



Royal Commission on the Pike River Coal Mine Tragedy
Te Komihana a te Karauna mōte Parekura Ana Waro o te Awa o Pike

UNDER

THE COMMISSIONS OF INQUIRY ACT 1908

IN THE MATTER OF

**THE ROYAL COMMISSION ON THE PIKE RIVER COAL
MINE TRAGEDY**

Before: The Honourable Justice G K Panckhurst
Judge of the High Court of New Zealand
Commissioner D R Henry
Commissioner S L Bell
Commissioner for Mine Safety and Health, Queensland

Appearances: K Beaton, S Mount and J Wilding as Counsel Assisting
J Haigh QC for Douglas White
J Rapley for Neville Rockhouse
S Moore SC and K Anderson for the New Zealand Police
N Davidson QC, R Raymond and J Mills for the Families of the Deceased
S Shortall for certain managers, directors and officers of Pike River Coal Limited (in receivership)
C Stevens and A Holloway for Solid Energy New Zealand
K McDonald QC, C Mander and A Boadita-Cormican for the Department of Labour, Department of Conservation, Ministry of Economic Development and Ministry for the Environment
G Nicholson and S Stead for McConnell Dowell Constructors
G Gallaway and E Whiteside for NZ Mines Rescue Service
N Hampton QC and R Anderson for Amalgamated Engineering, Printing and Manufacturing Union Inc
T King and C Baker for The Coal Association of New Zealand/Straterra Incident
R Wilson for New Zealand Council of Trade Unions
J Kay for MinEx

**TRANSCRIPT OF PHASE FOUR HEARING
HELD ON 3 APRIL 2012 AT GREYMOUTH**

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COMMISSION RESUMES ON TUESDAY 3 APRIL 2012 AT 09.30 AM**SUBMISSIONS: MR WILSON**

Mr Chairman, members of the Commission, thank you for the opportunity to
5 appear and to speak to the submission on behalf of the Council Trade Unions.
As this is my first substantive appearance, I'd like to first of all express my
condolences to the families. This is a tragedy which should never have
occurred. I should also like to briefly introduce myself. I'm not an expert in
10 mine safety but, as a lawyer and a union leader I have been closely involved
in the law and policy and the day to day workplace reality of occupational
safety and health for almost 40 years as a lawyer in the 1970s, a rail and port
union leader in the 1980s and 90s and as the president of the Council of
Trade Unions from 1999 to 2007. I was a member of the government
15 advisory committee of occupational safety and health, ACOSH from 1985 to
1990. I was the deputy chair of ACC from 1985 to 1991 and the chair from
2007 to 2009. I was a member of the tripartite implementation panel for the
2002 amendments for the Health and Safety in Employment Act and I'm a
co-author of Brookers Employment Law and the author of the HSE Act
20 commentary in that legal text. I was also a director of Ports of Wellington
Limited for seven years in the 1990s and I was a director of Kiwi Rail and a
chair of the board's health and safety committee. The objective of the CTU in
this inquiry has been to complement the EPMU with its detailed focus on
phases one to three and for us to address policy issues in phase four to assist
25 the Commission to identify and support policy solutions in the hope that we
can ensure that a tragedy like this never occurs again either in the coal
industry or in any other industry in New Zealand which brings me to the point
that the CTU looks at this from a high level of, a policy level view point than
the EPMU or the PSA which has also filed a submission but which didn't get
30 the opportunity to appear today but which has filed a note highlighting specific
points in their submissions.

The HSE Act and regulations are the statutory framework along with the
Hazardous Substances and New Organisms Act which is intended to protect

workers from injury and death in New Zealand. The CTU represents almost 350,000 of those workers and in undertaking its role acts on behalf of other workers as well. The submissions look at the adequacy of that statutory framework, both in the specific provisions and in how it has been administered
5 in practice by the Department of Labour and successive governments. This is general duty legislation which was intended to be supplemented by necessary, in some industries very necessary prescriptive regulations and supported by the three pillars, employers, the regulator and worker participation and representation.

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The CTU submission is in two parts. The first part addresses the issues which this tragedy has highlighted for the CTU. The second part specifically addresses the questions which the Commission expressed interest in, in minute number 10.

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Given the time constraints I will speak to some of those issues only briefly and spend a little more time on the issues where there is less consensus amongst the parties here. So if I could turn to the submission itself, to page 10, point seven, that's point seven on page 10 and this relates to the issue of
20 pre-operational approvals processes or the absence of it and the submission notes the bitter irony that while the Crown Minerals Act requires a permit to ensure quote "a fair financial return" for the Crown and the Resource Management Act requires resource consents for the protection of the environment there is no similar process for the protection for the health and
25 safety of workers. This is a bizarre ordering of priorities and I submit it must be addressed and there appears to be a consensus on the need for such process and the additional point which the CTU would make is that this should include an assessment of the financial and the technical capacity of the applicant to successfully implement the safety case or plan or whatever the
30 approval process is and yes, the CTU submits that the safety case or plan that should be subject to approval and not merely noting, possibly utilising specific contracted expertise from Australian jurisdictions. I turn now to page 12 and point eight on page 12 and this relates to the special focus on high risk

industries. The CTU submission supports the increased focus on high risk industries through the high hazards unit but the CTU questions the narrow scope of the focus of that unit and refer to and specifically support Dr Callaghan's concern in this regard expressed in her submission to

5 Phase Four from paragraphs 51 to 66. Dr Callaghan notes that Professor Taylor identifies I think 37 other industries which he considered would come into the high hazard category and I think I would add rail transport to that list as well, making 38 and I'm sure there may be others. I turn now to page 16, point 10(g) relating to regulations and codes of practice. The CTU

10 submits that the evidence to this enquiry points to an urgent need for the establishment of a properly resourced process for standard setting through a tripartite process. Absolutely safety is never guaranteed. The test in New Zealand is all practicable steps, with the definition that that has in the HSE Act and I note that in Queensland it is I think "an acceptable level of risk".

15 And for this reason the process of determining the minimum acceptable level of risk, however that's expressed in law must include the representatives of the workers who are exposed to the risks. This is a social process, it's not just a technical process. At point 10(k) as Gunningham and Neal note the Department of Labour has apparently chosen for reasons of Government

20 policy and because, well Professor Gunningham quotes "They are time consuming and onerous" not develop standards through ACOPS and by default the process is developed for some employer groups, not just in the coalmining industry but in many industries to develop their own informal codes. In my submission and with due respect to MinEx this is not

25 acceptable. Again I refer to Gunningham and Neal at point 10(l) in my submission.

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The caution is, "There is a risk of conflict of interest between industries concerned to minimise costs which might result in the creation of low

30 standards or no standards at all and the public and worker interest in approving occupational safety and health outcomes. Such codes might for example result in the lowest common denominator approaches and are de

facto lowering of the general standard of care, the general duty standard of care.”

5 Having said that I submit that for the reasons referred to by Professor Quinlan
in his report to the Department of Labour their task of setting and
implementing the standards in mining is relatively easy and I refer to his
comment in .10(i) and I emphasise relatively easy rather than easy and his
quote, “The major hazards in mining are relatively well known and a number
of control measures well understood. There is an argument that more
10 emphasis should be laid on prescriptive regulation.” Further down, “Where
control measures are clearly known in the relation to hazards a requirement
that they should be applied is unambiguous and assists management in terms
of compliance.”

15 And of course New Zealand has the benefit as I understand it of willing
assistance from the Australian jurisdictions which have long adopted such an
approach. I welcome the Department of Labour’s commitment at
paragraph 59 of the Phase Four submission for a comparable level of
prescription and for the acknowledgement that this could and I quote, “Further
20 reduce the probability of future catastrophic events.”

I found that statement in the submission quite breath taking. This is not new
knowledge and is exactly what was intended when the Act was past 20 years
ago. The worry is that this deficit also exists in many other industries and the
25 CTU submits that at .114 that a task force approach to addressing this deficit
should be embarked on as a matter of urgency.

Point 12 on page 19, the regulator. I just make three points here in addition to
highlighting what’s in the submission. Firstly there is a strong constituency
30 within the Council of Trade Unions which argues that the Department of
Labour has forfeited the right to continue as the Government agency
responsible for the Health and Safety in Employment Act.

Secondly, we note that the Prime Minister has announced that the Government will within a few months create a new super business ministry incorporating the Department of Labour which increases the CTU concern. Part of that concern is that OSH should be more than a few lines in the accountability documents of a large business department, but more importantly I think, is that Gunningham and Sinclair refer to the risks of regulatory capture and that is the concern that is shared by the CTU and I quote from Gunningham and Sinclair, “The location of an OSH inspectorate in a Government agency whose primary responsibility is the economic success and productivity of the very industry it purports to regulate is a prescription for disaster” and this applies of course or will apply with the super ministry, not just to the coalmining industry, but to almost every industry in New Zealand.

And so I refer to page 20 of the CTU submission to .12B and I'll just read from the submission, “An obvious alternative to the current Department of Labour or a super ministry is that a new Crown entity under the Crown Entities Act 2004 be created for the tripartite Government structure is a specialist agency focused solely on the development and administration and enforcement of the HSE Act and the workplace enforcement of the HSNO Act.

This new Crown entity would be a Crown agent as CAA, Land Transport New Zealand, the Environmental Protection Agency, Maritime New Zealand and ACC currently are or it could be an autonomous Crown entity in as is Standards New Zealand or an independent Crown entity as the Transport Accident Investigation is. Such a model would be consistent with the original recommendations of the 1998, 1988 ACOSH report as well as the models of similar statutory occupational safety and health authorities, what are referred to as the “Robens” countries, the UK, Canada and Australia. Such a model would ensure that an important regulatory function, the protection of the health and safety of workers in their employment is not subverted to or unduly influenced by the primary functions of the super ministry. We'd also provide greater flexibility to enter into co-regulatory or skill and resource sharing partnerships with for example Australian regulatory authorities. In promoting

this independent agency option, the CTU is not intending to question the integrity of well intended specialist staff and other staff in the Department of Labour.

5 **THE COMMISSION:**

Can I just interrupt you Mr Wilson –

MR WILSON:

Certainly.

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THE COMMISSION:

Is what you're proposing that the new Crown entity, this new independent agency would assume the full inspectorate function –

15 **MR WILSON:**

Yes.

THE COMMISSION:

20 - presently undertaken through Labour in relation to the Act so that what in the course of this inquiry has been referred to as the generalist –

MR WILSON:

Yes.

25 **THE COMMISSION:**

- inspectorate would be in the agency as well. It's not just a simple high hazard concept.

MR WILSON:

30 No, sir. I mean the point, yes, this is an issue that relates to the whole of the function of this responsibility within the department, the administration of the Act. Secondly, the high hazard unit, the scope of it as submitted should be much broader so we're talking actually about a lot more than the coalmining

and extractive industries, but the third point I think is the one that also Dr Callaghan makes in her phase four submission. Why should there be some sort of lower standard of care for, other than the high hazard units? Yes, there is a need for special focus and there is a need for a greater level of understanding of the processes of management in high hazard industries and there is a need, I think, as Professor Quinlan recommends for a beefed up worker participation system in high hazard industries but I think the whole responsibility should really rest with an autonomous well semi-autonomous Crown entity because it would still have to report to the minister through the Department of Labour which would have the basic policy responsibilities or whatever the department is. I'm still not sure actually, to be quite honest, that it would be appropriate for that reporting to be through a super business ministry. It may be more appropriate to look at some other Ministry support for the several bodies that undertake health and safety protection, Maritime New Zealand, Land Transport Agency and others.

THE COMMISSION:

It's just that there's an echo back to history about which we've heard a good deal in the course of this inquiry because prior to the enactment of the Health and Safety in Employment Act of course we had the situation of the mines inspectorate which was separated and housed originally within the Mines Department and it was really, on one interpretation of the evidence anyway, the beginning of the end when that mines inspectorate was transitioned initially to another department, I'm trying to remember which one, sorry.

MR WILSON:

MED, Ministry of, well it was Ministry of Commerce I think in those days.

THE COMMISSION:

Yes, that's right and then eventually lumped in with the general inspectorate, as it has been termed, perhaps unfortunately, but with the general

inspectorate of labour and that was, as I said, perhaps the beginning of the end of a specialist mines inspectorate at all.

MR WILSON:

5 But that –

THE COMMISSION:

Yes.

10 **MR WILSON:**

Sorry, sir.

THE COMMISSION:

The present or your proposal is movement of the inspectorate into a new
15 entity but the association of all inspectors together.

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MR WILSON:

Yes but that would be a specialist agency and sadly all of those
consequences which you have described sir, require conscious decisions at a
20 political and a management level within the department. That hasn't occurred
because of the one act one authority concept. It has occurred because of
specific decisions, very hard to understand some of them to effectively
de-specialise a very specialist function and I'm not referring just to my safety,
I'm referring to the health and safety function generally within the
25 Department of Labour where above the level of inspector it's very difficult to
find anyone with any knowledge of occupational safety and health. So I, the
CTU doesn't come to this lightly, sir.

THE COMMISSION:

30 No.

MR WILSON:

I was a member of the ACOSH that made recommendation and it was certainly seen that that would continue to be a well resourced body and the, if one looks around the world in other countries that's frequently the model and a model that works very well. As I make the point later in my submission, sir, the standard of safety is very much related to the level of resourcing of these agencies.

SUBMISSIONS CONTINUE: MR WILSON:

10 The next point, sir, is point 13 at page 21 employee participation and at 13(a) to (s) of the submission describes the difficulties for the council trade unions and unions in implementing the health and safety rep system under Part 2A of the Act since its introduction in 2003. The specifically the lack of promotion and enforcement of Part 2A by the Department of Labour, the hostility of some employers, the lack of recognition of and support for health and safety reps who are elected, uncertainty about resources for the training of health and safety reps. Yet the submissions to this enquiry and the oral submissions that I heard yesterday reflect an apparent consensus on the value of health and safety worker participation. So everyone in this room seems to saying yes, this is an essential part of the system, worker participation is part of the system of making health and safety systems effective and it seems there is also some ever consensus on entering into some arrangement to utilise Queensland standard regulations and expertise.

25 It's therefore disappointing that we then had counsel for Solid Energy and the Department of Labour itself urge the Commission to make an exception for employee participation. So we have a system that works, we're agreed that worker participation is an essential part of that system. We're all going to import that system for New Zealand but not the worker participation bit, that we understand also works. In the case of Solid Energy it promotes some "more flexible employee participation on the principle that relationships should be individual employer/employee relationships rather than selective and union" and some concern about industrial issues intruding.

In the case of the Department of Labour it sees merit in New Zealand aligning our regulations with Australian jurisdictions, and I refer to paragraph 113 for the Phase Four submission. But then recommends against any change to part 2(a) of the Health and Safety in Employment Act. So yes once again let's align our regulations but in every respect except worker participation and I make the following submissions in response to that. The health and safety representative system which deriving in New Zealand and Australia from the UK Robens Committee 1972 and its Swedish antecedents is based on the premise of unionised work places and collective representation and systems. The evidence before the Commission from Professors Gunningham, Walters and Quinlan and other witnesses supports a stronger worker participation system in high hazard industries like coalmining and I refer to 13AA at paragraph, at page 32 of the CTU submission and the comment of Professor Quinlan which is quoted there.

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“In high hazard industries marked by serious disasters in the past such as mining, the importance of providing workers with meaningful voice has often been seen by policy makers as deserving special attention beyond that found in general OSH laws.” Professor Quinlan again in paragraph BB noted the concerns of the sort that were raised yesterday about blurring of responsibilities, tensions in the workplace and what have you and concludes, as this report makes clear, a very comprehensive report of one of the three that he has filed for the Department of Labour, “There were a number of jurisdictions where similar arrangements had been operating over a number of years enabling the arguments on both sides to be tested against actual evidence.” And of course he concludes partly on the base of his own experience in Queensland which he quotes and refers to, that the system works very well there and that those issues that were raised again yesterday and had apparently been raised by employers in the 2006/2007 Department of Labour review simply have no substance. And of course we have the more anecdotal evidence from Sweden that the system works there and has been working there and in the UK and previously, prior to 1992 in New Zealand.

I submit that there's no answer at all for the counsel for Solid Energy to raise the concerns addressed by Professor Quinlan again to suggest that evidence could have been called on the safety role being used for industrial purposes but not actually call such evidence and then acknowledge in response to Commissioner Bell that such evidence probably doesn't exist anyway.

In my submission the evidence before the Commission is clear, that a check inspector roving rep system has worked well in Australia, has worked well in Sweden in various industries, worked in the UK, worked in New Zealand prior to 1992 and I understand some of the older inspectors have confirmed that at these hearings and in my submission on any evidence based policy analysis should be adopted in New Zealand with the other components of the Queensland system. This is a three pillar system and that aspect of the system is a crucial part of it.

The other area of employee participation I wish to address is the submission by the Department of Labour, the current Part 2A provisions need no amendment. There are two points here. Firstly, the current basic I refer to Part 2A provisions in particular the default provisions in the schedule to the Act. Professor Quinlan again notes and I quote there at the top of page 30, "That the participatory provisions in the HSE Act were arguably inferior or less 'demanding' to those found in comparable OHS legislation of a number of other countries."

Mr Chairman, members of the Commission in an industrial environment where the role of trade unions in health and safety or in any role at all has been seriously weakened by legislation, promoted by employer organisations. There is a need in New Zealand for health and safety representatives to actually be empowered to do this really important third pillar role to a far greater extent than at the present. If they're not able to be empowered, they're not able to effectively discharge that third pillar role and we're not

going to have that component of the system working in the way that it should for the protection of workers.

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5 The CTU has submitted that there should be a number of improvements made and those are referred to at page 30 of the CTU's submission and I'll just run through those briefly, extending the health and safety representation rights to include all workers, for example contractors, strengthening the requirement on employers to consult health and safety representatives with regard to process
10 and systems such as risk management and OSH systems as recommended by Professor Quinlan, requiring the inspectorate to recognise and consult with health and safety representatives. Yes, there is now a directive to do that which is, but it wasn't until 2009 that that role of acknowledging health and safety representatives entered the Keeping Work Safe enforcement manual
15 and a practice note wasn't issued until the beginning of 2010. A further amendment would be requiring the regulator to fund the proper training of health and safety reps under the Act further requiring the regulator to enforce Part 2A of the Act which requires, and I've just outlined there what the requirements are, providing a specific power for health and safety reps to stop
20 dangerous work. All workers are entitled, as a matter of common law, and specifically provided for in the Act to withdraw from dangerous work but the health and safety rep should have a specific role as a leader in that area and as recommended by the select committee review in 1996 chaired by Max Bradford to provide the health and safety representatives with a power to
25 issue provisional improvement notices as occurs in many Australian jurisdictions and, finally, and I think very importantly in the environment, the work environment in New Zealand these days, is providing health and safety representatives with the effective legal protection against discrimination and unjustified actions including dismissal if there's any cause to suspect that it
30 may be related to the duties as a health and safety rep. There is some protection in the Employment Relations Act but it's weak and it's ambiguous.

The second point relates to other high hazard industries and the CTU submits, for the same reasons as mining, more enhanced provision needs to be made for the health and safety reps roles and responsibilities in other high hazard industries and we simply note this because the same principle that

5 Professor Quinlan advances about the need for enhancement, the need for greater voice and power for workers applies generally but certainly in other high hazard industries as well as the mining industry and we note that the Swedish roving rep system which in a sense replicates the roving rep part of the Australian system addresses a range of industries in Sweden and was

10 particularly developed to address a situation of small workplaces as well and all the evidence is that that has worked well.

Point 14 at page 35, this relates to leadership and penalties. Many employers do the right thing conscientiously, that's a fact and I've worked with many of

15 them. Many need some encouragement and incentives and that's probably roughly a third as well but others only respond to coercion and they're the ones where the Honourable Bill Birch when he introduced the Health and Safety in Employment Bill in 1992 said that there needed to be a big stick approach and so in the CTU submission at pages 35, 36 and 37 we address

20 that issue of whether the penalties in the Act are adequate compared with other countries. Whether the current, I would call it soft, enforcement approach of the Department of Labour, serves the interests of the companies who actually do endeavour to comply let alone the interests of the health and safety of workers.

25 1005

Whether the cost to the country and OSH estimated in 1999 that occupational injury costs as high as 10% of the GDP and that occupational injury costs alone were about 3.18 billion based on the ACOSH formula, so in addition to the grief that accidents injury are caused to families, there is a high cost to the

30 economy of failing to have an effective enforcement approach.

Professor Quinlan in his report and I quote at the bottom of page 36, "The adequacy of the current penalty regime under the Health and safety in

Employment Act compared to those of other countries warrants consideration.” The CTU also submits that this Commission should recommend that the Government consider the introduction of a criminal offence of corporate manslaughter into New Zealand law similar to that introduced in the UK in 2006 and I believe that’s also been introduced in Australia and Canada. And this in my submission is not about victimising or unduly penalising, it’s about bringing home to employers at a corporate level that there is a major responsibility which they have and that might result in some leadership being generated at a board level and at a senior management level, which doesn’t exist in many organisations today and that them ensuring that they are aware of what’s going on, demanding reports and data about what’s going and monitoring what’s actually going on.

So the concept of corporate manslaughter has of course been thoroughly investigated by the UK Law Commission for example. They adopted the corporate manslaughter in 2006, other countries as I’ve mentioned, Canada and Australia have adopted corporate manslaughter. It may be time I submit for New Zealand to do the same and it would certainly be helpful if the Commission gave consideration to that and I’ve referred to a Canterbury Law review paper on corporate manslaughter and a proposal for New Zealand. I am not familiar with the author, I don’t know the author but it certainly provides a lot more information and references if the Commission is minded to look at that.

And finally there are the funding issues and I attach to the submission a paper on the HSE levy which is currently been collected and in fact has been collected since the late 1990s through the Department of Labour or through the Accident Compensation system on behalf of the Department of Labour. The paper itself highlights some quite curious things but the thrust of the CTU submission is to say that here exists already a mechanism which with some relatively minor increases could adequately fund the role of the agency doing an effective job in New Zealand. The first point in Dr Rosenberg’s paper, appendix 1 at page 51 is that the existing HSE levy is set at five cents per

\$100 of leviable earnings. It has been at this rate since the 1st of April 1999 when it was reduced from six cents. It's payable by employers or self-employed to meet the costs of the administration of the Health and Safety in Employment Act. The paper notes that from 2008 there has been an increasingly significant surplus accumulating in that account so we're talking about or we've heard reports of lack of resources to undertake the role under the HSE Act, yet from 2008 there was a \$2 million surplus in the account rising to nearly 16 million in 2011.

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10 And the paper actually notes that there is some contradiction between the way that that levy is collected and the way that resourcing of the department still purports to be done out of Vote Labour yet offset by the HSE level earnings. And I think the final point because my submission on behalf of the CTU is that this is an already existing mechanism which with some increases could adequately fund and is currently, it would appear although there is some hard to understand sort of accounting going on, would currently appear to be funding the high hazard unit costs and so the final point just to conclude is that the CTU submits that the Royal Commission should in recommending to the Government the work programme necessary to upgrade the Act and it's administration and enforcement, particularly in relation to high hazard sectors such as underground coalmining, propose that the HSE levy be used and increased as might be necessary to ensure that the work is properly funded. And I note there research evidence from the USA which shows that the coalmining fatality rate is closely related to the funding of the regulatory agency and there's a quote there from a paper by Hopkins and Wilkinson, again two Australian experts, note the quote states, "Research on US coal mines shows that the fatality rate is inversely related to the size of the Federal budget allocation to the regulator. The larger the budget the smaller the fatality rate. Moreover this is independent of the nature of the legislation being enforced. In short a well resourced regulator is the key to reducing fatalities."

So the final point Mr Chair, members of the Commission is, that it has been said that there has been a shortage of resources for the department undertaking its enforcement role and its administration role under the Health and Safety In Employment Act. Clearly resourcing is very important, there
5 already exists with HSE levy, the mechanism to do it. It just requires the political and administrative will to increase that levy to a level which will properly resource the function and as the USA expert report notes that's the key to reducing fatalities along with obviously having an effective system. Thank you, that's the end of my submission.

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THE COMMISSION:

Thank you. We have some questions Mr Wilson.

