding. This includes questions answered or documents provided that may tend to directly or indirectly incriminate them (derivative use immunity).[43]

The explanatory notes acknowledge the potential breach of fundamental legislative principles, but state that the purpose of the power is to assist the MRC to establish a cause of death and prevent similar deaths from occurring.[44] Obtaining a fulsome picture of the evidence is likely to put the MRC in a better position to acquire all the facts that relate to a cause of death and assist them in making appropriate comments or recommendations for the future.[45]

Existing safeguards in the Coroners Act would apply to the MRC in relation to the use of self-incriminating evidence.

Committee comment

While the privilege against self-incrimination is deeply ingrained in the common law and is an important component of the legal system, there are circumstances where the privilege can be abrogated. These include, for example, instances where the public interest is elevated over individual interests.

The committee notes that the ability of the MRC to effectively undertake their inquests to determine mining-related causes of death is in the public interest, particularly given the role of the mining industry in Queensland. The committee also notes that the Coroners Act contains safeguards related to incriminating evidence.

The committee considers the Bill provides adequate protection against self-incrimination.

2.1.1. Stakeholder submissions and department advice

2.1.1.1. Duplication of powers and functions

The Mining and Energy Union (MEU) submitted that the Bill would duplicate existing investigation powers and functions, noting that the *Coal Mining Safety and Health Act 1999* (CMSHA) already provides for Boards of Inquiry.[46] It also noted that RSHQ already has various powers with regards to investigations.[47] In the public hearing, MEU stated '[t]o put it bluntly, it is our view that this is just another investigation process on top of three

[43] Office of the Queensland Parliamentary Counsel, *Principles of good legislation: OQPC guide to FLPs*, Self-incrimination, 19 June 2013.
[44] Explanatory notes, p 7; Statement of compatibility, p 2.
[45] Statement of compatibility, p 3.
[46] Submission 4, p 5.
[47] Submission 4, p 5.

investigation processes that already can occur' and that '[i]t will not make our industry any safer and the mechanisms that we think the government should consider are already included in the current legislation'.[48]

The department confirmed that the MRC would have the powers of a coroner pursuant to the Coroners Act to conduct an investigation and an inquest. It noted that the Bill does not provide any new investigative processes that do not already exist within the current coronial framework, and would not make any changes to the investigative processes of statutory bodies responsible for safety in the resources sector.[49]

The department emphasised that the MRC has a different role to RSHQ, and that the investigations of the MRC may be informed by investigations undertaken by a relevant independent regulator such as RSHQ, or by the police.[50] RSHQ would continue to investigate accidental deaths that fall within the scope of the Resources Safety Acts.[51] RSHQ would provide information about its findings to the MRC, and provide information and technical expertise to the MRC, as occurs in the existing coronial process. The MRC would have 'broad powers to obtain information and can make recommendations to improve safety outcomes, including to RSHQ as the resources safety and health regulator'.

In relation to Boards of Inquiry, the department stressed that the Board of Inquiry has similar powers to that of a coroner, but unlike the powers of a coroner, a person can refuse to answer a question if doing so would incriminate them.[52]

Committee comment

The committee acknowledges the concerns expressed by the MEU regarding a perceived duplication of powers and functions by the MRC and regulators such as RSHQ and the operation of Boards of Inquiry.

The committee notes that the Bill would not provide investigative powers or functions to the MRC that do not exist under the current Coroners Act. The powers and functions of the MRC and RSHQ are complementary. The MRC would be able to make recommendations to RSHQ to improve safety outcomes, and RSHQ would be able to assist the MRC in its investigations.

The committee is satisfied that the establishment of the MRC, including the requirement to conduct mandatory inquiries and inquests, will provide a sufficient mechanism to investigate and inquire into mining related deaths.

[48] Public hearing transcript, Brisbane, 28 July 2025, p 10.
[49] Department of Justice, correspondence, 27 June 2025, p 7.
[50] Department of Justice, correspondence, 27 June 2025, p 7.
[51] Refers to the CMSHA, MQSHA, *Explosives Act 1999* and the *Petroleum and Gas (Production and Safety) Act 2004*.
[52] Department of Justice, correspondence, 27 June 2025, p 3.

2.1.1.2. Knowledge and expertise of the Mining and Resources Coroner

In its submission, MEU expressed concern that the government has not clarified the knowledge and expertise the MRC would have to underpin their recommendations across a diverse mining and resources industry including 'coal mining (underground and open cut), mineral mining, quarries, and petroleum and gas'.[53] It noted that the lack of provisions in this regard contrasts to the 'standalone specific Coal Mining Safety and Health legislation in a high-risk sector, which details specialised competences for all those in the sector, including Industry Safety and Health Representatives & Site Safety and Health Representatives'.[54] In the public hearing, MEU stated that 'having some exposure to the industry prior to taking up the position would be beneficial'.[55]

Other stakeholders were supportive of the appointment of a dedicated MRC, viewing the role as conducive to the development of significant expertise. The Association of Mining and Exploration Companies (AMEC) noted the following at the public hearing:

> *When you look quite deeply, the coroner is already addressing significant matters in the resources industry so he is already going to have the predisposition and the experience to look at those matters, as opposed to a separate coroner. If he is already dealing with other matters for coalmining … he is going to have that experience and knowledge around the industry and he is going to have a deeper understanding of what is required to undertake that investigation, as opposed to a separate coroner.*[56]

In response to stakeholder concerns, the department clarified that decisions regarding the appointment of the MRC are a matter for government.[57] The Bill would provide that the MRC is appointed by Governor in Council, and must be first appointed as a magistrate. The department noted that the MRC will have extensive legal experience and can seek assistance from any person they believe can inform the investigation, including technical experts. If this expertise cannot be obtained the Queensland Police Service or other involved investigative agency, the MRC may seek State Coroner approval to obtain an independent expert report.[58] In the public briefing, the department noted that appointing a single individual to the MRC role will enable them to build up knowledge, experience and understanding of the sector.[59]

[53] Submission 4, p 4.
[54] Submission 4, p 4.
[55] Public hearing transcript, Brisbane, 28 July 2025, p 11.
[56] Public hearing transcript, Brisbane, 28 July 2025, p 6.
[57] Department of Justice, correspondence, 17 July 2025, p 6.
[58] Department of Justice, correspondence, 27 June 2025, p 6.
[59] Public briefing transcript, Brisbane, 30 June 2025, p 9.

