the Australia and New Zealand School of Government

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Disaster at Pike River (B)

After the explosion at Pike River a Royal Commission of Inquiry along with a Department of Labour investigation and new legislation all sought to redress the identified gap between New Zealand standards and international best practice.

The report of the Royal Commission on the Pike River Coal Mine Tragedy, published on 30 October 2012, found that this was a tragic accident, caused primarily by a substantial methane explosion. The inquiry also found underlying causes which increased the risk of this type of explosion. These secondary causes were the company's systemic operational and management failures resulting in a corporate ethos of "production above safety".

"Administrative and regulatory reforms are urgently needed to reduce the likelihood of further tragedies," the Commission said. "The Pike River tragedy contains lessons for government, regulators, employers and workers, especially in high-hazard industries such as coal mining, where the frequency of major accidents is low, but accidents can have catastrophic results."[1] As Pike River's former health and safety manager, Neville Rockhouse told the Inquiry, "The rules of mining are written in blood." [2]

The first of the Inquiry's 16 recommendations was that, to improve New Zealand's poor record in health and safety, a new Crown agent focusing solely on health and safety should be established.

Other recommendations asked that an effective regulatory framework for underground coal mining should be established urgently, and that health and safety should be an integral

This case was written by Claire Callaghan for Dr Geoff Plimmer, Victoria University of Wellington, with editorial advice from Janet Tyson, Australia and New Zealand School of Government. It has been prepared from published materials, including the 2012 *Report of the Royal Commission on the Pike River Coal Mine Tragedy.* It is designed as a basis for class discussion rather than to illustrate either effective or ineffective handling of a managerial situation.
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[1] Royal Commission, Volume 1, recommendations.
[2] Donnell, H, 'Inquiry wraps after bullying claims', New Zealand Herald, 9-12-2011.

consideration when mining permits are issued, and monitored. An approved code of practice should be issued to guide directors on their governance responsibilities to manage health and safety risks, as well as a code of practice for managers on managing health and safety risks.

Worker participation in health and safety in underground coal mines should be improved through legislative and administrative changes, and the regulator should supervise the granting of mining qualifications to mining managers and workers. Emergency management in underground coal mines should be urgently reviewed.

By then, the Independent Taskforce on Workplace Health and Safety, set up in June 2012, was already working for the Minister of Labour on its mandate "to assess whether the workplace health and safety system in New Zealand is fit for purpose, and to recommend practical strategies for reducing the rate of workplace fatalities and serious injuries by 2020."[3]

The top recommendation in its report, published in April 2013, was that the Government "establish a new workplace health and safety agency with a clear identity and brand, and statutorily defined functions, including:

a. It should be a Crown agent.
b. The new agency should be constituted on a tripartite basis, including and independent chair and members reflecting the interests of workers, unions, employers and iwi, as well as other parties interested in the workplace health and safety system.
c. The new agency should have primary responsibility for workplace harm prevention, including strategy and implementation.

The Task Force's second recommendation was that the government should "enact a new workplace health and safety Act based on the Australian Model Law."

WorkSafe New Zealand and the Health and Safety Reform Bill

On 1 July 2012, the former Department of Labour, along with its Occupational Safety and Health business, had been absorbed into the new multi-functional agency the Ministry of Business Innovation and Employment (MBIE). It had already put in place a new High Hazards Unit. It was the health and safety personnel of MBIE who worked to establish the new stand-alone agency, to be known as WorkSafe New Zealand.

WorkSafe New Zealand began operation in December 2013, a statutory entity with an independent board appointed by the Minister of Labour. By then MBIE had responded to some of the recommendations of the Royal Commission, for instance by publishing Good Governance Practices Guidelines for Managing Health and Safety Risks in association with the Institute of Directors.

As the Royal Commission Inquiry came to a close, Peter Whittall had seemed more villain than hero. A bully, who was out of touch with his company; driven by funding and production targets rather than the safety and welfare of employees.

