**Submission Facilitating High Reliability Organisation behaviours in Queensland’s Resources Sector and Modernising Regulatory Enforcement**

**By Stuart Vaccaneo**

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**Conclusion**

**The real, identified, obvious and most problem is the failure of how risk management processes are used and implemented on Queensland coal mine sites and the seemingly deliberate inaction from the now RSHQ to do anything about it.**

**This is acknowledged by both the Brady Report (Recommendation 5) and the RSHQ Consultation Paper (pages 11 and 21). (Appendix A).**

**It is a failure of the correct hierarchy of controls where hard controls such as elimination of the hazard are not practised.**

**Every Workplace Safety and Health legislation in Australia requires the Duty Holder, (Obligation Holder) to apply the Hierarchy of Control for the management of risks that cannot be reasonably practicably eliminated, except for a Queensland Coal Mine.**

**As a matter of urgency Legislate to Amend the Coal Mining Act to clearly reflect that a parent company and its officers holds direct obligations under section 39.**

**Immediate Reintroduction of Mining Warden/Coroners Court for every Mining Fatality in Queensland is essential**

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**RECOMMENDATIONS**

1. **Do not enact any Legislation calling up wording such as High Reliability Organisations.**
2. **As a matter of urgency Legislate to Amend the Coal Mining Act to clearly reflect that a parent company and its officers holds direct obligations under section 39.**
3. **Immediately Mandating by Legislation the hierarchy of controls and in particular hard controls and their application to deal with unacceptable levels of risk** **that cannot be reasonably practicably eliminated**
4. **Immediate Legislative change to reintroduce a Mining Warden/Coroner Inquiry for every Mining Fatality.**
5. **The provision for a discretionary power to allow for extensions of time (up to 12 months) for the submission of reports after an incident has occurred. Only by the CIOCM after being provided an incident report as currently required after the current one month and on the clear proviso that the final Report will be published for distribution**
6. **Immediate publishing of all proposed changes (including the reasoning) to the Coal Mining Safety and Health Act and Regulations that have been recommended by the UQ Expert Legal Assessment CMSHA, CMSHR and Recognised Standards Report; endorsed by the Coal Safety and Health Advisory Committee (CMSHAC) and provided to RSHQ to develop into draft Legislation.**
7. **RSHQ be required to publish findings of all of its existing and future Fatality Nature and Cause Investigations, Coal Mine Worker Complaint Investigations, and other incidents/HPI’s that RSHQ formally investigates**
8. **RSHQ be required to immediately publish the Grosvenor Inquiry Recommendations feedback from the SSE’s including any templated documents.**
9. **RSHQ and the CIOCM to publish what if any actions that will be taken to ensure enacting of Grosvenor Inquiry Recommendations at each Mine**
10. **RSHQ be required to publish the mapping the Mines and Parent companies have done about mapping their status as an HRO.**
11. **To be appointed as a supervisor a person must be able to perform the tasks they are supervising (Competence means Competence for a task at a coal mine is the demonstrated skill and knowledge required to carry out the task to a standard necessary for the safety and health of persons.)**
12. **Invite Professor Michael Quinlan to do a Independent Study into Qld Mining Safety, specifically relating to Pathway 7: Failures in Regulatory Oversight**

**FOREWORD**

Enshrining High Reliability Organisation in the Qld Mining Legislation should be rejected totally.

It is nothing more than a social interaction theory.

The most obvious and effective way to ensure that the Corporate Officers have direct responsibility and legal exposure.

The only way to ensure that the Corporate Officers take the matter seriously is for the Government, Resource Minister and RSHQ to stop ignoring the Recommendation 17 from the Grosvenor Inquiry about Corporate Governance.

*“RSHQ takes advice as required and, if necessary, takes steps to amend the Act to clearly reflect that a parent company holds obligations under section 39”*

HRO theory proponents agree universally that it would be at best “quite difficult to come up with a concise easily understood definition.”

*“It is quite difficult to come up with a definition everyone agrees with” (Prof Brady)*

*“As Hopkins discusses how difficult it is to provide a concise and singular definition for a HRO”. (Page 65 Brady Report What is a High Reliability Organisation)*

If it cannot be easily and concisely defined, it has no place in Mining Safety Legislation

The Consultation Regulatory Impact Statement 2022 epitomises many of the past, current and future problems with the Public, Political and Industry Regulation of Safety and Health in the Queensland Coal Industry**.**

The Queensland Coal Mining Industry would make a Case Study into Professor Michael Quinlan’s finding about Pathway 7: Failures in Regulatory Oversight.

The Consultation paper relies on the advice promoted mostly by Academics who have never been employed as a Coal Mine Worker in the Coal Mining Industry at all, let alone underground.

The academic consultants also almost without exception hold no Coal Mining Technical or Statutory Competencies.

They almost without exception have no demonstrable knowledge or competencies with Coal Mining Legislation.

Many of these academics have had their working careers built around working for Institutions that rely on both Mining Company and State Government Grants and /or working as paid consultants to said organisations.

This immediately brings into question the ability for impartiality and leaves the question of improper influence and pre-conceived outcomes.

As the old saying goes “He who pays the piper calls the tune”

As a prime example the University of Queensland Panel recommendation to change the meaning of “Reasonably Foreseeable” regarding Regulation 296 Escapeways.

In short the meaning of Reasonably Foreseeable was decided in the Supreme Court of Queensland in 2004 and then in the Court of Appeal in what is known as the Grasstree decision.

