Since the close of evidence, the reviewers have met a number of times to formulate their findings and recommendations.

The Reviewers have been absent from their place of work and the family home for a considerable time during the course of this Inquiry and the writing of the Report. I thank those employers and the families for their understanding. I am sure all concerned understand the importance of the matters under consideration.

I thank the Reviewers for the impartial manner in which they approached their task. It is important in these matters that Reviewers be selected for their experience in the industry or their expertise in any special discipline of mining. If representation is going to be divided between various industry interest groups, as is proposed in the future under new draft legislation or amendments, then I feel that the impartiality of and the neutrality of the findings and recommendations could be thrown into some doubt. Such a result is not in the long term interest of the industry.

While an examination into the nature and cause of the accident necessarily implies that only those events surrounding the nature and cause should be examined to make those particular findings, the Reviewers have a duty to make recommendations in order that similar events in the future are avoided. Therefore a deal of evidence surrounding the operation of Moura No. 2 Underground Mine was examined, not to attribute blame, but to ascertain the facts and lay the foundations for the recommendations that the Reviewers must make.

I am satisfied that the recommendations are based on the evidence that the reviewers considered worthy of belief and which is uncontradicted by other evidence. The Reviewers are aware that the recommendations, 25 in number on 16 major matters, will have a significant impact on many aspects of the industry, particularly in Queensland. Hence long and careful considerations were necessary.

I turn now to some aspects of the Coroners Act 1958 as they relate to these proceedings.

Section 24(1) of the Coroners Act 1958 sets out the scope of an inquest on death. It reads as follows:

> 24(1) Where an inquest into a death is held under this Act, it shall be for the purpose of establishing so far as practicable -
>
> (a) the fact that a person has died;
>
> (b) the identity of the deceased person;
>
> (c) when, where, and how the death occurred;
>
> (d) the persons (if any) to be charged with murder, manslaughter, the offence of dangerous driving of a motor vehicle causing death as set forth in section 328A of the Criminal Code, or any offence set forth in section 311 of the Criminal Code.

Section 34(1) relates to the admission of evidence, and it reads as follows:

> 34(1) In any inquest the coroner may admit any evidence that the coroner thinks fit, whether or not the same is admissible in any other court, provided that no evidence shall be admitted by the coroner for the purpose of the inquest unless in the coroner's opinion the evidence is necessary for the purpose of establishing or assisting to establish any of the matters within the scope of such inquest.

Section 43(5) of the Coroners Act reads as follows:

> (5) the Coroner shall not express any opinion outside the scope of the inquest except a rider which, in the opinion of the coroner, is designed to prevent the recurrence of similar occurrences.

It will therefore be seen that the provisions of section 71 of the Coal Mining Act 1925 and the provisions of section 24(1) and section 43(5) of the Coroners Act 1958 are similar as to "scope" and "recommendations".

One procedural difference is that the Coroner does not sit with Reviewers, and the findings and recommendations (in the form of a rider) are his own.

However one might interpret section 43(5) of the Coroners Act to restrain the expression of any opinion, I am not so specifically restrained by Section 74 of the Coal Mining Act 1925, or by any prohibition in the Mineral Resources Act 1989.

Further, while section 74 of the Coal Mining Act 1925 and section 24 of the Coroners Act might attempt to place some limit on the jurisdiction of the Warden and the Coroner to make comment, one might look to the report of His Honour BR. Thorley in the Azzopardi Inquiry, paraphrasing Bowen JA in Bilbao V Farquhar (1974) NSWLR 377:

> the purpose underlying coronial inquiries include the satisfaction of legitimate concern of relatives, the concern of the public in the proper administration of institutions and matters of public and private interest.

It is generally agreed that one role of the Coroner is to alert the community and public authorities to the existence of perils or dangers which have been revealed in the course of an inquest or inquiry. (Coronial Law and Practice - Deputy State Coroner D.Hand - N.S.W.)

The deaths of eleven men at the Moura No. 2 Underground Mine is the third underground disaster at Moura in 20 years, and as such the public interest must be invoked, and the concern of relatives must be answered. On those grounds I put forward the following points.

DISCUSSION OF EVIDENCE - THE INSPECTORATE:

The Coal Mining Act 1925, Regulations and Rules thereunder are, with other legislation, administered by the Minister for Minerals and Energy through the Department of Minerals and Energy. Enforcement of the act, regulations and rules is carried out by certain statutory officials appointed under the act with the power to approve certain things and the power to enforce the act, regulations and rules by prosecution if necessary.