COMMISSIONER HENRY:

15 Mr Wilson I'm looking at page 4 of your submission and I'm interested in talking about the bottom three headings, tripartite advisory council, taskforce approach and the regulator.

MR WILSON:

20 Yes.

COMMISSIONER HENRY:

In regard to the tripartite advisory council you talk about the existing council which is the workplace health and safety council.

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MR WILSON:

Yes.

COMMISSIONER HENRY:

30 Who are the members of that council?

MR WILSON:

They're representatives from Business New Zealand, the Council of Trade Unions and the officials from ACC and the Department of Labour I believe.

5 **COMMISSIONER HENRY:**

And what does it actually do?

MR WILSON:

10 It's an administratively established council which basically supposedly has an advisory function but it doesn't have any powers.

COMMISSIONER HENRY:

And has it given any advice which is relevant to this Commission?

15 **MR WILSON:**

I'm not sure, sir, I'm not sure. But I think again one of the problems with these sort of organisations is that if they don't have some statutory basis, if they don't have some power, if they don't, you know, the right to have some influence, they can be ignored and I think it is a step forward to actually have
20 established a tripartite council of that it's only been in existence for a few years.

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But, the point that I'm making there is that really those key functions of you know policy discussions, standard setting, oversight and monitoring of what
25 goes on, on a tripartite basis should be done through a properly established, statutory established national level council and from that the industry councils of a similar tripartite nature would undertake their work, including of course the mining industry.

30 **COMMISSIONER HENRY:**

Thank you, the task force approach, can you just, that would be under the auspice of a reconstituted council from what you say here. What do you mean by a task force?

MR WILSON:

Well I think it just reflects the point I made in my submission that there is a real urgency about this. We can see now the causative impact of not having
5 these regulations and prescriptive regulations and approved codes of practice
in place in the coalmining industry. There are other industries, sadly, where
this is just waiting to happen and I think there is a sense of urgency that
should be engendered from the bitter experience from this tragedy that can
also you know benefit workers in other industries and addressing the situation
10 in other industries, particularly other high hazard industries I would see as a
priority and I've simply tried to highlight that by suggesting that there should
be a task force approach taken to it and because I think that should be at
least led at that level by a tripartite route, obviously there's a political
responsibility and a departmental responsibility as well, I suggested that that
15 properly constituted workplace health and safety council could undertake that
role.

COMMISSIONER HENRY:

Would there be a series of task forces then?
20

MR WILSON:

Yes, definitely.

COMMISSIONER HENRY:

25 There'd be several, would they –

MR WILSON:

Yes.

COMMISSIONER HENRY:

30 – on different subjects and so on –

MR WILSON:

At different.

COMMISSIONER HENRY:

5 – and different.

MR WILSON:

Well, yes, certainly initially. I think there's a huge deficit of standard setting in many sectors so you would have you know ideally tripartite industry bodies
10 undertaking that standard setting with expert support and hopefully the ability to import existing standards from other countries in those cases as well. There's quite a lot of resource, it'd be a resource intensive process and so it does require a significant amount of funding and, but in my submission it desperately needs to be done.

15

COMMISSIONER HENRY:

But the final area just on the regulator and you talked about this a little earlier and it was discussed yesterday about the taking of the function of health and safety inspection out of Department of Labour to a Crown entity and you say
20 that the Crown entity would have a tripartite government structure. Who would be the three participants on the government's board or whatever the structure is?

MR WILSON:

25 Well if, generally the tripartite structure is the employers, the unions and the officials. Where it's a board rather than say a Commission is it often as in other jurisdictions, you know that becomes a little blurred because generally the appointments to the boards are political appointments as the case with Maritime New Zealand for example, but again it would be necessary to reflect
30 the involvement of workers and employers in that government structure as well, but also experts you know experts in the area because whilst it's important you know for the workers' representatives and the employers'

representatives to have voice it's also important, but there is you know expertise in what are sometimes very complex areas.

COMMISSIONER HENRY:

- 5 If we were to do that in New Zealand take the inspection function out, of course we would be needing to take much more than the inspection out, wouldn't we? Inspection is just the sharp end of the whole process of –

MR WILSON:

- 10 Yes.

COMMISSIONER HENRY:

– strategy and compliance strategy, research –

- 15 **MR WILSON:**

Yes.

COMMISSIONER HENRY:

– case selection, all those sorts of things.

20

MR WILSON:

Well hopefully, sir, yes. Well I don't make the submission lightly and I must acknowledge that until the super ministry proposal sort of surfaced there was a bit of a balance about whether you know there would be a benefit in -

- 25 1020

COMMISSIONER HENRY:

Having a division or something.

MR WILSON:

- 30 And the transition and all of the kind of difficulties that result from establishing a new agency and getting it up and running, but there are – the idea of a super business ministry actually having responsibility for the regulation of health and safety at work as well is well the experts say, is a recipe for

disaster, it's certainly abhorrent to me personally. I just don't think that that's appropriate.

COMMISSIONER HENRY:

- 5 You don't think there could be a Commissioner with independent statutory function within the agency?

MR WILSON:

10 I think that used to work. That did work with the mining inspectorate, as much as I know about it but times have changed. I don't think it would work in a modern context because I think the environment has changed, the accountabilities have changed. The political relationship between the Minister and the chief executives' or heads of agencies has changed and I think that this sort of regulatory function is best isolated as much as possible from
15 political interference, can I put it that way. Secondly, I was certainly concerned and have long been concerned about the de-specialising or the de-skilling of the, a specialist OSH function within the Department of Labour, so getting rid of in brutal terms the people who actually do have specialist knowledge of occupational safety and health, particularly at a leadership level.
20 So what is the value in having inspectors in a departmental environment where they're reporting to people who have really no idea what they're reporting on and in an agency within a department led by people who are not actually specialists and as our discussion before in –

25 **COMMISSIONER HENRY:**

Well you're talking about the past now, I'm talking about what it could be.

MR WILSON:

Yes.

30

COMMISSIONER HENRY:

Within the agency.

MR WILSON:

And that was really why you know in my mind the balance was between the Department of Labour and I don't want to you know unduly sort of lay all this on the Department of Labour because I accept the primary point I think that's
5 made on the Department of Labour, the fundamental duty in the legislation is on the employer and however inadequate the legislation might be, that doesn't alter, but the department's performance here hasn't been great. Hopefully they've learnt something from that and with your support and recommendations would be able to rebuild something effective out of that,
10 which might be a better option than the kind of disruption of moving to you know a new agency, however good in theory that might be, but the super ministry I dare tip the balance quite markedly in my mind.

COMMISSIONER BELL:

15 Mr Wilson, I've got a few questions along the similar sort of lines to my colleague. You talked about locating mines inspectors in a separate group if you like. I mean are you aware that in Queensland and New South Wales and we've got most of Australia and more recently Tasmania, there's actually been a move to get the mines inspectorate out of the generalist web of safety
20 inspectorate?

MR WILSON:

Yes sir I did read Professor Quinlan's report on the Tasmanian experience and certainly you know I don't for a minute suggest that there shouldn't be
25 specialisation, that there isn't you know expertise that mining people need to regulate mining safety and as I understood it the Tasmanian sort of model was very much a sort of all in generalist model so I'm simply I suppose saying that in New Zealand under a single piece of legislation it's still possible to have an agency within which you know that specialisation occurs.

30

COMMISSIONER BELL:

And you don't see a possibility of that specialisation being diluted or being moved away from what it should be doing?

MR WILSON:

Given the experience to date, yes certainly there is. That's clearly the evidence of what has occurred, so I suppose it's a question of what is learned
5 from that experience and what confidence the Commission might have that the future would be different.

1025

COMMISSIONER BELL:

I'm just trying to see how you'd stop it happening if you have it there with the
10 best of intentions people do the best of things but sometimes it just doesn't work.

MR WILSON:

Yes and that's, I mean unfortunately well fortunately, you know, we live in a
15 sort of political environment, these things are subject to a whole lot of influences and issues including funding and pressure from interested parties so we can never be sure about that. But hopefully this whole bitter experience actually demonstrates through the evidence to this Commission that we have got it wrong in New Zealand and that there does need to be not just in the
20 mining sector but particularly in other high hazard industries as well, a specialist focus on the issues in those sectors and that those functions need to be properly resourced to ensure that they're effective.

COMMISSIONER BELL:

25 And finally on page 22 of your paper, you talk about under the existing legislations there's the power, workers have the power to serve hazard notices or the safety reps.

MR WILSON:

30 Yes.

COMMISSIONER BELL:

How many of those notices actually ever get served on anybody?

MR WILSON:

Very few, very few and this is quite an interesting point, sir, because at the time this was introduced there was a fire storm of protest from employers.

5 This was the end of the world that workers were going to be serving hazard notices and bringing industry to a grinding halt. But of course it hasn't occurred and it's partly because in many situations those workers are not sufficiently confident or empowered to actually serve the notices but secondly in my experience frequently having that power means that steps are taken
10 before the hazard notice is served to actually pre-empt that need and to address the issue. So having a little bit of power is a good preventative tool as I'm sure the check inspectors in Australia.

COMMISSIONER BELL:

15 And just on training these people, I mean I've read, you talk about a two day training course. I mean, do you think that's enough –

MR WILSON:

No.

20

COMMISSIONER BELL:

- to train people to give them the confidence to be able to make some of these decisions?

MR WILSON:

25 Certainly not, no. There are three levels sir, so the idea was to advance the training, actually to a fourth level which no one has been prepared to fund but we were in a situation, sir, where the Health and Safety in Employment Amendment in 2002 were being introduced without any apparent commitment
30 from any Government agency to do anything about training the reps and so the CTU went to the ACC and said, you know, you've got an interest in health and safety, can you see your way to helping us to fund a training course and that was as much money as we could get was to, for the, for a two day

training course. We progressively developed that to three levels of advancement but yes, I think to do a professional job, as health and safety reps they need a lot more training and support than they currently get.

5 **COMMISSIONER BELL:**

Has the Commission got a copy of training, is that training course available or is it on the web?

MR WILSON:

10 Yes, of course, we can certainly provide that material, sir.

THE COMMISSION:

Mr Wilson can I take you back to the workplace health and safety council for a moment. Robens, as we understand it envisages the existence of a tripartite
15 organisation with an overarching responsibility and it seems that in New Zealand this is at the moment?

MR WILSON:

Yes.

20

THE COMMISSION:

And we've been aware of its existence now for 12 or 15 months but have remarkably little information or knowledge of its functioning. Is the CTU
(inaudible 10:29:15).

25

MR WILSON:

Yes, sir. I mean I'm not thoroughly close enough to know, and don't, I'm not at the CTU anymore and so I'm not, you know, familiar with the day-to-day workings of the council.

30

THE COMMISSION:

And you're not placed to know –

MR WILSON:

I can find out, sir, if you want more information on that regard. I can certainly ensure that it's provided.

5 **THE COMMISSION:**

Well we're very grateful for your help, thank you for your submissions and there's a lot of meat in it and you've only spoken to it this morning as others have but you can rest assured that the balance of the submission will be considered by the Commission. Thank you.

10

MR WILSON:

Thank you.

1030

SUBMISSIONS: MR HAMPTON

The EPMU view consistently, not just at this inquiry because we've been putting questions about check inspectors from early on, I think on day one to Dr Elder, but going back historically the EPMU view has been that worker participation in underground coalmining requires, we say demands check inspectors. I'm grateful that I follow Mr Wilson because he, to some extent, enables me given the meat that you've just referred to, sir, enables me to trim back something, some of the things that I was going to comment on. So to some extent I want to, not so much take you to parts of the paper but to respond to other submissions if I may and to a considerable extent make this a plea for future workers in underground coalmining in New Zealand.

It's a great pity I suggest in respect of the Commission in that in the review that the Department of Labour did through '06, '07, '08 or whatever it was, particularly in '08 the union made strong submissions in support of check inspectors. The department had papers that it had commissioned from Professor Gunningham which put up as best practice which should be, should've been suggested should be followed the New South Wales and Queensland regimes which included as a necessary, as an essential part of any of those regimes, of both those regimes check inspectors, but the department chose not to recommend such and his move with glacial speed in relation to anything else coming out of that review and may I say that, and this is with respect of the families at the back, that if in '08 check inspectors, that regime had been adopted, we would've been looking, I suggest, at a very different scenario in Pike River and I regret, the union regrets, that you have been the persons to have suffered as a consequence. And there is chilling similarities to the rejection of the Gunningham advice, I suggest, and what has happened to the reports that had been commissioned by the department from Professor Quinlan and I'll come to that shortly when I look at the department's Phase Four paper. They commissioned Professor Quinlan. They get his paper, it's quite clear that it says, "Best practice includes check inspectors as a necessary, as an essential part," and then the department, and I'll come to it without apparent reason when you look at that part of the phase four paper,

just glides away from Professor Quinlan. It pays no heed in that Phase Four paper to the views of their own mines inspectors who have come out through the PSA saying that they agree with the need for check inspectors.

1035

5 So I want to deal with matters under four heads if the Commission pleases. First, some general remarks touching on matters in the executive summary in the EPMU final submissions. Secondly from about paragraph 12.1 of those submissions on deal with the Department of Labour, the inspectorate and their reasons or lack of reasons for the rejection of Professor Quinlan's suggestion
10 about check inspectors. Thirdly some matters arising as to Solid Energy which is effectively the major player now in underground coalmining in New Zealand and touching on some of the submissions made yesterday on Solid Energy as to their resistance quite why hard to discern I suggest, their resistance to check inspectors and fourthly, check inspectors themselves and how it has
15 been dealt with in the EPMU's submissions, particularly from paragraphs 12.6.1 through to 12.6.41. The greater part of those submissions, are devoted to employee participation check inspectors and over and above the evidence that we have provided there and as I have said, consistently it's been the EPMU asking through this inquiry of just about any witness who might know
20 something on the subject and asking open questions, not putting suggestions to witnesses but asking for open honest views as to opinions on check inspectors, the utility of check inspectors. It's that evidence that we now point to and it's strong and compelling and because we were aware the union was aware that we would be faced with the claim that this is just anecdotal, never
25 mind the fact it's historical and we've got – you can point around the world as to where it has worked in the past, this system, the union commissioned what Professor Quinlan, the person who Professor Quinlan describes as the world's leading authority, the man from Cardiff University Professor Walters and a very helpful paper from him has been put in front of the Commission.

30

All those matters go to support the idea of check inspectors and I want to look as well at some recent experiences over the last 18 months post the Pike

explosion but underline I suggest the need for check inspectors. So that's what I will speak to, but two other points before I go on if I may.

5 First, you heard yesterday from Solid Energy at paragraph 37 of their synopsis the submission that nothing has been identified which makes check inspectors an inherently better solution than what has been proposed by Solid Energy. Well with respect, I suggest that that question is better turned round this way in view of the evidence before the Commission, what evidence is there that there is a system that is better than, that is safer than check inspectors and as
10 I've already said, tried in many countries for many years and an integral part of both the New South Wales and Queensland systems.

And the second issue that I raise just before I turn to the executive summary is to this point that was again from Solid Energy yesterday suggesting that the
15 discussion about check inspectors or not should be left for another day or another process at another time.

1040

We've had that too much with respect in the past and I've already referred to the earlier review. Now is the time and this Commission is the place in the
20 EPMU's submission. And you are well best placed as Commissioners to look at and assess the evidence which the union has placed before you on this issue. So to turn to the executive summary and just pick up one or two things from that and first is to say that the union continues to stand alongside and will continue to stand alongside the families and their losses and their concerns.

25

Secondly to acknowledge the fellow unionists contribution to this inquiry, particularly in the form of the CFMEU's involvement not only submissions and indeed the Phase Four submissions which came I think yesterday, which I won't deal with in detail but I suggest that they're helpful and recommend
30 them to the Commission. But also in providing evidence at earlier Phases and indeed going back to the start of this tragedy in being involved through various members in the search and rescue effort. I also acknowledge Mr Wilson and

the CTU's support which I suggest, as I say, enables me to shorten some of what I was going to say today.

5 It's almost a year to the day that I stood in this Court before you at the first preliminary hearing, I think it was on the 5th of April last year, sirs, and that preliminary hearing said that there's been two decades, 20 years in effect of loss of institutional memory, of institutional knowledge, and of lagging behind in terms of regulation of coalmining in New Zealand. Much of what was said then has been borne out I suggest by the evidence placed in front of this
10 Commission and it is quite clear, there is the consensus that we should, in terms of the changes to come, align ourselves as far as possible with Queensland as being best practice and that is the, certainly the view that the EPMU has. Their preference, the union preference is for a standalone body, however it's, wherever and however it's situate but a standalone body and a
15 standalone regulator with prescriptive regulations which must include within them the provision of check inspectors.

Two other general things that come out of the overview is first, it's submitted with respect that the Pike River company failed abysmally to protect its
20 workers underground. Secondly in the union's submission it is apparent that the Department of Labour as the regulator allowed this situation to build and to occur, allowed this to happen and both of those matters, the company's position, the department's position resulted in the catastrophic consequences and the loss of 29 men. It's from that position that the union says on behalf of
25 any underground workers in the future and indeed contractors, workers, whatever, whether they're union, belong to union or otherwise, how can they, why should they have any faith in the Department of Labour, in the present set up as being the regulator?

1045

30 As Mr Wilson said and the union goes with this, they have effectively forfeited their right to fulfil that role. They have abdicated effectively their responsibilities.

The regulations probably haven't kept up, undoubtedly haven't kept up with mining practices, best mining practices overseas and overseas jurisdictions. The lack of ACOPS, fundamental documents is appalling, in the union's view, but those matters don't absolve the department from responsibility it submitted. First, they allowed the regulations to slide in the way that they have, it is submitted, and secondly in any event as we now see from the experience of Mr Taylor being seconded here and perhaps the different view he's taken as to all practicable steps, we see that whatever the failings in the regulations and the lack of ACOPS with the right mindset the existing regulations have been able to be put to effective use. The union have welcomed the appointment of Mr Taylor, the secondment of Mr Taylor and have welcomed the rolling over of his appointment for another three months, but the fact that he's been able to do what he has done within the existing frameworks suggest that it's not as such the regulations that are at fault, although as I have said it does need revision, it's not so much the regulations are at fault but it's rather the people and the culture. So they're the general submissions in relation to the overview and I want to keep the focus on check inspectors so I move then on to what is at page 27 of the union's submissions under the heading 12, "The Department of Labour Inspectorate." Now the union does not resile from anything that is said there where it says at 12.1, "I have read the submissions of the department, consider them to be further evidence of the ineptitude, the dysfunction, the lack of understanding that the department has demonstrated in health and safety." The union notes that, the department does not appear to understand the importance of employee, worker participation and representation and appears to recommend even less independence be given to workers under the current regime as found in its suggestion that an ACOP requires employers to simply appoint. We point out then the inconsistency with the expert evidence found in the reports of Professor Quinlan and say that the ineptitude of the department appears to be so profound it's submitted that it cannot even properly consider and understand the advice of its own experts and that's what leads to the recommendation, strongly recommends, that given the inadequacies of the

department that all health and safety functions of the department should be removed and placed with a new separate entity.

5 The EPMU submits the workers it represents, particularly those in underground coal mine, cannot and do not have any degree of confidence the department has the ability to provide any degree of protection to them in relation to health and safety.

1050

10 Just to comment on that submission a little by turning to what the department has said in its Phase four paper from page 59 on, so it's the reference for the record is DOL4000010005/59. So I want to just dissect it a little if I may. At paragraph 251 they conclude that paragraph by saying, "The department's view is that the more hazardous the workplace the more benefits there are to be gained from effective worker participation processes." Now everybody agrees with that, there's no doubt about that it seems from what's being said in front of this Commission. Then we go to 257 where it comments on the 2006/2009 review which recommended promoting the existing legislative provisions instead of regulatory change, that's what I've talked about earlier. The department acknowledges that in practice the development of this guidance has been slow. Well glaciers move fast with respect. That's when I bowed the head to the people in the back of this Court, as has been the case with other forms of worker participation guidance since 2002. A draft guidance for the mining sector has now been prepared by the department and is under consideration. That's how slow. The future content and standing of such a document is yet to be determined.

20 Then we go on to 258. Professor Quinlan recommends regulatory change to strengthen worker participation rights and obligations in the mining sector including the introduction of check inspectors. 259, noting the evidence presented to the Royal Commission and its own experience since the review in '06/'09 the department acknowledges that if there is to be a significant increase in the uptake of worker participation provisions in the sector it is likely to require more than guidance on existing provisions. 260, the department

therefore supports strengthening worker participation provisions for the mining sector and supporting the roles for worker health and safety representatives in the underground mining sector.

- 5 The department considers that some of the powers proposed for check inspectors already exist for elective and trained worker and health representatives and the ability to issue hazard notices et cetera. Well we've heard Mr Wilson, the response to Commissioner Bell about how successful that has been, yet that point is made by the department and it's made also by
10 the Coal Association of New Zealand as being a reason why we don't have to do this because we've got all these powers that are similar to check inspectors already existing in the legislation. Bear no fruit at all.

The department's view is that the issue is not one of introducing new powers
15 but increasing support to encourage the uptake and utilisation of these rights and processes already in existence. To maintain consistency this should be completed through the development of an approved code of practice for worker participation. And then this, this is how it goes on. "The department suggests further consideration," this was at 261, "Be given to the
20 development," note the words, "further consideration," "be given to the development of an approved coded of practice to strengthen worker participation in the underground mining sector by creating an industry standard that encourages operators to appoint qualified health and safety representatives." Where is the mandate necessary to properly empower
25 health and safety representatives in underground coalmining? Where are the reasons why they reject Professor Quinlan's recommendation? There's no discussion about that at all. Where are the reasons why they reject the recommendations of their own mines inspectors?

- 30 So the union is concerned about three things arising from that.

1055

First is the idea that all we need to do is develop an ACOP and we've got a great record for doing that, haven't we, in the department but develop an

ACOP that encourages creating an industry standard that encourages operators to a point. They are concerned with that. It's not even going to be compulsory, it's encouraging employers to do it and as was suggested even less power to the workers as a result. Second concern is the ignoring of Professor Quinlan's advice and I just want to and I'm not go into detail in view of Mr Wilson's presentation but I just want to take up one point that has been raised, that we raise in particular in relation to Professor Quinlan and the size of the industry in New Zealand and that's been some comment made on that and I respect what Commissioner Bell has said about that, no matter what size it – standards should always apply. But I draw the Commission's attention in particular to what Professor Quinlan has said in this regard and it's in a passage that we set out in our submissions at page 53, at 21.6.24 and it's in the middle of that quote from Professor Quinlan, "My impression was that the district inspectors played a valuable role in promoting OSH in the Queensland mining industry, including visiting small mines that would otherwise not have had much in the way of OSH expertise, either on the management or worker's side." We may be a small scale industry in New Zealand but that is the reason, or an additional reason why check inspectors are important and it's in Professor Quinlan's own materials provided to the department. And while I'm on small mines, there was something said by – and New Zealand's industry, there was something said in passing by the Solid Energy in relation to geographical isolation and I can best deal with that in this way, by referring you to the CFMEU Four Phase paper which has a number 0041 and at slash 15 where the CFMEU say this in relation to Solid Energy's arguments including the anecdotal and weak one but I won't deal with that at the moment. "However, Solid Energy do advance perhaps the most unique argument, we...", meaning the Australian Union, "...have ever witnessed being advanced against check inspectors. That is check inspectors are not necessary because New Zealand coal mines are not located in very remote locations." Well with the greatest of respect, some of the areas on the West Coast are extraordinarily remote locations and the CFMEU go on to say, "It would be our understanding that mine inspectors are actually located closer to coal mines in Australia than they would be for

example, in the South Island in New Zealand. Furthermore the topography of Australia means that coal mines are generally much easier to get to and more quickly.” The third point I was going to raise about coming out of the department’s papers was the speed of change and I’ve already covered that,
5 the glacial remark.