*https://archive.sclqld.org.au/qjudgment/2004/QSC04-181.pdf*

***[27] In summary, a reasonably foreseeable event for the purposes of s 296 is one which can be envisaged by a person of imagination and intelligence, but which is not far-fetched or fanciful.***

https://www.queenslandjudgments.com.au/caselaw/qca/2005/127

The University Panel has decided that the Supreme Court and the Court of Appeal were wrong in their interpretation and seek to get another definition of Reasonably Foreseeable in the Coal Mining Act and Regulations

*A “reasonably foreseeable event” for the purposes of section 296(1) is an event which a*

*reasonable person in the position of the site senior executive ought to have in contemplation*

*when ensuring that the mine has at least 2 trafficable entrances (escapeways).*

There are demonstrable conflicts of interest with one of the University Panel was one of the Expert witnesses appearing for Anglo at the initial hearing and the appeal, and unsuccessfully arguing their interpretation of “Reasonably Foreseeable”.

It is an absolute disgracefully shameless situation.

In my view this and other examples irretrievably tainted the whole UQ Expert Legal Assessment CMSHA, CMSHR and Recognised Standards Report.

This may explain the outright refusal of the RSHQ Commissioner, CEO, Chief Inspector of Coal and the Resource Minister to make public what the accepted Recommendations are, the process they were assessed by for “effectiveness” and the reasoning for change

Some of these academic consultants have been provided with information about RSHQ Fatality Investigation findings, that has and likely will never be made public to the Coal Miners of Qld.

*Reports have only been published for 3 of the 47 fatalities: Goonyella Riverside (2017), Newlands Open Cut Mine (2016) and Grasstree Mine (2014).* (Brady Report page 22)

**RETURN MINING WARDEN CORONERS COURT for EVERY FATALITY**

I have attached several papers/studies extolling the untold benefits from conducting Coronial Inquiries. The titles are

* Family Accounts of Their Experiences and Expectations of Authorities Following Sudden Workplace Death in Queensland Australia (2)
* Work fatalities, bereaved families and the enforcement of OHS legislation
* Bereaved Family Members’ Views of the Value of Coronial Inquiries

The direct reason why the now RSHQ Nature and Cause Reports for Fatalities are not routinely published is the unilateral decision by then Minister Tony McGrady to get rid of the Mining Warden who was also a Coroner appointed under the Coroners Act.

The Mining Warden thus also acted formally as a Coroner while conducting Mining Warden Inquiries.

Then Mines Minister Tom McGrady made the decision (unilaterally) to remove the provisions for Mining Warden Inquiries from the Coal Mining Safety and Health Act.

This was in despite of the fact that it was the Findings and Recommendations of the Mining Warden Moura No 2 Inquiry that drove the philosophy and structure of the CMSHA 1999 and the CMSHR 2001 and the equivalent Legislation in the Mining and Quarrying Act and Regulations.

Written formal objections from at least the CFMEU, that asked for the Mining Warden to be retained in both the Coal and Non-Coal Mining Sectors were ignored by Minister McGrady

One of the assurances given was for Coronial Inquests to be held for each Mining Fatality.

This never occurred.

Also, assurances were made that provisions allowing the formation of a Ministerial Board of Inquiry would be used whenever necessary.

The loss of the Mining Warden/Coroner Inquiry has led to a large number of Unintended Consequences, some quite obvious at the time, others have only surfaced over time.

There has also been a cascade of other negative consequences that have flowed from this decision.

1. Coronial Inquests are only held infrequently in both Coal and Non-Coal Mining Fatalities.
2. Since the last Mining Warden Inquiry in the Coal Industry, as far as I am aware there have only been Three (3) now RSHQ Investigations into fatalities made public.
3. As per comments in the Coronial Findings for Daniel Springer, the Mines Inspectorate has now taken a position that there is no need for a Coronial Inquest unless the now RSHQ decides not to prosecute, but still sees merit in the “public interest” in a Coronial Inquest for that fatality.
4. Now RSHQ routinely refuses Right to Information requests for the Mines Inspectors Fatality reports going back as far as between 2000 and 2010.
5. The now RSHQ does not indicate whether the fatality recommended to the Inquiry has been subject to a Review Panel as per Compliance Policies that up to 2009 at least were signed by the Mines Minister at the time
6. By mutual agreement of the parties Sections of the Mines Inspectors Fatality Investigation Report can be subject to redaction.
7. Daniel Springer Coronial findings appears to redact the findings the Site Senior Executive was not the Senior Person Appointed at the Mine by the Operator.
8. The decision of the Inspectors about addressing this gross breach of the Act is not mentioned in any Mine Record Entry I am aware of.
9. The decision process of the Department about not taking the decision to prosecute is secret and never subject to scrutiny.
10. Coronial Inquests do not normally make the transcript of proceedings available to the General Public.
11. Coronial Inquests held for Mining Fatalities in the past do not normally make public any of the material entered into evidence.
12. Despite the quite clear time periods to commence prosecution, the now RSHQ routinely uses the excuse of the possibility of prosecution for not releasing any Investigations such as the North Goonyella fire and explosion and the subsequent Grosvenor Mine Explosions.
13. RSHQ Safety and Health Information pages are quite easily argued contain far less information on events in the State compared to the other major mining States of NSW and Qld.
14. The RSHQ would rank among the worst in the English Speaking major mining Countries/States, with the current information made available for High Potential Incidents, accidents resulting in permanent disabilities and mining fatalities.

