TRANSCRIPT OF PROCEEDINGS

CORONERS COURT

HENNESSY, Coroner

IN THE MATTER OF AN INQUEST INTO THE
CAUSE AND CIRCUMSTANCES SURROUNDING
THE DEATH OF ROGER BRUCE BROWNE

ROCKHAMPTON

..DATE 06/03/2007

CONTINUED FROM 09/02/2007

..DAY 2

FINDINGS

WARNING: The publication of information or details likely to lead to the identification of persons in some proceedings is a criminal offence. This is so particularly in relation to the identification of children who are involved in criminal proceedings or proceedings for their protection under the *Child Protection Act* 1999, and complainants in criminal sexual offences, but is not limited to those categories. You may wish to seek legal advice before giving others access to the details of any person named in these proceedings.

CORONER: -----surrounding the death of Roger Bruce Browne. The findings were commenced on the 9th of February 2007, but shortly into them being delivered, there was a failure in the tape recording system so I will continue to read the balance of the findings into the record. They were delivered to the parties on the 9th of February, but the purpose of reading them into the record today is to obtain a transcript to be able to be dispersed to the parties.

I will commence at the beginning of the last paragraph when the tapes failed with the investigation.

I turn, now, to a description of the investigation into Mr Browne's death. At about the time of the search for Mr Browne being mounted by Dawson Mine executives, Moura Police were notified of the situation and Sergeant Haley travelled to the mine to assist.

Mr Browne's body was discovered prior to police arrival and the mine search and rescue personnel secured the scene for inspection. An ambulance was detailed to the scene. The incident was reported to Inspector Parkin of the Department of Natural Resources and Mines in Rockhampton. The inspector has over 40 years' experience in the mining industry.

Inspector Parkin compiled a report which included witness interviews which were very brief. He also undertook an ICAM analysis of the matter. The inspector was unable to determine

the cause of the accident as to how the deceased fell or from where.

No slip marks or physical indications were located at the scene. The police officer took more expansive statements from some of the witnesses and presented a report to the Coroner in the usual manner. Inspector Parkin left the employ of the department prior to the inquest being convened. His evidence at the inquest was unfortunately not very helpful or insightful.

Inspector Mike Walker reviewed the report and compiled further and more expansive information which assisted the Court in the investigation. The bulk of the evidence was provided following this review.

In the end result, I am satisfied that the information provided to the Court following the investigation was thorough and professional and that it addressed the relevant issues.

THE INQUEST.

A visit to the site of the incident and the Dawson mining operation generally took place on the 27th of November 2006. Unfortunately, due to illness on the day in question, I was unable to attend but counsel assisting me, the next of kin and legal representatives for the parties attended the mine.

I wish to express my thanks to the operators of the mine and those involved in the visit for their efforts on that day. A summary of the visit and overview of mine operations was presented in Court by mine personnel on the 28th which assisted the Court.

THE EVIDENCE.

I have summarised only those portions of the evidence I consider necessary to explain the findings I have made. I have taken all of the evidence before me into account in considering this matter.

The reason for the deceased being at the site.

The deceased held the position of contract holder for Leightons and Ostwald Brothers Contracts at the Dawson Mine at Moura.

As part of his duties, he was designing a change to a high wall at Dawson North. He had been working on the plans for about two months and on the day of the incident, he was quite relieved to be handing the plans in at a meeting.

He had discussed the design issues with John Hoelle, a geotechnical engineer at Dawson Mine. They had discussed

areas of similar geology that the deceased could inspect to assist him in the task.

Mr Hoelle suggested that he look at disused pit 8C as it had similar conditions and overlaying rock and was close to the office, about 10 minutes' drive. It is apparent that he visited the area on the morning of the incident and was going back for another look.

Mr Biggs, the deceased's supervisor at the time, gave evidence that it was reasonable that the deceased would go to pit 8C in those circumstances. Mr O'Brien, the SSE, gave evidence that there was nothing inappropriate in the deceased travelling to the site as he was a competent person, had radio contact with the office and it was an area which was traversed by others.