In May 2013 the Pike River company was convicted and sentenced to pay $3.4 million in reparation to the families ($110,000 each) as well as fines for breaches under the Health and Safety in Employment Act 2003. Although considered a "landmark" case, no one had been

[3] Report of the Independent Taskforce on Workplace Health and Safety, Wellington, April 2013. Retrieved from www.hstaskforce.govt.nz

held personally liable for the incident and the fines held little weight when reportedly, Pike River Coal (now in receivership) could only fund a maximum of $5000 per family.[4]

The Health and Safety (Pike River Implementation) Bill was introduced to Parliament in June 2013. Subsequently it was divided into the WorkSafe New Zealand Act, the Health and Safety in Employment Amendment Act and the Mines Rescue Act. In March 2014, the final moves in a wholesale reform of New Zealand's workplace health and safety systems, were outlined in the omnibus Health and Safety Reform Bill, intended to take effect from July 2016, and based on the Australian Model Work Health and Safety Act.

In December 2013, twelve charges of health and safety breaches laid against Peter Whittall, were dropped due to insufficient evidence. Amid claims of "shonky deals" to buy his way out of prosecution, Peter Whittall and Pike River Coal now had the full $3.4 million at their disposal to volunteer to the families. In a letter to the Ministry of Business Innovation and Employment, they proposed to pay reparation if the costly prosecution case against Whittall case could be avoided.

In an interview in December 2013 after Whittall's acquittal, Ged O'Connell, Assistant National Secretary for EPMU (New Zealand's largest private sector union) summarised this latest decision in the long line of investigations and judgments on the Pike River case as "an appalling indictment on the health and safety culture of New Zealand." [5]

[4] *New Zealand Herald*, 5 July 2013) 'Coal company sentenced for Pike River deaths'. Retrieved from hhtp://www.nzherald.co.nz/nz/news/article/cfm?c_id=1&objected=10894893

[5] Bayer, K, 'Charges dropped against ex-Pike River boss Peter Whittall, The New Zealand Herald, 12-12-203, Retrieved from http://www.nzherald.co.nz/nz/news/article.cfm?c_ide=1&objectid=11171336

Appendix A – The New Zealand Herald, 9 December 2011

The New Zealand Herald

Inquiry wraps after bullying claims

By Hayden Donnell
2:24 PM Friday Dec 9, 2011

Peter Whittall. Photo / pool

The latest section of the Royal Commission of Inquiry into the Pike River disaster has wrapped up after criticism was directed towards former CEO Peter Whittall over the mocking and bullying of managers...

Accusations Whittall bullied safety boss

Former Pike River Coal chief executive Peter Whittall bullied and humiliated his safety manager in front of colleagues, the inquiry heard earlier.

Counsel for the families of the Pike River dead today asked Mr Rockhouse whether, on reflection, he had been a victim of bullying at the hands of Mr Whittall.

He conceded he had.

Mr Rockhouse earlier accused Mr Whittall of abusing him while he was giving a PowerPoint presentation to mine management.

He said Mr Whittall had yelled at him, mocked him and slapped the wall with his hand, before "melting down" in front of managers.

The incident sparked one of his two attempts to resign from Pike River.

Mine Manager Doug White talked him out of his decision, urging him to take some "concrete pills" and telling him the mine would gradually improve.

Mr Rockhouse also conceded there were several major safety failings at Pike River, including the fact incident reports from miners were never passed on to management.

Other failings included a lack of in-mine monitoring to check whether safety systems were being implemented, he conceded.

He blamed his high workload for the lack of mine audits.

Mr Rockhouse yesterday said his son Daniel, who survived the first blast inside Pike River, had told him mine safety breaches were common.

Those included placing plastic bags over gas sensors, impairing the ability to pick up spiking levels of potentially explosive methane, he said.

He claimed explosives were used to help spread bags of stone dust against the walls of the mine – a process aimed at preventing coal dust explosions.

"I was absolutely gutted. I couldn't believe it. We'd put so much work into that place....It's beyond comprehension...

"The rules of mining are written in blood."

By Hayden Donnell

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