1100

Can I go from there then really to where I start, where the submissions start at page 45, 21.6 and following which deals with employee participation and then check inspectors because that’s where I now want to focus, but first say
10 something about Solid Energy which touches both on the mines inspectorate and the concept of check inspectors. First, I suggest there is a worrying to the union attitude shown by Solid Energy through Mr Smith to unannounced mines inspectors’ visits. The passage that we particularly have referred to, and in fact it’s earlier on in our submissions, occurs at 12.3.5 and it’s the
15 passage that leads up, follows on from where Mr Nicholson in quoting yesterday finished off and it’s the question and answer which I suggest, and it comes from page 3445 of the transcript, is a telling answer and I’ll start with the question before it, line 11, question, “But suppose he’s...” and we’re talking about the inspector, mines inspector, “...he’s not aware of anything in
20 particular, he just wants to make an inspection. Are you opposed to that?” Answer, “No, of course not.” Question, “So what’s the difficulty with Mr Firmin turning up. I don’t understand please?” Answer, “Mr Firmin’s time is precious and the last thing I want to be accused of is having the inspector sitting outside because he’s turned up without any notice, sitting outside for one, two,
25 three hours while a machine and the person qualified is found to take him on his inspection. Our purpose is to facilitate his conducting of his job and if that requires unannounced visits then that’s his call. My belief is that he doesn’t require in our operation...” and these are the telling words, “...my belief is that he doesn’t require and our operation doesn’t require unannounced visits,”
30 that’s his determination. Now I suggest that is the critical passage and I go on to ask the question, “That’s what troubles me Mr Smith. You’re of the view that unannounced visits aren’t required on Solid Energy, aren’t you?” “Of course I couldn’t, I wouldn’t be doing my job if I thought that there was

anything going on, on any shift that I wasn't aware of." Question, "Is that not a dangerous attitude to adopt in a hazardous industry such as mining, Mr Smith?" "No, on the contrary it's a commitment that we have to make. We have to do everything we can to ensure there's adequate systems, adequate training, the culture is right. The people are in power to report, to do their job the way they've been trained to do and to report when things are out of order and that we'll take whatever steps, whatever steps we need to ensure that's happening." So that's the rest of the passage, so that's of concern. Secondly, I refer to some evidence from Dr Elder and I'm not going to go into this in any detail but there are two aspects to his evidence at pages 84 to 87 of the transcript, first as to the non-worker participation in the health and safety charter at Solid Energy and that was gone through in some detail and, secondly, the fact that Dr Elder was unaware of the Robens philosophy at page 85 of the notes of evidence and, thirdly, in relation to Solid Energy generally at this stage is the attitude that comes through from that, from the cross-examination of Mr Firmin where he, as the mines inspector, and I quote this passage it's quoted in full in the submissions at paragraph 12.3.2 where he was being asked about cable flashes, you may recall, and we get the description of what a fire is and he's Googled a definition of a fire and this is a man who's been a mines inspector a long time.

1105

But the worrying concern and it's highlighted in this way in the submission at 12.3.2, "Whilst the example is taken from a cable flash incident that occurred at Spring Creek Mine the EPMU submits it's indicative of the approach to such questions by the department, illustrates an unacceptable culture of simply accepting an employer's interpretation of the regulations without adequate research and scrutiny," and the actual passage was an answer that went this way, asked about cable flashes, I put to him what Mr Hughes and Mr Bell, former chief inspectors had said about it, I heard Mr Hughes, what he thought it was defined as a fire. Question, "And you disagree with him?" Answer, "Yes, I'd like to agree with him because I think they should notified but I think the regulations to say a cable flash is a fire and the fact that I haven't been notified by anyone in the industry..." note those

words “Not notified by anyone in the industry, means the industry haven't determined that they were a fire and then when I went to the mine...” and this is of greater concern, “Then when I went to the mine to investigate these cable flashes I asked them why they hadn't notified and they said, well there

5 wasn't a requirement to and I said, well what section V and they said, well no, it's not a fire, so it's ambiguous and I think whether the question should be brought to the senior advisor and maybe we should get it put into the code of practice or something.” So he took the employer's word and the employer was Solid Energy. So those general points about Solid Energy, they're the

10 submissions that are made by Solid Energy and we heard about yesterday. I don't want to go into those in detail because you've heard Mr Wilson about them now but the material supplied as to check inspectors, they criticise as anecdotal and weak. With respect we have now provided quite clear evidence about it from experts and from experience. The experts Quinlan and

15 Walters, experience the whole range of people and I haven't counted them up but most of those pages that I referred to earlier about check inspectors are quotes from the evidence that we ascertained from a variety of witnesses. They raised the overall, the bogey of industrial, it being used, check inspectors being used for industrial purposes. No evidence supplied about

20 that at all and the Queensland regulations which we say should be the model and you'll see how we've, the union have adapted it in appendix 1 of, to the submissions in the model of check inspector that we put forward both as to site inspectors and as to, as it were, the district inspector. But it is made quite clear that in, a check inspector cannot use his powers for industrial purposes.

25 Just lastly on Solid Energy before I turn to check inspectors finally. Mr Stevens in his synopsis yesterday, para 34 referred to a survey by the Jonah Group as to Solid Energy. Now I just want to do this to give some pause before too much weight was put on that survey. I note for a start that it was done in November 2011. We don't know too much about the

30 methodology and so on. I suspect that would need to be looked at, in any event. I emphasise the date November 2011 because that is prior to some quite serious incidents that have occurred and this is where this survey relates

to, Spring Creek, that have occurred at Spring Creek since November 2011 and I wonder what a comparable survey will show now.

1110

5 And if I may, just to illustrate the dangers of these things ask Ms Basher whether she could put up answer 5 at page 10 of that survey please and this is one that we didn't see yesterday but which I suggest is of interest. It says, "Spring Creek genuinely cares about its employees. The benchmark says 69% should agree. Spring Creek 51%," and the commentary goes, "This result shows a significant deviation from the benchmark." Clearly there are
10 frustrations that need to be fully understood and if possible addressed. If people experience a perceived lack of care it eventually may have an impact on the safety performance of the site." Now why weren't we shown that yesterday?

15 Then Ms Basher if you could please put up at page 30, number 67 which is related. "The general mood in the workplace is reasonable at the moment. Benchmark 63%. Spring Creek 48%," and commentary again, "This result here in combination with the result in statement 5 suggest there are frustrations and possible unresolved issues between management and the
20 workforce. As stated before, it is important to identify and address these issues as they may be in the way if implementing successfully any initiative to improve safety."

25 Now I could go on, there are others that might be worthy of looking at. I'll just note them for the record's sake. Number 59 at page 27, number 82 at page 34. That's Solid Energy.

30 Now if I can turn then where I've taken you before to check inspectors and as I've said from page 45 of our submissions through to page 70. I've already commented enough on them I suggest, plus what Mr Wilson has said to – found the submission that what is said by the union is evidence based, particularly on Professor Quinlan, Professor Walters and indeed if you go back you can find some of those papers in the '08 review that Professor

Gunningham was in effect endorsing the same thing. And then you look at the evidence that we've set out in detail from so many witnesses that I suggest creates a compelling case in favour of check inspectors. It's got to be – it's an integral part of the Queensland system that we are being asked – we have a consensus that we should import so why do you import a system and then leave out one integral part. The three legged stool we've always referred to, if we're going to call it three pillars, so be it, so you're chopping off one of the legs.

1114

10 But I want to not just there, then if I may without going through that in any detail, take you to what we say in the submissions at 21.6.5 where it is said, "The EPMU notes the evidence of Mr Smith," and I've already talked about that. It also notes, "The view, based on other evidence of events at Solid Energy, especially Spring Creek, does not appear to be limited to Mr Smith alone. A number of these events were put to Dr Elder and Mr Firmin at phase one, including occurrences and non-notification inspectorate, lack of response. The EPMU also notes the answers to the interrogatories currently with the department may provide useful information. They may wish, we may wish to address these at the oral hearing..." and then we finally note the evidence of Mr Bolderson as to employee representation at Spring Creek generally and the non-notification to the inspectorate of an incident occurring as recently as 17th February 2012.

1115

25 So can I comment then, because I suggest this is additional material that clearly indicates the need over and above what I've already said and what is contained in the written submissions which clearly supports the need for check inspectors. First, the incidents of April to June 2011 and all of these events are post the Pike explosion, so Spring Creek, Solid Energy are on notice. This is all events post Pike River explosion, so not only is Spring Creek and Solid Energy on notice but also the department and its inspectors are on notice and this is why I want to highlight what has occurred since, so first we have the April to June 2011 four incidents including the two cable

flashes. I'm not going to go through those. The references to them in Dr Elder's evidence and Mr Firmin's evidence are in the submissions.

5 Secondly, though I want to look at in a little more detail the answers to what we described as the interrogatories. It's the Department of Labour's response to questions of the EPMU regarding certain incidents in Solid Energy mines dated 29th of March 2012.

COMMISSION ADJOURNS: 11.17 AM

COMMISSION RESUMES: 11.36 AM

THE COMMISSION ADDRESSES MR HAMPTON

5 SUBMISSIONS CONTINUES: MR HAMPTON

Well if I can take then if the Commission pleases to the Department of Labour's response to questions and it's a document that's now numbered as DOL7770050001 and there are six incidents that are related, that this document relates to. I'll just, the first relates to an incident at Huntly East on
10 the 14th/15th of November which is a Solid Energy mine and if I could have up please Ms Basher page 3 of that document and you'll there see the incident described as being on the night of the 14/15 November, 1.3, "The incident was not...", and it involves methane passing through an auxiliary fan causing cut-off and the cut-off then being deactivated by employees. "The incident
15 was not reported until 17th November..." that's 1.3, "...and my manager believing he was not required to notify the Department of Labour." The answer at the bottom of that page that I draw your attention to, the department's view that this incident was required to be notified under regulation 10 so again it is the disconnect between what the union says was
20 the miner, Solid Energy, failing to notify in terms of its obligations under the regulations. If I could go to page 4 please Ms Basher and answer 9 and I just underline this because it goes to the department this time, "The department is currently drafting a new notification form that will standardise and facilitate reporting. Guidance will also be provided to operate as setting out the
25 department's expectations concerning the meaning of as soon as possible." So it's only now post Pike that we're starting to get attention to some of the matters that should've been long since looked at. Answer 10 on the same page, details the departmental response. For a start there is nobody else to
30 take up the work until Mr Firmin returned following attendance to the Royal Commission hearing which underlines the lack of numbers and the fact that it wasn't until the 25th of November that the improvement notice was finally drawn and done, but some 10 days after the incident itself.

1140

And just finally on that aspect of the incident, and it's at page 5 please Ms Basher the notice itself was drawn by Mr Bellett who is not a mines inspector. I think we had evidence that he was by trade a carpenter so that just underlines some of the things we've been talking about in terms of the union's view about the inappropriateness of the regulator continuing to be within the Department of Labour and answer 14, same page, where the department expresses to satisfaction with the answers given by Solid Energy and is working with them to establish the necessary level of evidential detail and rig it the department requires.

10

Incident two, this is the first of the Spring Creek incidents on 15th of November and all I do is refer to page 6, it was an accumulation of methane, and the answer given, "The department is not satisfied with any delay in notification of incidents pursuant to regulation 10(k)." This was an incident that happened on 15th of November not reported until, not notified until 17th of November, and then so that's aimed at Solid Energy but then the next part to clarify the department's expectations the acting chief inspector, and thank goodness Mr Taylor is here, intends to provide guidance for duty holders as to what the high hazard unit considers to be an uncontrolled accumulation and what it considers to be an acceptable period for a duty holder to report. All things that are so fundamental to operation submitted of a regulator's inspectorate.

20

Incident, and this matter's still not it seems resolved from the answer at paragraph 17. There's still, discussions are still continuing. Incident three is the second Spring Creek matter, rather similar, 15th of November, two days to report so it's rather a similar position on page 7 of that document, but perhaps of some interest or concern on this topic is the answer 20 on page 7, "When the department denies it has failed to substantively respond to the notification, it has a number of concerns with a succession of reports and notifications and is making its expectations very clear to all mine operators, including Solid Energy." The department wrote to Solid Energy on 8 December requesting a meeting to discuss recent incidents. The requested meeting took place 14th of December, a further meeting on 7 February.

30

Incident four, again relates to Spring Creek on the 28th, an incident on the 28th of November 2011, a faulty seal allowing leakage of methane and nitrogen into a roadway, suspension of extraction followed that.” There the point that I would note in relation to that is found on page, or two points in relation to those, that matter on page 8, first answer 22, the delay of notification, as indicated, answer 22, “As indicated in earlier answers, the department has a number of concerns regarding reports received from Solid Energy...” those concerned, could Solid Energy’s response to incident 4 in the department’s view the delay of notifying this matter was not acceptable?
1145

And then at answer 24 without going through it, “The department are not satisfied with the incident investigation or the report received from the company and has conveyed that to the satisfaction to Solid Energy.” So things are not as rosy with Solid Energy particularly at Spring Creek as might have been portrayed yesterday I suggest.

Then the fifth incident again at Spring Creek on the 20th of December and its page 9 of the answers that I will refer you to. Again answer 26, “There was a delay of a day in notifying. The department is of the view that there is no reason why it also should not be informed immediately after the incident comes to the attention of the mines manager.” So there was delay in reporting and then at answer 28 and this relates to a failure of ventilation of a period over 30 minutes. 28, “In the department’s view there would appear to be problems with the ventilation safety management system at Spring Creek Mine. There was another recent incident in the mine that resulted in the department issuing a prohibition notice on 20 February 2012. In addition an improvement notice requiring Solid Energy to audit and investigate the reliability of the main ventilation system and provided the results and any corrective actions to the department was issued on 14 March 2012. The department notes that the ventilation safety management system at Spring Creek was a part of the audit conducted with the department on 19/20 March 2012 and an audit report will be filed with the Commission.” So

again, problems underlying in which I submit on behalf of the union indicates the need for check inspectors.

5 Just before I put that document down though it's interesting to see and I ask the Commission to look at the answer which is part of answer 36 at page 12 where it sets out Mr Taylor's view as to how the high hazards unit is going about enforcing the New Zealand legislation comments on the all practicable steps and so on. And it goes on, "The high hazards unit will be working to ensure all mine operators properly understand their duty to take all practicable
10 steps to manage workplace hazards. The department further proposes changes to be made to the regulations to remove the all practicable steps requirement."

I leave that answer paper of that, I'm conscious of time and just briefly refer
15 you then if I may to the evidence that was submitted by the EPMU from Mr Bolderson. It's EPMU 0034 21st of March 2012. In that statement of evidence Mr Bolderson who works at Spring Creek and is as a leading hand and is an elected health and safety representative there comments, "And I commend the Commission to look at these as to employee participation at
20 Spring Creek both prior to and subsequent to the Pike River explosion and the difficulties that there have been trying to achieve a collective agreement that incorporates employee participation agreement within it."

1150

But of more relevance to the present purposes he speaks at pages 7 and 8 of
25 that statement as to three recent incidents at Spring Creek, the 5th of February 2012, the 16th of February 2012 and incident three on 16th of February. I just concentrate on that one where there was a fire resulting in a discharge of carbon monoxide into the underground workings. It's paragraph 15 in Mr Bolderson's evidence. The spike in carbon monoxide
30 underground was determined to have been caused as a direct result of the fire breaking out on the surface diesel compressor. A fire resulted in carbon monoxide being pumped into the mine via the reticulated air supply. There are approximately 20 men underground in the mine at the time. The fire went

unnoticed for approximately 16 minutes before any action was taken. Prompt action from the supervisor minimised the danger. My understanding is that notification of such an incident was required under the regulations. The following day Mr Bolderson says on 17th of February I was having a general discussion about mining health and safety with mines inspector Brian Harrington. It became apparent during that discussion that Mr Harrington had not been notified of the incident by Solid Energy. I understand that following Mr Harrington becoming aware of the incident he discussed the matter with Solid Energy and a prohibition notice on 20th of February. That's the current state and I note in Solid Energy's recent evidence from Mr Hunt there was, and the paper is SOL559194/6 at paragraph 10.3 the brief comment, "Incident Three, 16 February surface compressor fire resulting in discharge of carbon monoxide. I acknowledge that this wasn't reported in line with the legislative requirements." And the end result is I suggest that if you had properly mandated, properly empowered check inspectors this would not be occurring. And just finally on the brief of evidence if I refer you to the concluding paragraphs, Mr Bolderson 18, 19 and 20 and the concerns he raises there as a worker in the mine, the confidence of underground workers in Solid Energy and I suggest that what he says there is somewhat backed up or corroborated by those slides that I put up earlier from that survey very helpfully put in by my learned friends for Solid Energy. I've done my time, sirs, I'm open to questions. I was going to go on and elaborate on some of the other matters in the check inspectors' part of the submissions but I won't do that now.

25

COMMISSIONER BELL:

Mr Hampton, page 5 of your document talks about partial safety case. Can you explain what you mean by partial safety case?

30 **MR HAMPTON:**

It relates to the inception or the inception of the mining, yes, I confess that I'm not au fait with partial safety. Can I ask Mr Anderson, my junior to answer that?

COMMISSIONER BELL:

By all means.

5 **MR HAMPTON:**

If he can, thank you Commissioner.

MR ANDERSON:

Sir, yes, a partial safety case, that we suggest in the submissions relates to as
10 Mr Wilson has already discussed as well, the need for some sort of process at
an early stage to identify issues such as might be apparent in terms of
Pike River with the second egress and we suggest as part of that process that
the financial means, the experience of those involved in the projects be
assessed in some way so that at an early stage those issues can be identified
15 and addressed if necessary.

1155

COMMISSIONER BELL:

I'm just trying to differentiate between a partial safety case and a safety case
because the safety case normally involves the regulator signing off on the
20 document and the problem I have with that is the mine manager is responsible
for safety of the mine, not the regulator.

MR ANDERSON:

Yes, sir we have –
25

COMMISSIONER BELL:

Does your partial case involve the regulator signing off on the –

MR ANDERSON:

30 I would suggest there'd be a review, sir, and possibly also involving, as we
suggest, the union industry check inspector that we propose, the equivalent of
the district inspector as well, but certainly some review by the inspectorate or

the regulator, not necessarily sign-off, sir but that's somewhat up in the air from our perspective at this stage, sir.

COMMISSIONER BELL:

5 The reason I'm raising it is because it's not universally accepted in Australia that mining regulators use safety cases. They're used extensively offshore in petroleum, but they're not used to the same extent with mines because the inspector has to take responsibility in some respects. I'm putting it to you, I see it as a potential problem.

10

MR ANDERSON:

Yes sir, it's accepted from our perspective.

COMMISSIONER BELL:

15 Thank you. Just one other, Mr Hampton, what I want to, talking about unannounced visits which you've gone to a few times, well sorry at least once, what do you see the benefits of an unannounced visitor, an unannounced visit by a mines inspector?

20 **MR HAMPTON:**

Well as I understand it, sir, you come upon the mine as it were, "unawares" in its ordinary, everyday state whether it be on a day shift or a back shift or a night shift. You get a proper view of conditions underground, what goes on day to day, night by night, rather than an announced visit where certain tidy-up can occur and anecdotally from the evidence you've already heard, does occur. The inspectors known to be coming and a tidy-up takes place and coming out of the recent Big Branch matter, there's material, and I haven't got it in front and I can find it and put it in front of the Commission if needs be, coming out of the Big Branch thing, that a lot of unannounced visits suddenly
25 occurring right through the United States with what seems on the face of it to have had hugely beneficial results as a matter of, in relation to health and
30 safety. There were some figures that were quite astronomical. Suddenly the

regulators were getting off their bottom ends and doing what I suggest a regulator should do from time to time.

COMMISSIONER BELL:

- 5 So the EPMU's position would be that should be a routine part of a mines inspector's normal activities?

MR HAMPTON:

- 10 Indeed, and I think that that passage oft-put by me I think to various witnesses from New South Wales in coming from the Gunningham report where it was quoted, we endorse that approach.

THE COMMISSION:

- 15 Mr Henry's had second thoughts, Mr Hampton, as well.

MR HAMPTON:

Bother, bother. No disrespect sir.

COMMISSIONER HENRY:

- 20 Check inspectors, you've emphasised those I think would be a way of putting it, and you took us through those incidents at Spring Creek. Now incident one was methane rich air going through an auxiliary fan and there was a couple of days' delay before it was notified, as I remember it.

25 **MR HAMPTON:**

Yes.

COMMISSIONER HENRY:

- 30 Happened on the 14th, 15th, the night, and it was notified the day after, day one on the 17th.

MR HAMPTON:

Seventeenth sir, yes.

COMMISSIONER HENRY:

What I can't figure out is what difference would a check inspector make to that?

5

MR HAMPTON:

A site check inspector would be there in the mine, would be, should be immediately aware of and should then notify, as a matter of course, as a matter of the processes that would be in place, just go into discussions with management and notify the mines inspectorate in any event.

10

1200

Hopefully a check inspector might have prevented some of these incidents occurring in the first place but it would expedite the processes, the necessary processes that should be put in place as a consequence of a particular incident. The first incident is perhaps not the most serious of incidents, sir, but that's the general scheme of it, sir.

15

COMMISSIONER HENRY:

So you're saying that they would help prevent, but they would also ensure notification is that what?

20

MR HAMPTON:

Yes, and thirdly would be an eye all the time as to housekeeping and maintenance within the mine and, additionally, would accompany a mines inspector when he does his journey around whatever it be, whether it be announced or unannounced. They'd be the major benefits, probably more than that.

25

COMMISSIONER HENRY:

Yes, okay thank you.

30

COMMISSIONER BELL:

You raised appendix 1 which is your model for check inspectors. I've read both for the site check inspector and for the union industry check inspector and I don't see any mention of the word industrial anywhere in there.

5 **MR HAMPTON:**

No.

COMMISSIONER BELL:

10 Maybe I've missed it, but I think we did talk about, you do say, "The minister may terminate the appointment of an SCI if he or she can prove the SCI is not performing their functions satisfactorily," but it doesn't actually say anything about getting involved in the industrial unit or maybe I've missed that, if you could point me to.

15 **MR HAMPTON:**

It's supposed to be there. If it's not there, well it's certainly got to go in because we're basing it on the Queensland model which has that in.

COMMISSIONER BELL:

20 Yes, because it's not in either of them that I can see.

MR HAMPTON:

And I thought –

25 **THE COMMISSION:**

There's provision for terminating the appointment by the minister to terminate the appointment if the duties are not carried out satisfactorily. Are you relying on that?

30 **COMMISSIONER BELL:**

Yes, that's -

MR HAMPTON:

This is the union check inspector, sir, that's the one we're relating it to I assume, sir because they're the –

5 **COMMISSIONER BELL:**

Yes.

MR HAMPTON:

- that's the inspector that has the greater power?

10

COMMISSIONER BELL:

Yes, that's right.

MR HAMPTON:

15 So at page 84 the reference at paragraph 4 I suspect, the footnote will refer back to the, I hope, to the Queensland legislation that refer to that and then on page 86 at 8 and 9, "mustn't necessarily impede production," 9 "can't perform," that may be the provision you're looking for, sir.

20 **COMMISSIONER BELL:**

I don't appear to have it in my copy so I may –

MR HAMPTON:

25 At page EPMU 0035/86 in provision 9, "UICI may not perform a function or exercise of power under the Act regulations for a purpose other than the safety and health purposes," and 10 days, "It'll be an offence to – oh, no it's the obstruction offence, sorry, but that's the provision sir and I think that's may be what you were looking for. I certainly intended it to be there.

30 **COMMISSIONER BELL:**

Yes, and I just I couldn't see it all that clearly that's all.

MR HAMPTON:

It's a first crack at a draft, sir, and it perhaps shouldn't be seen as biblical but it's you know it's based on Queensland and that was –

5 **COMMISSIONER BELL:**

Because it is a matter of some contention that there is a provision there if an ISHR in our terms strays in the industrial realm, it can be removed by the minister and it should be removed by the minister.

10 **MR HAMPTON:**

The EPMU understands that, sir, and goes along with that. There's no difficulty with that whatsoever. That should be a part of it which answers my friend's problems with union involvement in industrial matters.

15 **THE COMMISSION:**

I was just going to make the comment, Mr Hampton, we'd rather anticipated a spirited response having heard from Mr Stevens and Mr Holloway yesterday and we've not been disappointed and we have the message concerning the issue of check inspectors and you can rest assured it'll be grappled with,
20 despite the width of the divide.

MR HAMPTON:

Thank you, sir.