At pit 8C the deceased left his vehicle running without lights illuminated, indicating that he probably arrived before dark. Certainly, if inspection was on his mind, there would have been little use in the deceased going to the site after dark.

Inspector Parkin indicated that it became dark on that night at about 6.30 p.m. The deceased was last seen at around 4.40 p.m. by Bryce Robey - the commercial manager for Anglo Coal - at the toilets in the administration block at the mine. They had a conversation and Mr Robey noted that the deceased appeared normal and there was nothing out of the ordinary.

The deceased's mobile phone was left in the vehicle, but his hard hat was located in the pit, indicating he was either wearing it or had it on him at the time.

The Physical Site

Pit 8C was not a closed or restricted area of the mine at the time of this incident, and was described as a disused mining site. It provided access for service trucks, watering plant, shutdown and blast crews. Mr Turner, the OCE, described the area as "inactive work area". It was not subject to regular inspections such as that which applied to active high walls and pits.

Mr Turner indicated that the inspection regime for such an area was restricted to checking to make sure the rills were in place in a drive-past type of inspection, required by industry practice and sections 117 and 118 of the Coal Mining Safety and Health Regulation 2001.

A rill is a continuous mound of soil purposefully dozed into place to provide a barrier against inadvertent access to a dangerous area by personnel, and particular vehicles.

Inspector Walker gave evidence that the rill, at the site of the incident, was on the surface reasonably unconsolidated (with largish rocks and loose material). The rill was about 1.5 metres high and was about three metres from the brow - the edge of the high wall. The top of the rill is the high point

in the area. The brow, whilst not loose, may have been obscured from sight by vegetation in places.

Inspector Walker stated that the strata of the end wall could adequately be seen from a location near the rill.

Movement of personnel over the rill

Whilst the evidence was unable to indicate just how the deceased came to end up in the pit, there was an underlying assumption that he crossed the rill in order to fall over the high wall. The risk of a person falling over the high wall is a well-identified hazard, which fortunately does not occur very often, according to Mr O'Brien, the then SSE.

All of the evidence was that Mr Browne was very experienced in the mining industry, having worked on other mine sites prior to Dawson for many years. As a professional person with experience, the assumption was that he had undergone appropriate training during his career.

Mr O'Brien gave evidence that Mr Browne had obtained a qualification (completed in January 2005), which is designed to give an appreciation of the need to be alert to risks and any particular tasks and how to assess those risks. All of the witnesses felt that the deceased was a competent and experienced person.

Inspector Walker stated that he would never recommend that a person cross over a rill, and that doing so was an inherently unsafe practice, which fact is acknowledged in the industry. However, he also expressed the view that it is quite usual within open-cut mining for certain personnel to move quite close to the high wall for a number of reasons, especially inspection.

It was stated that it was accepted industry practice to observe the pit from the high wall (behind the rill). Inspector Parking felt the industry practice was to stand on the top of the rill but not to pass over it. The Inspector agreed that crossing the rill was a dangerous practice and should not be done unless the proper safeguards were in place, example, harnesses.

Mr Ferry, an OCE at Dawson Mine at the time of this incident, gave evidence that there is a need for personnel, such as surveyors, to approach close to the edge of the high wall for various reasons, including checking the integrity of the high wall for cracks. He said that such persons would particularly need to approach the edge of the high wall if the rill was some distance back. He stated that some dangers are unavoidable, and that, in particular, the risk of tripping at an area adjacent to a void could not be prevented.

He stated that the unwritten rule at mines was not to approach within a certain number of metres of the high wall for any reason.

Further, Mr Ferry gave evidence that he, himself, had crossed rills at various times during the course of his work (he later refined that to two occasions and stated that it was not a common practice). He said that you could not protect against the unexpected, and the best one could do was to undertake the task as safely as one could, and not get into a dangerous position.

