

Lessons from Pike River - Part 2

In this edition of *The Legal Lounge* I conclude my two part series summarising the key findings of the Royal Commission on the November 2010 Pike River Coal Mine tragedy. I also outline some of the key recommendations that may have broader implications, including for the aviation industry.

In the first part of this series I summarised a number of causal or contributing factors leading to the fatal explosion of methane gas in the mine, including a deficient regulatory approvals process; inexperienced and under resourced mine development and significant delays in getting the mine operational; serious management and culture problems at the mine; inadequate ventilation and methane management systems; and other possible electrical or mechanical problems that could have sparked the actual ignition.

I continue below with the Commission's findings as to what it saw as an almost total failure by both the company and the regulator, to adopt, monitor and enforce an effective health and safety regime, and a lack of adequate regulation, in what is known to be a high hazard industry.

6. Pike River – Inadequate health and safety systems and risk management focus

The Commission noted that Pike's management plans and procedures at the time of the accident were in considerable need of attention. The health and safety management plan for the mine was still mostly in draft form, some four to five years after the development of the mine began. The investigation of incident reports was also haphazard, with the result that in October 2010 a backlog of outstanding investigations was simply written off.

I summarised in the first article serious problems with the management and wider culture within the organisation, which culminated in lax health and safety controls of contractors, bypassing of safety sensors on machinery underground, and repeated reports of high methane levels being ignored or not acted on by senior management. The Commission also considered that the Board failed to provide effective health and safety leadership and protect the workforce from harm. Although the Board received a monthly report containing a health and safety section, which was contributed to by a two-man subcommittee from the Board, this did not cover the hazards relevant to a catastrophic event such as an underground explosion. An insurance risk survey at Pike River in July 2010 identified serious concerns about the hazards posed by hydro mining, windblast and a gas explosion, and urged a comprehensive risk assessment of the entire mining operation. This report was not seen by the Board. The Commission found that the Board did not verify that effective safety systems were in place, and that risk management was ineffective, relying instead on management to bring any major operational problems to its attention.

Amidst this environment, the Commission found that both Executive Management, and the Board, were focused on hydro coal production, and that there was a "culture of production before safety" that permeated throughout the organisation from the top down.

7. Lack of regulatory oversight and inadequate mining regulation

The Department of Labour first inspected the mine in early 2007 when the drift was under construction, and from then on, every quarter. DOL's policy was to tailor a regulatory approach appropriate for individual employers, based on the assessed level of compliance risk.

However, the Commission found that DOL *assumed* Pike was a ‘best practice’ and ‘compliant’ employer (thus attracting a low-level compliance approach), even when there was ample evidence to the contrary.

The most significant example concerned the need to provide two emergency exits from the mine. In mid-2009 the main ventilation shaft was designated the second means of egress. To use it involved a 110m ladder climb that was challenging at the best of times, but probably impossible in an emergency. In 2010 an inspector told the mine manager that the shaft was not a suitable emergency escapeway. Mine staff had also voiced concern about the suitability of the second egress. In August 2010 DOL advised Pike by letter that a new egress was required ‘as soon as possible’. In November 2010 Pike said a new egress would be established by mid-2011. DOL considered this unsatisfactory, but took no further action before the explosion. The Commission stated that the commencement of hydro mining in September 2010 increased the level of risk to the mine, to the point where DOL should have issued a notice prohibiting this practice until an acceptable second egress was in place.

DOL’s compliance strategy did not require an assessment of Pike’s safety and operational information, and the inspectors did not have a system, training or time to do so. When shown examples of safety information obtained by the Commission from Pike’s records, the Commission noted that the inspectors were “visibly dismayed”. It stated that this was not a case of individual fault, but of departmental failure to resource, manage and adequately support a diminished mining inspectorate.

In reviewing the role of DOL since it replaced the former mining inspectorate after 1992, it concluded that DOL did not have the focus, capacity or strategies to ensure Pike (or other mines) were meeting their legal responsibilities under health and safety laws. The Commission also commented adversely on the change in regulatory structure from 1992. At that time, the Health and Safety in Employment Act came into force, which adopted a less ‘prescriptive’ legislative regime, with general principles that could be flexibly applied to the health and safety hazards confronted by all employers. While accepting that this approach was sound in principle, the Commission stated that it was not on its own sufficient to govern higher hazard industries like mining. The Commission concluded that “*the special rules and safeguards applicable to mining contained in the old law, based on many years of hard-won experience from past tragedies, were swept away by the new legislation, leaving mining operators and the mining inspectors in limbo*” and which placed New Zealand’s regulatory framework for underground mining years behind that of other advanced countries.