1205

SUBMISSIONS: MR RAPLEY

Sir Mr Rockhouse has filed submissions and I just want to orally address the Commission on some select points and in particular perhaps answer some things that have been said by others in some of their submissions.

5 Mr Rockhouse was interviewed by the police and Department of Labour in March 2011 and the interviews were comprehensive and occupied a number of days. Mr Rockhouse has provided information to the Royal Commission, its investigator and counsel assisting and Mr Rockhouse has given evidence in Phase Two and Phase Three of the Royal Commission of Inquiry hearings.

10 Throughout I suggest Mr Rockhouse has told the truth and importantly, told us about the culture of Pike River Coal Limited and told us in very real and graphic terms the pressure that he and others were under because of the need to obtain coal.

15 Mr Rockhouse sets this out in his final submissions. This production pressure has been spoken about by many witnesses, particularly Mr Rooyen, Mr Couchman and Ms Gillman. Mr Rockhouse believes that almost everyone had the right safety attitude and intent to start with. However, as time went by he saw attitudes to safety change due to production pressures. Now I
20 suggest it's clear from the evidence that we've heard that there were such pressures and it's clear there were problems with Pike River Coal Limited and these problems were many and varied. These problems permeated throughout the whole of the company. Mr Rockhouse was the health and safety manager. His role was to create health and safety systems.

25

Mr Rockhouse did his level best to prepare extensive health and safety systems and procedures and these have been commented upon favourably by the Department of Labour, Dr Callaghan and by the Department of Labour investigative report, the systems in particular have been commented upon
30 favourably, but the problem was that the safety systems in some parts weren't used and safety was siloed from other key departments and that what's the investigative report told us.

Mr Rockhouse told us how the engineering department in particular under the stewardship of Mr Goodwin failed to align its maintenance systems with a focus on safety. Now Mr Goodwin took his lead from Mr Whittall. Mr Rockhouse clearly encountered problems with Mr Whittall. Now
5 Mr Whittall's lawyer, my learned friend Ms Shortall in her submissions accepts no responsibility or blame on behalf of her clients. Mr Whittall in his Phase Three brief which he filed by way of reply, which in itself seems a bit unusual has not been given in evidence and it hasn't, because he hasn't given evidence in Phase Three, it hasn't been tested or cross-examined, but he
10 accepts no blame or responsibility. In fact the directors or officers, board of company Mr Dow, Professor Myer, Mr Nattrass, Mr Whittall, Mr Ellis, Mr Ridl all represented by the one counsel accept no responsibility or blame at all and say if they were at fault then everyone else was as well.

15 Now I suggest this is in stark contrast to Mr Rockhouse. He fronted up, gave evidence and accepted shortcomings. Now Mr Rockhouse accepts mistakes were made by him.

1210

Mr Rockhouse accepts he should have done things which were not done.
20 Mr Rockhouse accepts responsibility and some fault on his part and he's told us about that during his evidence, openly and frankly I suggest, he held nothing back in his evidence and as I said, this acceptance and willingness to learn from mistakes is in stark contrast to the evidence given by others such as Mr Dow, Mr Whittall and even to some extent Mr White.

25

Everyday Mr Rockhouse asks himself could he have done more. Could he have done something differently which would've prevented this tragedy, which would've allowed his son Ben and the other 28 men to come home from work that day. Now Mr Rockhouse was working in a hostile environment. He was
30 bullied and intimidated by Mr Whittall. The climate in which he was working was a contributing factor I suggest to this tragedy. I suggest the fact that safety and the need by each department to address safety at times became secondary to production and Dr Callaghan has reviewed that and said a fish

rots from its head, well counsel for certain directors as I said including Mr Whittall state the responsibility for implementing the health and safety systems lay with Mr Rockhouse. It did not. Even Mr Whittall accepted that each department was charged with implementing their own health and safety systems. That's because the various TARPs, SOPs and management safety plans had to be written by those who had the specific technical knowledge. There simply no way a person such as Mr Rockhouse could write detailed technical documents about engineering for example.

10 Now my learned friend Ms Shortall responds to Mr Rockhouse's criticisms in her submissions on behalf of Mr Whittall and others I've named and disputes his management style was as Mr Rockhouse says. She refers to Mr Rockhouse sending Mr Whittall a congratulatory email on his appointment as CEO and because he said he was an intelligent person with a nice family. I suggest that the submissions that the evidence by Mr Rockhouse was truthful, what he says occurred. The submission by Mr Whittall's counsel is wrong, it has no substance to it. Mr Rockhouse is not being wise in hindsight and being influenced having sustained a personal loss as was put by counsel for Mr Whittall.

20 So Mr Rockhouse's criticism of Mr Whittall during this Royal Commission have been direct. These criticisms were warranted and justified and although at times it may have felt like a battle between Mr Rockhouse and Mr Whittall, the reality is that other witnesses have now given evidence corroborating Mr Rockhouse's evidence. They've all agreed that Mr Whittall's management style was unpleasant and obstructive, the management style of Mr Whittall seeped down through the company and infected it.

30 The Commission is tasked with finding out what went wrong at Pike River Coal and what lessons can be learned from this tragedy. There can be no doubt that the problems at Pike River were due to management and leadership style of Mr Whittall. It's accepted on behalf of Mr Rockhouse that there were other contributing factors that led to this disaster. Mr Whittall was

not the only problem. We now know there were many other factors which led to it and Dr Callaghan puts it, "It was a state of affairs where there was literally an accident waiting to happen." The evidence has highlighted problems with deputies and underviewers, seemingly not appreciating the powers that they
5 in fact possessed or their obligations. We now know their reports that were being provided apparently to and by these underviewers and deputies were not being acted upon or provided to management.

1215

We now know about the lack of uptake from the health and safety systems
10 designed by Mr Rockhouse and that was a problem and involved Pike River Coal Limited management and staff from top to bottom. So we now know that combined with the internal Pike River Coal problems at the same time there was a lack oversight by the Department of Labour. The second means of egress has naturally been a focal point in this enquiry.
15 Mr Rockhouse opposed this vent shaft with a ladder being classified as a second means of egress at all. We now know that Mr Couchman and Mr Rockhouse, that a drill was done with Mines Rescue to demonstrate its shortcomings. Mr Rockhouse hoped to obtain support from the Department of Labour inspector. He felt certain the Department of Labour
20 inspector would advise the company that it was inadequate, much to his surprise Pike River Coal was allowed to continue its daily operation with this as a temporary second means of egress on the promise that a proper one would be created as soon as possible. It suggested that this is a prevalent theme that is present throughout. Well-meaning, well-intentioned people
25 recognised there were problems at Pike River Coal. It was drawn to the attention of management that many management plans were in draft. It was drawn to the attention of the Department of Labour inspector, the statutory mine manager Mr Whittall and others that the second means of egress was inadequate. It was drawn to the attention of the mines manager and indeed
30 Mr Rockhouse that there were concerns about contractors and whether they were adequately addressing and managing their health and safety needs. Almost on every occasion it was decided that the situation was far from satisfactory but the mine would continue operating and at some stage these

problems and issues would be addressed. It seems at no point was it ever suggested that work would be stopped until the identified problem was fixed. Stopping and holding production just did not seem to be an option. It is for these reasons that Mr Rockhouse in his final submissions pleads for greater
5 Department of Labour involvement and for an awareness that the regulator needs to have clear non-negotiable lines in the sand. Such lines in the sand should be that the mine cannot operate until key documents, such as ventilation plans, strata control plans, emergency management plans and gas monitoring plans are developed and filed with the Department of Labour.

10

Mr Rockhouse goes further and says, "And these key procedures and systems needs to be assessed and approved by the Department of Labour." Mr Rockhouse suggests that if there is such a regulatory requirement in place then it's almost certain that these crucial aspects of the mine will be attended
15 to, completed and implemented by the mining company because whether they can mine or not is dependent upon it. Therefore, there needs to be rules in place suggested where the Department of Labour will refuse to allow mining to commence or continue until these key systems and documents have been completed and implemented to the Department of Labour's satisfaction.
20 That's why Mr Rockhouse supports the Department of Labour playing a key and active regulatory role in the oversight of health and safety for all mines.

Now we're aware that the Department of Labour themselves suggest that draft principle hazard management documents be provided prior to the operations
25 commencing. We go further and say, the Department of Labour then need to check that these appropriate and have actually been implemented. In short Mr Rockhouse did his best in difficult circumstances. The health and safety department was overwhelmed by documents and operating under extremely difficult conditions given Mr Whittall's management style and lack of support.
30 Evidence given by Mr Couchman, Ms Gilmour and others support that submission.

1220

Mr Rockhouse accepts some failings and a degree of blame as I've said and as he's told us. He's told the Commission at no stage would he have allowed anyone to go into the mine if he'd thought it was unsafe or if he'd appreciated the full extent of the problems we now know about. Mr Rockhouse
5 unfortunately was not privy to some terrible shortcomings that permeated throughout the company. Mr Rockhouse believes that joint consultation with all stakeholders in any safety management system is the cornerstone of overall success. So this is true not only in the mining context but across all high hazard industries in New Zealand. Mr Rockhouse therefore agrees in the
10 need to have a suitably qualified check inspector and my learned friend Mr Hampton quotes the evidence by Mr Rockhouse on that. Check inspectors have both the ability and authority to interact with mine management in the Department of Labour and check inspectors would have assisted him. This is an essential component in the creation, implementation and maintenance of
15 any sustainable, safe system of work for all. Mr Rockhouse endorses the views of Dr Callaghan and recommends changes to the current regulatory system, greater involvement by Department of Labour to ensure that this never happens again.

20 So, Commissioners, that's all I wanted to say on behalf of Mr Rockhouse. He's filed submissions setting out matters he considers very important. I'd be happy to answer any questions if there are any.

THE COMMISSION:

25 I think everything that Mr Rockhouse has said is fully understood, Mr Rapley. Needless to say we're grateful for his input throughout the inquiry and on more than one occasion and also acutely conscious of the toll that that exacted on him given his personal situation, so pass that on to him if you wouldn't mind please.

30

MR RAPLEY:

I will do. Thank you sir.

THE COMMISSION: Mr Davidson.

SUBMISSIONS: MR DAVIDSON

Your Honour, Commissioner Bell, Commissioner Henry, at the heart of these
5 submissions lies a premise which I advance at the start, that some years ago
New Zealand began to lose its way by different routes. It took away the
effective regulator and it took away the effective worker participation in health
and safety, and by doing so it allowed this company but it could have been
another, to fail on so many fronts without the fundamental protections all
10 workers deserve. If there is a theme beyond those two or that basic premise,
it is of a complete dislocation with that dismantling. A dislocation between
what should have been the arms working cohesively as an effective system,
whether we describe it was the three pillars or the three-legged stool, and in
many respects this Royal Commission of Inquiry has been presented with a
15 set of facts where the issue is not so much except in one crucial area what
happened, what was going on, but why it happened, because without
determining why these things happened no advance can be made, and
because of the deep-seated failure across the three levels to which I have
referred both in the regulator and the worker participation and the company,
20 the rebuild of an effective system is an enormous task but it is a task of the
greatest urgency.

1225

Listening to the submissions that we've heard in the last two days, I
acknowledge has compelled the families and we as their legal team to reflect
25 hard on the elements which are required for the future. The debate for
example about the check inspector or an alternative version, and while we
have refrained in our written submissions from getting into that territory
because you like our specialist advisor in Dr Callaghan does not purport so far
to intrude into the debate.

30

I want to advise the Commission that she is following every word of this
process and the submissions being filed and as she has recorded in the
submissions she has made, intends with leave of the Commission to

contribute further after she reflects on these matters. So the temptation right now is to look to the future and concentrate on that but the families have some pressing needs that they wish us to advance before the Commission on a number of fronts. I just want to set the scene for how we propose to approach our submissions. First, I just want to complete this very short introduction, then Ms Mills will address the question of context. Mr Raymond will address search, rescue and recovery and I will return to the cause of the explosion, oversight and Phase Four policy looking forward. I just want to make these preliminary observations because isn't just a punctuation mark in this Royal Commission process as we come to the oral hearing and its conclusion tomorrow.

I want the Commissioners to know that the families have not just sat following assiduously the process so far. You've seen them and, sir, you've commented on that at the end of Phase Three, but behind the scenes of this hearing room the families have been following on the live-streaming and have been tuning in to teleconferences from around the world every week to be brought up to date with the facts as they emerge in this Commission to gain an understanding and that really is the heart of what we are trying to achieve with you is to give them an understanding for what happened and you'll immediately understand that their gaining a comprehension of what caused the explosion is a major factor in their minds and of course whether their men could have been rescued. So that determination to know why this happened is at the heart of the submissions we make before you.

The second element I want to raise in opening is that they are bewildered and have a sense of injustice that for what seems such obvious defaults within Pike River, and I talk about the company as opposed to individuals, there seems to be no recognition. The evidence that was filed for example by Mr White, the evidence given much earlier by Mr Whittall seems to acknowledge no awareness at all of anything being wrong as in health and safety at the mine. Regrettably, families do not accept that. The evidence and the submissions that we advance against that evidence is of a failure

which was obvious and identified and identifiable. In essence the submission is that this mine caught a disaster on many fronts and the evolution of its problems can be traced from the very start. We try not to personalise our submissions. Inevitably people come into the narrative but the goal behind these submissions is to point to the failure within this company so far as Pike River is concerned.

Before I ask Ms Mills to proceed in the context, as to context, I just want to make one point which we've tried to make previously.

10 1230

Since the police made a decision to hand over to the receivers in January 2011, so now 14 months ago, 15 months ago and not many weeks after the explosion on 19 November, there has been nobody, no party carrying responsibility for recovery of the men. We do not seem to have gotten this across to the public through the media, the police made a decision and they made statements around the handover indicative of this not being a viable recovery process. In fact the police referred to this in the long term, a permanent memorial to the men will be established at the mine and it would be quite wrong for the police to hold out great hope that the men will be recovered and the mine's company's receivers have been unable to come up with an achievable plan. Since that time and relevant to the terms of reference because recovery is part of that before you, a moment's reflection will tell you the angst of these families, nearly all of them, as to the fact they have had no umbrella support for recovery of the men at all. The receivers have made it clear, stabilisation of the drift for the purpose for sale is their commercial imperative and to be fair to them, that's been their position from the outset. But once the police had departed, once the receivers had their commercial imperative, recovery of these men has been an incident of a sale which may never have taken place and the angst of the families today still waiting for the moment of reclamation of the drift, as the first step, cannot be overstated and I say this because there are many times in the past 14 or 15 months, the families were confronted publically and privately. A refrain that it is time to let this go. These people know of the man seen in the mine, they

know the degree of destruction shown there which has surprised so many people by its relatively limited nature compared with the fact of four explosions, they've observed the body lying in the mine and their determination to get into the mine is as firm as ever. But their patience has
5 been well and truly tried.

There has been no one except within themselves and their team and those who will come aboard that team to support this and the only bright light in recent times has been the announcement of the conditional sale to
10 Solid Energy which now affords an opportunity if its confirmed to link that to recovery. With that I move to the question of context and ask Ms Mills to address the Commission.

SUBMISSIONS: MS MILLS

Sir, the families said that there was a lack of geological knowledge at the outset of the development of Pike River Mine. This led to serious delays in the project which in turn placed extreme financial pressure on
5 Pike River Coal Limited. The evidence produced to the Commission supports the view that the geography and geology of the mine area was complex and that it was essential that PRC understood the geology before they started development. It is submitted that they did not. In her evidence
10 Dr Jane Newman summed up the characteristics of the Pike River development as being insufficient resource characterisation, negligible understanding of the complexity of West Coast coal geology and a reluctance to fund cost affected work to gain that understanding. Dr David Bell it was quite clear that the mine geology was over-simplified given the relatively wide space, drill hole intersection. That was a view supported by Dr Elder,
15 Dr Newman and Dr Cave. Udo Renk has said that the exploration work which was done until 2007 was insufficient for safe mining of Pike River tunnel and for the development of the mine.

1235

The independent report prepared for PRC in May 2010 by Behre Dolbear
20 Australia, (BDA), stated that the project was developed with very little geotechnical knowledge of the tunnel and the structural complexity of the deposit was still largely undefined in 2010. It appears that BDA understood that surface drilling had been constrained by consent conditions. It is not clear how that rumour was propagated but that was what people thought. The
25 evidence is that no borehole request was turned down by DOC and that the type of location approvals from DOC were down to less than a day. In justification for the lack of boreholes, directors and officers have quoted BDA approving PRC's misplaced reliance on in-seam drilling as an alternative. Dr Newman has now repeated her submissions that Pike River could not
30 reliably interpret those results in such an unknown structural complexity. The unexpected geotechnical difficulties driving the drift led to the tunnel being 100% over budget and two years late and the mine was already running out of time before coal was reached. It is submitted that starting with the initial

failure to establish the geology of the mine area, Pike River embarked on a development path driven by increasing financial pressure. Mr Renk was clear that the siting of the ventilation shaft in incompetent ground was so that resources could continue to be focused on the main drive and on reaching
5 coal. The result was its disastrous collapse. Unsuitable machinery was purchased which could not carry out the development work, causing further delays and financial pressure. The lack of geological information led to extensive reliance on in-seam drilling and the failure to establish an adequate pre-drainage regime for the methane. As a result of the exploration boreholes
10 ran in front of the development, draining methane often under high pressure and were frequently being cut through by the development teams. The trial panel position had already been changed to re-site it inappropriately close to the lighter mine roads so that coal could be extracted earlier. As a result of the urgent need to increase ventilation to allow extraction, the underground
15 fan was commissioned before a further risk assessment was undertaken. Extraction was ranked up rapidly from five eight-hour days a week to 24/7 without any time to establish protocols, train staff and deal with the ventilation issues created by the hydro start-up, in fact, without even waiting until the main underground fan was fully commissioned. As a result of the push for
20 extraction the development towards the second egress was not prioritised, neither was a fit for purpose FAB, an adequate methane drainage pipeline or a tube-bundle system.

The development of the mine as detailed above, should be set alongside the
25 New Zealand Oil and Gas evidence of the financial pressures on PRC as the mine consistently failed to meet targets or fulfil the forecasts provided to investors.

The question has been asked of this Commission as to who had oversight of
30 the design and development of the mine and who could have intervened. Looking at the oversight by statutory agencies, there was no external agency which questioned the overall design and development of the mine. The technical side of mining, including the process by which mining permits are

granted and administered, is the responsibility of MED. The access arrangements for Pike fell to DOC, the environmental side to the local authorities, and the health and safety aspects to the Department of Labour. This separation of the health and safety aspect of mining, which involved the transfer of the mining inspectorate to the Department of Labour meant that none of the agencies with statutory responsibility for approving, consenting and permitting Pike River had a requirement or a practice to consider the dangers inherent in the constantly changing mine design and the development process.

10

DOL had oversight of health and safety in the mine as soon as it became a workplace but failed to challenge the design and development of the mine. Robin Hughes set out in his evidence the depth and thoroughness of the role that inspectors had prior to 1991, 1998 changes in reviewing those mine plans. The mines inspectors raised with permit applicants the issues relating to the design of the mine and the health and safety in the mine at that time. In Mr Hughes' view it was essential that inspector was involved at the application stage as well in reviewing the changing plans.

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Harry Bell said that if he had still been the chief inspector of mines he would not have let PRC go through the Hawera Fault with a single drive under any circumstances.

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The evidence of the mine inspector for the 2005 to 2008 period was that in essence the department's role was not to approve the design of the mine but rather to conduct some enquiries to see what was happening and raise issues if they were obvious.

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Sadly Mr Firmin's evidence resounded with a sense of powerlessness and pragmatism. While recognising that design is inextricably linked to health and safety, the inspector's role appear to be one of a bystander, cautious not to do anything which might smack of approval and with a function of receipt of mine plans but no purpose attaching to those.

30

It was not just the statutory agencies who had oversight for the development of Pike River, clearly the board and the managers had that responsibility. However no one at PRC has accepted responsibility for Pike River. The board's repeated view was that they expected senior management to implement the board's strategy of developing a safe coalmine. Mr Dow stated that he had no reason to believe this was not being done. In fact the board had a duty to find out if it was being done and they failed to do so.

10 The senior manager Mr Dow was relying on from 2005 until the 2nd of October 2010 was Mr Whittall. It is of deep concern to many of the families in seeking the understanding of what went so wrong, that whilst it was clear Mr Whittall was in charge of the day to day management and development of the mine, he left that to his managers. This despite the mine managers, six in two years, moving on after very short tenure and the evidence before the Commission that Mr Whittall micro-managed. Despite the documented extensive nature of his role as mine manager, Mr Whittall said he could only build the mine on the basis of what had already been decided. He said when he became involved all the concepts of what was going to be done were done.

In his evidence and interviews he has deferred to Mr White's responsibility for oversight of the mine in 2010. However, Mr White's submission echoes his. He says within the framework of what he was presented with he did all he could.

In conclusion, some final comments of Gunningham and Neal seem very apt. They argue that the most important single improvement in mining safety would come from greater Government intervention at the critical initial stage where permission to mine is granted. Noting that if the financial model at the permitting phase shows cashflow difficulties, this may lead to unsafe eye level decisions and shortcuts in a corporate level. Those will then cascade down to the workforce resulting in fair of job losses and the potential for shortcuts to be

taken. At the design and planning phase, critical risk can and should be identified and systematically addressed, in particular safety features locked in. It is submitted that Pike River demonstrates if flaws in planning and design are not corrected then they will compound the financial pressures and manifest later. By that time it is often too late to address them effectively. By late 2010 the only option would've been to stop Pike River extracting coal but no one had the resolve to do so.

SUBMISSIONS MR RAYMOND:

May it please the Commission, as my learned friend Mr Davidson has indicated I am dealing with Part C of the submissions, the search and rescue and recovery phase and highlight some of the main issues which the families
5 wish to address further in addition to the written submissions.

The deaths of the men and the location of the men in the mine firstly, there seems to be wide spread general consensus amongst the main submitters including the police and the Department of Labour that the police and
10 Department of Labour reconstruction of where the men might have been at the time of the first explosion on 19 November is as good as we're going to get.

1245

The police and the Department of Labour interviewed a significant number of
15 people and have pooled together the best evidence that we have on where the men might be with one significant qualification and that is that this was, the explosion was just about on a shift changeover and the men could've easily moved about this small mine and been somewhere else and the police readily accepted that in cross-examination by both Ms Shortall and myself on
20 that issue. There is some difference between the police evidence and the Department of Labour evidence on exactly where the men might have been in the final moments before the explosion and in our submissions we have detailed what the differences are between those two reports and it's only in three or four respects in the submissions and I don't intend to refer to that
25 now. As to the likely cause and timing of deaths, again happily there is widespread consensus between the main submitters about the Coroner's findings remaining undisturbed. Judge MacLean concluded that the death of all 29 men occurred on 19 November either at the immediate time of the explosion or shortly thereafter. He details the cause of death and the families
30 have no basis to challenge those findings. It's fair to say some family members have their own views, theories in relation to the timing of death but at the end of the day there is no evidential basis to challenge those findings in

a serious way and the submission of the family therefore is, as in the written submissions, to leave the Coroner's findings undisturbed. The related –

THE COMMISSION:

5 Can I just ask something? What do you take from the phrase, “shortly thereafter”? How are you interpreting that?

MR RAYMOND:

Well within minutes, sir. I think the exact words he used was “or a very short time thereafter.”

10

SUBMISSIONS CONTINUE: MR RAYMOND

On the related issue of the CAL scan evidence and the self-rescue box or the fire equipment box, the families' primary concern here as Commissioners that the evidence of the open box came to the families very late in the piece. It was not disclosed to them. It was dramatic, disturbing and potentially highly relevant information that came to the families almost by chance through the briefing process where counsel were talking with a third party and the information literally popped up. It was of considerable concern to the families to learn about it in this way given the families first policy and the policy of open and full disclosure to the families and no surprises.