During examination by Mr Roney (for the mine), Mr Ferry stated that the area between the rill and the edge of the high wall was a "no-go zone", unless notifying someone that it is what you are doing, and staying three to four metres from the edge. He felt that if a harness was needed to be worn, then the area was too dangerous to enter.

Mr Turner gave evidence that lighting and pump plant operators may have to cross the rill from time-to-time in order to adjust the equipment being used on the high wall, although stated that most of the equipment was designed to be pulled back from the high wall, adjusted, and placed back into position without the need for personnel to move over the rill.

Ms Andrews proposed to various witnesses that she had seen such workers moving very close to the brow of high walls at Dawson. This was not admitted by the witnesses.

Mr O'Brien gave evidence that legitimate work would have taken Mr Browne over the rill. He denied that it was a practice to move across the rill, and stated that, in fact, vision would be restricted by moving closer to the high wall, not enhanced.

Safety actions regarding crossing the rill

Inspector Walker's evidence was that once the rill is established as a barrier, safety is a matter of training, awareness and reinforcement of the safety message, with consequences for breaches of the safety standard.

Inspector Parkin's evidence was that the relevant standard operating procedure -(SOP) - in place at the time of the incident,(which was not strictly on point for this situation), was a comprehensive and satisfactory procedure.

Mr Biggs gave evidence that the SOPs were kept on the intranet in the office at technical services. All personnel were alerted to their position and various SOPs were discussed at meetings and safety talks. The deceased took part in some of those meetings and received minutes of the meetings he did not attend. Assessments were not always conducted following those safety discussions.

Locating the deceased

At the time of the incident, there was a sign-out board in the foyer of the building containing the deceased's office. He did not complete the board prior to heading to pit 8C. The board was used, primarily, to keep track of the vehicles available to the occupants of the building. As the deceased's work required him to travel regularly to Dawson North, it was known that his vehicle was not available for use by others in the office, and it was consequently not expected that he would use that board.

Further, the deceased was effectively working solo, and not as a member of the technical services team, as such. Consequently, the other members of the office in which he worked would not necessarily have been alerted by his failure to return to the office. As it was part of the deceased's responsibilities to regularly go to Dawson North, he was often out of the office. Mobile phone range is variable around and between the sites, and the deceased was often uncontactable by phone when he was out and about.

During the evening of the 19th, a number of service vehicles used the access road beside pit 8C. One such vehicle was driven by Mr Engel. He saw the deceased's vehicle parked at the high wall during the night, but thought nothing of it as it was a common occurrence for vehicles to be parked or abandoned for periods of time for various reasons. He had no

cause to stop to inspect the vehicle or notice that the engine was running.

Was there an emergency?

The deceased's partner, Debbie Andrews, rang the mine at about 7.30 p.m. on the 19th. She spoke to Ms McInlay in the office with whom she was friendly. She told Ms McInlay that the deceased had not come home after work. Ms McInlay recommended that Ms Andrews speak to the open-cut examiner, but to keep things "low key". It seems that the reason for this was to keep matters private to avoid unnecessary gossip in the small community.

Ms Andrews then spoke to Mr Turner - an OCE on duty - and asked whether the deceased was still at work. Mr Turner stated that the deceased would be finished work for the day, but promised to make some inquiries. Mr Turner went to the deceased's office and spoke to the cleaner who was leaving. That person told him that the deceased was not in his office, and the building was now closed.

Mr Turner checked and saw the deceased's work vehicle was not in the car park. He rang the deceased's mobile and left a message. He informed Ms Andrews of the inquiries he had made. He found Ms Andrews to be concerned, but not requesting any further action. He did not take any indication of alarm from Ms Andrews and thought the phone call to be another of the many from family and friends attempting to locate a worker at

the mine. He did not infer from the phone call that the deceased was "missing".

Mr Turner was also aware that the deceased was involved in the local RSL, and thought that he may have gone there after work. As Mr Turner received no further calls, he took no further action.