Committee comment

The committee is satisfied that the Bill provides for appropriate knowledge and expertise for the MRC. The committee notes that the MRC would hold extensive legal experience as a magistrate, and would have the ability to seek expert specialist and technical advice to inform investigations. Further, the committee notes that establishing the role of a dedicated MRC will allow the appointed individual to develop significant industry knowledge and expertise.

2.1.1.3. Appointment and removal of the Mining and Resources Coroner

The current Coroners Act provides for 5-year terms of appointment for the State Coroner and the Deputy State Coroner.[60] Local coroners, appointed under section 82 of the Coroners Act, are not subject to a term of appointment. However, the Coroners Act also provides for the appointment of other coroners under section 83, who would be subject to a 5-year term. The Bill proposes that the MRC would be a local coroner, and therefore not subject to a term of appointment.[61]

In its submission, MEU recommended a 5-year term limit for the MRC, noting that the State Coroner is limited by a 5-year-term.[62] It submitted that, without a mechanism to limit the term of appointment, the legislation effectively gives the MRC an appointment that can only be ended by either resignation or compulsory retirement of a magistrate, currently at 70 years of age.[63] In the public hearing, MEU stated:

> *The main issue we have with that is that you potentially have someone in the same or a similar position who is not subject to the same or similar scrutiny. Changing things out every five years might help with different perspectives on matters. I do not understand why we would introduce this coroner but not ensure they are subjected to the same conditions or term of appointment as other coroners.*[64]

In response, the department clarified that the MRC would be a local coroner (appointed under section 82 of the Coroners Act) and not an appointed coroner (appointed under section 83 of the Coroners Act). The department advised that all other coroners are also local coroners, and there are currently no appointed coroners pursuant to section 83 of the Coroners Act.

The department noted that the Bill, in new section 82A, would provide that the MRC may be appointed by Governor in Council. The Attorney-General must consult with the Chief

[60] Coroners Act, ss 70 and 78.
[61] Bill, s 82A.
[62] Submission 4, p 6.
[63] Submission 4, p 6.
[64] Public hearing transcript, Brisbane, 28 July 2025, p 11.

Magistrate and State Coroner before making a recommendation to the Governor in Council.

The department further advised that, pursuant to sections 82(1) of the Coroners Act, every magistrate is a local coroner. This means the MRC must first be appointed as a magistrate by Governor in Council under the Magistrates Act. A magistrate has tenure of office pursuant to section 42 of the Magistrates Act. The Magistrates Act provides the process for suspending and removing magistrates from office, including the MRC. The department noted that, under the Magistrates Act, Governor in Council may suspend a magistrate from office. A magistrate must also be suspended from office immediately if the magistrate is charged with an indictable offence. To remove a magistrate, the Attorney-General must apply to the Supreme Court for a decision that there are reasonable grounds for believing that proper cause for removal of the magistrate exists. There is proper cause to remove a magistrate from office if the magistrate:

- is incompetent or guilty of serious neglect of the duties of office;
- is mentally or physically incapable of carrying out satisfactorily the duties of office;
- is guilty of proved misbehaviour, misconduct or conduct unbecoming a magistrate;
- fails, without reasonable excuse, to constitute a Magistrates Court at a particular place in accordance with a transfer decision as required by the Chief Magistrate; or
- is convicted of an indictable offence.[65]

In response to a question taken on notice at the public briefing, Queensland Law Society (QLS) stated that it advocates for 5-year terms for the MRC, noting:

> *QLS recommends the Mining and Resources Coroner be appointed on similar terms to State and Deputy State Coroner given it is a specialised position. This will also enable the role to be reviewed to ensure the objectives of the reforms are being met.*[66]

Committee comment

The committee considers the accountability in public appointments to be of paramount importance. The committee gratefully acknowledges stakeholder comments in relation to the appointment and removal of the MRC.

The committee notes that the MRC would be appointed by Governor in Council, and that the Chief Magistrate and State Coroner must be consulted in relation to a potential appointment. The Magistrates Act provides robust mechanisms for the removal of a magistrate, and the MRC, as a magistrate, would be subject to these provisions. The committee is of the opinion that these accountability mechanisms could be considered adequately robust.

[65] Department of Justice, correspondence, 11 July 2025, pp 2-3.
[66] QLS, correspondence, 1 August 2025, p 1.

2.2. Mining related reportable deaths

Clause 5 of the Bill inserts new section 11AAA, which would provide that all mining related reportable deaths must be investigated by the MRC.[67] New section 11AAA(3) would provide that a person's death is a mining related reportable death if:

- it is a reportable death under section 8(3)(b) i.e. the death is violent or otherwise unnatural
- the person dies at any time after receiving a mining related injury, that caused or contributed to the death and without which the person would not have died
- the person receives the mining related injury at a coal mine, a mine, or at a petroleum and gas site
- the person's injury is not intentionally self-inflicted.[68]

The definition only requires that the deceased person receives the mining related injury on a site within scope and does not require that the person dies on the site.[69] New section 11AAA(4) defines a mining related injury as an injury from:

- coal mining operations under the CMSHA, schedule 3
- operations under the *Mining and Quarrying Safety and Health Act 1999* (MQSHA) section 10
- data acquisition activities
- petroleum tenure activities
- water monitoring activities.[70]

The MRC may decide to hold an inquest if a death is not a mining related reportable death but is still a reportable death under the existing provisions of the Coroners Act.