From the 3 public Nature and Cause Reports and some of the content, I have no doubt that a major part of the deliberate decision to not publish anything from the Reports is to save the now RSHQ and its political masters from public scrutiny about RSHQ actions and inactions

**FAILURE of RISK MANAGEMENT, HEIRACHY OF CONTROLS, INEFFECTIVE REGULATORY OVERSIGHT**

**The real, identified and obvious problem is the failure of how risk management processes are used and implemented on coal mine site and the seemingly deliberate inaction from the now RSHQ to do anything about it.**

This is acknowledged by both the Brady Report (Recommendation 5) and the RSHQ Consultation Paper (pages 11 and 21). (Appendix A)

*The majority of the 47 fatalities involved at least one failed or absent control that could have prevented the fatality.*)

*In addition, the reported corrective actions put in place in the aftermath of Serious Accidents – incidents with a demonstrated capability to require hospital admission for treatment –* ***were in 62% of the cases administrative controls only****. Administrative controls, despite having their place in the industry, are some of the least effective controls available. (Brady Report Executive Summary page iv)*

*The Brady Review also found that the causes of fatalities are typically a combination of*

*everyday straightforward factors such as a failure of controls, a lack of training and/or absent or*

*inadequate supervision. They were not attributable to a single cause such as human error, bad*

*luck or freak accidents. Many were preventable and there was rarely a single cause. Almost all*

*of the fatalities were the result of systemic, organisational supervision or training failures,*

*either with or without the presence of human error*. (RSHQ Consultation Paper Page 21)

It is a failure of the correct application of the hierarchy of controls where hard controls such as elimination of the hazard are not practised.

The Failure is at both the Mine Site and Company Corporate Level as well as in the Regulatory and Political System

**STATE of QUEENSLAND, RSHQ and OFFICERS PROTECTION from LIABILITY EXPOSURE**

*Section 276 of the CMSHA 1999 “Protection from liability”*

*(1) An official does not incur civil liability for an act done, or omission made, honestly and without negligence under this Act.*

*Example of an act done— giving information or advice*

*(2) If subsection (1) prevents a civil liability attaching to an official, the liability attaches instead to the State.*

The Inspectorate see all the Mine Site HPI reports and the so-called corrective actions which they agree are overwhelmingly all administrative, soft, and the most ineffective controls.

The only explanation is that the now RSHQ has been in effect an integral part of the use of 62% soft controls to address HPI’s.

If the now RSHQ had taken any action to alter the outcomes of HPI’s and forced additional “hard” controls, I am sure it would have pointed out how often they have

The now titled RSHQ appears by its own admission to have done absolutely nothing about the use of inadequate controls and kept it all secret for decades as noted on page 68 of the Brady Report

*For the Regulator, it should play a key role in collating, analysing, identifying, and proactively disseminating the lessons learned from the incident and fatality data it collects from industry. The Regulator is ideally placed for such a role – they have access to industrywide information in the form of incidents, as well as significant detail pertaining to each fatality. They should play a key role in trend identification, analysis and the dissemination of best practice. This, however, has been a role that the Regulator has not been entirely comfortable with to date. While it is changing, there appears to have been a reluctance to publish detailed incident and fatality information to the industry in the past. Typically information has been released in the form of bulletins and statistics in the annual report*

Then as a further example there is this finding from the Grosvenor Inquiry.

***Finding 60***

*Grosvenor’s history on previous longwalls was such as to require close attention by the Inspectorate to the mine’s gas management systems and practices at LW 104. This did not occur, with the result that there was a lost opportunity to discover that the mine’s production rate exceeded the capacity of its goaf drainage system. The Inspectorate should have been more proactive.*

If I was one of the mineworkers injured by the events at Grosvenor Mine and was making a permanent disability claim, I would be instructing Legal Representative to include RSHQ and/or pertinent Officers

Their admitted lack of action is an enormous part of the problem and in my view constitutes “**WILLFUL NEGLIGENCE”**

Yet instead of having concrete proposals to mandate how controls are identified, applied and monitored, both Brady and RSHQ virtually ignore what they both identify as the most blatantly obvious reasons for the fatalities.

The Consultation paper also ignores and/or undermines the Grosvenor Inquiry Recommendation about Corporate Governance

“*RSHQ takes advice as required and, if necessary, takes steps to amend the Act to clearly reflect that a parent company holds obligations under section 39”*

The RSHQ consultation paper also ignores totally the fact that the Mine Managers Association of Australia also identifies the same problem in their Submissions to the Qld Transport and Resources Parliamentary Committee.

[*https://documents.parliament.qld.gov.au/com/TRC-645B/I-1147/submissions/00000010.pdf*](https://documents.parliament.qld.gov.au/com/TRC-645B/I-1147/submissions/00000010.pdf)

*As predicted by some at the time, the theory and the practice are not aligned. In many instances the SSE has no real control over the resources, those being dictated by corporate headquarters and the UMM, in some instances, has been relegated to that of a compliance manager and not even on the actual, as opposed to unofficial, management structure at the mine. This we perceive as a major concern as that type of structure could lead to a significant incident.*

Those who are actually currently performing the senior Statutory functions point out that real control exists at the Corporate level.

There is no analysis that considers whether non- compliance to the Act and Regulations was a contributing factor to any of the 47 Fatalities investigated in the Brady Report.