At the time, there was no system in place to be able to determine whether a staff member was on site or not. In relation to workers, timesheets recorded the end of their shift, and were noted as they left for the day, but professional staff were not subject to that procedure.

At 7.30 a.m. the following morning, Ms Andrews, again, contacted the mine as the deceased had still not arrived home. She spoke again to Ms McInlay, who spoke to management about Ms Andrews' concerns. Ms Andrews reported the deceased missing to the Moura Police.

Ms McInlay made various inquiries following the call from Ms Andrews. She apparently felt badly over the situation, and by this time was very concerned. Given the brevity of the statement from Ms McInlay, and her unavailability to give evidence due to health reasons, the exact extent of those inquiries is unclear.

After making inquiries that were within her province to make, she was unable to locate the deceased.

At 9:30 a.m. she contacted Mr O'Brien and advised him the deceased had not returned home. He advised her to contact the HR manager and have him make inquiries. It was then discovered upon examination of the deceased's office that his computer was still on and that his wallet and bag was still in the office.

Mr O'Brien was immediately advised and the emergency response procedure was activated. At 10:20 a.m. mine staff contacted the Moura police and advised that the deceased was missing and a search of the site was being conducted for him. At 10:30 a.m., Mr Welsh, a member of the search team, located the deceased's vehicle at pit 8c with the engine still running. He shortly after discovered the deceased at the bottom of the pit, at the water's edge, and determined that he was deceased.

The police officer in transit was advised that the deceased had been located. The mine rescue personnel secured the scene pending the arrival of the police. The emergency response procedure was described by Inspector Parkin as operating when it was identified as being needed, and the implementation of the system worked well, however, he noted there was a lack of written procedures regarding missing persons. Unfortunately for My Browne and his family, given the medical evidence I will refer to shortly, there was no chance of his being saved if he had been located earlier. In fact, it seems that immediate medical attention would not have altered the outcome for the deceased.

Notification to next of kin

Ms Andrews indicated to the Court that she, as the next of kin, was informed by telephone of the deceased's death. She was informed that the deceased was found near his own vehicle. She then made arrangements for the deceased's mother to be informed. Her father and brother heard later of the fall being the cause of the deceased's death at the hotel and told her.

At the funeral she was approached and informed by a mine worker that the deceased had survived the fall and made his way to the edge of the water in the pit. Until that time, she had assumed that he did not survive the fall. This information distressed her and the family, mostly due to the manner in which it came to them, and the lack of official information coming to them. It left the family with the question of whether he could have been saved.

Unfortunately that question was not dealt with finally until the inquest. Those issues could have been answered by earlier access to the medical information at an earlier stage in the investigation. An autopsy was performed on the 22nd of September 2005 by Dr Buxton in Rockhampton. The doctor found that Mr Browne had suffered numerous fractures, including the sternum and ribs, and internal injuries. Of significance was a dislocation of the first cervical vertebrae with skull compression of the spinal cord.

Dr Buxton found the injuries were consistent with a fall from height but was surprised that the deceased was able to struggle to the edge of the water prior to death. The injuries were fatal from infliction and were not survivable for more than moments in any circumstances.

Findings required by section 45, sub-section 2

I am required to find, as far as possible, the medical cause of death, who the deceased person was, and when, where and how he came by his death. I have already dealt with this last aspect of the matter, the manner and circumstances of the death. As a result of considering all of the information contained in the exhibits, and the evidence given by the witnesses, I make the following findings:

Identity of the deceased: The deceased was Roger Bruce Browne, who was born on the 25th of August 1964.

Place of death: Mr Browne died at the Dawson Mine near Moura in Central Queensland at pit 8c.

Date of death: Mr Browne died on the evening of the 19th of September 2005, aged 41 years.

Cause of death: Mr Browne died as a result of injuries sustained when he fell from height into a pit full of water. There is insufficient evidence to find how that fall occurred.

There is no evidence of contributory factors, such as alcohol, drugs or impairment of the deceased.