Principally those duties fall to the local Inspector of Mines, Electrical Inspector of Mines and the Mechanical Inspector of Mines.

There are a number of coal mines in Central Queensland, both open cut and underground, currently operating, with further mines to come into production in the very near future. Inspection duties in relation to those mines are shared between staff of the Rockhampton Inspectorate and the Mackay Inspectorate.

The examination and cross examination of Inspector Walker of the Rockhampton Inspectorate (transcript 4141 - 4177) brought forward evidence that was most disturbing. The evidence indicates that for a number of years, the staffing levels of the Rockhampton Office were lamentably inadequate. The Moura No. 2 Underground Mine is within the Rockhampton Inspectorate District. The evidence indicates that Walker raised a number of issues, both orally and in writing, particularly staffing levels and the work load of the remaining members of the Inspectorate a number of times with his senior officers in the department, only to be rebuffed with what I consider to be spurious excuses.

Some positions were left unfilled for extra-ordinary lengths of time, namely years.

It is apparent from the evidence of Walker, which I accept, that the Rockhampton Inspectorate exhibited a high degree of concern for the health, welfare and safety of coal miners that appeared to be sadly lacking in others.

Reviewing the evidence of Walker, one is left with the impression that as far as head office was concerned, safety, health and enforcement of the regulations were secondary to budget considerations.

The concerns of Walker were finally brought into the open in a meeting with Paul Breslin the then Director General of the Department of Minerals and Energy. It is obvious that Breslin went into that meeting with a predetermined opinion and a lack of understanding. If anything, the events of 7 August 1994 proved that Walker was right, and Breslin was wrong, or badly informed, or both. It is noted that Breslin had none of the relevant practical experience or qualifications which would have allowed him to make a personal definitive assessment of any particular situation relating to health or safety of miners.

Members of the Inspectorate are recruited from the industry because of their qualifications, experience, and commitment to the industry. Their appointment is a statutory appointment, ie they are empowered to act under the relevant legislation. They themselves must exercise their own discretion as to how and when those duties are carried out, and they must not be subject to the orders or directions of any administrative officer. Any Inspector can exercise his powers under Section 63 of the act at any time.

The Mining Warden can exercise his powers under Section 64, or the inherent jurisdiction of the Wardens Court under the Mineral Resources Act 1989 to ensure that the Inspectorate carries out its statutory duties as prescribed in the act without undue hindrance. Any action taken would be in the form of injunctions and restraining orders, and any breach of those orders would be a serious matter.

CONCLUSIONS AND RECOMMENDATIONS.

After consideration of the evidence and the submissions, I have come to the following conclusions:

:- it is a matter of regret that the department has allowed positions in the Inspectorate which affect health and safety issues to go unfilled for a number of years.

:- it is a matter of regret that staffing levels in the Rockhampton Inspectorate appear to have affected their capacity to carry out their duties is the manner that they as statutory officers see fit.

:- it is a matter of regret that due to the actions of others and low morale, valuable qualified and experienced members of the staff left to find alternate employment.

:- it is a matter of regret that under the circumstances imposed upon them, members of the Inspectorate have not been able to carry out inspections on a more regular basis and establish regular face to face contact so necessary in health and safety issues.

:- it is a matter of regret that although recruited for their qualifications and experience, the department appears to place the operational needs of those statutory officers secondary to budget considerations.

:- It is a matter of regret that while the Inspectorate lacked resources, a level of administration comprised of persons not necessarily qualified or with industry experience was created within district offices.

:- it is a matter of regret that some appointments to the Department lack the qualifications or relevant experience and background in the industry, and those persons do not perceive the safety role that the Inspectorate must play in the industry.

:- it is a matter of regret that while there are announcements of new mining developments in Queensland, there is no counter announcement that the resources of the Inspectorate will be similarly increased to monitor the health and safety of miners.

:- it is a matter of regret that the one percent per annum dividend payback to the Treasury was applied to field staff with health and safety responsibilities. This infers that the department was prepared to accept a level of death and injury in the industry so long as budget targets were met.

I note that in the recommendations of the Reviewers, members of the Inspectorate will have extra duties if the Minister honours his commitment to implement the recommendations. In addition, new mines will come into production within the next 12 to 18 months. The recommendations will have an immediate effect on those new mines, and the implementation of those recommendations will stretch the resources of the Inspectorate as it now stands. At the very least, the Inspectorate should not be under the administrative control of Managers or Directors who have neither the qualifications, experience, nor the legislative authority to direct such Inspectors.

