Submission No 54

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: CFMEU Mining & Energy Union Division, NSW Branch

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Inquiry into the Coronial Jurisdiction in New South Wales

Submission to the NSW Legislative Select Committee on the Coronial Jurisdiction in New South Wales

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Submitted by: Grahame Kelly, General Secretary of the Mining & Energy Union
(A Division of the CFMMEU)

Executive Summary

Coal mining is an inherently dangerous industry. In open cut mining hazards include vehicles the size of three-story buildings interacting with light vehicles near vertical drops, geological instability meaning the ground can literally shift beneath workers in the dark of night and handling of massive amounts of explosives. Underground mining is unlike any other workplace, with workers doing their jobs kilometres underground facing the risk of gas outburst, spontaneous combustion and rockfall.

The reality of the mining industry that most of the safety improvements that have been gained over the last century have stemmed from inquiries and investigations into tragic accidents where workers have lost their lives or been seriously injured.

That's why the Mining and Energy Union is highly invested in making sure NSW has a well-resourced coronial process. Our recommendations are focused on removing obstacles to the thorough and independent investigation of every fatality in the NSW coal industry, so that families have the full information about what went wrong and so that every possible lesson can be learned and applied in order to prevent further death and injury. We thank the Committee for the opportunity to contribute to this Inquiry.

Recommendations

1. **A stand-alone Administration responsible for all aspects of Coronial Inquests and Inquiries, independent of the Local Court Administration, to ensure that all inquests and inquiries are dealt with in a consistent way and don't have to compete with other criminal and civil matters for time and resources.**

2. **Amend the Coroners Act 2009 to give organisations representing members at a coal mine where a fatality occurs the right to appear at the inquest, due to the impact of the fatality and any recommendations stemming from the inquest on the broader workforce.**

3. **Amend the Coroners Act 2009 to prevent the inconsistent treatment of evidence where a witness seeks to avoid self-incrimination. A Coronial Inquiry must be possessed of all the relevant facts and information to ensure all lessons from a workplace fatality are learnt.**

4. **Recommendations arising out of Inquests and Inquiries relating to reducing safety risks should be dealt with promptly and transparently, with relevant authorities required to respond promptly and all parties to the Inquest along with industry stakeholders able to view progress against recommendations by way of a register.**

Who is the Mining and Energy Union?

The Mining and Energy Union is a Division of the Construction Forestry Maritime Mining and Energy Union. The Mining and Energy Union is the principal union representing workers in the Black Coal Mining Industry in Australia including NSW. The Union dates back to its first Federal registration in 1915 as the Australian Coal & Shale Employees Federation.

In New South Wales the Mining and Energy Union represents more than 11,000 employees in the Black Coal Mining industry through the Northern Mining and New South Wales Energy District and the South West District.

The Mining and Energy Union is passionate about the health and welfare of its members and indeed the entire workforce in the Black Coal Mining industry. Mining is regarded as amongst the most dangerous occupations and in terms of fatalities is regularly in the top five occupations in Australia where fatalities are likely to occur.

The Mining and Energy Union has demonstrated its commitment to workplace safety through its representation of its members, advocacy on the issue and as a stake holder in Coal Services Pty Limited, the primary provider of health and safety services and oversight in the Black Coal Mining industry in New South Wales as well as control of NSW Mines rescue.

A standalone, well-resourced coronial process

Sadly, the Mining and Energy Union has had a lot of experience with the coronial process over time as a result of deaths, fire and explosions in Coal Mines where members are employed. Indeed, one of the legal representatives of the Union has been involved in over 75 Inquests over the last 30 years. Even though the investigation into any fatality is carried out by the NSW Resource Regulator we see it as important that a body, not directly engaged in the management, supervision and regulation of the industry has an opportunity to review the investigation and where necessary hold an inquiry. We see this as the role of the Coroner's Court.

Our experience is that from the date of a fatality to the finalisation of the Coronial process there is generally a gap of not less than 12 months and often longer. Whilst some of that time would be taken up with the initial investigation by the Resource Regulator there is, in our observation, a delay in obtaining an inquiry date. We note in various submissions before the Committee that examples of delays of up to five years have been cited. To the extent that such delays are contributed to by lack of financial, human and physical resources we support the Committee's recommendation that additional resources be allocated by the Government to ensure a timely and efficient finalisation of the process without compromising the depth of inquiry and the outcome.

The current process is embedded within the Local Court Administration and by their appointment all Magistrates are Coroners. Whilst it is acknowledged that within that organisation there is a State Coroner and Deputy State Coroners, not all Inquests are dealt with by the "*State or Deputy State Coroners*". Many inquests are held in the Local Court closest to where the event occurred. Without in any way demeaning the work of hard-working magistrates this can lead to inconsistencies and time

pressures arising from the *"day to day"* work performed by magistrates in the busiest courts in NSW. In turn it is conceivable that there might be subconscious pressure brought to bear on parties to agree to dispense with an inquest or hold a truncated hearing.

Given the paramount importance of an inquest into a death or an inquiry into a fire or explosion, consideration ought to be given to a stand-alone Administration responsible for all aspects of Coronial Inquests and Inquiries. The effect would be to ensure that all inquests and inquiries were dealt with in a consistent way and not have to be balanced between other criminal and civil matters that make up the bulk of the work in the Local Court. Of course, to work, the Administration would need to be appropriately resourced and funded.