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THE COMMISSION:

Can I interrupt again Mr Raymond? Can you just explain this, a little more to us, and there's quite a bit of material in the submission about, no it may not be in the submission, it may be in a document that came in quite recently from the families. It's the one that deals with the history of events from the families' perspective in relation to their dealing with the police and other authorities and it's pretty much a day by day or week by week account and it's evident from a reading of that, that was repeated revisiting of underground information that had been obtained at various times. There's also evidence that the CAL scan images were shown on the day of the inquest after the event. It's just not

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30

readily apparent what the lateness is that you're referring to. When in fact did the families become aware?

MR RAYMOND:

5 The 31st of March last year. In an interview that I was dealing with, a worker at Pike River across the road at Hannan Seddon, the CAL scan images that you're referring to, sir, that were shown at the time of the inquest did not show the self-rescue box being opened. As the Commission knows it's very much how, the CAL scans work very much on the basis of how they are
10 manipulated by the operator and whether by design or by default that particular angle was not shown to the families and it wasn't highlighted during the course of the hearing before the Coroner and the importance of it or otherwise was not mentioned in any material way or any substantive way.

1250

15 There was oblique reference to it as we know in the report of one of the witnesses before the inquest and that was all. No one appreciated the significance of it.

THE COMMISSION:

20 And what happened post 31 March?

MR RAYMOND:

Well, having received the evidence we had to test the veracity of it somewhat and also the source of the information and in due course having been
25 satisfied that what we'd been told was sound and valid, we raised it directly with Assistant Commissioner Nicholson and also my friend Mr Moore and thereafter received very prompt and helpful assistance from them both to get to the bottom of what it was that we were looking at. There was some uncertainty for a period but it wasn't too long before we were gathered with
30 the police looking at the CAL scan images ourselves with the police –

THE COMMISSION:

When was that?

MR RAYMOND:

- in Christchurch. That would have been mid-April.

5 **THE COMMISSION:**

Is this at the Hornby Police Station or something?

MR RAYMOND:

Yes it was sir.

10

THE COMMISSION:

Okay.

SUBMISSIONS CONTINUE: MR RAYMOND

15 And there was no doubt about what we were then looking at and it was
consistent with what we had been advised earlier. So throughout that period
of April as I was about to say, the manner of its disclosure gave rise from the
families to suspicion and mistrust unfortunately at a time when those
sentiments were already manifesting themselves following the police
20 withdrawal from the search and rescue and recovery exercise and what
seems to families at that time as an abandonment of them by the police and
what was a pass to the Pike River company in receivership of the problem of
recovery to a company which was obviously in receivership and was clearly in
financial difficulty and the families at that time, of course, were very concerned
25 to hear that the police were handing over control of the process and also
apparently withholding crucial information and evidence in relation to a self-
rescue box. It certainly was an unhelpful and unpleasant time for the families
and, as I said, the mistrust and suspicion grew at that time. But returning to
the actual evidence. Whether the box was open or not at the time of the first
30 explosion, whether it was a fire box or a self-rescue box, by whom it was
opened and when, we simply do not know. Like so many things which
unfortunately confront this Commission process, the police have expressed a
view as to what type of box it was. There is evidence which clearly points the

other way. The Commission will have to deal with that competing evidence and no submission beyond that made in writing is put forward at this stage. The short point on whether the evidence should be revisited by the Coroner is that the evidence is speculative and inconclusive, there are a range of
5 unsubstantiated scenarios as what the open box might mean, and it has been closely examined in this Commission process. The view of the families is that that evidence is unlikely to improve and I acknowledge here the considerable work that Development Inspector Tom Fitzgerald did in relation to that work and the co-operation that he extended to the families in getting to the bottom
10 of this issue, which has been appreciated. But in the final analysis, it is our submission that it's not in the public interest, it's not in the families' interest to refer this evidence on to the Coroner for further examination, and I understand that to be the view of the police as well, with the proviso that if new evidence does emerge they have the power to refer matters back to the Coroner at any
15 time. Slightly out of order, Commissioners, I wish to now turn to the police assumption of control, section 16 of the submissions. The families' position is set out in written submissions and in short the families share some of the concerns put forward by Mines Rescue Service and Solid Energy about the structure and decision-making process and I don't intend to repeat those here.
20 Rather, I wish to respond to submissions made by counsel for the police and for the Mines Rescue Service.

1255

Mr Moore for the police made a submission about the response co-ordinator and his submission was it could only be based in Wellington. Amongst the
25 reasons for that Mr Moore said is that there were diplomats or consults based in Wellington that senior managers were available to consult from the Government departments residing in Wellington and that Ministers of the Crown who have an interest in matters such as this were also based in Wellington. The families do not accept that the response co-ordinator had to
30 be Wellington. We had heard many, many, many times from the police and indeed from Mr Buchanan through the New Zealand Fire Service Commission submission that the CIMS model is flexible, it is regarded as one of its strengths. Well if it's that flexible it could adapt to the situation that we had

with this search and rescue recovery operation and the response co-ordinator role could have been in Greymouth and in a family submission it is preferable for it to have been in Greymouth. It would've enabled the response co-ordinator, Assistant Commissioner Nicholls to have consulted regularly
5 with the incident controller and had ready access to the many experts that were at the forward command at Pike River including the seven first class mine manager certificates which my friend Mr Stevens referred to yesterday in his submissions. None of which were available to him in Wellington. In the modern day and age with video conferencing, emails, cellphones and the like
10 the reference to consulting with Ministers, heads of department and so on could have easily have been done from a Greymouth base. Assistant Commissioner Nicholls could've drawn on his team or staff in Wellington as needs be for the major logistical exercises or support if that wasn't able to be done from Greymouth. The families acknowledge and are grateful for the
15 police acceptance that many operational decisions could have been made and should've been made in Greymouth which were otherwise made in Wellington. The routine decisions like drilling of boreholes and the deployment of robots into the mine where so much time seems to have been spent in having those issues examined in Wellington. The police however
20 maintain that two key decisions, the sealing of the mine, whether or not to seal and the question of re-entry into the mine are such significant issues that they should've been dealt with at that higher strategic level in Wellington. It follows I think as my friend Mr Gallaway noted the police adhere to the three-tiered approach which they operated on with this search and rescue. The
25 Department of Labour seems to advocate for a two-tiered approach although as Commissioner Panckhurst noted that is unclear. Paragraph 202 of Ms McDonald's submissions referred to the "in hindsight" view of the Department of Labour that it considered that two levels of decision for significant decisions would provide the desired objective decision making. I
30 first thought that that might have been the two levels beyond or below the incident management team but the use of the phrase "in hindsight" tends to suggest otherwise. Because of course it was a three-tier decision making structure that was in place. I understand that the Department of Labour will

file further written submissions clarifying that apparent inconsistency between the two major Crown entities involved. I just pick up on one further matter before the Commission may wish to break for lunch and it draws on a comment from Commissioner Henry, that the issue, the main issue for an
5 emergency response is re-entry. The police still say that operational decision be dealt with at a strategic level in Wellington. We observe that the window for a re-entry may be very narrow. Decisions may need to be made very quickly with the experts on site. The people on site with the forward command and the incident controller which I'll come to you later which our submission is,
10 should be on side also, is best placed to advise and resolve and consider issues of re-entry in a timely way onsite.

1300

In our submission it is an incident controller decision with consultation with the response co-ordinator, but the decision making process resting with the
15 incident controller at site and that the question of re-entry is therefore not, at the third tier.

If any question is to be left to the third tier, then that would only leave the question of whether to seal the mine or not, which we accept is a very
20 significant decision of national significance where there is a risk of completely extinguishing any prospect of life and that that is a major decision, which if there's to be a three tiered system, maybe appropriate to be dealt with at that level. But the question of re-entry we would echo what appeared to be the sentiment of Commissioner Henry that that is the key operational decision best
25 left to the experts, onsite.

COMMISSION ADJOURNS: 1.01 PM

COMMISSION RESUMES: 2.01 PM**SUBMISSIONS CONTINUE: MR RAYMOND**

Turning then to the question of incident controller, the families,
5 Commissioners, do not support the submission from both Mines Rescue and
Solid Energy that the mine manager or a statutory mine manager could be the
incident controller and I'll return to that in the context of Mr Gallaway's
submissions shortly. Mr Moore on this topic said that one of the focuses of
10 the incident controller is on the nature and scale of the operation and the
controller must have skills and experience in a major incident management
role but he said with access to a miner with a first class ticket. In my
submission the police incident controller under that scenario is still the person
making the decisions in a field he has absolutely no expertise in, that is the
15 mining field, yes, experience in major incident control but not in mining. In my
submission the situation should be the reverse of that suggestion by
Mr Moore. That is the incident controller should be a first class, have a first
class mine managers ticket working closely with the police but making the
crucial decisions on matters relating to the mine with the police, having a
wider significant incident experience.

20

As to the location argument put forward by Mr Moore, whether that incident
controller should be at the site or at Greymouth, in support of his position he
said that the incident controller could not be expected to travel long distances
twice a day and so on. The short point in response to that from the families is
25 that Superintendent Knowles, as incident controller, should not have been
communicating with the families. We well accept, as Mr Moore said, that
there should be a families' first policy and of course the family support and
encourage that, but Superintendent Knowles' focus should have been on
control and command. Superintendent Knowles is clearly a very experienced
30 well regarded senior police officer and the families wouldn't suggest for a
moment that that was not the case. He has risen to senior positions in both
Tasman and now in Canterbury and that is acknowledged and respected.
The point is though that his skill possibly does not lie in empathetic

communication in a mine rescue situation such as this. The families would have preferred a model where there was a police communications officer trained in this sort of emergency response conveying the police information, that side of the search, rescue and recovery phase, and a Mines Rescue
5 Service representative on the rescue and recovery phase and I'll return to that in the communication issue shortly.

Mr Gallaway for Mines Rescue said that Mr Watts and other members of Mines Rescue formed a view very early on that there was no or low prospect
10 of survival. I think a question was posed by the Commission, "Was that made clear?" In our submission it wasn't made clear and that was a shortcoming of the Mines Rescue Service during the search and rescue phase. MRS said that they were talking about survivability at the site, but not at the IMT meetings. In our submission surely that was the place to raise it and very
15 clearly. My friend said, "It was difficult to discuss due to the size of the meetings." He also said that Mr Watts felt, "Constrained by the Department of Labour position," and "he felt unable to push the issue hard." The families are disappointed at what they regard as this weak response.

1405

20 MRS had a clear responsibility and a duty to make itself clear on the issue of survivability and indeed sealing and certainly on the survivability issue, it failed to do so at the incident management level. Mr Watts said in his evidence that he'd never actually even met Superintendent Knowles.

25 If I could refer now to the evidence of Mr Watts on some of these issues and it's in the transcript 002 at page 2532 and during my cross-examination of him I was referring to some of the references in the evidence with phrases like "unbeknown to the IMT" and was putting to Mr Watts that there seemed to be things that were being kept relatively quiet and he was not beating his chest
30 about things like the question of sealing and at page 2534 there was this exchange at line 12. "Do you think that your concerns as you've just expressed them were getting through to the incident controller in the forceful way that you've just described?" Answer, "In the early stages we thought we

were talking to the incident controller to be honest, in those first few days.”
Question, “I’m talking at this stage of course post-second explosion to stop the
third and fourth explosion. Were you making your views known to the
contacts which my friend Mr Moore has referred to or to Mr Knowles himself
5 directly to ensure that this happened?” Answer, “We thought the processes
that was in place at the time was filtering the, well, providing Mr Knowles with
the clear information from what was occurring at the mine site. I didn’t have
any direct meetings with Mr Knowles.” Question, “I think you acknowledged to
my friend that with the benefit of hindsight you would in a similar situation be
10 beating a path to the door of Superintendent Knowles in making it more clear
what MRS views were on these issues. Is that fair?” Answer, “That’s correct,
sir.”

Just whilst on this question of response and the question of survivability.
15 Ms Shortall filed a document yesterday entitled “Supplementary submissions
on behalf of certain directors, officers and managers,” in relation to various
submissions which she considers have inaccurately referred to the transcript.
And the families, Commissioners, have filed a brief or if they haven’t filed it will
be shortly, responding to all of those points. Just on the question to Mr Ellis
20 and the issue of survivability, it was suggested, it appears at paragraph 18 of
that supplementary submission from Ms Shortall that she was taking issue
with the contradiction in Mr Ellis’ evidence about survivability. You will recall
that before this Commission he was saying that he thought that the men
would’ve survived several days, right up to the time of the second explosion
25 but with a less and less chance of that. Whereas he had said to
Mr Rockhouse’s family, very shortly after the first explosion, that all of the men
would’ve died at or shortly after the first explosion and he referred to the
Queensland black book, you might recall on that topic. In addition, however,
he was saying to this Commission he thought otherwise. Mr Taylor’s
30 evidence was put to him where it was suggested or Mr Taylor said that
Mr Ellis had said that inside this room we’re talking recovery outside this
room, we’re talking rescue. That was clearly put to Mr Taylor, he consulted
with his counsel before he answered that question and in our reply

submissions in paragraph 18, I'll just refer to that, Mr Ellis when asked about Mr Taylor's evidence of what he said could not recall saying those words, however Mr Taylor was unequivocal after seeking permission to confer with his counsel he said, the transcript 2 page 1539, "Steve Ellis did come into the
5 room and made a comment as I clearly heard, that outside the room it was still a rescue operation but within the task room it was clearly a recovery operation." So I don't think Commissioners there's any misquoting of the evidence on that point and the evidence supports the submissions earlier made.

10

As noted earlier the families disagree on the issue of incident controller, in particular the mines rescue submission that it should be the statutory mine manager. And Mr Moore referred to our response in his submission and I won't repeat it, its paragraph 16.7.2 of the written submission. And the reason
15 that we take that view is that we believe the statutory mine manager would face a conflict on at least two fronts.

1410

Firstly, there's the real likelihood if not certainty that he would know all of the men in the mine. That could cause him to make the wrong decisions on re-
20 entry and be conflicted with emotion. Secondly, there is the prospect, heaven forbid, of a statutory mine manager wanting to protect the reputation of the mine and indeed not let people get in to the mine for fear of what that might disclose in terms of evidence, or if that wasn't in fact the case there's the risk of a perception that that might be so.

25

In response to questions from the Commission my friend Mr Gallaway said that sometimes it might be the statutory mines manager and sometimes not. The problem that poses is how would you decide in the context of an emergency situation in all of the chaos, tension and emotion which would
30 inevitably be flying around, who would make the call? How would that process actually work? It would lead to further confusion, delays and be particularly unhelpful I would suggest.

On the question of communication with the families by Mines Rescue, Mr Watts has said that he regarded at the time that that was difficult for him because of the emotional element. Nonetheless, Mines Rescue submit that communication with the families is vital, which of course it is, but not
5 appropriate for Mines Rescue and Mr Gallaway said a robust structure should be able to determine quality information being conveyed.

The submission was that the general manager should remain onsite but Mines Rescue were happy to provide information to a mining person.
10 Commissioners, the families feel very strongly about this. They were the recipients of this process. They were in effect the consumers or the target audience and it's admitted, they simply must be listened to on this. They are best placed to provide the Commission with their actual experiences of what happened during those days after the explosion and subsequent explosions.
15 They did not want to hear from the police officer, clearly with no experience in mining, delivering information which was often not clear, was sometimes wrong and where the response was often, "I don't know, I'll have to defer to Mr Whittall, I don't know the answer to that, I'll have to come back to you," and sometimes wouldn't, with the refrain, "We have the best of the best up at the
20 mine site." It was very frustrating for the families, particularly those families who had a mining background and were talking to their mining husbands or sons or uncles or grandfathers back home, and yet being fed information which was inconsistent with what they were hearing elsewhere.

25 They wanted, they had a strong desire and they expected to hear from Mines Rescue Service and it's admitted that the response yesterday and in the written submissions from MRS, is entirely inadequate on this point. We understand the difficulties it might've placed Mr Watts in. We understand the important role that he was playing up at the mine site, but there must have
30 been a way and recommend for the future, a way where someone senior within Mines Rescue Trust, a trustee or another senior manager can attend on the families such a situation and convey accurate mining terminology reports,

or employ someone, a communications officer with mine experience for that purpose and we hope that that takes place if ever necessary in the future.

5 On the question of consultation with the police since this incident and improvements which could be made, Commissioner Bell asked the question as to whether or not there had been consultation and it was indicated by Mr Gallaway that there has been none. Well in our submission it's a two-way street. MRS could have easily instigated consultation themselves. The families are disappointed that that has not happened. There could be another
10 incident such as we had at Pike River at any time. If it was tomorrow, the similar issues that we experienced could happen again. The interim period, this waiting to see what happens is of concern.

The model then from the families' perspective, we recognise immediately that
15 we have no expertise to really provide comment on this area. The Fire Service Commission has filed written submissions which I'll comment on in a moment.

1415

The police clearly have wide experience, MRS likewise but we have observed
20 and listened to the evidence, the criticisms, the areas that went or worked well and the families have a view. Our submission is that at the site, the forward command, there should be the IMT meetings obviously and the makeup of those meetings we think was, there was a suggestion from MRS as to who that might be and we concur with that.

25

The incident controller, in our submission, should be at the mine site. That incident controller can be kept separate from the IMT meetings to avoid this issue about emotional interference or too much pressure being applied. The sites are usually large. There's plenty of officers. There can be an IMT centre
30 and there can be an incident control centre. Where it's a mine rescuer's here, in our submission there should be compulsory allegation of the incident control function by the police to a first class mine manager who has a first class certificate, not the mine owner, not the statutory manager. We find

attraction on the idea of the Chief Inspector of Mines being involved in that process and the incident controller should be involved in all operational decisions including, as I've already submitted, the question of re-entry. As for the response co-ordinator, our submission is that it should be and could have
5 been in this case based at Greymouth or the nearest centre to the incident. Responsible for the logistical element, co-ordination and a third tier is necessary under the CIMS model, then the question of sealing.

We do find attraction, however, Commissioners in the submission from the
10 New Zealand Fire Service Commission on this issue, paragraph 32, of Mr Buchanan's submissions. He made this observation. The New Zealand Fire Service Commission respectfully submits that to focus on the operational structure, including whether to use the CIMS model, and the lead agency or incident controller roles, is to miss the point. Rather the criticisms of what
15 happened in the management of Operation Pike to the extent that the Royal Commission might accept them as a valid signal the need to improve the quality of pre-incident planning in risk assessment, whether by the mine operator, Mines Rescue or by the emergency services and then to manage any incident accordingly through an appropriately designed operational
20 structure.

Paragraph 40 he went on to say, the Commission nevertheless acknowledges there is room to improve pre-incident planning in the mining sector, particularly where large operations are involved and where the likely scale and
25 complexity of an incident are such that control will need to be assumed by one of the emergency services. It is essential to involve the emergency services in planning and exercises at all levels for those types of incidents and the Commission would welcome a recommendation from the Royal Commission to this effect and the families find attraction in that submission because there
30 clearly was not, before this incident, any high level communication between the emergency services on how to respond to an incident such as this, starkly illustrated by the fact that Assistant Commissioner Nicholls had to Google the New Zealand Mines Rescue Service when the incident got under way.

In terms of the equipment and facilities available to the men, our submissions were directed primarily at the fresh air base issue, egress and in my submission enough has been said on the question of smoke lines which were
5 clearly inadequate.

I do, however, wish to address the fresh air base question and the second means of egress for the families. The Commission is well aware of the quality of the fresh air base, its shortcomings of which there were many. It was at
10 best a changeover station. It provided, in our submission, an entirely inadequate protection for anyone who might've sought to seek refuge or shelter there. The focus for now in these oral submissions is how so many parties did and have since avoided taking any responsibility for the fresh air base's inadequacies. A primary concern for the families and something I
15 suggest check inspectors may well have assisted with is that no one, absolutely no one, was prepared to stand up and say,

1420

"Enough, we have no second means of egress, we have nowhere safe to go in the event of an explosion. Mining must stop until it is sorted." There was
20 no process for such a stand. There was no culture for doing so. The closest we got was Mr van Rooyen accepting that not signing a permit to mine would have been a means by which he could have expressed his disapproval about what was going on. Even if the mine manager could sign it and overrule him, he accepted at least that would have been a mechanism for him to express
25 his concern although he didn't.

The second key concern for the families is that there was a complete lack of priority afforded to the construction of a proper fresh air base or refuge. Both Mr Borichevsky and Mr van Rooyen said "It was well down the list." Frankly,
30 Commissioners, on behalf of the families that situation is simply outrageous. It's clearly unacceptable and so, so difficult for the families to understand how the management and directors of this mine should act in such a contemptuous way towards its workforce. The gap in time between the operation as it was

and what may later be built, that interim period was or should have been a daily concern. Production pressure clearly overrode safety and I concur with my friend, Mr Rapley's submission on that. The directors and officers seek to distance themselves from any concern. They go so far as to say that the

5 Department of Labour criticism can be accorded little weight. Their position is that the men received a self-rescuer. Their position is that the men were able to access more self-rescuers at the fresh air base and that they were audited. What is ignored is that if there is an incident outbye of the Slimline shaft or injured men or blockage in the drift, those men were doomed in that mine.

10 There was no way out and no safe haven. They deflect blame with the refrain it was inspected by Mines Rescue, it was inspected by the Department of Labour and no issue was raised. Well, Mines Rescue were of the view that a refuge was to be built following its August audit and we now know from the further evidence supplied by Mr Watts that there was internal discussion with

15 brigadesmen who worked in the mine in September, and I refer to the further brief recently filed by Mr Watts. He said at paragraph 12, sorry paragraph 9 firstly, "I understood that the intention of Pike River Coal was to install a refuge bay at the bottom of the Slimline shaft." He goes on to say at 12, "My understanding is that as a result of the risk assessment process the main vent

20 shaft was not considered to be a suitable second means of egress in an irrespirable atmosphere." And in 13, "I thought, given I did not hear anything further from Pike River, it had been decided for the fresh air refuge bay to be installed at the bottom of the Slimline shaft." And he goes on to say at 16, "I firmly believe that a refuge bay was the best option." The concern that the

25 families have with that recent evidence is the huge assumption that Mr Watts made. He had concerns in August, he had concerns in September internally, and there was a risk assessment in January and he then assumes that Pike River were going to do something about it and build a fresh air base and we know for 11 months that they did not. We know that even as at 19 November

30 the priority was well down the list. I'm unsure of the basis for which Mr Watts was able to make that assumption that something would be done, particularly because Glen Campbell who is of Mines Rescue was responsible for training at the mine or had a training role, and Glenville Stiles also at Mines Rescue,

ordered the safety equipment. Both of those men would have been in the mine or in contact with miners and it seems somewhat extraordinary that there was no communication with the general manager of Mines Rescue on that issue about the refuge and the families are concerned, very concerned, that
5 that was allowed to drift and I'll come back to the mines rescue role in a moment.

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As to the second excuse proffered by the directors and officers that the DOL inspected it and found that it was adequate. Our submission is that the DOL
10 inspectorate was entirely inadequate and ineffective, on many fronts but in particular on this one from the families' perspective. Pike River Coal had primary responsibility under the Health and Safety in Employment Act, the suggestion that they can be relieved of responsibility because they've regular internal and external audits and "had no reason to believe" that appropriate
15 steps were not being taken falls well short of the mark. Mr Whittall, Mr Ellis, Mr White and mine managers before them were all experienced senior mining men who knew how inadequate the situation was and they permitted it.

On the second means of egress there was none. It is overwhelming that it
20 was entirely inadequate and ineffectual, it was an arduous climb, it was virtually impossible if not impossible in an irrespirable atmosphere. There were no harnesses at the foot of the vent shaft, they were in the safety department outside the portal. There was no clear direction for the men to even use it. There was not even one single drill in that mine for that entire
25 year 2010 to determine its effectiveness. It is an appalling situation.

As with the refuge no priority was given to this, resources we have heard from several witnesses were directed to the hydro panel. The senior management knew it was not effective and they did not act. The board did not question it.
30 Had they visited that mine, had they gone underground and been subjected to an unannounced emergency drill scenario whereby the drift was blocked and there was an irrespirable atmosphere, they would've seen the bottle neck at the vent shaft. They would've seen that there was no harnesses there for the

men, they would've seen that it was where the smoke would naturally vent, they would've witnessed the chaos in their mine, they would've seen that there was nowhere safe to go and you can be assured they would not have sent their sons into that mine and I've already mentioned the role of MRS in relation to the refuge and it's the family submission that on this question of egress they well could have done more.

