From: Cleo Gerdes [redacted]
Sent: Friday, 4 November 2022 8:27 AM
[redacted]
Cc: Brian Gerdes [redacted]
Subject: Mine Inquiry Addition

Good Morning,

My name is Cleo Gerdes, I am the sister of Jack Gerdes. Jack died in a fatal mining incident at Baralaba Coal Mine on 7 July 2019.
The below letter was issued to the State Coroner, on behalf of myself and my parents, after reading the Coroner's report and finding that it lacked information and accountability despite taking 20+ months to form the report.

We were interested in this being included in your inquiry into the Moranbah Mine Safety Cover-up, if at all possible, since we missed the closing date of October 5th.

On 16 March 2022, my parents Brian and Cheryl Gerdes and I received a copy of the Coroner's findings in relation to the circumstances of Jack's death made by the Central Coroner Magistrate O'Connell dated 24 February 2022. Magistrate O'Connell found that Jack had been crushed between a fixed and rotating handrail after reaching to access an emergency release button on a retractable staircase on an excavator used at the mine site.

After reviewing the findings made in relation to Jack's death, my parents and I are disappointed the Coroner has not properly investigated or acknowledged the failures by the mine operator or Golding Contractors to ensure a safe system of work which our family believes is the reason for Jack's death. My parents and I therefore would like a copy of this email to be sent to the State Coroner so the content of this email may provide reason to reopen the investigation into Jack's death because the circumstances warrant further investigation.

The reason we believe Jack's death requires further investigation is because it appears insufficient regard was made to the contents of the investigation report issued by the Queensland Mines Inspectorate after the incident. In particular, that report identifies four possible scenarios as to how or why the incident occurred. Those different scenarios primarily concern Jack either tripping on a trip hazard on the stairway and inadvertently engaging the emergency release valve or Jack deliberately reaching through the handrails to access the emergency release valve at the time he became entrapped. Each of these scenarios outcomes could have been avoided had the mine operator or Golding Contractors undertaken a risk assessment on the stairway for the excavator.

Importantly, the investigation team found in relation to the incident that:

· the operators for the excavator had in the months leading up to the incident and contrary to instructions lowered the staircase using the emergency release valve rather than the control panel;
· there was no evidence (based on machine data) that Jack had ever lowered the stairway with the emergency release valve;

· no one on the mine conducted their own risk assessment on the excavator and no steps were taken to identify possible crush zones; and
· the failure to identify the risk of injury resulted in an inadequate engineering controls to safeguard against the risk which could have been avoided by installing inserts on the rotating handrails to prevent someone entering a crush zone and covers on the emergency release valve to discourage someone reaching for it.

A closer review of the findings made by the Coroner identifies that no regard was made to the mine operator or employer's failure to identify the risk and implement sufficient controls to safeguard against the risk. It appears the findings simply blame Jack for being in a rush, without any evidence that he would in fact have been in a rush, and despite there being no evidence he ever lowered the stairway with the emergency release valve in the manner found by the Coroner. The findings also appear to dismiss the likelihood that Jack tripped and inadvertently engaged the emergency release valve causing him to become entrapped without apparent regard to one of the scenarios raised by the mines inspectorate that his final position would have been determined from the rotating staircase.

Our family simply wishes to bring these matters to the State Coroner's attention so that a further investigation could be made to ensure that, had Jack's death been caused or contributed by an unsafe system of work, then further attention is drawn to it so that mine sites adopt a safe system of work in relation to retractable staircases on plant used during mining operations to avoid further injury or death.

Please feel free to give myself or father, Brian Gerdes, a call.
Thank you for your time.

Cleo Gerdes
[redacted]

Brian Gerdes
[redacted]