One of the only 3 publicly available Nature and Cause Reports is for the death of Daniel Springer at Goonyella Riverside. (Appendix C)

The RSHQ (then DNRME) Report found that the Site Senior Executive was not the most Senior person on site.

It is hard to find or even imagine a more high-level breach of the Coal Mining Act than this.

There is nothing in the RSHQ Investigation Report to state that they have raised and corrected this with the Operator (BMA).

BMA were not prosecuted.

There is no Mine Record Entry available at Goonyella Riverside that raises this issue as being discussed either at site or in a formal Compliance meeting with both Site and Corporate Officers.

The only reason that this became known is that RSHQ decided not to prosecute BMA and or its Officers and then recommended a Coroners Court occur and the Investigation report was tendered as evidence.

Otherwise, it would be secret just like any other Compliance/Non Compliance issues for the other 44 still unpublished and secret Fatality Nature and Cause Investigation Reports from the now RSHQ Mines Inspectorate

It would seem that BMA has persuaded the Coroner that this breach of the Act is not relevant to the Coronial Inquest and so was not addressed at all and by the looks of things were even redacted

*I also accept the submission on behalf of BMA that matters of housekeeping and perceived non-compliances specific to BMA (a traversed within the DNRM report), and not causative to the circumstances surrounding Mr Springer’s death, are beyond the ambit of the coronial inquiry.*

The University of Queensland Panel recommended changes to the Regulations remain shrouded in secrecy so it is totally impossible to make any comment on them until they are effectively fait accompli.

There is nothing about how the shroud of secrecy that surrounds RSHQ and its decades long refusal to publish any findings of its Fatality Investigations and Formal Complaints has been addressed. For example

*The Regulator does not typically publish in-depth analysis of the data in a manner that would assist industry to identify emerging trends (Brady Report page 34).*

**GROSVENOR INQUIRY RECOMMENDATIONS IMPLEMENTATION SECRECY BY RSHQ**

The current Chief Inspectors written and then verbal testimony to the Qld Transport and Resources Committee on the 24th of October 2022 about the total lack of feedback from the Industry about the implementation of the Grosvenor Inquiry Recommendations is an utter disgrace and is emblematic of the inability of the current industry outlook to change.

*With respect to the recommendations from the board, as I mentioned in my opening speech, I requested the industry to provide me with an update of where they are at. In fact, I even gave them the template to fill out. Five days from the end of October, I have not received one. In terms of my inspectors’ and my inspections and audits of coalmines, I have a view that the 27 recommendations for industry and the further three particularly for Grosvenor have not all been implemented. If there is a learning from the past, be it Moura No. 2 or Moura No. 4, it is the time industry takes to implement recommendations. Hence, I am sure the committee will be asking those questions of industry. As I say, the fact that, five days out, industry has not responded to a request from the chief inspector for an update on where they are at is sad.*

The CIOCM Newman states that NO Mine has responded.

This begs the obvious questions.

1. How did the RSHQ Inspectors decide that Grosvenor Mine could restart operations if they had not showed how they had implemented all the recommendations?
2. What stage is each Mine up to implementing the Grosvenor Recommendations?
3. What actions if any is the CIOCM Newman and RSHQ in general taking to enforce adoption and compliance to the Grosvenor Inquiry Recommendations to try and ensure an acceptable level of risk

Further the CIOCM testimony brought the whole futility of the HRO push and the supreme waste of time and attempted camouflage for taking no proactive changes.

*“there have been some organisations that are mapping their current systems and processes to HRO principles to ascertain, ‘Well, we do that, we do that and we do that; we are an HRO,’ which is not necessarily what is meant by becoming a high-reliability organisation and living by those principles.”*

**TEN PATHWAYS to DEATH and DISASTER Pathway 7 Failure of Regulatory Oversight**

One of the most respected analyses of Mining Disasters is written by Professor Michael Quinlan in his book **Ten Pathways to Death and Disaster: Learning from Fatal Incidents in Mines and Other High Hazard Workplaces by Michael Quinlan**

Quinlan identified Pathway 7: Failures in Regulatory Oversight

The Queensland Coal Mining Industry would make a Case Study into Professor Quinlan’s findings.

It is easy to point out all of these situations described over the last 20 odd years and currently.

The situation is arguably getting worse every year that passes.

Quinlan makes the following findings about Failures of Regulatory Oversight when discussing Internal government processes, interest groups and the corrosion of reformon page 212

*Once findings and recommendations are handed down the next hurdle is the extent to which the government agrees to implement all or some of the recommendations.*

*A range of factors can affect this, including*

* *the lapse of time (usually a year or more has passed since the incident),*
* *the level of community pressure, the government’s own policy agenda and the implementation process itself in terms of those given input, transparency, time-lines etc.*
* *Ministerial and Cabinet approval for substantial legislative change is commonly subject to intense lobbying by influential interest groups seeking to block or water down the legislation in a discreet fashion.*
* *Such activity is seldom reported.*

*On the other hand, those in favour of the change will need to scrutinise the regulatory drafting to ensure the legislation will actually achieve its purpose.*

*Key appointments to legislative oversight bodies and within the public sector can act as either lubricants or sources of friction with regard to the reform process.*

*The legislative drafting can be critical.*

*Even seemingly minor revisions can have significant effects. Equally critical is the provision of adequate infrastructure like inspectorate resourcing and strategic direction to implement the changes.*

*Even when regulatory change is successfully introduced powerful interest groups often seek to influence its implementation, to lobby their political representatives to reverse legislation or undermine its enforcement, or to refashion the laws years later when the heat has gone out of the debate*

**Failure of Risk Management Practises and not using Hard Controls**

**Queensland Coal Mine as the only workplace in Australia not required by law to apply the Hierarchy of Control to manage workplace risk.**

The real and obvious problem is the failure of how risk management processes are used and implemented both at a corporate level and on the coal mine site.