RECOMMENDATION 1:

A stand-alone Administration responsible for all aspects of Coronial Inquests and Inquiries, independent of the Local Court Administration, to ensure that all inquests and inquiries are dealt with in a consistent way and don't have to compete with other criminal and civil matters for time and resources.

Right of Appearance

Section 57 (1) of the Coroners Act 2009 provides that the Coroner may grant leave to appear at an inquest to "*any person, who in the opinion of the coroner has a sufficient interest in the subject matter of the proceedings".* Our submission is that the Committee should consider a recommendation to amend the legislation to enshrine the right of an organisation who had members working at the Coal Mine where the fatality, fire or explosion occurred to appear at an inquest or inquiry.

Whilst it might be argued that section 57(1) provides for such an appearance, it falls short of guaranteeing a right of appearance. The deceased may well have been a member of the Mining and Energy Union but not necessarily and the organisation would almost certainly have anywhere from a modest number of members to a large number of members at the site whose health and safety may have been affected by the event and whose future health and safety may be affected by the outcome of the inquest.

Section 57 could, for example, be simply amended to add a subsection along the following lines:

A Coroner holding an inquest or inquiry concerning a death, suspected death, fire or explosion at or in a Coal Mine must grant leave under section (1) to an Organisation whose members are employed by or at the mine in which the fatality, accident, fire or explosion occurred.

RECOMMENDATION 2:

Amend the Coroners Act 2009 to give organisations representing members at a coal mine where a fatality occurs the right to appear at the inquest, due to the impact of the fatality and any recommendations stemming from the inquest on the broader workforce.

Objections to giving evidence – Protection against self-incrimination

It is important for witnesses to fatalities or fire and explosion Inquiries to give full and frank evidence so that the inquiry is possessed of all of the relevant facts and information, not only with the view to providing the families with a comprehensive explanation as to what happened to their loved one but also to prevent similar events occurring in the future.

Section 61(1) of the Coroners Act 2009 provides that a witness may object to giving evidence on the grounds that the evidence may tend to prove that the witness has committed an offence or is liable to a civil penalty. In turn the Coroner has the power to compel the witness to give evidence where the Coroner considers it is in *"the interest of Justice",* section 61(4)(b). The certificate given by the coroner means that the evidence given cannot be used against the witness in criminal and civil proceedings.

In our experience, the way objections to giving evidence are dealt with is inconsistent. For example, some coroners will excuse the witness from giving evidence, others will provide a *"global"* certificate covering all of the witness's evidence and others will deal with the issue on a question by question basis. Whichever way the issue is dealt with it can be distressing for the loved ones who are observing the proceedings and potentially an impediment to the coroner getting to the truth of what happened. It also creates uncertainty in the minds of witnesses who are waiting to give evidence as they do not know what process will be applied to them.

It is submitted that the prime objective is to ascertain the truth of what happened. The question of whether a witness will be compelled to give evidence or not should not be on a case by case basis, rather, the Act should prescribe a procedure that ensures that all of the relevant evidence is before the Inquiry.

Sections 155 and 171-181 of the Work Health and Safety Act 2011 already provide a mechanism to allow an Inspector from a Regulator to compel a person to produce documents and to provide written or oral evidence to the Inspector.

Section 172(1) of the same Act provides that "*A person is not excused from answering a question or providing information or a document under this part on the ground that the answer to the question, or the information or document, may tend to incriminate the person or expose the person to a penalty".* Sub-section (2) further provides that *"However, the answer to a question or information or a document provided by an individual is not admissible as evidence against that individual in civil or criminal proceedings other than proceedings arising out of the false or misleading nature of the answer, information or document".*

It seems inconsistent that an inspector can require a witness to provide information and then that information may or may not be able to be tested in an Inquest. Our submission is that wording similar to that contained in the Work Health and Safety legislation be adopted and made mandatory, rather than discretionary.

RECOMMENDATION 3:

Amend the Coroners Act 2009 to prevent the inconsistent treatment of evidence where a witness seeks to avoid self-incrimination. A Coronial Inquiry must be possessed of all the relevant facts and information to ensure all lessons from a workplace fatality are learnt.

Recommendations arising out of Inquests and Inquiries

It is often the case that at the conclusion of an Inquest or Inquiry the Coroner will make recommendations to the relevant authorities to reduce the risk of similar events occurring in the future. That is a valuable exercise in the interest of safety. Those represented in the Inquest or Inquiry are able to bring evidence and make submissions in relation to proposed recommendations. It is essential that the relevant authorities acknowledge, consider and respond to those recommendations in a timely manner.

The Mining and Energy Union supports the proposition that the relevant authorities respond within three months to any recommendation made by a Coroner either explaining why the recommendation has not been implemented or implemented in full or confirming that the recommendation has been acted upon. All parties to the Inquest and the relevant industry should be able to access the response by way of a register.

RECOMMENDATION 4:

Recommendations arising out of Inquests and Inquiries relating to reducing safety risks should be dealt with promptly and transparently, with relevant authorities required to respond promptly and all parties to the Inquest along with industry stakeholders able to view progress against recommendations by way of a register.