2.2.1. Stakeholder submissions and department advice

2.2.1.1. Suicide deaths

Several stakeholders opposed the exclusion of deaths from suicide as mining related reportable deaths.[71] The MEU submitted that suicide rates in the mining, energy and construction sectors are 80 per cent higher than in the general population, with 190 deaths by suicide reported each year.[72] The MEU further noted that workplace cultures that lead to suicide are not likely to be ones that prioritise health and safety in an inherently dangerous work environment. It suggested that, if not properly investigated, irrespective of the location in which the death occurred, this type of fatality can endanger and cause serious detriment to the lives of other workers.[73]

[67] Or by another coroner if the MRC is not available. Bill, cl 5.
[68] Department of Justice, correspondence, 27 June 2025, p 6.
[69] Department of Justice, correspondence, 27 June 2025, p 6.
[70] Explanatory notes, pp 9-10.
[71] CALS, submission 1; AMEC submission 2, MEU, submission 4.
[72] Submission 4, p 2.
[73] Submission 4, p 3.

The AMEC and the Coronial Assistance Legal Service (CALS) also advocated for mandatory inquiries for suicide deaths.[74] CALS suggested that the exclusion of suicide deaths 'removes the ability to place specialist scrutiny on industry specific and systemic factors that may contribute to deaths by suicide occurring in situ in mining and related operations and within the FIFO community'.[75] It suggested that the exclusion of suicide deaths is not in the public interest because of the higher prevalence of suicide deaths of FIFO and industry workers and in FIFO communities. CALS recommended that any on-site deaths be subject to a mandatory inquest, or failing that, mandatorily reported to and investigated by the MRC.[76] In the public hearing, CALS further stated that it believes excluding suicide is a 'missed opportunity for the specialist knowledge and jurisdiction of the Mining and Resources Coroner to be applied to all deaths that occur on a mining site which might be influenced by the particular conditions of that worksite or of that workforce'. It suggested that 'the committee should adopt the principles that exist in other specialist settings, like deaths in custody and deaths in care, for the specialist setting of the mining and resources industry'.[77]

The QLS also stated that it is supportive of the inclusion of deaths by suicide:

> *We are aware other submitters have objected to deaths by suicide being expressly omitted by the bill. The QLS agrees there is a public interest in bringing these deaths within scope in appropriate circumstances, noting the psychosocial hazards in the workplace are increasingly being exposed and examined. We urge the committee to recommend further consultation be undertaken on these issues.*[78]

The CALS and AMEC also expressed concern in relation to how intentionality will be assessed in cases of suspected suicide.[79]

Responding to stakeholders, the department noted that the proposed exclusion of suicide deaths under section 11AAA(3) applies only to mandatory inquests by the MRC, and does not exclude suicides from being investigated within the broader coronial jurisdiction. Suicide deaths would remain reportable deaths under section 8 of the Coroners Act, and must be investigated under section 11 of the Act. The department advised that the exclusion of deaths from suicide under new section 11AAA(3) 'acknowledges that there may be a range of reasons as to why a person commits suicide, that may not be related to mining operations or an operator's safety and health obligations'.[80]

The department provided practical examples, noting that the MRC may, for example, decide to conduct an inquest 'where a coroner investigates a person's death by suicide in accommodation on a mine site and it becomes apparent during the investigation that the person's death could be attributed to failings by an operator in fulfilling their safety and

[74] Submission 2, p 11.
[75] Submission 1, p 2.
[76] Submission 1, p 4.
[77] Public hearing transcript, Brisbane, 28 July 2025, p 2.
[78] Public hearing transcript, Brisbane, 28 July 2025, p 15.
[79] Submission 1, p 4.
[80] Department of Justice, correspondence, 27 June 2025, p 6.

health obligations'.[81] The department noted that allowing discretion in relation to suicide deaths will enable the MRC to focus on inquests that will 'improve the safety and health obligations of an operator rather than conducting inquests into all suicides'.[82]

In relation to the assessment of intentionality in suspected suicide deaths, the department noted that the State Coroner's Guidelines provide that the standard of proof applicable to a finding of suicide 'can only be arrived at where there is clear evidence'; and that 'in its absence, a finding of accident or an open verdict is the proper outcome'. This assessment would depend on the facts and circumstances arising out of an investigation.[83]

Committee comment

The committee acknowledges stakeholder concerns in relation to suicides and psychosocial hazards in the mining and resources industry. The committee also acknowledges that systemic issues within the industry may contribute to these deaths. The committee notes that suicide deaths are reportable deaths under the existing provisions of the Coroners Act.

2.2.1.2. Mine dust lung diseases

A number of stakeholders advocated for the inclusion of mine dust lung diseases as mining related reportable deaths.[84] The MEU submitted that it is concerned the Bill fails to make it clear if a death from a dust disease acquired from coal mining falls within the definition of a mining related reportable death.[85] The QLS submitted that the MRC should be required to investigate reportable deaths form an illness or disease, such as a dust disease, caused by the work undertaken at a mine site or related in scope work.[86] It submitted that excluding these deaths contradicts the intent of the amendments, and recommended treating such deaths in the same way as if they resulted from a physical incident causing death.[87] In the public hearing, AMEC stated that it would be a 'logical progression' for diseases acquired on a worksite in a mine to be included under the purview of the MRC.[88]

In relation to how these issues could potentially be addressed, QLS stated that 'there may be some additional issues to navigate, such as the passage of time between work activity/exposure and death'. The QLS suggested appropriate parameters and guidance could be developed. It forwarded the example that 'the scope could be limited to cases