*The majority of the 47 fatalities involved at least one failed or absent control that could have prevented the fatality. (Brady Report Executive Summary page iv)*

It is a failure of the correct hierarchy of controls where hard controls such as elimination of the hazard are not practised.

Every Workplace Safety and Health legislation in Australia requires the Duty Holder, (Obligation Holder) to apply the Hierarchy of Control for the management of risks that cannot be reasonably practicably eliminated, except for a Queensland Coal Mine. Even the Queensland Mining and Quarrying Safety and Health Act (Regulation).

Whilst Queensland Coal Mining, arguably one of the highest risk workplaces possible, has legislation that focuses on Risk Management, the Recognised Standard for Risk Management (RS02) has not been updated since it was first Gazetted in July 2003. Despite a new cover page in 2018 the content still references obsolete documents (MDG 1010), standards (AS4360) and competency requirements (G2). No mention of the Hierarchy of Control.

With all of the research, publications, improvements and increased knowledge in Risk Management over the generational period since the introduction of Risk Management into Queensland Coal Mining following the disasters of the 1970’s, 80’s and 1990’s, the Recognised Standard for Risk Management for a Queensland Coal Mine is still primitive in terms of risk management.

This leaves a Queensland Coal Mine as **the only workplace in Australia** not required by law to apply the Hierarchy of Control to manage workplace risks.

It should be no surprise then that the Review of Fatal Accidents in Queensland Mines found a lack of effective higher order controls for these fatal risks.

How can it be that such a high-risk industry, with increasing deaths and mine explosions still doesn’t even mention or require the hierarchy of control when it has been a requirement in every other Australian workplace for over 10 years. How can arguably one of the highest risk workplaces have a Risk Management Standard which has never been updated in 20 years. How can the Standard refer to obsolete references?

If a mine did this, RSHQ would want to prosecute them. The same RSHQ who told white lies to the Black Lung Parliamentary Inquiry. The same RSHQ who best response to a spate of fatal accidents was to have a state-wide waste of time called a Safety Reset.

For the lives of Queensland Coal Mine Workers, how hard can it be to have a standard which at least requires a Coal Mine Operator to use the Hierarchy of Control? It seems like every other workplace in Australia has done it, why not at a Queensland Coal Mine. It can’t be that hard.

**HIGH RELIABILITY ORGANISATIONS. Not easily definable and has no place in Mine Safety Laws**

The whole push for mining companies and HRO behaviours even by promoters is acknowledged as

*“It is quite difficult to come up with a definition everyone agrees with” (Prof Brady )*

*“As Hopkins discusses how difficult it is to provide a concise and singular definition for a HRO”. (Page 65 Brady Report What is a High Reliability Organisation)*

The whole proposal to legislate for High Reliability Organisations (HRO) is probably going to be the greatest waste of time and effort ever foisted on the Queensland Coal Mining Industry.

If it cannot be easily concisely defined it has no place in Mining Safety Legislation.

It will in fact be counterproductive.

It will not create any changes to the behaviours of the real decision makers in the Mining Companies.

Instead, it will be used for years as a further defence to say please give us more time to get the HRO philosophy embedded.

If the so called Mine Safety Experts proposing this social theory experiment cannot come with a concise agreed definition it has no place in any Safety and Health Legislation.

It does nothing about addressing the relevant findings and Recommendation from the Grosvenor Inquiry.

From my reading of the proposed Legislation Recommendation 17 from the Grosvenor Inquiry has been ignored altogether.

There is nothing proposed to make anyone company Officer above the Site SSE directly accountable for the decisions that they impose from above

**Chapter 6 – Corporate governance**

*Finding 74*

*If a parent company of an operator company holds obligations under section 39 of the Act, officers of the parent company would have the obligation under section 47A of the Act to exercise due diligence to ensure that the parent company complied with its obligations under section 39. The legislation should be cast in terms that remove any doubt that this is so.*

*Recommendation 17*

*RSHQ takes advice as required and, if necessary, takes steps to amend the Act to clearly reflect that a parent company holds obligations under section 39.*

MINE MANAGERS’ ASSOCIATION OF AUSTRALIA INCORPORATED

https://documents.parliament.qld.gov.au/com/TRC-645B/I-1147/submissions/00000010.pdf

*As predicted by some at the time, the theory and the practice are not aligned. In many instances the SSE has no real control over the resources, those being dictated by corporate headquarters and the UMM, in some instances, has been relegated to that of a compliance manager and not even on the actual, as opposed to unofficial, management structure at the mine. This we perceive as a major concern as that type of structure could lead to a significant incident.*

The whole process as published by RSHQ, does not directly address the major identified failings that the Brady Report identified in the 47 fatalities by Professor Brady.