Comments on issues and preventative recommendations

Section 46 provides, in part, that a Coroner may comment on anything connected with a death that relates to ways to prevent deaths from happening in similar circumstances in the future. An understanding of the underlying causes of the accident, that is, the risk of falls from height, particularly at high walls and the systemic procedures relating to a person being "missing on site", whilst not contributing directly to Mr Browne's death, are necessary for the development of prevention strategies for future similar situations. Certainly, if Mr Browne had survived his injuries, or the circumstances were less severe, the issue of the period of time before his location on site could have been critical to the survival of such an incident.

(A) *Safety at high walls*. The result of Mr Browne's apparent actions on the evening in question raised the issue of movement at the top of the high wall by mining personnel. The evidence raised a suggestion that various personnel crossing the rill whilst unrestrained does occur, despite all official warnings to the contrary. If it was the case that Mr Browne presumably moving to the edge of the high wall was a completely isolated incident, then that might be the end of the matter. Evidence from various other witnesses indicated that such action might be undertaken for a number of reasons,

but there was also evidence that such actions should never be undertaken. Reports of industry practice varied, but it was clear that there is industry-wide acknowledgement of the risk of falls from height at high walls and voids, and the safety reason for rills.

The apparent departure from safe procedure in approaching an area of dangerous height was critical in this matter. I do not believe that the dangerous acts were as a result of a lack of knowledge. Mr Browne was apparently well trained and very experienced in the mining industry, and was, by your reports, a dedicated worker. The coal mining safety and health regulations make provision for responsibilities of SSEs with regards to this issue and section 92 "Working at heights" and section 117 "[indistinct] dumps and excavated faces". The SOP for Dawson Mine, which was in place at the time of this incident, related to working at heights, but was said not to specifically address the factual situation here and did not seem to have direct application.

Since this incident occurred, Dawson Mine Management has undertaken a number of actions addressing the issues of safety at high walls and the training of personnel. Those changes include:

- Risk assessments conducted on working on or near high walls.

- Working at heights has become a golden rule. Golden rules have been reinforced with all personnel, including golden rule charts and stickers for all hard hats, with pictorial charts reminding personnel of safety regarding high risk tasks.

- Standard operating procedure reinforcement process has been undertaken with workers and has included a review of the SOPs for major hazards.

- Three viewing platforms have been constructed in sites around the mine, two mobile and one fixed, to enable viewing of the mine in safety, especially near high walls which enable persons to be positioned above rills to see into the pit. One platform has been situated in the vicinity of a public road to provide a safer access for viewing by curious members of the public.

- Behaviour management system includes yellow card reporting for breaches with a focus on discussion towards correcting unsafe behaviour, rather than punishment in the first place.

- Increase and persist on near miss reporting.

- PERSONAL IMPAIRMENT PROCESS being introduced regarding alcohol, drugs, fatigue, psychological and psychiatric impairment.

(B) *Access to certain areas*. Pit 8c was a former mining area which was used occasionally for other purposes, particularly water cartage; was located reasonably close to the administration centre and is situated beside a regularly used access road. Access to pit 8c was unrestricted at the time of the incident. The area was not subject to a regular inspection regime beyond that previously described. An industry submission detailed later has suggested that categorising mine workings as "active", "non-active", "restricted", or "closed", or similar, would assist in controlling such areas. The Coal Mining Safety and Health Act, section 42FV, places an obligation on an SSE "to provide for appropriate inspection of each workplace at the mine, including, where necessary, pre-shift inspections". Further, provision of the regulations, including section 94; "checking and examining work areas", section 99; "restricting access to parts of a mine", section 106; "inspecting surface excavations", section 118; "restricting access to hazardous areas and section 141; "safety inspections" should be referred to in this regard.

Since the incident the mine has reviewed its approach to such areas. Old working areas have become restricted, are marked by signage indicating that status, and access to the area requires prior permission of the OCE.

The OCE must be informed of the reason for the access, the time required in the area, and the time in and time out checks.