[81] Department of Justice, correspondence, 17 July 2025, p 2.
[82] Department of Justice, correspondence, 17 July 2025, p 2.
[83] Department of Justice, correspondence, 17 July 2025, p 2.
[84] Bernard Corden, submission 3; MEU, submission 4; QLS, submission 5.
[85] Submission 2, p 2.
[86] Submission 5, p 1.
[87] Submission 5, p 2-3.
[88] Public hearing transcript, Brisbane, 28 July 2025, p 7.

where there was an accepted "injury" under the *Workers' Compensation and Rehabilitation Act 2003*'.[89]

In response to written submissions made by stakeholders on this issue, the department advised that deaths from mine dust lung diseases are not generally categorised as reportable deaths and are not usually investigated under the current coronial framework. It drew the committee's attention to the State Coroner's Guidelines, noting that they state that such diseases are generally not regarded as unnatural.[90] The department noted that:

> *One reason for this is that the diseases which ultimately develop often involve the complex interplay between multiple environmental and genetic factors. I think those guidelines give us some kind of marker as well in terms of how those particular types of diseases might be treated…*[91]

The department clarified that deaths such as those from mine dust lung diseases can be considered on a case-by-case basis to determine whether they are reportable deaths. If a death is reportable and there is a connection to the resources sector, the MRC can decide to investigate the death, and may conduct an inquest if it is in the public interest. At the public briefing, the department gave an example of a comparable case in which deaths relating to a rheumatic heart disease cluster, the RHD Doomadgee cluster, were the subject of a coronial inquest.[92] These deaths would have otherwise been considered 'natural cause' deaths.[93]

The department noted that work is being undertaken to prevent and manage mine dust lung disease. It noted that RSHQ is 'focusing on prevention and early detection through effective risk management, air monitoring, mandatory health surveillance of workers and ongoing data analysis to understand changes over time and incidences of disease in the worker population'.[94] As of 30 June 2025, RSHQ has received reports of 685 workers diagnosed with mine dust lung disease since 1984. Reports of mine dust lung disease will continue to be received for some time due to the long latency of these diseases. However, with reforms implemented since the reidentification of mine dust lung disease in 2015 to ensure effective exposure controls are in place, the number of reports would be expected to reduce over time.[95]

[89] Submission 5, p 4.
[90] See: *State Coroner's Guidelines 2013*, Chapter 3 (Version 4, amended December 2022), pp 7-8, https://www.coronerscourt.qld.gov.au/__data/assets/pdf_file/0009/807777/osc-state-coroners-guidelines.pdf.
[91] Public briefing transcript, Brisbane, 30 June 2025, p 6.
[92] Public briefing transcript, Brisbane, 30 June 2025, p 7. See: Coroners Court of Queensland, *RHD Doomadgee Cluster*, 30 June 2023, https://www.courts.qld.gov.au/__data/assets/pdf_file/0006/770109/cif-booth-sandy-george-20230630.pdf.
[93] Coroners Court of Queensland, *RHD Doomadgee Cluster*, 30 June 2023, p 4.
[94] Department of Justice, correspondence, 17 July 2025, p 5.
[95] Department of Justice, correspondence, 17 July 2025, p 5.

Committee comment

Mine dust lung disease is a significant public health issue in Queensland, and the committee notes the work currently being done by RSHQ to detect, manage and prevent mine dust lung disease.

2.2.1.3. Travel to and from sites

In their submissions, QLS and MEU advocated for the inclusion of deaths occurring during travel to and from sites as mining related reportable deaths.[96] In the public briefing, AMEC confirmed that it also believes travel to and from sites should be included.[97] The QLS argued that including deaths occurring during travel will require the MRC to investigate deaths related to fatigue, which is a significant issue in the resources sector.[98] It noted that it 'cannot identify any particular barrier to bringing these deaths within the scope of these reforms' and does not consider there will be a material impact on resources, as such deaths may ultimately lead to the referral to the MRC. It argued that 'amending the Bill to expressly include these deaths will alleviate concerns in a particular matter about whether there should be a referral and could prevent delays and confusion for affected families'.[99]

In advocating for the inclusion of deaths occurring during travel, MEU also drew attention to fatigue, suggesting that a death due to fatigue reflects a 'potential failing by an operator in fulfilling their safety and health obligations', and are in the public interest to be investigated, and should not be placed at the coroner's discretion.[100] The MEU specifically noted that travel from mine sites often occurred on roads that are 'poorly maintained, overused, and not built for the heavy traffic they now carry', and that this combines with 'shift work, long hours, early starts and late finishes' to increase the risk of accidents for mine workers.[101]

The department advised that deaths that occur while a person is on their way to or from a site would not be included as in the scope for a mandatory inquest for the MRC. However, under the existing provisions of the Coroners Act, a coroner would still be obliged to investigate accidental deaths if they are considered reportable deaths. The department noted that there may be a range of reasons that deaths occurring travelling to and from a site may be unrelated to the safety obligations of a mining operator. If the MRC finds that the death is related to the safety obligations of a mining operator, the MRC may conduct an inquest, if it is in the public interest.[102]

[96] Submission 4; Submission 5.
[97] Public hearing transcript, Brisbane, 28 July 2025, p 6.
[98] Submission 5, p 2.
[99] Submission 5, p 2.
[100] Submission 4, p 2.
[101] Submission 4, p 3.
[102] Department of Justice, correspondence, 17 July 2025, p 5.

Committee comment

The committee recognises that fatigue related deaths are a significant systemic concern in the mining and resources industry. Long shifts, the nature of fly-in-fly-out work and drive-in-drive-out work, and road conditions in remote locations can all exacerbate fatigue related risks within the sector.