The Department of Labour role was entirely unsatisfactory as well. I refer to our submissions at paragraph 14.2.8 where the role of the Department of Labour in this aspect was examined, in particular at sub-paragraph 2.10 where there was this exchange with Mr Poynter. The introduction to the question was following an answer from him where he said, "The events of an underground fire or spontaneous combustion event or an explosion, the vent shaft would have been venting for the –" and I interrupted, Question, "For the fumes and the fire and the smoke and so on. That's the point though isn't it Mr Poynter. If there was an explosion, if there was a fire and if there was a blockage there was no second means of egress, was there?" Answer, "No there was not." Question, "When?" Answer, "If you are asking with the benefit of hindsight it would've been better to have used enforcement action through the process that may well be the case. The focus I had was trying to get a solution and the solution was to get the company to voluntarily put in that second means of egress. It was always going to take time." Again you will see the glaring problem with that - is that this interim period is entirely unsatisfactory for the families now when the men had no second means of egress from when you visited in April until the time of the explosion, waiting for a drive to be put through. It's not satisfactory, is it?" "No." And as I go on to say, "The Department of Labour through Mr Poynter acknowledged that he took no steps to actually ascertain whether someone could climb out, notwithstanding the view that he'd expressed that technically people could climb out and that technically it could be a second means of egress.

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He did not climb out himself and took the word of managers on that. And he acknowledged that in the event of a blockage and therefore the egress not

being able to be used, the men should go to the fresh air base and he used the word, "refuge," but then acknowledged its shortcomings. The families' submission of that the Department of Labour played a significant hand in that whole issue and again, had been let down.

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This raises an ancillary point relating to Mines Rescue which didn't neatly fit into the contents of pages suggestion by the Commission in relation to the role of Mines Rescue Service. It's not in our written submission. The Mines Rescue Service is a creature of statute and it was put to Mr Watts during the course of his evidence that it lacked teeth. I can refer to the transcript at page 2540 and in particular 2541 to 2542 on this issue when a series of propositions were put to Mr Watts about what condition they knew the mine was at. Smoke lines, the egress, the fresh air base, the gas monitoring system and so on and that it really should not have been a surprise to Mines Rescue when they turned up that there was such difficulty in ascertaining the atmosphere below ground. And you'll recall a phrase I put to Mr Watts about the briefs almost being categorised by some sort of rights of indignation about that when really they must've known or should've known about the situation which would confront them. He went on to say, line 16, page 2541, "For rescue to occur we needed information and we've already heard about the lack of information from within the mine, that's correct. My understanding around the fresh air base was that a fit for purpose wall was being constructed for a fresh air base with an airlock on it. I only became aware that that didn't occur after the explosion." He went on to say, "We did not audit the mine and we've got no statutory powers to audit a mine." That comes to my next question to you and reiterate again all of those things which you knew or perhaps should've known were extant at the time of the explosion on the 19th of November. And it comes back I think to what Mr Hampton was asking you about and that is the desirability or otherwise of Mines Rescue Service having, really having a bit more teeth to be able to effect change in circumstances where in particular it involves health and safety, but more in particular rescue to ensure that mines have the best opportunity for rescue, self-rescue for underground operations." And then he went on to say that he

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thought there was a strong case to ensure that independent audits are done. Question, "Under an MRS umbrella?" Answer, "Certainly, with those emergency things that you're looking at, that's my personal view and I firmly believe that we have a role in that area, we have been doing it for a number of

5 years at Spring Creek." Question, "And with teeth to sanction the mine in the event your audits are not complied with?" "I believe," he said, "That that is a way to deal with that because you know there will be legislation changes obviously, but if MRS was the agency that were completing an external independent audit, I would assist them in a mine but that audit would be sent

10 to the mines inspector as well as the safety manager or the mine manager at the mine for transparency because the mines inspector is the man or the person that can enact change." So in my submission Mr Watts was clearly open to the idea that Mines Rescue providing greater input on the question of external independent audits as they have done at Spring Creek but on a more

15 formal basis across the industry, particularly on issues relating to the self-rescue or rescue capability. And we would encourage some recommendation along those lines from this Commission.

I do not intend to say anything more at this stage on the availability of

20 information as to the men in the mine it's been submitted on and information as to the mine atmosphere.

Touching briefly on the window of opportunity, it's fair to say that there are some different views amongst family members on this delicate topic. Our

25 formal submission has been to the effect that we accept the evidence from the experts that there was no window of opportunity.

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However, that was qualified with the phrase in varying degrees and the Commissioners may have wondered what was meant by that. There is an

30 element within the family group who take a different view, hence the proviso, and I simply say this on their behalf, that in New Zealand we have a history, a proud history which Mines Rescue Service are rightfully proud of, of rescuing men from mines in an emergency situation. The expression has been used

about not leaving men behind on the battlefield and so on. MRS say that they were frustrated about their inability to go into the mine and effect a rescue. That would be an understatement for the families. They have felt enormous frustration on this issue and still do.

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For those who believe that there may have been a window of opportunity, they have the luxury of looking back with hindsight on the five days that passed from the first explosion to the second and say, "Well there you go. There was such a window." Whereas counsel and the families themselves recognise the obvious answer to that, but nonetheless that hindsight vision allows us to see that opportunity. Other family members cannot help but refer to the earthquake disaster in February in Christchurch where there were literally hundreds of examples of men and women spontaneously going to the rescue of others, crawling into collapsed buildings, collapsed facades, piles of rubble to help and rescue men, women and children from that situation. It's easy to say that it's a very different situation, they're not two and a half kilometres inside a mine. They can easily withdraw, but those men and women, those construction workers, those city office workers, passers-by, people of all persuasions, spontaneously went to help in circumstances where they knew they were putting their lives at risk any time there was a second aftershock, as clearly there were. There were no risk assessments. There was no pause for thought and for many family members it is a very bitter pill to swallow to have the huge resources, the expertise of Mines Rescue, the fire service, St John's Ambulance, the police, all of those emergency response services onsite and their men so tantalisingly close but yet it seemed so far when comparing it to the earthquake scenario and a deference to those family members who hold that view I simply make those observations to you.

On the question of communication and welfare, firstly welfare I think I can do no better than read the submission at paragraph 20.3.1 in public, "There has been no identification at least by the families of any shortcomings in relation to the welfare assistance that was provided. It seems clear that those who wanted such assistance were offered it or was certainly there to seek out if

need be. The quality of assistance appears to have been consistently very good and across several agencies. The families are very grateful for the support that they received. Not all availed themselves of it, choosing to handle the disaster in their own way. Counsel do not submit that the welfare process was flawed and indeed commend and thank all of those welfare agencies who assisted,” and in particular the summary of those agencies and I hope that we’re not leaving anyone out at 20.2.35 of the written submission one of the family witnesses, Janet Holling said this, in terms of welfare she said that, “There was a consistent level of care and assistance to any family member who wanted it. That care was provided by the Red Cross Centre, by the Polytechnic, Air New Zealand liaison officers, the police, Focus Trust and local church and community groups.” She regarded the welfare agencies as professional and well co-ordinated. She said that, “Their respectful behaviours and processes enabled them to assist whoever and however it was needed,” and that was certainly the common refrain from many family members that we briefed for the Phase Two hearings.

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On the question of communication with the families, this is a vexed topic and Mr Moore in his submissions reflected the wide diversions of views on that, as you would expect amongst a family group of some 150 people whom we represent. There were very widespread views and we thought that the only way to do justice to that was to summarise those views in the written submissions and to group them together where the theme became consistent and clearly there was some, Janet Holling being one and several others who regarded the meetings very highly, flow of communication, quality of the meeting, the people who delivered the message, the empathy they displayed and so on. There were however a large number of my members who provided evidence and Ms Shortall has done a careful analysis of who has and who hasn’t and contractors who have and miners who haven’t and whether it’s proportionate and representative and so on. Well it’s up to the families what they put it in, we didn’t have any rules or regulations around who was to submit. Anybody was invited to do so and everyone who wanted to do so did put in a brief, whether it’s proportionate or representative or so on, I

haven't done the analysis, Ms Shortall has done, I think it's entirely relevant. There's a good cross section of views put forward. The overriding observation is one of false hope being delivered. Mr Whittall has said in his evidence, he searched his memory and tried to think of any reason, any conceivable reason
5 why he would want to give false hope to anybody. The families don't say that he set out with that intention, the families don't say that he was malicious or deliberately set out to mislead them. As with Superintendent Knowles it's accepted that he was doing his best in very trying circumstances and good on him for fronting up, day in/day out, during those days and speaking to the
10 families and to the media. He was an effective communicator, he is an effective communicator and that's acknowledged but for whatever reason, the best of intentions that he had, false hope was given. Family members who are from a mining background knew that, they found it a very difficult position to be in, when so many other family members were hanging onto every word
15 that Mr Whittall said. That's why they wanted Mines Rescue Service there, that's why they wanted to hear about survivability, sealing, the real prospects of survival, where these men might be. But hunkered down together in a stub, sucking on a fresh air line, coming out hungry, all these things that were said to them really did make it very difficult for the families.

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We've also heard evidence about the two horrific meetings and the dates were, I think, the Wednesday and then the January meeting where there was conflicting messages conveyed to them. For whatever reason those meetings were handled very badly but again the families recognise that people were
25 doing their best in difficult circumstances, it's just very unfortunate the way that turned out. Had there been trained police community liaison officers or others involved in a massive emergency type situations, the situation might've been very different.

30 The next of kin issue is again a difficult one for the families. If I could refer to paragraph 20 of the submissions and just note the summary or the theme of the evidence on this issue. These issues are merged from the briefs. Firstly that there was no contact with next of kin at any stage following the first

explosion from either Pike River or from the police and in many cases still to this day no contact at all. Secondly where there was contact made it was either very late or lacked substantive information and thirdly, regrettably in some instances the contact which was made was inappropriate. The person
5 communicating with the next of kin was curt or unhelpful and the messages conveyed during attempts by some family members to obtain information were confusing and frustrating for them. Clearly the submission from the families is that there must be for the future prompt reliable and empathetic contact with the next of kin and it's submitted that goes without saying. There must
10 therefore be a system that the employer operates which has next of kin contact details which are regularly reviewed and updated.

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It is submitted that at any point in time the mine employer must know who is underground, when they went underground, and when they are no longer
15 underground, and in the written submissions we make reference to Mr Devlin's evidence on the electronic personal locators and perhaps it is time for those to be introduced into the mines.

Finally, I would like to deal reasonably briefly with the question of re-entry into
20 the mine, and if I could talk to the submissions from paragraph 19. The submissions go into some detail to the steps which took place from December 2010 to date and that was largely solicited from the evidence of the cross-examination of Mr Ellis. For the families, progress has been agonisingly slow. I've already mentioned the frustration as did Mr Davidson. But in short,
25 in December last year we started with the recovery plan which was put to the police and rejected by them. From there we went to the mine stabilisation plan in early 2011. That was to stabilise the drift. There was no reference in that plan to recovery of the bodies. There was no significant steps towards a stage re-entry or any plan towards recovery of the deceased miners in the
30 period to May 2011. When that dawned on counsel for the families, we convened a meeting with the police, the Department of Labour, Mines Rescue and other parties, the union, to discuss this issue. It's somewhat incredulous that nothing had happened on that front or was being driven by any other

entity. Alarming, what became quite clear (paragraph 19.1.9) at that meeting held in Christchurch at the Commodore, was that there was no confirmed budget or indeed any intention at that stage to actually do the stage re-entry from the receivers' perspective. As Mr Ellis confirmed in his evidence, the plan was only to complete stabilisation.

Following that meeting (subparagraph 1.14) a working group was formed. Mr Watts was a member of that group, Mr Bell and Mr Neville Rockhouse and Steve Ellis, where re-entry was considered. It became pretty clear soon into that process that Mr Ellis preferred another option relating to this Rocksil sealing that we've heard a bit about recently. Subparagraph 15, and this is of real importance to the families. As at September 2011 Mines Rescue had proposed the proposed prospect of a reconnaissance walk. A risk assessment was completed by mid-August with three objectives: recovery of the drift, view potential sealing sites for other temporary seals, and thirdly, identify the possibility of remains of the deceased miners which may be in the drift from the 1800 metre mark to 2.4 kilometres. As at September last year, we didn't have the benefit of the Department of Labour report or the evidence of Mr Reece or Mr Reczek. There would have been a fourth reason for that reconnaissance walk had we had that information and that would have been to get to pit bottom in stone to observe the electrical equipment housed there which appears to be of such interest to the expert panel for the Department of Labour. One wonders what further assistance may have been given to Mines Rescue and to the families had that fact been known at that time. After Mines Rescue had produced the risk assessment for the reconnaissance walk, that was on 15th of August last year, Mr Ellis turned up to one of the meetings with his own plan, the tunnel reclamation plan. It was that plan which he sent to the receivers' expert panel which was approved. Unfortunately he didn't provide the expert panel with Mines Rescue's reconnaissance walk plan. He somewhat peremptorily and without any consultation decided he was not in favour of it.

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As at September last year during the Phase Two hearings the reconnaissance walk issue was put to – just at the end of sub-paragraph 19 now, the reconnaissance walk issue was tested with Mr Ellis and as statutory mine manager he was of the view that it was safer, it was better, it was his prerogative to have this Rocksil seal installed at the top of the drift which would allow Mines Rescue men and Pike River men to walk into the tunnel and reclaim the drift in a irrespirable atmosphere. The families were opposed to that because it involved some further delay but Mr Ellis' response to that was by the time Mines Rescue get their act together and are ready to go in the time will be the same as the Rocksil seal going in and was hard to argue against that when clearly there would've been a walk in a irrespirable atmosphere and less danger to Mines Rescue even though Mines Rescue were happy to do it and had done their own risk assessments on it.

What is extremely frustrating for the families is that Mr Ellis confidently proclaimed at that stage that we would have the drift recovered and the Rocksil seal done by Christmas and these families waited patiently since that time. Christmas has come and gone and here we are in April, no further forward with that as at today's date, we don't know what's happening with the Rocksil. There's no plan for its pouring.

It was delayed further by the Department of Labour requiring risk assessments that hadn't been done by Mr Ellis and his team and Mines Rescue have said they're frustrated and I reiterate the families are extremely frustrated and their patience has worn completely thin on this and rightly so. It appears that there has been no one driving this issue apart from the families and now with the imminent hopeful sale to Solid Energy we simply do not know what the current position is despite regular if not daily enquiries on that front.

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COMMISSIONER BELL:

Mr Raymond I have just one question, just talking about sealing the mine or the decision to seal the mine am I correct in assuming you're still saying that should be referred to Wellington?

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MR RAYMOND:

We're saying sir that if there is a requirement to keep the third tier and therefore reserve some decisions at that strategic or high level, then the only decision that we see falling into that category is sealing. We don't necessarily see the need for a third tier but we don't have the requisite expertise or knowledge in that area to make a sound strong submission on that. What we are saying is that if it's going to be something more than a two tier approach and remain under the CIMS model at the three tier level, then of all of the decisions that were made, that might be one that is appropriately dealt with there because of the national significance, because of the prospect of completely ending any likelihood of survivability.

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15**COMMISSIONER BELL:**

Well why would there be any better expertise at Wellington than what would normally be at a mine site?

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MR RAYMOND:

Well that's a good question and our response to that is that in the future there must be a first class mine managers certificate holder on the expert panel at the response co-ordinator level who is able to understand the recommendations from the forward command and the recommendations of the incident controller. It should be almost a rubber stamping process but one that nonetheless should be gone through given the significance of it.

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30 THE COMMISSION:

Isn't one of the lessons from what happened at Pike that the reality was that as Superintendent Knowles was putting it, the best of the best was there at the mine.

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Dr St George said so in Wellington and then when it became a task to assemble a second group of experts the obvious problem arose, there's nobody left, at least locally or within easy reach and doesn't that suggest as
5 Commissioner Bell has said that the proper approach is to do it according to CIMS on site.

MR RAYMOND:

We agree with that, sir. As I say what we are submitting is if there has to be a
10 third tier under the CIMS model and is –

THE COMMISSION:

Well what basis.

15 **MR RAYMOND:**

Well because –

THE COMMISSION:

We don't even understand the CIMS model to contemplate a third tier.

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MR RAYMOND:

Well it's based, when you say what basis. I'm making the submission on the basis of what the police have advocated for. What the New Zealand Fire Service Commission support as being an appropriate model flexible enough to
25 have that arrangement. The New Zealand Fire Service seem to think that it was all perfectly fine and that the convened panel experts were suitable and overlooked the question of the first class mine manager certificate issue. We're simply, we would agree that all decisions should be made where the expertise pool resides. What I'm saying is if there has to be under the CIMS
30 model and we don't understand that there has to be like you, but if there is that would be the only decision that we could see that could be made at that level but only if had the requisite panel of expertise.

THE COMMISSION:

You read in extract from the submission of Mr Buchanan filed on behalf of the New Zealand Fire Service which I haven't got in front of me but it began with an observation to the effect that certain aspects missed the point and as I understood it or recall it, that was questions about the structure that had in fact imposed in this instance and instead he went on and said that the real problem and the real lesson to be taken from Pike River was the need for simulation and planning exercises in advance. Now I just want to be clear. As to the second proposition, it's an absolute no brainer I would've thought, that that is a lesson to be taken out of this tragedy. But are you subscribing to the first proposition as well that it misses the point to looking at the detail of the structure that was applied here. Because it seems that there is an abundance before this Commission which suggests that there were fundamental problems that emerged in relation to the utilisation of expertise, decision making, just usefulness of the people who had volunteered their services and reached a point of desperation to the extent that some of them were contemplating leaving on account of a feeling that it was futile their being involved. So does that not suggest that the nature of the structure has got to be looked at as well and it's naïve to say well, planning is all that matters?

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MR RAYMOND:

We agree with that, sir. I said in my submissions that the families adopt the concerns held by mines rescue and Solid Energy on structure and the response, in particular the risk assessment process. What I understood Mr Buchanan to be saying is that there's a lot of heat and light's been generated for example, on who should be the lead agency. Certainly during the hearing process although that seems to have settled in the submissions to be a common acceptance but almost all of us, that the police were the appropriate lead agency given the likelihood of fatalities, the involvement of the Coroner, recovery of the remains and simply the sheer scale of the operation. So I accepted what he said on that front about missing the point. In terms of focussing on the operational structure and the incident controller issue, likewise whether it should be the mine or a statutory mine manager or a

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first class mine manager certificate holder, our submission is it should be one of those persons but not the police. I think that, what I took out of the submission, that those things are important. Too much focus on who should be the lead agency and so on tended to undermine, wasn't really too much of a focus of the evidence during the hearings from the response agencies, that more could've been done in planning. In hindsight everyone said that it sounds like a good idea but there was clearly no evidence of it happening prior to, and my reference to paragraph 32 and the endorsement of it was to emphasise that point.

10 1500

THE COMMISSION:

Just a matter of detail, in your paragraph 20.1.5 you're talking about a tag system and suggesting tags for going in and out of the mine but also a submission that there should be an additional tag for going in and out of each work section. I don't quite understand how that would operate? Is that an underground tag board?

15

MR RAYMOND:

If it was an electronic personal locator system that would be easier because you'd be able to, you would pass through an electronic gate as you were going into different sections of the mine so the problem which I started the submissions with about the likely locations of the men would be less of a problem. Not only do you know where, that they've gone into the mine but you know that they're up at a heading or in hydro panel –

25

THE COMMISSION:

Well all I'm wanting to understand is, I see the next paragraph you deal with an electronic system –

30 **MR RAYMOND:**

Yes.

THE COMMISSION:

– but that one seemed to be talking about a tag board, but you're not advocating tag boards underground?

5 **MR RAYMOND:**

No, sir that came directly, to be frank, from a family member who wished us to include that. He wasn't, when he put forward that suggestion, giving too much thought into exactly how it would work which is why I built into the next paragraph the electronic system which seemed to me to be the way that
10 would address that. A tag board might have been the wrong expression.

COMMISSIONER BELL:

Mr Raymond, Judge I might be able to add some value here. Sometimes in larger mines there are two tag boards. There is a tag board on a surface and
15 a tag board underground at a particular section where you want to limit the number of people in there so sometimes there are two tag boards.

MR HAMPTON:

I'm just going to back Mr Raymond on that, sir. These are, it's my
20 understanding that's the position as well from what I've been told by the CFMEU and it can in the bigger mines, it's perhaps not as well in the New Zealand context I suspect.

THE COMMISSION:

25 Finally, Mr Raymond, I'm just not sure where you were at and it may be that you were between a rock and a hard place perhaps, but you've made a submission about the window of opportunity and I guess you are, as I've put it
–

30 **MR RAYMOND:**

The overarching submission from the families is as the one in writing.

THE COMMISSION:

Thank you, and I just wondered about your analogy to the earthquakes as well. You've got to factor in, in relation to Pike River, the circumstances of a drift of 2.3 kilometres in order to get into the mine.

5

MR RAYMOND:

I did preface my comments sir with that. That it clearly it's easy to say that easy parallels can't be drawn between the earthquake situation where you can easily withdraw and you've got people around you and you're not two kilometres underground. It was more the sentiment of spontaneous rescue and putting one's life at risk to help others which the family, some family members, not all, refer to and wished me to observe.

10

THE COMMISSION:

15 Thank you, Mr Davidson?

SUBMISSIONS: MR DAVIDSON

I'm going to endeavour to work within the bounds of the time allocation sir which means I'm going to have to restructure to a degree in sections as they're filed in sequence and that means I'll be moving around a little to get
5 the key points across.

The first issue I wish to address is the probable cause of the first explosion and I preface the submissions for the families with the obvious comment that we have not had the ability to consult with an expert to evaluate the evidence
10 as it's come forward. Now we've had to accept that and do the best we can and therefore we've been very dependent on the analysis in the report by the Department of Labour investigation by the team.

1505

I suppose the issue which now perplexes us relates to the discussion which we appreciate having received from the 13th of March involving the experts and it was very helpful to read that material which came to us last week and to see the debate which still exists on some crucial elements of the determination going to the determination of what caused this explosion. I suppose to reduce the issue in the families' minds as far as I can in the time
20 available it is this, that when we read the report we noted the conclusion and this is set out in FAM0060/37 of the submission you filed, that the model which most matched the parameters, the known parameters was of 1944 kilograms of methane at AF005 ignition point equivalent to two and a half thousand to three thousand cubic metres of undiluted methane. But the
25 comment was made there but that was consistent with the temperature and shock wave velocity to the survivors and conditions of the portal but the duration of the blast is still too short which may result from assumptions about methane distribution. So it seemed to be as it must be in the circumstances of working from what inferable evidence there is, there was still some reservation
30 about that conclusion and it seems there must be that today.

A further comment in the report was made with regard to the material that came out of the vent shaft and the temperatures to which that material had

been exposed and that was in a temperature range inferred from a sample to suggest if they'd come from the base of the ventilation shaft, then the coal could've been picked up by the hot gas stream after the initial explosion or it would've been subjected to much higher temperatures. So that has led as an important part of the reasoning in this report to the conclusion of consistency with the explosion being inbye the main fan and indicates the combustion site did not reach the ventilation shaft although it was probably not that far away.

Now in these submissions all we reasonably can do is to note the reservations that are here, note the language that's used in the report in that regard and then work back to the conclusion which has been reached in the report as to the most likely source of ignition being the gas from the goaf having come across the return into the cross-cut, knocking over a stopping and being ignited at the what's called AF005, as I read that. That's the theory and of course not only is it important for the Commission to wrestle and come up with the position which seems to best fit with the facts, but for the families there is a fundamental consideration always as to where the explosion occurred and where their men were.

The second element of that however is that the report does not exclude but certainly recognises the possibility that there was ignition at the main fan. Now there are reasons why there could've been ignition there including the fact that the brattice, the door under pressure could have seen gas reach the main fan motor. But for the reasons I've been through as we read the report, the inference is that by virtue of the material that's come out of the vent shaft it's taken not to have been an explosion at that point. The further element of this is that we have been working on evidence to date of the sort of explosion which is referred to in the model and it's clear that this is and I think this is a unique circumstances, that there is the ability to observe the venting at the portal for the purpose of measuring the blast and making a calculation as a result against the volumetric size of the mine. So these seem to be cornerstones of the thinking at this stage.