(C) *Locating persons on site.* In the present case, once Ms Andrews made inquiries as to whether her partner was still at work, the mine management was unable to quickly determine whether he was on site or not. The mine must be in a position to ascertain the location of an employee on site, particularly in the circumstance of a potential medical or safety emergency, not only for the safety of the employee but also for the benefit of the family of the employee and other employees of the mine.

Of course, any effective emergency response procedure must be able to provide a complete accounting of all personnel in a timely manner, particularly in emergent circumstances.

Further, personnel safety would be enhanced if they were provided with the means to raise an alarm in the event that they became incapacitated. At the time of this matter reliance seemed to be placed on two way radio and/or mobile phone contact. The coverage for mobiles is apparently patchy (as one would expect at a reasonably remote site) and of

course radio contact would necessitate the person to be in the vicinity of the vehicle.

Further, the response must have the capability of consistency and application. In this matter it seemed that there was significant reliance placed on the person receiving a call from family to assess the tone of the call. The urgency or otherwise of the tone of the caller, or the insistence of calls (particularly in number) could have enormous impact on the action taken.

It was a very subjective approach which left the system open to large fluctuations in application. The mine has made some changes since this incident, including:

- Whereabouts boards for all staff located in main office requiring time in and out signage with follow-ups when staff members are overdue by two hours. Information recorded includes location, expected time away, two-way sign and mobile phone number. It is also recorded that a person is on or off site. There are consequences for not attending to this task.
- Inquiries from family members. When a call from a family member occurs, despatch is contacted and they immediately contact the person sought through the various contact details retained.
- Regular training in the location response to be undertaken in the same manner as other emergency responses, including mock exercises.

- Emergency response management plan has been updated and tested.
- GPS Online Man Down System is being trialled (At Norwich Park and Dawson). The system includes a distress button which sends a signal to base through the vehicle it is attached to. If the person moves out of a certain range from the vehicle an alarm is set off. An alarm signals a lack of movement of the person for three minutes.

(D) *Abandoned vehicles*. The evidence of Mr Engle as to treatment of vehicles abandoned on site, i.e. to effectively disregard them, expose the potential for a person in trouble to be missed. He passed the deceased's vehicle a number of times during the night that the deceased was unaccounted for. Whilst he noticed that it was there, there was nothing unnecessarily unusual in that and for instance, there was no imperative for anyone to stop and check the vehicle.

As its engine was running, any such action may have alerted somebody to something being amiss. Mr Engle was quite affected by the circumstances of this matter and gave evidence that since that time he always stops and checks vehicles and it is now common for light vehicles abandoned on site to be reported by him.

Certainly, a mine policy in this regard would seem to be sound safety practice. He suggested that if a vehicle did need to be abandoned that it could be marked by witches' hats or a sign indicating the problem.

In addition, tracking of all mobile equipment could be beneficial in this regard. Some equipment is already monitored at Dawson Mine but including light vehicles would significantly increase the coverage of personnel on site.

(E) *Contact with next of kin and coordination of information*. I have already referred to the distress the family of Mr Browne suffered in the aftermath of this matter, partly as a result of the information provided to them and the way in which that happened.

Ms Andrews was a person who was familiar with the mine culture and miners, her father and brother having worked at Moura for many years, yet she was quite reticent in contacting the mine despite her concerns for her partner. The potential for gossip in the small community of Moura and her reticence were matters that the mine managers seemed quite surprised by at the Inquest.

Ms Andrews acknowledged that the mine had assisted her significantly, particularly in a material way, but there is much that could be improved.

In addition, workmates and colleagues of the deceased were not aware that earlier intervention on their behalf would not have assisted the deceased's prospects of survival.

Some months had passed from the incident to the Inquest and it seems that the Inquest was the first opportunity for those persons to be assured that other actions would not have changed the outcome.

All of those persons were adversely affected in the situation where access to available information could have provided some relief to them.