Recommendation 2

The committee recommends the Department of Justice consider publishing information clarifying how suicide deaths, mine dust lung disease related deaths, and deaths occurring during travel to and from a mining and resources site, would be investigated within the coronial framework and how these investigations intersect with existing regulatory powers.

2.2.1.4. *Health care*

The explanatory notes state that Clause 5 of the Bill would amend the Coroners Act to provide that a person's death will be a mining related reportable death if the death was a reportable death under section 8(3)(b) of the Coroners Act.[103] Under section 8(3)(d) of the current Coroners Act, a death is a reportable death if it was health care related.

At the public hearing, committee members inquired as to whether deaths under section 8(3)(d) should be included as reportable deaths under new section 11AAA(3). This would cover 'health care that should have been provided or reasonably provided but was not provided at the time, or that there was a failure to provide proper health care and a death occurred onsite'.[104]

In response to a question from the committee, QLS stated:

> *… that the functions and role of the Mining and Resources Coroner should be expanded, and certainly a corollary of that would be that health related deaths should not be excluded. I think that is a logical next step.*[105]

However, QLS also noted that '…the current wording of the proposed provisions is wide enough to effectively capture myriad circumstances'.[106] In the public hearing, MEU stated that it agrees that health care related deaths should be considered a reportable death if the death occurs on site.[107]

[103] Explanatory notes, p 4.
[104] Public hearing transcript, Brisbane, 28 July 2025, p 17.
[105] Public hearing transcript, Brisbane, 28 July 2025, p 17.
[106] Public hearing transcript, Brisbane, 28 July 2025, p 17.
[107] Public hearing transcript, Brisbane, 28 July 2025, p 13.

Committee comment

The committee is satisfied that the current provisions of the Coroners Act adequately capture health care related deaths.

2.3. Definition of coal mine, mine, quarry, and petroleum and gas site

New section 11AAA(5) includes definitions for area, coal mine, data acquisition activities, data acquisition authority, mine, petroleum and gas site, petroleum tenure, petroleum tenure activity, water monitoring activity and water monitoring authority that would be applied for the purposes of new section 11AAA.[108] Definitions correlate to various resources safety and health legislation. Key definitions are summarised below:[109]

- **Coal mine:** defined within the meaning of the CMSHA section 9. Includes on-site activities that are carried out unlawfully because the land is not the subject of a mining tenure. Includes a mining railway under the Rail Safety National Law (Queensland) that would otherwise be excluded under the CMSHA. Excludes places mentioned in section 9(1)(e) of the CMSHA which relate to tourism, education, or research and includes buildings for administration, accommodation and associated facilities on the coal mine site or on land adjoining or adjacent to the coal mine site.
- **Mine:** defined within the meaning of the MQSHA, section 9. Includes operations that are carried out unlawfully because the land is not the subject of a mining tenure. Also includes a mine under the *Work Health and Safety Act 2011*, and a mining railway under the Rail Safety National Law (Queensland). Also excludes places which relate to tourism, education, or research, and includes buildings for administration, accommodation and associated facilities on or adjoining the mine site.
- **Quarry:** falls within the definition of a mine under the MQSHA and is defined as a place on land where operations are carried on, to produce construction or road building material. Does not work as part of or use at a construction site, to extract gravel or river-sand, to redevelop the place as a place for housing, a shopping complex, an industrial estate, a recreation area or a landfill site.
- **Petroleum and gas sites:** defined to mean the area of a data acquisition authority, petroleum tenure or water monitoring authority:
    - A **data acquisition authority** enables the holder to conduct geophysical surveys on land contiguous to the tenure area and enter land to carry out these surveys, even if it is outside the original tenure boundary.

[108] Explanatory notes, pp 9-10.
[109] Department of Justice, correspondence, 27 June 2025, p 2.

- A **petroleum tenure** can include an authority to prospect or petroleum lease and allows the holder to carry out authorised activities and incidental activities within the area of the tenure, including pipeline construction and operation.
- A **water monitoring authority** supports the tenure holder's responsibilities for managing the impacts of petroleum operations on underground water systems and allows monitoring activities on stated land outside the tenure area and land that may be within another petroleum authority's area.
- A petroleum and gas site may be a place where data acquisition activities, petroleum tenure activities or water monitoring activities are carried out if these activities are unlawful because land on which they are being undertaken is not within the authority area, and also includes buildings for administration, accommodation and associated facilities in the area of, or on land adjoining or adjacent to a data acquisition authority, petroleum tenure or water monitoring authority. [110]

- **Area:** For the purpose of a data acquisition authority, petroleum tenure or water monitoring authority, the term area adopts the meaning given in the *Petroleum and Gas (Production and Safety) Act 2004*, schedule 2.[111]

2.3.1. Stakeholder submissions and department advice

The AMEC provided technical feedback, taking issue with several definitions contained within the Bill, expressing concern that these definitions limit or inadequately define the scope of the proposed legislation.[112] In response to these concerns, the department provided some clarification regarding definitions, and noted that:

> *[i]f a reportable death occurs that falls outside of a mining related reportable death, the death will still be subject to a coronial investigation and an inquest will be held if it is in the public interest.*[113]

The AMEC's submission, and the department's response, are briefly summarised below.