As a result the Commission issued a string of recommendations directed to once again building up a prescriptive regulatory structure for mining, and to assist in rebuilding the lost expertise, and monitoring capability that existed under the previous inspectorate system.

Recommendations with possible implications for aviation industry

I don’t have the space within this article to cover all recommendations of the Commission, which can be viewed at <http://pikeriver.royalcommission.govt.nz>. However I summarise below the key recommendations which may have the potential to directly or indirectly impact on the aviation industry.

1. Duties of Directors

The Commission notes that current health and safety legislation places general duties on employers, managers and others in the workplace, but places no statutory obligations on Directors. It recommends that the statutory responsibilities of directors should include health and safety in the workplace, and be reflected as part of their governance responsibilities. Even aside from legislative change, the Commission goes on to state that Directors should see health and safety risks as their concern, and should give them the same careful attention they apply to other risks facing the company.

2. Clearer safety management plans, and greater worker participation

Although directed primarily at the mining sector, the Commission recommends the need for the adoption and enforcement of much clearer and comprehensive safety management systems and plans to specifically address how health and safety risks and potential hazards are managed and incidents or concerns followed up on. It is acknowledged that similar initiatives are already well under way within the aviation industry.

The Commission also comments on the need for health and safety obligations and information to be made clearer and more readily available to employees, and for the need for employees to take greater ownership and responsibility for their part in adhering to good health and safety practices.

Comment on how this may affect aviation organisations

There is currently a wider ministerial task force examining the adequacy of New Zealand's health and safety laws, and it is likely that the Commission's recommendations will receive close consideration as part of that review. It may therefore transpire that specific statutory duties will be created for Directors, and that further statutory obligations may be imposed on companies and workplace employees under health and safety legislation.

Directors should also be aware that, even absent specific legislative duties, failing to ensure that the company has adequate health and safety procedures and that safety risks are regularly scrutinised at a Board level, could potentially expose Directors (as well as management) to risk of civil or criminal liability, or could create insurance issues, in the event of a serious incident or accident. These are matters that I will be discussing in my presentation to the 2013 Aviation Industry Association conference in Dunedin later this year.

In terms of HSE compliance, DOL's health and safety functions with respect to aircraft "in operation" are delegated to the CAA, and company practices and documented procedures in this area are regularly audited by the CAA HSE unit. However, this by no means covers all aspects of health and safety within the workplace, and aviation organisations should not assume that the company exposition, which is written specifically to comply with civil aviation laws, is also sufficient to cover all of its health and safety law obligations. (Refer for example to my article about the Safe Air accident in the November 2012 edition of *The Legal Lounge* at www.amclegal.co.nz).

Management and Directors of aviation organisations would be well advised to undertake a wider review to ensure full compliance with health and safety laws, and/or if safety management systems are in place or being developed, that these extend beyond civil aviation obligations to include all aspects of their operations.

Steps should also be taken to make sure that relevant information about health and safety practices is routinely made available to employees, and that employees are included as much as possible in the development and implementation of health and safety guidelines and best practice.

3. Creation of new agency to monitor and enforce HSE legislation

There has been some comment within industry on another recommendation of the Commission, regarding the creation of a stand-alone entity responsible for HSE. I don't agree with some comments suggesting that this would necessarily result in the CAA losing its current delegation (and as noted above, this is by no means all encompassing). Rather, it could simply result in a change of reporting lines between the CAA and the responsible agency. At the very least, there is the opportunity for those concerned about this issue to make their views known to the ministerial task force. In my view, the findings of the Commission itself as to the deterioration of mining regulations and inspection standards, and the emergence of a regulatory gap in terms of government approval and oversight of mines, caused by the separating of various functions of the former inspectorate across many different agencies from 1992 onwards, itself may provide plenty of fodder for those who wish to argue for retention or indeed extension of the current delegation of HSE functions to the CAA within the aviation sector. I note that the ministerial task force is due to report back to the Minister for Business, Innovation and Employment by 30 April 2012.

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