It is recommended that if the Inspectorate cannot be fully funded within the department to the level necessary to allow those statutory officers to perform their duties, the Inspectorate be placed under the control of SIMTARS for all funding, operational and staffing purposes.

In the alternative, it is recommended that SIMTARS be given the power to investigate and report on fatal or serious injuries, and to achieve that purpose a special investigation unit be established within SIMTARS, modelled on overseas institutions such as MSHA.

DISCUSSION OF EVIDENCE - FUTURE INVESTIGATIONS:

During the Inquiry, some attention was given to the method and manner of taking statements from witnesses and other persons. While I understand that the circumstances that existed at the time were traumatic and stressful to all concerned, the statements were taken in such a manner that it would not be possible to rely on such statements for prosecution purposes if it was considered that the evidence of a serious criminal charge existed, such a charge being one on which the police could initiate proceedings or on which the Coroner might commit a person for trial. It is clear that although the Inspectorate have the qualifications and experience to investigate mining accidents, they are not trained in the method and manner of investigating criminal offences of a serious nature. I consider they should not be burdened with that responsibility. They do not have the resources or the training to do so. I consider that police officers have the training and the resources in manpower and equipment to conduct those interviews. I have some concern that evidence which might be available to substantiate a prosecution could "fall through the cracks" due to unsatisfactory investigatory methods used by the Inspectorate. For instance, no interviews were electronically recorded.

I am aware that there might be some sensitivity in some parts of the industry to this course of action. However, the matter must be addressed in the interests of justice. The legislation should be amended to give some protection against self incrimination to those persons who come forward to assist in the accident investigation.

CONCLUSION AND RECOMMENDATION.

After consideration of all of the evidence and the submissions on this point, I have come to the conclusion that the whole system of accident investigation must be overhauled. If the Inspectorate is to continue its investigative role, then further training in such matters is urgently required.

It is recommended that police investigators take a more active role in the investigation of fatal accidents, at least to the stage where they satisfy themselves that there is no evidence or insufficient evidence to substantiate a criminal charge.

To assist police in the discharge of their duties, it is recommended that all police officers stationed adjacent to operating mines be given induction and familiarisation tours in addition to participation in disaster planning and disaster exercises.

In the event that it is considered that the Inspectorate should not be involved in such investigations, it is recommended that a specialist unit be created within SIMTARS to supervise and conduct detailed investigations of mining accidents both fatal and non-fatal.

It is further recommended that the legislation be amended to give protection against self incrimination to those who come forward to assist in any accident investigation.

In accordance with Section 74 of the Coal Mining Act 1925, I have arranged for a copy of the findings as to nature and cause, and the recommendations of the Reviewers to be handed to the Attorney General in Brisbane this morning. I formally adopt those findings and recommendations under section 45(5) of the Coroners Act 1958, and add my own recommendations as riders to my formal findings under section 24(1) as previously handed down.

COMMITTAL FOR TRIAL:

I have, at a previous hearing, heard submissions in relation to paragraph (4) of section 24 of the Coroners Act 1958, ie should any person be charged with murder or manslaughter. That is the final matter for consideration.

I am aware that there is some perception in some minds that although thirty-six miners have lost their lives in underground incidents at Moura, nothing has been done. I am unable to comment on the two previous inquiries involving incidents at Moura.

However, in relation to this incident, there are four levels at which "action" may be taken.

:- The Minister for Minerals and Energy may refer this file to the Board for Examiners for any action that they consider necessary. The Minister only has the right of referral. He has no legal power to direct or request the Board to take any particular action. Any action taken is taken at the discretion of the Board of Examiners, and no other person. Any notice to show cause action is directed through the Wardens Court, and hence I wish to say nothing further in relation to this point.

:- The Inspector or Chief Inspector has the power to commence a prosecution for any offence under the act or regulations. That has not been done, and due to the effluxation of time, can now not take place, not withstanding the definition of "negligence" in section 104.

:- A prosecution action for a criminal offence under the statutes as they existed in Queensland at the time of the incident may be commenced by the Police or the Director of Prosecutions. That has not been done to date and is unlikely to occur for several reasons which are given below.

:- A "committal for trial" from the Coroners Court.