Definition of area

The AMEC submitted that the Bill's definition of 'area' is 'deficient, potentially leading to ambiguity and misinterpretation in the application of the law'.[114] It recommended that the definition be revised to 'consider all tenement types relevant to all mining activities in QLD'.[115]

The department responded by clarifying that the MRC's scope is grounded in the Resources Safety Acts, given these Acts regulate safety and health in the resources

[110] Explanatory notes, p 5.
[111] Explanatory notes, p 10.
[112] Submission 2.
[113] Department of Justice, correspondence, 17 July 2025, p 3.
[114] Submission 2, p 1.
[115] Submission 2, p 1.

sector.[116] The CMSHA provides a definition of mining tenure to include an exploration permit, mineral development licence, or mining lease granted under the *Mineral Resources Act 1989* (MRA). MQSHA provides that 'mining tenure', for land, means a prospecting permit, exploration permit, mineral development licence, mining lease or mining claim for the land under the MRA. The Bill also provides the definition of a petroleum and gas site to include several tenure types.[117]

Definition of 'activities'

The AMEC submitted that the definition of 'activities' was deficient, noting that 'it may not adequately cover exploration activities or environmental rehabilitation efforts'. It recommended revising the definition of 'activities' to consider 'all tenement types relevant to all mining activities in Queensland'.[118] In the hearing, AMEC elaborated:

> *If we were to drill down specifically to exploration, exploration can occur on the high wall and anywhere from the high wall back to the edge of the tenure. We do not want to see an exclusion of activities where people are arriving at the resources site, they are performing works for the purposes of winning that resource and then there are potentially unforeseen circumstances that result in death. We definitely do not want to see that delineation with activities because exploration is the key part of any resource activity in Queensland.*[119]

In response, the department noted that, under the CMSHA, a coal mine includes a place that was a coal mine or part of a coal mine while on-site activities were carried on and there is an authorisation to enter the land under section 344D of the MRA is in force. Section 344D authorises carrying out rehabilitation activities on the final rehabilitation site.[120] Under the MQSHA section 9(1)(g), a mine is a place that was a mine while operations were carried on and there is an authorisation to enter the land under section 344D of the MRA. Section 344D authorises carrying out rehabilitation activities on the final rehabilitation site.[121]

Definition of 'mine'

In relation to the definition of 'mine', AMEC suggested that 'the exclusion of the definition of a mine under the *Mineral Resources Act 1989* means that the mine activities that operate specifically under that section of legislation are also potentially excluded, and this should be reviewed'.[122] In the hearing, AMEC reiterated that it would like to see the inclusion of area activities in a mine under the MRA included in the Bill:

> *We just want to explicitly not exclude the definitions for winning of mineral from a place where it occurs. That is the definition under section 6A(1) of the Mineral Resources Act. The activity itself within the area still has to be an activity that is for the winning for the resource. If there is another activity that is occurring—*

[116] Department of Justice, correspondence, 17 July 2025, pp 2-3.
[117] Department of Justice, correspondence, 17 July 2025, pp 2-3.
[118] Submission 2, p 1.
[119] Public hearing transcript, Brisbane, 28 July 2025, p 7.
[120] Department of Justice, correspondence, 17 July 2025, p 3.
[121] Department of Justice, correspondence, 17 July 2025, p 3.
[122] Submission 2, p 1.

> *for example, I think earlier they were talking about agricultural activities that may be occurring—and a death may occur but it is not related to the resource activity, we understand that there can be that delineation, but if the activity is for that purpose—so exploration and/or other that we would normally see—we really want to make sure that is included.*[123]

In response to a question taken on notice at the public hearing, AMEC clarified that specifying section 10 of the MQSHA in proposed new section 11AAA(4)(b) of the Bill is significant as:

> *… it specifically refers to Operations and also sets out what is **not** included such as "transport to and from a mine on public roads or public railways or within a pipeline" among a long list of other mining related areas that should be considered.*[124]

In response to the concerns expressed by AMEC, the department provided clarification in relation to the definitions used in relation to coal mine, mine or coal mining operations, noting that these definitions are sourced from the CMSHA and MQSHA.[125] The department also stated that 'if a reportable death was caused by a resource related activity that does not fall within the definition of a mining related reportable death, the death will still be subject to a coronial investigation and an inquest will be held if it is in the public interest'.[126]

At the public hearing, QLS also commented on the scope of definitions contained within the Bill, noting in relation to the definition under section 9 of the CMSHA:

> *It is a very broad definition. Obviously, the definition specifically stipulates what a coalmine is but subsection (2) further clarifies the definition and extends to things like accommodation, such as camps, administration buildings and associated facilities, which could capture car parks and the like. It is a very wide definition. I do not think it is aimed at being overly exclusionary. The definition of a mine site itself under the legislation is very broad and is designed to capture those ancillary types of locations where coalmine workers would specifically or commonly be.*[127]

Committee comment

The committee notes the concerns expressed by the stakeholders. The committee is of the opinion that the definition of a mining related injury and mine area as provided by the Bill is sufficiently broad and provides sufficient scope for the MRC. The committee also notes that a death resulting from a mining related activity not covered under the definitions provided in the Bill would still be subject to a coronial investigation or inquest if found to be in the public interest.

[123] Public hearing transcript, Brisbane, 28 July 2025, p 9.
[124] AMEC, correspondence, 30 July 2025.
[125] Department of Justice, correspondence, 17 July 2025, pp 3-4.
[126] Department of Justice, correspondence, 17 July 2025, p 3.
[127] Public hearing transcript, Brisbane, 28 July 2025, p 18.

2.4. Timeframes for investigations and inquests

The explanatory notes state that one of the key objectives of the Bill is to 'provide more timely answers and certainty to families that mining related deaths will be investigated and an inquiry conducted to determine the cause of the death'.[128] The Bill does not change the current framework, however, to ensure the timeliness of an inquest into a mining-related death following any proceedings, the Bill clarifies that a coroner may hold a pre-inquest conference while criminal proceedings are underway. A pre-inquest conference provides the opportunity to identify parties to an inquest, issues to be investigated, witnesses to be called and hearing dates for an inquest.[129]

2.4.1. Stakeholder submissions and department advice

The MEU recommended that timelines are implemented to ensure that all reports from the company, RSHQ and MRC detailing the nature and cause of death are made public within a certain time frame (e.g. 12 months), to prevent delays and provide timely findings to the family.[130] In the public hearing, MEU noted that:

> *…where there is a potential prosecution, the inquest will not be held and the information will not be released and we will see some delays. We are not opposed to an extra resource for something like this, but how that resource is executed will be caught up in the current process.*[131]

In response, the department advised that mining related deaths are complex in nature, and the timeframes of investigations will vary on a case-by-case basis. It noted that, by establishing the position of MRC, mining related coronial matters will be dealt with in a timely manner, as they will be managed and investigated by a dedicated person rather than being including in the general coronial list.