Given that the official availability of medical information often needs to await the processing of various tests, and when provided to the Coroner would not be the subject of widespread release, earlier access to the information, for example, through the forensic pathologist in consultation with the Coroner, should be considered where appropriate.

The mine has been working on the issue by looking to improve communication with the families of the employees on site. One way in which they have done this is to provide emergency contact information for the mine to families by way of fridge magnets with contact numbers.

Further, Mr O'Brien indicated that the mine has considered adopting the following procedures regarding actions with next-of-kin, which I would endorse.

- Next of kin to be properly notified by qualified staff and updated regularly.
- Counselling to be offered to immediate family and not just next-of-kin recorded on staff records.

- Next-of-kin to be informed of the details in person.

In a letter received from the solicitors for the mine following the Inquest, the mine management expressed their concern regarding this issue.

> "One of the great difficulties for any mine operator responding to an event such as this is that the mine management is often reliant on many of the same sources of detailed factual and investigative information as the deceased's family, namely the police and the medical examiner. The consequence is that often, as appears to be the case here, official findings and relevant information is not made known to the people that would most benefit from that information until months after the incident. It is also usual and prudent not to discuss in detail the nature and cause of an incident whilst official investigations are pending and the facts are still being considered. The problem is compounded when the precise cause and circumstances of an incident are unknown."

In mining matters the investigation runs on two courses. The inspector investigates the matter and presents the Coroner with a report. Consideration is also given to immediate safety issues, alerts to the industry and possible breaches of legislation.

Police, who are usually charged with investigating deaths at the direction of the Coroner, also conduct an investigation. Of course, if there is any prospect of criminal charges arising from the incident causing the death, then the matter is investigated by police to determine whether charges should be laid.

In this matter, there seemed to be some communication difficulties between the investigators. The information initially supplied to the police officer (that the deceased had been located near his vehicle) and then passed onto Ms Andrews was not quite correct.

After that time no information was passed officially to Ms Andrews concerning the factual circumstances. It seems from the statement in the letter from mine management there were also gaps in the information provided to them.

Recommendations

Whilst progress has been made at Dawson Mine regarding some of the issues which arose from this matter, there are some areas requiring further attention.

Many of the issues have industry-wide application and for that reason I will proceed to make recommendations to the industry as a whole with a view to reducing the likelihood of a similar occurrence in the future.

Following the Inquest, representatives of the mines inspector, the CFMEU and Dawson Mine, met and formulated a joint submission to the Coroner regarding recommendations which would operate to mitigate against similar occurrences in the future.

To my mind this is the best possible advice a Coroner could receive, given that it is drawn from the significant experience and practical knowledge of the business involved, representatives of the workforce and the regulator.

I sincerely thank those parties involved in the discussion and preparation of the relevant submission. I trust that the industry will acknowledge the strength of the recommendations and the experience and expertise which lies behind them.

I consider that the submission has great merit and that the proposals are supported by the evidence in this matter.

I acknowledge the submission from which I have drawn information included in these findings. I accept, strongly support, and make the following recommendations from the joint submission to the industry.

Recommendation 1: It is recommended that senior site executives review their safety and health management system to ensure that adequate provision is made with respect to:

(1) personnel exposed to a potential fall from an edge of an excavation.

(2) the ability to locate personnel around the mine workings, particularly those working alone and/or in remote or less frequented areas.

(3) old non-current mining areas, particularly with respect to inspection and monitoring and controlling the entry of personnel.

(4) emergency response to reports of missing persons.

I make further recommendations in relation to other matters arising from this Inquest as follows.

Recommendation 2: That a system be developed to categorise and sign vehicles abandoned on site for any reason or period of time.

Recommendation 3: That the Coronial system provide a process which ensures that the family of the deceased are provided with accurate information regarding the death of their relative and to have access to forensic pathology information as is appropriate in the circumstances in a timely fashion.

Recommendation 4: That the protocol between the inspectorate and the Queensland Police Service be reviewed to ensure effective and timely communication flow between the organisations during the investigation.

I now close the Inquest.
