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To Rachel and her children and Jason's extended family and friends my sincere condolences for their loss. I thank Rachel for her involvement and assistance throughout the Inquest and hope that the process has helped her in some way.

I close the Inquest.

A M Hennessy

Coroner

10 September 2009

Coronial Recommendation 1

That the Department resolve the outstanding issue of notification to next-of kin with Queensland Police Service as a matter of priority.

I further recommend that coal mine operators adopt the following guiding principles in relation to the important task of notifying next-of-kin of coal mine workers in the event of a serious injury or fatality:

Refer to the Inquest report for full details of this recommendation.

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Coronial Recommendation 2

That the Minister for Mines give serious consideration to amendment of the Coal Mining Safety and Health Act to provide for tripartite investigations involving the employer/coal mine operator, Department and ISHR, into serious accidents involving grievous bodily harm and all fatal incidents. Further, consideration be given to amending the Act to ensure that all material generated as a result of such investigation including but not limited to all statements, reports, diagrams, digital images and recordings be privileged such that they cannot be used by any person (including the Department) in any proceeding under the Act, any other statute or the common law, other than a Coronial hearing.

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Coronial Recommendation 3

That all coal mines include in Alcohol and other Drug Policies a requirement for all workers involved in fatal incidents or those involving serious bodily injury, be tested for the presence of drugs and alcohol. The results of such tests should be provided to the Department and QPS as soon as they are available. The Queensland Mines Inspectorate Manual and QPS Operation Procedure Manual should be updated to include the requirement that the investigating inspector and investigating officer require the Site Senior Executive to ensure that the tests are carried out and the results are obtained in a timely manner. In the event of suspicious circumstances, QPS should conduct their own testing for evidentiary purposes.

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Coronial Recommendation 4

That underground coal mines review arrangements in relation to the interaction between pedestrians and machinery and, following a suitable risk assessment process, revise and to the extent necessary, establish No Go and Restricted Zones to govern the interaction. Where this occurs, coal mine workers should be trained in them and they should be enforced. To assist, where appropriate, the No Go and Restricted Zones should be represented in pictorial form and made available in crib rooms and other such locations to act as a reminder for coal mine workers. Ultimately, operators of mobile equipment must ensure that it is safe to move equipment before they do so.

Coronial Recommendation 5

That coal mining operations equip each underground district with airbags of sufficient capacity to move or lift the heaviest equipment in the district. Operations should conduct a risk assessment to establish the most likely causes of trauma to coal mine workers, which as a minimum contain a trapping which may result in a crush injury.

Coronial Recommendation 6

That all coal mining operations urgently audit the efficacy of their management of change standard and if one does not exist, it should be immediately developed.

Coronial Recommendation 7

That coal mining operations and the Department (as the approval body) move quickly with manufacturers and other appropriate bodies to have developed, tested and approved proximity detection devices for use in underground coal mines to detect the presence of pedestrians in and around mobile equipment including shuttle cars.

Coronial Recommendation 8

That the Department move to ensure that any uncertainty which may exist in the legislation, that there be one safety and health management system at a coal mine, be removed.

Coronial Recommendation 9

That a working party comprising the Department, coal mine operators, workers, Union representatives and other interested organisations form to meet with manufacturers of shuttle cars to review and discuss, with the intention of designing out or improving the design of some of the concerns related to the ergonomic and/or safety factors and control surfaces of shuttle cars.

Coronial Recommendation 10

That manufacturers of coal mining machinery and stakeholder groups investigate whether the regulations and regulatory bodies governing modification to design of machinery are unnecessarily prohibiting or delaying the implementation of innovation within the reasonable time frames.

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Coronial Recommendation 11

That the Department liaise with emergency service providers (police, ambulance, fire, rescue service providers and where appropriate medical personnel) to establish an ongoing program to familiarise emergency services personnel who are based in mining communities with mining operations. Where practicable, this may include relevant personnel receiving generic inductions to mining operations. Mining companies should take all reasonable steps to assist in the successful implementation of such a program.

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Coronial Recommendation 12

That the coal mining industry adopt a system (whether through a central database or otherwise) whereby a coal mine worker, on departure from an operation, is provided with a full copy of their competencies, tickets and authorisations achieved whilst employed on that site. Further, that those documents be required to be placed on the record at subsequent operations the worker might be employed at in order to provide a ready cross reference of previous experience. The Department should consider legislative amendment or other requirement being issued for this system to be implemented across the industry.

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Coronial Recommendation 13

That a Memorandum of Understanding be established between the Queensland Mines Inspectorate and the Queensland Police Service which incorporates the provisions of section 8.5.5 of the QPS Operation Procedures Manual and also includes the assistance of QPS forensic science facilities and staff should they be required in determining the nature and cause of any mining related deaths in Queensland.

Coronial Recommendation 14

That the Department review and if amended, reissue, Safety Alert MDA 148/06 in light of this incident to enhance the alert with respect to these factual circumstances.

Coronial Recommendation 15

That the Minister for Mines give serious consideration to the amendment of the relevant legislation to require all coal mine operators to submit to the District Inspector of Mines electronically (in an approved format) a copy of the Safety and Health Management System for the operation. The document is to be updated annually by the coal mine operator and any amendments submitted by the required date upon the written request of the Chief Inspector to the SSE.

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Coronial Recommendation 16

That the Standards Review Committee formed as a subcommittee reporting to the Coal Mining Safety and Health Advisory Council thoroughly review the “place change” system of mining with a view to establishing best practice guidelines to be recommended to the Advisory Council for consideration of developing a Recognised Standard for promulgation to the Minister. The Standard should include the guidelines and seek to ensure that risk assessments are conducted to the highest possible standard to ensure the lowest level of risk.

Coronial Recommendation 17

That the Department make the SIMTARS simulation prepared for this matter available for use as a training tool.

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Coronial Recommendation 18

That in all industrial deaths, particularly mining deaths, the autopsy on the deceased person be conducted by a Forensic Pathologist and that the autopsy should include a full internal and external examination of the body including the taking of photographs (and x-rays and other tests if warranted in the circumstances of the death) to ensure that such deaths are treated with the same level of attention as suspicious deaths in order to ensure that the circumstances of the death are able to be fully understood from a medical viewpoint.