These failings are the failed and absent controls that could have prevented the fatality and the increasing use of soft “administrative” controls and RSHQ not sharing the findings of their Nature and Cause Reports to Industry and the Public

* *The majority of the 47 fatalities involved at least one failed or absent control that could have prevented the fatality. (Brady Report Executive Summary page iv)*
* *In addition, the reported corrective actions put in place in the aftermath of Serious Accidents – incidents with a demonstrated capability to require hospital admission for treatment – were in 62% of the cases administrative controls only. Administrative controls, despite having their place in the industry, are some of the least effective controls available. (Brady Report Executive Summary page iv)*
* *The Regulator does not typically publish in-depth analysis of the data in a manner that would assist industry to identify emerging trends. (page 34)*

I have attached a paper that discusses the problems for trying to use HRO theory for industries such as mining.

**Moving Beyond Normal Accidents and High Reliability Organizations: A Systems Approach to Safety in Complex Systems. By Nancy Leveson, Nicolas Dulac, Karen Marais, and John Carroll**

I have taken a number of relevant quotes from the paper about why HRO theory is not appropriate for mining.

Rather than summarise them I have just boldened what I consider the most important pieces

***5. Reliability vs Safety***

***Safety and reliability are different properties.******One does not imply nor require the other — a system can be reliable and unsafe or safe and unreliable. In some cases, the two system properties are conflicting, that is, making the system safer may decrease reliability and enhancing reliability may decrease safety.*** *To fully understand the differences and even potential conflicts between reliability and safety requires defining terms. Reliability in engineering is defined as the probability that a component satisfies its specified behavioral requirements over time and under given conditions. Safety can be defined as freedom from unacceptable losses (accidents). Note that the reliability of nuclear power plants with the same design as Chernobyl is very high, i.e. the calculated mean time between failures is 10,000 years.*

*Indeed, the systems and organizations often cited in the HRO literature have such good safety records because* ***they have distinctive features that make the practices they use to improve safety rates difficult or impossible to apply in other organizations.*** *For example, La Porte and Consolini have characterized HRO organizations in the following manner:*

*‘HROs struggle with decisions in a context of nearly full knowledge of the technical aspects of operations in the face of recognized great hazard... The people in these organizations know almost everything technical about what they are doing — and fear being lulled into supposing they have prepared for every contingency ... This drive for technical predictability has resulted in relatively stable technical processes that have become quite well understood within each HRO.’ (La Porte and Consolini 1991: 29–30; emphases added)*

*While these properties certainly help to engineer and operate safer systems and they do exist in the systems that were studied,* ***they do not apply to most systems.***

*The first property identified for HROs is that they have nearly full knowledge of the technical aspects of operations. If technical knowledge is complete, however, it is relatively easy to lower risk through standard system safety and industrial safety techniques. As Perrow noted, the challenges arise in complex systems when the interactions between components cannot be thoroughly planned, understood, predicted, or guarded against, i.e. when full knowledge does not exist****. In fact, complete technical knowledge does not exist in most high-risk systems, and society is usually unwilling to defer the benefits of these systems until that knowledge can be obtained, perhaps only after decades of research***

*. While technical stability has improved accident rates,* ***it is not a practical or desirable goal for most organizations, particularly profit-making organizations that must compete on innovation, efficiency, quality, and other attributes.***

*In summary, an important problem with HRO theory is that the practices were observed in systems with low levels of uncertainty and stable technical processes****. For most systems in competitive industries where technological innovation and advances are necessary to achieve the system mission and goals, these features do not exist or are not practica****l. The practices the HRO researchers observed in these special cases may not apply to other systems or may be much more difficult to implement in them.*

*HRO practices have been identified by observing organizations where safety goals are buffered from conflicts with other goals because of the nature of the mission. For example, La Porte and Consolini claim that in high reliability organizations the leaders prioritize both performance and safety as organizational goals, and consensus about these goals is unequivocal (La Porte and Consolini 1991). While this state of affairs is clearly desirable, it is much easier to achieve if safety is indeed the paramount goal of the organization.* ***For many of the organizations studied by HRO researchers, including aircraft carrier landing operations in peacetime, US air traffic control, and fire fighting teams, safety is either a primary goal or the primary reason for the existence (i.e. the mission) of the organization, so prioritizing it is easy.*** *For example, in peacetime aircraft carrier operations (which was when La Porte and Consolini observed them), military exercises are performed to provide training and ensure readiness. There are no goal conflicts with safety: the primary goal is to get aircraft landed and launched safely or, if that goal is not successful, to safely eject and recover the pilots. If conditions are risky — for example, during bad weather — flight operations can be delayed or canceled without major consequences.*

***For most organizations, however, the mission is something other than safety, such as producing and selling products or pursuing scientific knowledge****.* ***In addition, it is often the case that the non-safety goals are best achieved in ways that are not consistent with designing or operating for lowest risk. Management statements that safety is the primary goal are often belied by pressures on employees to bend safety rules in order to increase production or to meet tight deadlines***

**BRADY REPORT**

Brady was given exclusive one-off access to the RSHQ Fatality Investigation Reports, and he is the only person outside of RSHQ that has ever been given access.

The additional problem that totally exacerbates that problem is the quite deliberate and long term refusal of RSHQ to disseminate any of the findings of the their own Nature and Cause Investigations.