The department noted that an inquest will be able to commence once any related prosecutions have been finalised. However, it may take several years to finalise criminal proceedings. Ensuring an inquest does not commence until after prosecutions have been finalised safeguards the integrity of the prosecution process and minimises the risk of jeopardising a successful outcome.[132] The department advised that preliminary work may occur to expedite consideration of the matter, including holding a pre-inquest conference to determine the issues to be investigated at the inquest. If charges are not laid, the MRC will be able to commence an inquest as soon as possible after an investigation has been finalised.[133]

[128] Explanatory notes, p 1.
[129] Department of Justice, correspondence, 27 June 2025, p 5.
[130] Submission 4, pp 5-6.
[131] Public hearing transcript, Brisbane, 28 July 2025, p 10.
[132] Department of Justice, correspondence, 17 July 2025, p 5.
[133] Department of Justice, correspondence, 17 July 2025, p 6.

2.5. Support for families

The Bill would provide for funding for a family liaison and engagement role to engage with families of the deceased during the coronial investigation and inquest process within the Coroners Court of Queensland (CCQ). According to the department, this will ensure that families and agencies are provided with a direct point of contact for information about the coronial investigation.[134] It is intended that this position may also be used to benefit families in non-mining related coronial investigations.

CCQ will work closely with specialist investigation liaison support officers (within the Office of Industrial Relations) who provide support to family members of a person who dies from a workplace fatality from the time that RSHQ commences its investigation, to ensure continuity of support.[135]

2.5.1. Stakeholder submissions and department advice

A number of stakeholders have raised issues in relation to family. MEU was concerned that no victims' families have been consulted in the process of developing this legislation and strongly recommended that next of kin be able to request a coroner not hold the inquest.[136] In contrast, CALS suggested that it is important that the requirement to hold a mandatory inquest should not be dismissed for reasons relating to family trauma. It notes that this may be at odds with the objective of the Bill, being to improve safety and hold mining companies accountable.[137]

In response to MEU, the department noted that a key purpose of the Bill is to 'provide certainty to families that their loved one's death will be investigated, and to conduct an inquiry to determine the cause of the death'.[138] It reiterated that there is no ability for families to request there not be an inquest, and that there may be situations where a family do not want the inquest to proceed, but the MRC wishes to make findings or recommendations that will improve the safety on these sites and prevent deaths from occurring in the future. The department advised that, if engaging in the process is too difficult or re-traumatising for the family of the deceased, one option may be for family members not to participate in the inquest.[139]

[134] Public hearing transcript, Brisbane, 30 June 2025, p 4.
[135] Department of Justice, correspondence, 27 June 2025, p 8.
[136] Submission 4, p. 7.
[137] Submission 1, p 4.
[138] Department of Justice, correspondence, 17 July 2025, p 8.
[139] Department of Justice, correspondence, 17 July 2025, p 8.

Appendix A – Submitters

Sub No.	*Name / Organisation*
1	Coronial Assistance Legal Service
2	Association of Mining and Exploration Companies
3	Bernard Corden
4	Mining and Energy Union Queensland District
5	Queensland Law Society

Appendix B – Public Briefing, 30 June 2025

Department of Justice

Gregory Bourke	Executive Director
Tara Linnan	Acting Director
Jessica Thiel	Acting Senior Legal Officer

Resources Safety & Health Queensland

Michelle Anderson	Director
Renee Te Kani	Principal Policy Officer
Kerrie Musgrave	Principal Policy Officer

Appendix C – Witnesses at Public Hearing, 28 July 2025

Queensland Coronial Assistance Legal Service

Klaire Coles	Legal Practice Director, Caxton Legal Centre

Association of Mining and Exploration Companies

Kate Dickson	Head of National Operations & Queensland Director
Amy Warden	Queensland Policy Manager

Mining and Energy Union – Queensland District

Mitch Hughes	District President
Jason Hill	Industry Safety and Health Representative
Blair Kidd	Industry Safety and Health Representative
Craig Smith	Industry Safety and Health Representative

Queensland Law Society

Kate Brodnik	Principal Policy Solicitor, Queensland Law Society
Adam Moschella	Member of Queensland Law Society Criminal Law Committee
Rohan Tate	Member of Queensland Law Society Industrial Law Committee

Statement of Reservation

STATEMENT OF RESERVATION
CORONERS (MINING AND RESOURCES CORONER) AMENDMENT BILL 2025

The Queensland Labor Opposition believes that everyone has the right to come home safe from work.

Labor has consistently championed the health and safety of workers by prioritising their well-being through robust legislative reforms. Reforms which enhance the rights of Health and Safety Representatives, extend industrial manslaughter laws, and prevent workplace harassment.

In addition, Labor introduced Australia's first paid reproductive health leave for public sector workers and implemented the respect at work laws to improve workplace safety and culture.

In contrast to the LNP's history of undermining worker protections, Labor's consistent advocacy in partnership with unions has solidified Queensland's position as a leader in workplace safety, ensuring workers are protected, empowered, and valued.

This commitment requires continued updates and improvements to safety measures and the systems that enforce them.

The hardworking men and women who dedicate their lives to Queensland's mining and resources sector deserve that same safety, and given the considerable risks involved with some positions in the mining sector, the Labor Opposition is committed to evaluating and improving safety standards.