The meeting that took place or teleconference that took place on the 13th of March involving some experts has cast further light or further thinking on what sort of explosion this was and we can only at this stage take what we can from it and try and understand whether it alters any of the other primary
5 conclusions set out in the report.

1510

Now I just want to say that from the families – for the families the understanding that we have from this is that by further calculation of the volume of gas that must've been involved starting and working back to the
10 exploded volume these are said to be, I think some part of the discussion we have recorded, huge amounts of methane compared to other known explosions in the developed world. That's the pure methane, that's the content of the discussion and from there in the discussion we read it moves to a conclusion that that volume of gas could only have likely therefore come
15 from the goaf. So it's returned by a different route to the primary conclusion contained in the investigation report. The difference is and we can only observe it and the family members of course are listening to the discussion and thus becoming aware of the evidence, there seems to be agreement between the experts that this was what's called a big weak explosion. Now if
20 it's a big weak explosion of a huge volume of gas, logically for the families we understand the thinking contained in this discussion of going back to the goaf as the source. There are reservations expressed in this discussion about a plume of gas of such size mixing sufficiently with the air to create the explosive mix. We note those reservations and because this is a discussion
25 between people over presumably some hours we stop at that point to make the observation that it seems to be a qualification, if you like, undone or reversed by looking at the amount of gas that was involved. Now there doesn't seem to be too much doubt about the amount of gas, apart from one element which hasn't really been given much attention in this Commission
30 process, in that there is - this factoring in a range between two and five by virtue of the heat element of expansion. So there are a range of calculations made here before the conclusion is reached. I'm saying this Your Honour, Commissioners because this discussion brings into play a different kind of

explosion which seems to turn in part on the methane potentially being in the upper range of explosive effect. It seems to talk about in the range of 15% before it passes out into the non-explosive range but of huge volumes. So in terms of the cause of the explosion for the families we raise that issue and ask this question? Does that effect the primary conclusion of the report that if the gas was of this quality we're describing or is described here, would it still be of the velocity and the pressure to have the effect of taking out the stopping and potential ignition at auxiliary fan and secondly, and I'm going to answer the question we pose for ourselves here, does that discussion of the large weak explosion alter anything in the conclusions regarding the survivability or survival of the men and we take from the discussion which we see here that indeed that would not be the case. It may not have had the concussive effect which is contemplated in the Coroner's inquest but the effect of asphyxiation by virtue of the oxygen deprivation seems to be consistent with our understanding of the hypoxic condition and the toxic gases are consistent with what the Coroner had put before him by the experts at that hearing. Because that conclusion seems to be reached, and what is to us, a helpful debate between the experts as has been recorded.

1515

It's not an absolute transcription but it's a very helpful understanding of what was discussed. Nothing has changed in our submissions as to the cause of the explosion but for the question I raised with regard to the finding or conclusion in the report of the stopping being taken out and ignition at that potential source. The second qualification which has existed quite apart from this discussion on the 13th of March, is that the report itself has gone into some, at some lengths to look at the accumulation of gas inbye, and without reverting to the report, the issue we wish to raise for the Commission is that with an inadequate ventilation inbye, and that seems clearly established on the basis of the investigation report, on this report anyway there was one heading too many in play. There was gas in several important headings most inbye and the possibility of accumulation and of layering is observed in the report itself and in this discussion on the 13th of March.

Now the families raise this without the technical backing, but it's there in the report the investigators, the experts had to consider the possibility of that being the case, and we want to raise one other matter. It's a lay question on behalf of the families. Is it conceivable that inbye with the amount of gas that was present, and the amount of gas that was known to have been propagating in that area, that what might be called a localised ignition could have transported along a methane gas layer and reached the goaf. The conclusion of the report before this discussion took place seems to turn against the first part of that postulation because it does not seem to conclude there could be enough gas derived from that sort of accumulation inbye even with boreholes intersected, even with gas coming out of the seam, and a very successful cutting would have taken place. So we put it not as a submission but as a question which does not seem to us to have been squarely addressed, other than the fact that the possibility of the layering of gas through those sections is discussed between the experts on the 13th of March, is expressed recognition of that fact. And to complete that summation of our understanding from this discussion on the 13th of March, we understand the expression that is employed is that this is a very large explosion but not a powerful explosion, so deflagration rather than detonation. That's something that would be familiar no doubt to the Commissioners, not an expression which has been used a great deal in the evidence in this Commission but it's called a very fast burn rather than violent explosion which led to very rapid mixing. The same consequence as we understand it but a different type of explosion, and the question of layering is squarely addressed at page 11 of the notes of this discussion. And the only other element of the cause of the explosion that we want to raise is this in relation to the main fan. We live with the constant reference to us by people well meaning, some with some expertise, some not, and the point that we wish to raise with regard to the main fan is a source of the explosion apart from recognising the evidence described of the material thrown out of the vent shaft and the degree of heat it was subjected to, is that while it is true that the variable speed drive had been replaced, feeding the main fan, motor, there seems to be a further issue regarding the connection of a variable speed drive to the motor it is powering.

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It is referred to in the investigation report at page 155 at paragraph 3.37.7.8 which refers to the location of the variable speed drive in pit bottom south and B heading, increasing the distance between the fan motor and the VSD to a
5 cable length of approximately 95 metres. Now our understanding, derived from information given to us through a person with electrical qualifications, is that is well outside the length of cable that one would use and further that this was essentially a trailing cable and not the cable which would usually be employed in such a connection.

10

We can't go further with regard to the arching, but there have been problems with commissioning of the main fan. It is in a place where with the brattice weakness that I've discussed, which is discussed in the report, methane laid in here, mix could have reached the main fan, particularly under the expulsion
15 from the goaf of a pulse of air and the same report, investigation report at paragraph 3.37.9.8 refers to the gas guard detector that was held in the main vent shaft and a component in the control box was examined which was in a shed nearby found to have been subject to arching of sufficient energy to a pit at the metal surface of the earth posts. Now again the postulation is, was that
20 or potentially is that a product of arching from the variable speed drive or is it a massive electrical fault at the time of the explosion, question? And we raised it with you because it's been raised by a person whose taken the closest of interest in this particular issue.

25 Now as to any other elements of the discussion in the report of the cause of the explosion, I'm just going to make this absolute summary of the point, these points. First, we do now understand the likelihood of the goaf being the source of the gas. We do understand that there are a series of ignition sources which cannot be discounted. The issue of harmonics is but one, but
30 that issue if it has validity could see arching in many places. It requires only a conduit to the point for example of the auxiliary fan or the main fan itself or other parts of the mine. It seems the report has landed on this issue of the harmonics on the basis of the coincidence of the start up of the water pumps.

Diesel vehicle engines were a source of potential ignition. Other possible ignition sources, we have to acknowledge them all, include contraband, but there is no evidence of a scale of default regarding contraband in the months
5 leading up to 19 November which points to that position. We cannot narrow, as for the families, the source of ignition, there are too many sources and there are too many places in which the gas may have ignited. We are dependent entirely on the experts' analysis for your conclusion.

10 1525

Broadly with regard to the issues which come under the issue of health and safety and oversight, there is much in the section of the report to do with the way the mine was conducted, which bears directly on that issue of oversight. But to try and reduce this topic and link it to the opening remarks we've made
15 today, the submission for the families is that from the top of all the structures that were in place to the bottom, to the men who worked, those without authority, simply there to do their job there were failures and there was a severance or dislocation in their functions. And what is very hard for the families to understand is to accept is to understand for a start the reasoning
20 and thinking of the board with regard to health and safety. It's dealt with in our submissions at page 89 and I just take from it these few points.

In essence, for the families, we do not understand how the board can treat health and safety in that mine whether developed a steady state or not, but
25 particularly in a phase of development and trial and difficulty, how they can delegate the responsibility of the management and with one notable exception, ironically on the 15th of November 2010 when Mr White was questioned closely at a meeting. Leave it at that. The board has responsibility for overall health and safety and the corporate governance
30 manual expressly records its responsibility. Its charter requires it to exercise oversight of management in this regard and we do not understand how there can be any concept of separation of powers, of church and state as Mr Dow described in the context of the most critical thing in this mine. This refrain of

separation of governance from management is one heard across industry and across commerce. If it has any place anywhere, it has no place where men and women work and are exposed to danger. Mr Dow's statement to this Commission is, "During my time on the board I always felt confident in with the
5 quality of senior management employed by the company at its mine site.

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An important factor that influenced my original decision to join the board was the presence of Mr Whittall as general manager mines." Yet Mr Dow must have felt the seeds or scene, sensed the seeds of concern because he
10 described this at the submissions at page 93, "Struggling with a lot of issues underground and the board was of a view we could deal with some of them by offering a bonus, we might at the same time with some of the particular challenges we were observing. Most of the issues related to productivity or efficiency." He talked about absenteeism, an incentive to achieve a certain
15 amount of drivage. And it's seen again at page 94 of the submissions when the board meeting of 15 November took place and Mr Dow said this, "Up to this point..." talking about the board, "...had extensively considered the issues of health, safety and environment, we were just about or we had just got started on hydromining and the question of the management in monitoring of
20 gas was of particular issue of concern to the board and so we specifically scheduled a part of the meeting at the scene onsite have a presentation from Mr White on the steps that the company was taking to ensure the measuring, monitoring and managing methane underground," and Mr White according to Mr Dow described the methane as, "More of a nuisance rather than something
25 that was, you know, a problem or that it was giving it any great, you know, concern." Now if the Commission addresses that statement in the context of the fact the sensors had been down, the two underground sensors had been down for weeks at this time. There was no reading above ground. The gas had been spiking over weeks. There had been 12 spikes since the main fan
30 was commissioned.

1530

The hydromining had been conducted now for two months. This is an example so we submit, of this company constantly getting ahead of its health

and safety obligations leaving them behind and putting its production above those fundamental obligations. A new process and a totally inexperienced project manager, limited experience in the men notwithstanding the submissions from the Department, the directors and officers. Mr Nishioka, whether you take in as he gives his evidence or not or part of it, on his own evidence under cross-examination acknowledged the key people on whom he relied around him had substantially gone within a month, which is when he left, a month after the hydro-monitor started. This board seems to have worked on this premise, at page 94 of the families' submissions, "I guess the issue always is at the early stages of development of a mine like Pike when their safety management systems are still in the process of being bedded down, whether you get full value out of a third party audit." You see that and a number of references were given in our submissions, indicates the board and others have had an attitude at Pike River, "When we get into a steady state production we'll do these things. We'll audit when we have management plans we could audit. Haven't got them yet. We must have them in place by the time we get to steady state production." This was a working coal mine. More than that, it was trialling a process that had not been used in this mine before. It was a process that had not been conducted by the manager or the project manager of the hydro. It had some inexperienced men. Our submission is generic.

COMMISSION ADJOURNS: 3.33 PM

COMMISSION RESUMES: 3.49 PM**SUBMISSIONS CONTINUES: MR DAVIDSON**

5 I'm shortly going to move across from the board to the next level down, to
management. But before I do so I want to make the observation or
submission that when we look at the actual activities of the health safety and
environmental committee of the board, the Commission knows that this crucial
link between the board and management on health and safety are met on two
10 days in September 2006, September 2008, March and October 2009 and a
year had passed without a meeting as at 19 November. This is during a
period of ramping up of production, of the hydromining coming into play and
the minutes of the meetings are remarkably bare of detail and of any critical
overall analysis which one would've expected by that committee. The issues
that Mr Dow acknowledged were horrifying, that he discovered subsequently.
15 It simply never reached board level, that's a fact, they just never got there.
The submission for the families is that they should've got there because the
board could not blindly rely on the management to bring such issues to them.
They could not rely on management because nowhere in the system should
there be proposed an absolute responsibility on a level of management
20 without the supervision or surveillance of the board in some way and in that
regard it brings to mind the old expression which in a modern idiom is "Who
guards the guardians?" The board here have the obligation to ensure that
what was required by Pike River in health and safety terms was being done.

25 Above a board, if we look at supervision from above, if we take the
Civil Aviation Authority in New Zealand, that regulator has supervision from
above, from the International Civil Aviation Organisation. In other words at
every level there is a degree of surveillance. Here there was the regulator to
look at the company. Within the company the board to look at management.
30 The management to look at its line reports and in the line reports to work
down through the hierarchy to the men in the mine. And a comment is made
in the investigation report which we think (inaudible 15:52:30) it, it appears our

submissions at page 91 paragraph 11.2.12. “Investigations into disasters across the world have shown that often a factor in their cause was the lack of the right information to be provided to board level and they often remain in blissful ignorance while health and safety risks were increasing.” Well that is
5 Pike River.

Then if something comes out of the Commission in this regard, our submission it must be that that separation of church and state so called cannot be tolerated if it even should be contemplated as the board did not
10 meet its own obligations. But when we drop down a level and to see where things in senior management were being addressed or known we have this, I submit, quite extraordinary result. When we look at the evidence that Mr Whittall has given and this is referred to in the family submissions at page 28, paragraph 1.4.10 and I'll paraphrase it. Mr Whittall has said this. He
15 left his managers these issues.

Firstly we submit that given the accessible location of the so called fresh air base that's revealing that he denies ever having been into it, or having any real knowledge about it, he didn't know how many men it would hold or how it
20 could be sealed. He said he had limited knowledge of the ladders in the vent shaft and gave confused evidence in relation to the critical circumstances on this issue. As the ventilation, he said, Mr Rowland's reports were commissioned by and delivered to the mine manager and the mine manager owned the ventilation management plan until 19 November. I don't recall ever
25 seeing Mr Rowland's reports, they weren't ever addressed to me, copied to me or given to me. It's the mine manager's responsibility. He denied any real knowledge of installation of the underground fan that was currently installed underground. The actual detail design of that and installation of it I'm not the
30 right person to be able to comment on that. Asked about volumes of gas being extracted from the mine, being stable or decreasing or increasing in the 12 months. He answered, “It's not an area I keep track of in detail.”

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As to gas drainage he understood Miles Brown reported and the technical department got that done but he wasn't a recipient of the report to his knowledge and I don't think I've ever read any of the three of them other than to know they exist, so they weren't reports for me. They're operational for the technical department to be used for advice to the operational department. I asked to be, if expected to be told about the statement by Miles Brown, the four inch gas pipeline was inadequate. "No, as I've said this report's going to a technical services manager. There was a mine manager onsite and operations manager above him," and this, "I have absolutely no knowledge of what sensors were working or even in place." "That wasn't a function whether I worked there or not. That wasn't a function in my role and whether I would normally look at that detail." Mr Harry Bell called him in October 2009 when he was the statutory mine manager to relay the concern about the advice from the Australian deputies passed to Mr Bell regarding health and safety at the mine, that health and safety policies were not being enforced. "Gas has not been dealt with and adequate ventilation system," and the reply Mr Whittall gave was, "Your officials let you down."

Now at another level, treating Mr Whittall as having two levels for these purposes, Mr White didn't know the gas sensors were down underground and the discussion on 13 March between the experts goes into that to quite some degree as to the knowledge of those gas sensors. The two reporting above, from below to above ground were not working for weeks beforehand and to the families this is inconceivable. How could it be that the fundamental issue as part of ventilation in this mine was now known to be reported to the surface. They had the sensor in the vent shaft but the discussion on 13 March does elaborate a good deal on that as to whether that was flatlining or latching and whether, given that it was reading differentially to the sensor that had been at the bottom of the vent shaft by a factor of two, in other words they were reading at that differential top to bottom, my submission is, our submission is that the Commission cannot be confident that that sensor, the one that was left was functioning properly, it certainly was latching at 2.8% and it appears from the discussion we read that it may be thought acceptable

that it read accurately up to 2.4% and this was what was available at Pike River.

5 We cannot conceive, we cannot understand for the families, nor they, how such a fundamental thing could not be known to management and still that management comes to this Commission and says, as far as they were aware, everything was being done according, as it were according to, well. And because it's such a gross, in our submission, departure from what would usually be required, we have no explanation for it other than that the
10 concentration in this company was, as so many people have said, production, production, production, but even so in the context of men's lives the departure from what must be usual standards of observation is quite extraordinary, in our submission quite shameful, but it is part of an analysis which is provided in the report which links, and I'm only going to mention I think two more of these
15 aspects, the first is the ventilation. The ventilation management plan should have been followed scrupulously yet it was not. It was simply not reflected in practice and yet signed off in November 2008. It makes references to procedures which were simply not in place at Pike River. It refers to documents that do not appear to be used and just as, this is the importance of
20 them, the alarm log book, mine inspection plans, stoppings SOP, SOP for single entry, risk assessments for the restricted zone, TARP for planned restart and so on. The roles and responsibilities under the plan made reference to a position that did not exist or held a different description and there's one example of a response to someone who looked at this by way of
25 review, Mr Sanders, our submissions at page 49, he picked it up and this is what he said,

1600

“Phew, you're joking. Got to sort that out guys.” Mr Rowlands, “There is considerable work to do to make it a truly valuable management tool.”
30 Mr Rowlands again, “To be honest, I don't like it either. Unfortunately I cannot start on it without all the other management plans to see how they can dovetail them together. It's gigantic and to be blunt, far too specific in my opinion in a lot of areas.” How could it be reviewed and reduced as obviously

was contemplated when the management plans have not been finalised themselves. Perhaps it comes to this. Mr White's description is a current working document under review. A current working document under review when this mine is up and running, cutting coal successfully and both
5 conventional mining methods and by hydromining (inaudible 16:00:57) coal as well. And it seems to the families that there's a real clue as to what happened here and that is that the new main, the main fan underground, referred to at page 49 of our submissions, did seem to every man that we spoke to who made observations of the difference between the pre and post-installation, to
10 have made a huge difference and so it seems when we look at the graph that's provided in the investigation report at page 50 of our submissions.

But it comes to this. At the same page at paragraph 4.1.11, Mr Rowlands advised the company in October that the mine, modelling indicated the mine
15 was restricted from the quantity perspective. His readings were taken on 27 October after the main fan was running but before the ventilation change involving the new overcast. He calculated the total mine ventilation, I'll paraphrase this. Calculated the four places being ventilated auxiliary fans and the area at pit bottom south and then he concludes this. "Given an 80%
20 ventilation deficiency the absolute minimum air required would be 150 cubic metres but the fan installation at full speed would only have provided one of 28 cubic metres at the mine resistant current. In essence, the mine had a ventilation shortfall and should have been working at least one place less. Result is that the accumulation of gas inbye sits there still as a major
25 consideration for this Commission.

And at page 51 the report's conclusion is that ventilation inbye was fragile in design and installation and struggled to cope with extended mining operations and gas load in the mine. It is a major concern still for the families that the
30 ventilation should have been assumed to be sufficient and perhaps from Mr White's perspective it was, but he wasn't the ventilation engineer. The calculations were those that he could not make, or if he did make them they were clearly in error or the attempted number of headings was inappropriate.

It links back to the fact of chasing production. Things being done before they are ready to be done. The hydro-monitor which goes from a trial to full scale production, as Mr Raymond said, in weeks 24/7. The ventilation was suspect, the gas was of a considerable risk and the ventilation control devices, and I'll
5 just refer to this in a sentence. Plainly were inadequate. They should have been rated, as page 53 submission refers, Mr Whittall said as to weighting, "The legislation here doesn't require that so again it comes to best practice and best standard when we go to look at our weighted stoppings. So for standard stoppings they won't necessarily be rated, they are just built. In
10 other words, they're not meant to withstand anything other than nominal pressure." Well, what goes on in that section of the report is a discussion from the men themselves about failing stoppings, inadequate stoppings, wrongful assumptions about the stoppings allowed in mines by Mr White as to seven temporary stoppings. The fact is even applying a New Zealand, trying
15 to apply the Australia standards would have seen these stoppings rated, and had they been rated, then on the primary conclusion of the investigation report with regard to the gas expulsion, the gas would not have reached the auxiliary fan thought potentially to be the source of ignition.

1605

20 So at every level in gas monitoring, in ventilation and in stoppings, this mine fails and each of itself constitutes risk. Together they accumulate to warrant the close analysis given in the report as to the cause of the explosion.

I make one comment about machine monitoring, it appears at page 59 of our
25 submissions. One of their machines had the radiator hose crimped off, it's referred to in the report paragraph 6.2.5 and a safety alert going out. This is what the safety alert said, it expresses amazement that someone had done this given the consequences of such an act, so here is recognition of a real problem, but how is it expressed? The consequences where the company
30 would potentially be up for 10s of thousands of dollars in costs with either repairing or even replacing the engine of a drift runner. Well so what, in the context of the risk. Three of the seven vehicles examined for the purpose of the report were unsuitable for use in an underground coalmine.

Now I'm going to depart from this issue and stick as closely as I can to our time allowance and come very briefly to health and safety systems. I'm not now going to make a further submission than that in a written submission
5 about where things went wrong in the level below management. If the board was not watching and the management did not know of crucial elements of mine conduct and equipment, such as I've just described, then it's not likely they're going to know what's going on beneath, logic would indicate that, but what we see is a very significant difference between reporting of incidents and
10 hazards and the response. I don't want to go into that because it's been laid bare in this Commission at great length. Our submission is this is no occasion for blaming an individual for what occurred here. It is astonishing of course when the health and safety manager is so unaware of things that were happening underground, but that seems to be the product of the reporting
15 back down the line to the departmental managers to go further in the system to be resolved and to come out by way of resolution. And this Commission knows that didn't happen. What it also knows is that many of these incidents were signed off including incidents signed off on the 19th of November and for time reasons, I would simply ask Commissioners that you consider once again
20 the brief of Dene Murphy which is filed under FAM00057 which describes the number of times he, as an experienced underground worker, referred matters of concern for no reply to be achieved. This was a man who did something wrong himself, acknowledges it and insisted a report go in which recorded that fact about his own conduct. He is someone to be reckoned with in terms of
25 assessing what happened underground at Pike River.

The submission is that the vast number of matters that were being reported were dealt with in the most minimalistic casual and inconclusive way and in so doing Pike River allowed the risk to accumulate. It accumulated on a scale
30 which seems inconceivable now recognising the danger in this mine.

1610

On the question of the contractors, it is stark that there is a great deal of criticism to be levelled at the way the company inducted and observed their work. Mr Slonker said this was an area that the company “failed miserably,” his description. There was the attempt to get the contactors trained or all those underground have further training on Fridays. One or maybe two sessions took place, but the evidence is that that stopped because the men were needed underground for production. Did the deputies come across the contactors? Mr Bisphan’s evidence, “They pretty much looked after themselves.” Mr Murphy says there was no system to track where they were except to walk around and find out. Evidence indicates it depended on the deputy if and how often they were visited and the report is in a neat summation of the position, we submit right and it’s said to be oversight of contactors in the mine appeared to be in practice everyone’s responsibility but no one’s in particular. We think there were seven men underground on the 19th of November with more than two years’ experience of underground work. Many contractors have very limited experience underground, many miners had limited experience underground.

Turn now very briefly to the Department of Labour inspectorate. I prefer to deal with this under Dr Callaghan’s submission and I’m going to adopt a position, Your Honour, Commissioners, which reflects the discussion yesterday about the going in their report. It does not provide anything of great substance to this Commission. For the families it represents, given its primary conclusions, frankly something of an insult. That in the first two or three pages it extols the virtues of the inspectorate, of the way it works, and salt to the wound, they refer to our submissions but I’m going to make another reference to it here. When one of the authors of that report was interviewed on the 19th of August 2011 he went much further. It’s there to be listened to. In talking about the way Pike River was inspected and the way the inspectors went about their work, and he praised the actions and thoroughness of the inspectors. My submissions are not directed to a criticism of the inspectors.

Our families' submissions are the inspectorate was woefully ill-served by the structure in which it functioned, the resources it did not have, and the time it did not have to carry out its role. It comes down to that. It was ineffectual and the inspectors themselves realised the limitations and if anything comes from the Gunningham report, it is the recognition in there when the inspectors explained what they would like to have done but could not do. They knew it themselves. They were functioning without the tools they need to do their professional job. But when Dr Neal was questioned in this *Checkpoint* article which is there for everyone to listen to, he was asked about the prosecution and he got around that question which is fair enough, and he praised the actions and thoroughness of the inspectors, and when the interviewer then asked if it was not then surprising that things went so horribly wrong, he answered, "Well to put it crudely shit happens." Now that is an extraordinary thing for the author of the report to say. When that report was being held up as a reflection of the way the inspectorate carried out its work these authors had not been given any of the raft of material regarding underground circumstances and conditions at all. They'd looked at six circumstances of referral of report and investigation and from that and discussions with the inspectors reached this conclusion.