After reviewing the evidence and upon consideration of the submissions on the evidence and the law, I have reached the conclusion that there is insufficient evidence on which I could commit a person for trial on a charge of murder or manslaughter, the only two offences available under the Coroners Act on which I could act. To commit for trial, I would have to be satisfied that the evidence disclosed a reckless action with grave moral guilt in the knowledge that the death of a person was most likely to be the result. I consider the evidence falls short of this requirement.

There is also the difficulty relating to the statements which I have previously mentioned.

No person is committed for trial.

CLOSING REMARKS.

Given our foreign debt and balance of payments situation, the mining industry is particularly important to the economy of Australia, and coal mining is a major stakeholder in the mining industry. Coal is our largest export in volume and value. It will continue to be so for a number of years. From coal mining, we produce a very large part of our export income, and the flow on effect in meaningful employment opportunities, and the generation of other skills and services, is almost incalculable.

It is important that we, as a nation, acknowledge the importance of the coal mining industry and the efforts of all those persons who work in the industry.

Governments, which derive large benefits from such an industry, have a duty to ensure that mining is carried out in as safe a manner as possible. Governments have, through legislation, given themselves the right to regulate the industry and to enforce the acts, regulations and rules that govern the day to day operations of the industry. With the right to regulate comes the responsibility to ensure that the work place is made as safe as possible for those men and women who work in the mines, shift by shift, day by day, year in and year out.

Governments have no moral right to walk away when a disaster happens and decline to accept any responsibility. They are, by association and legislation, clearly involved. Put bluntly, they must either regulate the industry properly or they hand the regulatory duties over to some other authority.

It goes without saying that all those witnesses, including Walker, that came forward and gave evidence at the hearing will receive protection from the Court if necessary.

Any attempt to "shoot the messenger" as predicted by Walker will cause the Court to consider the remedy it might take under the wide powers that are available to it. It is not the function of the Wardens Court to protect the Minister or to act as a rubber stamp for the Department of Minerals and Energy.

If our wide ranging search for "truth and justice" uncovers inadequacies within the Department, then the Court has a duty to draw attention to such matters. If the Minister or the Department cannot accept this situation, then under the separation of power principles, the administration of the Wardens Court should be removed to another appropriate body.

Given the lack of accommodation and resources that we have suffered over the last five years, such a change of administration may be beneficial to the Court and the stakeholders. The Court, during the term of the Moura Inquiry, has been physically re-located three times.

For some people, this Inquiry and Inquest marks the end of proceedings. However, for others, much work needs to be done. I suspect that for the next of kin and the families, it will never be over.

The matters that the Reviewers considered, and the matters that I have dealt with are of grave importance. We are dealing with the health, safety and financial security of miners and their families, perhaps even into the next generation.

No doubt there will now be a plethora of steering committees, advisory panels and consulting groups. I concede that such things are necessary, given the impact of the recommendations.

Research into better mining methods, education, and training must be ongoing, and health and safety must always be paramount in our minds. It is with some satisfaction that I, as Warden, will be in a position to closely monitor the recommendations. In particular, new applicants for coal mining leases will be required to address the recommendations contained in the Moura Report prior to achieving any favourable recommendation from the Wardens Court.

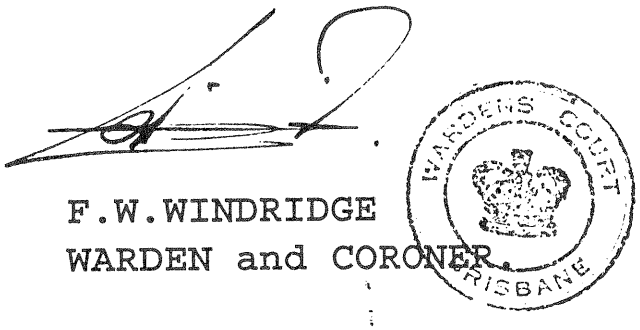
I would urge the Minister to take action to implement the recommendations as soon as possible, keeping reviews and restructuring to a minimum, and dealing with the real issues.

Those miners who have died on the Moura Lease in the last 20 years deserve that commitment, and nothing less.

This inquest into the deaths of the eleven miners trapped underground at Moura No. 2 Underground Mine is formally closed.

The Inquiry under Section 74 of the Coal Mining Act 1925 is formally closed. The Report is formally released.

Dated at Rockhampton this 17th day of January 1996.



F.W.WINDRIDGE
WARDEN and CORONER.