The Brady Report notes on page 22, 34 and 68 respectively

* *Reports have only been published for 3 of the 47 fatalities: Goonyella Riverside (2017), Newlands Open Cut Mine (2016) and Grasstree Mine (2014).* (page 22)
* *The Regulator does not typically publish in-depth analysis of the data in a manner that would assist industry to identify emerging trends. (*page 34)
* *While it is changing, there appears to have been a reluctance to publish detailed incident and fatality information to the industry in the past. Typically information has been released in the form of bulletins and statistics in the annual report.*

As Prof Brady states in his report and then is quoted by RSHQ in its consultation paper the major problem is identified on page 21

***The majority of the 47 fatalities involved at least one failed or absent control that could have prevented the fatality***

Even after HPIs occur it has been identified that in 62% only soft administrative controls are enacted

**HRO Hard to have an agreed definition Brady and Hopkins**

Professor Brady notes in his online presentation webinar presentation into his Report states at about 6 minutes and 30 seconds.

“*It is quite difficult to come up with a definition everyone agrees with*

https://www.youtube.com/watch?v=HXK6c9C\_kj4

*As Hopkins discusses how difficult it is to provide a concise and singular definition for a HRO. For*

*example, what is the best way to statistically define ‘near accident-free performance’? Hopkins*

*also points out that attempting to use an organisation’s performance record is problematic –*

*operations can have high performance, but also be unsafe.*

*Hopkins considers that the most useful way to define a HRO is to assess whether or not it*

*exhibits five key characteristics 113.These key characteristics were developed by Karl Weick and*

*Kathleen Sutcliffe and are defined as:*

*1. Preoccupation with failures rather than successes,*

*2. Reluctance to simplify interpretations,*

*3. Sensitivity to operations,*

*4. Commitment to resilience, and*

*5. Deference to expertise*

**SUPERVISOR COMPETENCIES**

The Industry has had over 22 years to get their thoughts around this topic and introduce competencies themselves.

That they have not done so, shows that they have no intention of doing so even though the Legislation says they have to for over 22 years.

Therefore, it is up to the Legislation to spell it out

The Australian Mine Managers Association dealt with this issue in their submission to the Transport and Resources Committee re Inquiry into Coal Mining Safety. *https://documents.parliament.qld.gov.au/com/TRC-645B/I-1147/submissions/00000010.pdf*

In part they state in page 6 then 8

*At open cut coal mines, the requirement for a First Class Mine Manager, who was responsible*

*for the mining operations at the mine, was eliminated. This effectively meant at some*

*operations the only statutorily qualified personnel are Open Cut Examiners (OCEs) and their*

*numbers are being depleted to the bare minimum. We know of operations were there are no*

*persons with either mining or civil engineering qualifications being appointed to Mining*

*Manager positions. Indeed, there is one notorious incident where the newly appointed*

*Mining Manager asked her predecessor if the ‘large wall’ in front of them was known as the*

*highwall. This unacceptable situation combined with the appointment of supervisors that*

*have limited experience means that hazards are not being identified and or effective control*

*measures are not being applied.*

*In several incidents of which we are aware, the experience and competence of the immediate*

*‘supervisor’ was less than what we would describe as desirable. The qualification, experience,*

*and training standard of supervisors, particularly in the open cut sector require urgent review.*

*We would question the ability of some supervisors to adequately identify hazards and the*

*necessary controls to minimise the risk to acceptable levels. Supervisors should not, in our*

*opinion, be a substitute for statutorily qualified individuals.*

*Fit for purpose equipment – overriding this topic is again, the subject of competence. In many*

*instances engineering managers, both mechanical and electrical, are being appointed and*

*their knowledge of mining equipment and legislation is highly questionable. They are being*

*appointed by corporate officers, and as many corporate officers are ignorant of industry safety*

*and health requirements, they are oblivious to the standard required. Just because one has*

*tertiary qualifications in engineering does not mean you have a working knowledge and*

*understanding of mining equipment.*

I also refer to Submissions made to the Transport and Resources Committee in 2020 for the Mineral and Energy Resources and Other Legislation Amendment Bill 2020

*https://documents.parliament.qld.gov.au/committees/SDNRAIDC/2020/1MEROLAB2020/submissions/013.pdf*

In particular take note of pages 11 to 13.

The submitter who has had their identity withheld by the Parliamentary Committee summarises it better than I

*So to summarise what I believe the intent for supervisors is, it is that the supervisor must be*

*able to perform the tasks they are supervising ( competence means Competence for a task at a*

*coal mine is the demonstrated skill and knowledge required to carry out the task to a standard*

*necessary for the safety and health of persons.) and has the relevant competency which is S 1*

*S2 S3 and G2 and as such the SSE must only appoint those to superviso1r roles who hold*

*those attributes.*

*There simply is no other competency for supervisors and the above is being abused to the*

*point we now have supe1visors who are looking after large crews and have only been in the*

*industry for a very few years or in charge of work groups for which they have never worked*

**APPENDIX A**

**HRO APPLICATION and GROSENOR INQUIRY RECOMMENDATIONS SO FAR**

Peter Newman CIOCM 24th Oct 2022 verbal evidence to Qld Transport and Resources Parliamentary Committee

***“Mr WALKER****: With regard to the high-reliability organisational principles that were*

*recommended by the 2019 Brady review, can RSHQ comment on how they are being adopted across*

*the industry? Has there been any resistance to the introduction of these principles?*

***Mr Newman****: In terms of their introduction across the industry, QRC and the commissioner’s*

*office have commissioned a review of where mines are up to with respect to the implementation of* *HROs and the principles. That was across not only underground operations but also surface*

*operations and the metals, mines and quarrying sector. It would be fair to say that there is a broad*