It is for this reason that the Queensland Labor Opposition won't stand in the way of the majority of amendments proposed under the *Coroners (Mining and Resources Coroner) Amendment Bill 2025.*

However, it is vital to also note the concerns of not only the Queensland Labor Opposition but also key stakeholders in regard to aspects of the Bill.

The Queensland Labor Opposition holds significant reservations regarding Clause 5 (d), and the decision of the Crisafulli LNP Government to remove intentionally self-inflicted injuries from the scope of the Mining and Resources Coroner's responsibilities.

We find this specific omission concerning due to the nature of traditional 'fly-in, fly-out' (FIFO) mining work which requires many employees to board in company-owned accommodation for the duration of their time on site. These circumstances can be significantly isolating and recognise that mining sector FIFO or 'drive-in, drive-out' workers have disproportionately higher suicide rates than other forms of work.

This sentiment is echoed in four of the five submissions made to the committee, including by the Mining and Energy Union, who stated:

> *"Suicide rates are 80% higher in the mining, construction and energy sectors than in the general Australian population… [excluding suicide] is a failing of obligations to protect the health and safety of workers under Queensland's resources safety and health legislation. If not properly investigated, irrespective of the location in which the death occurred, this type of fatality can endanger and cause serious detriment to the lives of other workers."*[1]

This is also recognised by the Coronial Assistance Legal Service, who state in their submission:

> *"Suicides in mining are a contemporary societal and industrial issue that should be proactively addressed by the Act. Mining is recognised as a locational, institutional, and occupational setting with an elevated suicide risk… This leads to our starting point that the MRC is a specialist, industry-specific position, and the full extent of its novelty, innovation and expertise should be utilised."*[2]

The introduction of a specialised mining coroner to address mining related deaths would be remiss if the coroner was not also responsible for considering the psychosocial impacts of mining related work. Investigations into suicides may assist in strengthening the sector's culture and the types of supports that are provided to its workers.

Further to this, Clause 5 of the Bill does not include scope for fatalities on public roads when the person killed is driving to and from mining sites for work related activities. The Labor Queensland Opposition is concerned the exclusion of work-related road fatalities is in direct contradiction to public interest and would provide more timely answers to the families of those affected.

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[1] https://documents.parliament.qld.gov.au/com/PIRC-1135/CMRCAB2025-2F7A/submissions/00000004.pdf page 3
[2] https://documents.parliament.qld.gov.au/com/PIRC-1135/CMRCAB2025-2F7A/submissions/00000001.pdf page 4

This is acknowledged by the Queensland Law Society who state in their submission:

> *"Fatigue related injuries and risk management remains a significant issue for the resources sector. While measures have been developed over time to address these risks, enforcement and review need to be a priority."*[3]

The MEU holds similar sentiments, stating:

> *"In the mining industry, where shift work, long hours, early starts and late finishes are common, coal mine workers are especially vulnerable to fatigue. Coupled with aging infrastructure and inadequate maintenance, which has led to worsening road conditions…this has increased the risk of accidents, particularly for tired or distracted drivers."*[4]

The proposed amendments of the Bill pose a contradiction to the intent of the reforms due to illness or disease caused by mining and other work-related activity not resulting in mandatory referral to the Mining and Resources Coroner.

The amendments should not overlook deaths occurring from an illness or disease caused by the work undertaken at a mine site. An example of this would be dust lung diseases. The Queensland Law Society makes note of this in their submission, stating:

> *""Injury" is not defined in the Coroners Act, nor is it defined in the Coal Mining Safety and Health Act 1999 (Qld) (CMSHA); however, "injury or illness" is used throughout the CMSHA in sections dealing with risks and risk management. From a health and safety and risk management perspective, injuries and illnesses are treated the same, and this extends to liability. If there is a possible causal link between the death and the 'in scope' work activity, the death should be treated in the same way as if it resulted from a physical incident causing death and be referred to the MRC."*[5]

The disregard for these vital considerations has raised concerns on the development of the proposed amendments. The consensus position from the majority of stakeholders and the Queensland Labor Opposition is that, if the government is going to introduce a dedicated Mining and Resources Coroner on the basis that they will develop expertise in the mining industry, why would the government explicitly exclude suicide, traffic fatalities traveling to and from a mine, or death caused by an illness or disease caused by working at a mine?

It is the overwhelming view of the Queensland Labor Opposition and submitters to the committee that the Mining and Resources Coroner must be all encompassing of mining related deaths.

Finally, the Queensland Labor Opposition notes that there is not a mechanism in place to limit a term of appointment. This differs from that of the State Coroner, which is limited to a 5-year terms, that can be extended.

When questioned the Queensland Law Society expressed the view that the appointment terms of the Mining Coroner should be consistent with other Coroners.

The Labor Queensland Opposition supports this view, and we hold concerns that there is no way of removing the Mining and Resources Coroner under the proposed amendments, indicating that the Mining and Resources Coroner would have to resign or reach compulsory retirement of a magistrate, which is currently at 70 years of age.

We believe this is an oversight and should be adjusted to align with the initial Coroner's Act.

JAMES MARTIN MP
MEMBER FOR STRETTON
DPEUTY CHAIR OF THE COMMITTEE

TOM SMITH MP
MEMBER FOR BUNDABERG

[3] https://documents.parliament.qld.gov.au/com/PIRC-1135/CMRCAB2025-2F7A/submissions/00000005.pdf page 3
[4] https://documents.parliament.qld.gov.au/com/PIRC-1135/CMRCAB2025-2F7A/submissions/00000004.pdf page 4
[5] https://documents.parliament.qld.gov.au/com/PIRC-1135/CMRCAB2025-2F7A/submissions/00000005.pdf page 3