*spectrum of where organisations are at in terms of adopting those principles. As to whether there has been any resistance, certainly from my observations there has not been any resistance.*

*However, there have been some organisations that are mapping their current systems and processes to HRO principles to ascertain, ‘Well, we do that, we do that and we do that; we are an HRO,’ which is not necessarily what is meant by becoming a high-reliability organisation and living by those principles.*

***Mr MILLAR****: In response to the board of inquiry recommendations, how does the inspectorate*

*see the coal industry is managing competing priorities of coal production rates and worker safety?*

***Mr Newman****:* *With respect to the recommendations from the board, as I mentioned in my*

*opening speech, I requested the industry to provide me with an update of where they are at. In fact,*

*I even gave them the template to fill out. Five days from the end of October, I have not received one.*

*In terms of my inspectors’ and my inspections and audits of coalmines, I have a view that the*

*27 recommendations for industry and the further three particularly for Grosvenor have not all been*

*implemented. If there is a learning from the past, be it Moura No. 2 or Moura No. 4, it is the time*

*industry takes to implement recommendations. Hence, I am sure the committee will be asking those*

*questions of industry. As I say, the fact that, five days out, industry has not responded to a request*

*from the chief inspector for an update on where they are at is sad.*

**APPENDIX B**

Recommendation 5 Brady Report

Recommendation 5: The industry needs to focus on ensuring the effectiveness and enforcement of controls to manage hazards. Given the increasing Serious Accident Frequency Rate, industry should implement more effective controls (such as elimination, substitution, isolation, or engineering controls). A significant number of the controls reported put in place in the aftermath of an incident were administrative in nature.

The majority of the 47 fatalities involved at least one failed or absent control that could have prevented the fatality. The underlying factors for these absent controls often stemmed from decisions made at a supervisory and/or organisational level in organisations.

In recent years, the role played by ineffective controls in incidents, including Serious Accidents, is increasing.

In addition, the reported corrective actions put in place in the aftermath of Serious Accidents – incidents with a demonstrated capability to require hospital admission for treatment – were in 62% of the cases administrative controls only. Administrative controls, despite having their place in the industry, are some of the least effective controls available.

The RSHQ Consultation Paper

https://www.rshq.qld.gov.au/\_\_data/assets/pdf\_file/0010/1640926/FINAL-CRIS-Version.pdf

The Brady Review found almost all of the fatalities were the result of systemic, organisation, supervision or training failures, either with or without the presence of human error.

Human error alone would not have caused, and should not be accepted, as the cause of, these fatalities.

For instance, the review of each of the 47 individual fatalities revealed:

• 17 of the fatalities involved no human error on the part of the deceased

• 17 of the fatalities involved a lack of task-specific training and/or competencies for the tasks being undertaken. A further nine fatalities involved inadequate training

• In 32 of the 47 fatalities, the worker was required to be supervised when undertaking the tasks and 25 of these involved inadequate or absent supervision

• The majority of the 47 fatalities involved at least one failed or absent control that could potentially have prevented the fatality

• There were 10 incidents involving known faults/issues, where individuals were aware of them, but no action was taken

• Nine fatalities had known near misses occur prior to the fatality

• In some cases, prior fatalities had occurred in a similar manner.

On page Pg 21 the RSHQ Consultation paper

The data demonstrate that approximately 75-85 per cent of HPIs do not result in injuries and as

Brady states, “these HPIs are near misses, which offer genuine opportunities for the industry to

identify hazards and remove them before they can cause harm.”

The Brady Review also found that the causes of fatalities are typically a combination of

everyday straightforward factors such as a failure of controls, a lack of training and/or absent or

inadequate supervision. They were not attributable to a single cause such as human error, bad

luck or freak accidents. Many were preventable and there was rarely a single cause. Almost all

of the fatalities were the result of systemic, organisational supervision or training failures,

either with or without the presence of human error.

**APPENDIX C Daniel Springer Fatality**

DNRME Report page 13

Site Senior Executive

The investigation revealed evidence to suggest that the appointed SSE at Goonyella Riverside mine was not the most senior officer employed who has responsibility for the coal mine as required by section 25 of the Coal Mining Safety and Health Act 1999. Evidence given by the maintenance manager showed that he did not report to the SSE but to the General Manager of Goonyella Riverside mine.

Since the SSE did not appear to manage the maintenance manager’s routine individual development and performance review process, he could not ensure that he had the competencies required to carry out his responsibilities, and that he was effectively carrying his responsibilities as stated in the management structure.

This is contrary to section 55 of the Coal Mining Safety and Health Act 1999, which states that the SSE for a mine must develop, implement and maintain a management structure that helps ensure the safety and health of persons at the mine.

CORONERS FINDINGS

67. At the conclusion of the five days of oral evidence, those with leave to appear negotiated redactions to the Nature and Cause report. The redacted report was exhibited to the coronial brief of evidence. BMA and IMS both agreed they would address their respective client’s outstanding issues with the Mines report through written closing submissions. Mr Bulger was not required to provide oral evidence to the inquest.

68. As submitted by IMS I accept the conclusions and findings within the DNRM report should be viewed through the lens of the greater volume and quality of evidence available with the benefit of the coronial investigation and Inquest.

69. I also accept the submission on behalf of BMA that matters of housekeeping and perceived non-compliances specific to BMA (as traversed within the DNRM report), and not causative to the circumstances surrounding Mr Springer’s death, are beyond the ambit of the coronial inquiry.