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For the families that was hurtful, that is hurtful, and our submission is the Gunningham report is valuable more for what it doesn't say about how good the inspectors were because it exposes the weaknesses within the Department of Labour itself. We have made extensive written submissions in this regard.

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1615

I want to conclude by coming to two discrete matters, firstly Dr Callaghan's evidence, I'm sorry, secondly Dr Callaghan's evidence and something about the union. We have not made a formal submission regarding the check inspector and frankly our doing so has been based on the fact that we do not obviously hold ourselves as experts in that regard and we chose to read and to listen to, read the submissions and listen to the submissions made to this Commission including some today and we have the view that once the role of

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the union, as we knew it, was removed it exposed a gap which can only be replaced by its equivalent and we have reservations whether what Solid Energy is advancing will work. That is not an anti Solid Energy stance, anything but that. The families have expressed their great satisfaction that
5 that company may be the purchaser of Pike River, but the problem with the proposition is that it does not seem to be proven, one, and two how would it apply? How would it work in the context of the company that ran amok as we submit occurred at Pike River?

10 With a responsible company, state owned, making these statements, one can give it a credibility that we cannot attach to, for example, a private mining company with inexperience and new investors so we have moved to the position of considering that the check inspector, because there is no proof, of a system which works as well as it clearly has done and does work elsewhere,
15 particularly as Commissioner Bell has referred, by removing the objection to its political position. It seems to us, as night follows day, there is a logic in it which we should endorse unless this Commission could be satisfied that the alternative would work as well and the interesting story of the union at Pike River, a story in itself, comes to the families in an awkward way because we
20 have amongst our members, our families, many members of the union, many past members of the union, deep connections with the union across all fronts and the families have never really understood why what happened at Pike River happened in the context of a union traditionally being able to intervene.

25 They regard it as inconceivable what happened at Pike River and was observable, was allowed to continue without union intervention but they have come to the view, as you read the evidence, that the union was in an unfriendly union environment on the company. It was still getting going. The legislation restricted it. It did not have a participation agreement and therefore
30 it stands out like a beacon when there's one instance at Pike River where the union is directly involved in a health and safety matter and that comes in the context of Mr Winter's evidence when there's one direct union intervention identified at paragraph 27 and 28, "When the union delegate contacted the

union to say there was no SMV to take the men out of the mine and asked if that meant he was concerned for his safety and he said he was, the men were led out of the mine.” Mr Winter, for the union, informed Mr Knapp and then returned when the SMV was fixed and it was within three and a half hours. So
5 when the union was asked to act on that occasion, and it did, and it had the effect described. If we just put the families now, and all of us, in the position of reflecting, if the union had been empowered in this mine and the men had been coming to the union to address the grave issues of safety that were occurring, I agree with Mr Hampton’s submission and address to the families,
10 it is likely this accident would not have happened or at worst there would’ve been interventions that would’ve stopped the multiple failures occurring at this mine.

1620

It’s appropriate also to acknowledge the assistance of the union to the families
15 throughout the periods since the 19th of November. They have been a stalwart of support as have their counsel.

I come to Dr Callaghan. First it is with dismay that we see a submission made that her evidence should be dismissed by this Commission. One of which
20 grounds for which is that she has some linkage should not be seen independent because her coming to us through Mr Rockhouse. She did not do so. She came to the families through Mr Mount referring her name to us as an expert amongst many, we were trying to contact. We made that contact and she has given her time and the university’s time for nothing since that
25 period. We find it insulting that her evidence has been sought to be undone in that way. But her evidence in this Phase in our submission is much more than looking forward, it also reflects the current position.

What we find, we hope is a real consequence to this Commission is that
30 Dr Callaghan speaks about something which appears to have the endorsement of a Government. She refers to a statement made by Honourable Bill English and of Honourable Steven Joyce in March that New Zealand must identify skilled and safe workplaces as a key area

essential for New Zealand business growth. Her evidence is based on what they know, what she knows and at paragraph 13 page 3 of her evidence she says that the literature supports the concept if an employer looks after the workers the workers will respond to that and productivity will rise. There's a very strong economic argument and investment in the health and safety and wellbeing of the New Zealand workforce. She then sets out the cornerstones of what is required and the absolute key cornerstone as Mr King yesterday is leadership and from the questions the Commission has asked, you have read that evidence or aware of its content in that she is seriously questioning whether the high hazard unit which she endorses in itself, in a sense is appropriately restricted to the two industries it identifies and she considers that evidence based backing for that unit measured against the similar dangers which exist in other industries means that it is not been reasoned properly or completely by the Government in establishing it. She does not decry it, she simply says it must be extended to other hazardous industries. In fact she says at paragraph 13 that while endorsing many things that Department of Labour has issued in recent times, including the health and safety snapshot, that some of the statements it makes about the admitted number of inspectors, the huge number of enterprises in New Zealand do not demonstrate leadership. In a sense what she's saying is they defeat, it's recognising they are sort of beaten before they start and there must be reversal of such a stance. Health and safety must come first.

So to conclude, firstly if I may just in the next two or three minutes address some gratitude on behalf of the families, well gratitude on behalf of the families to the way this Commission has been conducted. I address that Your Honour and Commissioners to you, to counsel Mr Wilding, Mr Mount, Ms Beaton, to Ms Basher, Ms Jones, to security Mr Lee. It's been made easy for us to function here with your assistance and with the assistance from your secretariat to the Commission. For the families, this is their last chance to speak in public and to express these thoughts and their feelings. Their grief has been laid bare in a very public space but in a sensitive and receptive way.

What we ask is that those who have been in this process, keeping in mind, we depart, and they stay.

1625

5 The Commission reports, but if we anchor all that we do and you report in them and those whom they represent, the men and those who they represent, then the responses will work. I don't know whether there's any statistical value in this but when one looks at the history of New Zealand mine disasters we see intervals, we see years passing between for example '67 and '85 in the material that the department has given us. We then see clusters of fatal
10 injuries but in the gap between, institutional knowledge can be lost. The report at this Commission cannot rest, it must be actively picked up by this Government in the way we predict it should be on what we expect or hope to be your findings and recommendations. It's remembering the men and their families which will drive the reform. They have come to understand why the
15 men worked under an inspectorate which was so disempowered, under resourced, so uncertain so much it seemed, that can only be fixed by Government action and Dr Callaghan acknowledges how difficult it is on a safety issue to get political traction. We have to drive through the blockage of that sentiment that money spent on safety is money that could go elsewhere
20 be allocated elsewhere. It cannot.

We hope the Commission will recognise the isolation to which we have referred today of the families since the accident. They have been on their own in terms of recovery. We hope you will consider some recommendation
25 with regard to some authority which will retain responsibility for taking the question of recovery as far as it reasonably can go because that abandonment has been deep seated and has plagued them every day since the 19th of November.

30 I suppose it comes to this that in essence what we hope, what we expect is that the report and its recommendations will allow us to abide by the principle, Lest We Forget. Because time passes and sentiment passes, we hope that everyone in this room will carry the support they've shown to these families

into action in some way. We hope that vigilance rather than laxity will be the end of those who work and look after men and women who work in dangerous occupations. We must never know, must never hear the refrain, "We did not know, we left it to others. " We must never hear that again.

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Out of the shame of this disaster there must be a system which New Zealand can feel proud of and hold up to the light, that is the least that can be expected for the memory of these men and for those who love them. Lest We Forget.

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COMMISSIONER HENRY:

These questions might be a bit mundane after the speech you've just made or the submission you've just made but you'll have to forgive me on that Mr Davidson. You talked quite a bit about the Government's management split, the so-called church and state analogy. The board of directors directs the management and the management acts under the delegated authority of the board is my understanding of the legal and practical situation. Are you submitting in any way that there should be any legal changes, for example to the Companies Act in this regard?

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20 1630

MR DAVIDSON:

We think the obligation of the board is there, sir, already. We don't accept the separation described. We don't accept the refrain of separation in the way it's been relied on here. The surveillance of the board was something it was required to do by its own governance manual and charter and therefore in that sense it does not require reinforcing. I think it comes back to the question of the extent to which that obligation is going to reflect when there is failure and in that regard there are two possible areas of pursuit which I regard as the end of the line because it's the fact there are controls in place and obligations in place which prevent things happening. There is the civil remedy and there is the potential for a criminal remedy which was discussed yesterday. Now I don't think it's appropriate, sir, for us as the families' counsel to advance that but to recognise that that is there. It really requires a reflection of what

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happened at Pike River. Is this something that could happen elsewhere? If it is then it needs an institutional change and that would be my answer. I have, we have very strong views about that excuse of separation and just don't accept it applies even in the circumstance here.

5

COMMISSIONER HENRY:

Do you believe that the board did not know the state of health and safety at the mine?

10

MR DAVIDSON:

On the evidence, sir, we cannot identify that they did know, other than that the passage to which I referred this afternoon where there were problems and difficulties getting production underground. Things were going wrong and hence the bonuses were brought into play. Whether that linked to knowledge that things were being done hastily or wrongly or cutting corners we cannot say. There appears to be a separation on the evidence. We cannot prove otherwise sir or say otherwise.

15

COMMISSIONER HENRY:

20

Do you believe the management did not know the state of the health and safety systems?

MR DAVIDSON:

Well it's quite clear, sir, that for example notwithstanding Mr White's denial of being aware of anything wrong but he wrote an email very shortly before the 25 19th of November which expressed considerable frustration with issues that came up in operation in a health and safety meeting so he was aware of some things but we have no evidence that he was aware, for example, the gas sensors were down. What we say is, maybe he was not aware but how could he not have been aware by his own inquiries? The failure seems to be 30 another level altogether. It's not just knowledge. It's a lack of surveillance because that applies to a number of people.

COMMISSIONER HENRY:

On a separate topic, you haven't mentioned in your submission, I don't think, you may have done, about the hydro bonus which we heard evidence about. It appeared from the evidence that quite a large number of people were going
5 to receive what? Certainly to them would be a significant amount of money if a certain stage was reached. Now do the families consider that a bonus had any effect on the attitudes of the men towards production and so on?

MR DAVIDSON:

10 They do, sir, because there's an evidential basis to so think. The evidence of Mr Murphy, of Mr Houlden, and there's a whole lot of witnesses to this effect is that it did produce this response and on top of that the company's requirement for example not even to spend time as they were, it was a hot seat change in the hydromining to keep and the hydro-monitor to keep going, yes, there
15 seems no doubt about it. It was a direct driver to, and the union evidence is highly critical of the bonus in that regard. It believes it leads to unsafe practices so, yes.

THE COMMISSION:

20 Thank you Mr Davidson. Mr Haigh we've got 25 minutes of normal sitting time left.

MR HAIGH:

I should be able to finish within that period or very soon thereafter
Your Honour.

1635

5 THE COMMISSION:

Right, and you'd like to carry on, obviously.

MR HAIGH:

I would thank you.

10

SUBMISSIONS: MR HAIGH QC

May it please the Commission. Can I first of all say that nothing in my
submissions detract one iota from the terrible loss of 29 lives and the enduring
pain and loss that the families must go through on a permanent basis. I
15 acknowledge their pain, I acknowledge their loss and my deep regret both on
behalf of Mr White and myself, personally.

In terms of my submissions Your Honour and members of the Commission
can I refer to one paragraph that I'd seek to withdraw? That's paragraph 8.1.

20 I think that I've overstated the position there in the submissions and I don't
seek to rely upon that at all. Overshadowing these submissions and
Mr White's evidence before this Commission has been the ongoing police
inquiry. That has affected the way he has given evidence and to some degree
the issues that I propose addressing in my submissions. Now that is
25 inevitable because whilst standing back and being as objective as possible I
can say that, I cannot see for one moment any evidential foundation on the
law which would warrant a prosecution of any description of Mr White and in
particular one alleging an omission or act which constituted an offence of
manslaughter. But of course the final decision on that issue does not lie with
30 me. For that reason I have taken the approach, as I must do and indeed I
would be failing my obligation if I did not, that during the course of his giving
evidence here I have cautioned him not to answer certain questions. Relied
upon the privilege against self-incrimination and I make no apology for that.

Indeed as I said, I would be failing in my duty because no matter how remote the possibility of any charges being laid against him, that is a risk I, as his counsel, cannot take.

5 So when I hear criticism from various counsel that he hasn't accepted responsibility that's not something that I regard as an appropriate submission although, and I'll qualify this, what some of the counsel here aren't aware of or haven't seen are the three full days of interviews that Mr White gave to the police and the Department of Labour. Two full days in Greymouth and one full
10 day in Bathurst, Australia, where he conceded where appropriate failings within the system and for example, where he himself may have failed and for example, an acceptance by him of being responsible, even though he was never appointed to that position of being the mine ventilation manager. So my friends may not be aware of that but when they submit to you that he has
15 failed to take responsibility first of all I don't accept that and secondly that has to be put into context of my advising him for the reasons I've outlined, not to answer certain questions before this Commission.

And the position altered of course because on one hand he's making
20 statements to the Department of Labour and the police, hours of them. On the hand he's here on oath and as we've got closer to these hearings the spectre of a police inquiry has loomed larger and of course as I've said he was on oath before this Commission.

1640

25 So if there's to be any criticism of his failure to accept responsibility for anything, which I don't accept any how in this Commission is because of the advice that he was provided with on what in my submission, were good grounds. I don't accept and again, I don't know whether – well no, I think I've covered that point as to responsibility, but when that claim is made
30 Your Honour and Commissioners I'd ask you to take into account the circumstances which I have just outlined and the constraints that existed of necessity when he was giving evidence.

What I'd like to do is address some of the issues which are particularly relevant to Mr White's position. First of all, the short duration of his employment. He commenced in January 2010 as the operations manager, became the statutory manager in June until, and this is important, the
5 appointment of another statutory manager which was envisaged at the time of his appointment and then became general manager upon Mr Whittall becoming CEO in October. He was never employed as the ventilation engineer or manager. Indeed, his terms and conditions of his appointment are bereft of any adequate job description. But, being the type of person he
10 is, he accepted responsibility for ventilation and he acknowledged that. He had no choice because no one else was going to take responsibility and the company failed to appoint a ventilation manager as it had intended to do and as it specified that it would do. So from that point on, from the time that he was employed in each of those roles, despite overt criticism now, it's my
15 submission to this Commission that he undoubtedly did his best in the circumstances that prevailed including design faults that existed, systems that had been implemented well before he came along. It was said at some stage that safety wasn't necessarily – or a number of criticism had been made about the safety systems that existed after he was involved or employed.

20

What I'd like to do is refer to the improvements in all aspects of the mine including health and safety from the time that he was employed. It's important in my submission to recall that he received almost universal praise from all those involved in the mine and its surrounds in terms of their involvement in
25 the mine from the time that he commenced his employment. He was the only manager who made the effort to improve morale, which was abysmal, to change attitudes including what he referred to as the number eight wire attitude which was reflected in some aspects of the mine and which probably again reflected earlier management and he went out of way to improve as he
30 should've done, defective health and safety deficiencies. And I do rely upon the almost universal praise as being the first manager to make a real difference because that can easily get lost in the most recent criticism of

Mr White and his alleged failure to take responsibility and his apparent lack of knowledge as to deficiencies and I'll come back to that.

5 His focus was on health and safety. He was a man who was down the mine at least once a week, frequently two or three times a week. He was concerned about the men and that in my submission is undeniable. For whatever failings that occurred, he was doing his best in terms of safety.

1645

10 Now it may be that the Commission concludes that there were failings on his part, systemic I suggest rather than anything which could be said arose from his sitting on his hands and doing nothing because no one could ever say that he was satisfied with the existing situation and failed to take steps to improve the positions. I accept that some of the improvements that he was implementing didn't go as speedily as one would've wanted. I accept that and
15 I think he accepts that. The stoppings for example he, the temporary stoppings were coming to an end and the permanent stoppings were replacing them on a gradual basis and in fact those were continuing, that is the replacement of the temporary stoppings were to continue and had been delayed because of the contractor, so other commitments were to continue
20 the week following the explosion.

There have been other criticisms relating to the, not just the stoppings and the delays in that occurring and taking place but in the second egress and ventilation issues and even stone dusting, that's a risk but for example with
25 stone dusting the mine was, he implemented a system in the mine whereby at the end of each shift, stone, lime stone dust had to be applied towards the early part of November I think it was Mr Poynter made it clear that he thought there should be a stone dusting management plan implemented and Mr White went along with that and that was in the process of being completed as at the
30 19th of November. So I reject the suggestion if that's what's to be inferred from what some of my friends put to you, that for example he was focussed on production and failed to follow up or pursue health and safety issues. That simply is not correct and I have to respond to one of the remarks or one of the

submissions made by my learned friend, Mr Davidson, where he suggested that the lack of knowledge by Mr White as to some of the deficiencies and some of the problems relating to ventilation and the most obvious one, the failings of the gas sensors that somehow that was related to focus on
5 production. Now there is no link there and that's a terrible submission to put to you that somehow the lack of knowledge by Mr White of those issues, those deficiencies is linked to production and that is a step too far in my submission and I want to deal with that lack of knowledge of, for example the spiking and of the fact that the gas sensors underground, the two gas sensors
10 weren't working and I accept immediately that that is unacceptable.

There's no other possible description, but Mr White was entitled to rely upon surely his expert managers, managers with expertise in the field and those who should have been reporting these breakdowns, these deficiencies. Now I
15 don't offer that as a plea in mitigation. It's a simple fact that he was running a mine with a myriad of issues to deal with and in my submission was entitled to rely upon those below him to pass on such information. I accept that it's open to say well these reporting deficiencies can't be ignored as being somehow reliant upon management not instituting the correct policies in terms of
20 reporting. Well I'm not sure that the evidence came out that way that there were failings in the reporting lines, but that's not my recollection but there's no doubt that there were deficiencies in reporting but again it's doubtful whether the Commission can say that the fault for that lies with Mr White.

1650

25 It may lie in the systemic issues pertaining to reporting lines and it might be arguable that management should've known that there were failings and somehow dealt with it. But surely when you employ experts, shall I say people of technical competencies below you, there has to be some degree of reliability upon those persons and as I said, it's not a plea in mitigation but it
30 really is a simple fact which I would ask the Commission not to ignore.

In terms of then his health and safety focus, there were a number of matters that he implemented a number of changes, they're all in the evidence and I

don't intend to outline them unnecessarily at this point in time. There was an endeavour to introduce the tube-bundle system as well, changes which were actually implemented. The tube-bundle system there's a disagreement here between my friend Ms Shortall, representing Mr Whittall and myself
5 representing Mr White as to who knew what and who said what at various times but what is undeniable is this. That shortly after he commenced his employment with Pike River and started examining what deficiencies there were there and trying to remedy them he at a very early point decided that the mine needed a tube-bundle system and he raised this with Mr Whittall early
10 on and his evidence was that it was to go into the November budget. It didn't go into that, there were then discussions where Mr Whittall says, we must have a chat about this but it didn't progress.

Now I can't recall whether it was then put into the January budget with
15 Mr White's knowledge and may well have done. But here's the crucial thing, when he realised there were delays in the intended purchase of the tube-bundle system he, in June 2010 and he'd only been employed in January and had raised this issue earlier, started writing to SIMTARS in Queensland about a leasing programme and there is correspondence back and forth. There
20 were costings given and then he receives the letter from SIMTARS saying it's been quashed by senior management or someone above Mr White. So here was an opportunity, heavens knows when it would've been introduced, whether it would've been there before November but the point is, that he tried to get the leasing process implemented and that was stopped. So that's just
25 one example of or an example of a proposal to implement safety improvement which didn't get past the gate as such.

But there were others that were implemented by him and again I fall back upon the universal praise for Mr White including Mr Rockhouse bar a couple
30 of concerns that he had. So that all those factors are relevant to the Commission's analysis of where he stood in terms of responsibility as such and it must surely be a factor which is critical to the Commission's consideration.

A couple of points I want to raise, the EPMU submissions, just there's one issue I want to take with them and that is at page 13 it refers to the submissions of the cause of the disaster and in the first paragraph it refers to an employer referring to Pike who for whatever reason under resourced, financially uncaring, laissez-faire, was laissez-faire or worse as to health and safety or an employer that is vehemently opposed to union involvement and health and safety matters such as Pike River and then goes on to say the check inspector system worked well, as I agree it would in an environment such as that. Well first of all in terms of I don't think this is attributed towards Mr White but there no evidence indeed to the contrary that he was every anti-union and nor is there any evidence that he was laissez-faire towards health and safety but I'm not sure whether the criticism was directed at him, but if it was, it's unsustainable.

15 1655

I want to refer briefly to the regulatory issue. Much has been said about that and I intend to be very brief and that is this that clearly the obligations in the Health and Safety in Employment Act lie fairly and squarely with the employer. But, and there is a but here, it's my submission that the way in which the mine inspectors with all the limitations financial and otherwise imposed on them, the way that they approached problems, those acts and omissions in the mine may well have led to mine management including Mr White to take some comfort from the position held by or the position relayed for example by Mr Poynter about the second egress. Now I don't and it was with qualifications that there was a second egress, a walk out egress being built to the west. I don't put this forward again as a means of justifying any position taken by management in relation to whether or not the Alimak raise was satisfactory because it clearly wasn't. But at the time as I said, some comfort was taken from the endorsement by the Department of Labour official on that and it's with some comfort that I read in the department's submissions that changes have been made to the underground mining regulations and that this is paragraph 237 that the Department of Labour has moved to provide clearer guidance on regulatory compliance to the mining industry and I think my

learned friend made reference to Ms McDonald, to the fact that the department recognised that guidance wasn't as good prior to the 19th of November as it could've been.

5 So again without trying to criticise anyone I simply say this, that the way the relationship that built up between the inspectorate and mine management may have given comfort to systems which on reflection were not adequate. But that seems to be something which no doubt this Commission will comment on and no doubt rule on.

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And Your Honour and Commissioners I don't, subject to questioning, have any further questions or any questions at all or intend to address you any further. We've got submissions, we've got his evidence and I just point out when he was criticised when there has been criticism that twice he came to
15 this Commission to give evidence. Both occasions he was living in Australia, so it's not as if he attempted to shirk his responsibilities at all and I say that with the knowledge that any qualification is one that imposed or directed by myself as his counsel.

1659

20 That there were systemic problems is undeniable but the weight of these problems and deficiencies should not in my submission fall on his head and there, it needs a recognition with respect by the Commission that here was a man who arrived late on the scene, confronted by a mine with existing deficiencies which it started well before he came on the scene and who did
25 what he could and that has been recognised by those involved in the mine and I just ask the Commission to take those matters into account and recognise this man made a positive difference. Those are my submissions Your Honour and members of the Commission.

30 **COMMISSIONER HENRY:**

Mr Haigh could you please comment on, if you can, on paragraph 15.1 of your submission where you deal with the search and rescue and Mr White's involvement as the original incident controller if I can put it that way?

MR HAIGH:

I'm not sure how, sir, you want me to comment other than whether you want me to expand on that.

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COMMISSIONER HENRY:

Well I'm particularly interested in the issue as to whether he should have called emergency services after he went in to the control room and saw that the voice communications to the mine was still intact but there was no response from below. That the, all the telemetric information had gone and the electricity had gone.

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MR HAIGH:

Yes, I think there was a 30 to 40 minute delay. Is that what you're referring to, sir, before that was implemented?

15

COMMISSIONER HENRY:

Well he went into the control room –

20 **MR HAIGH:**

Yes.

COMMISSIONER HENRY:

- around that 4 o'clock mark, didn't he, having been alerted by Dan Duggan and the suggestion's been made that at that point there was enough information for him to call emergency services before he went off and did other things.

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MR HAIGH:

I can only rely on his evidence, sir, which was that at that point he didn't appreciate the magnitude of the problem and that had he done so he would have immediately communicated with the emergency services. I think that his evidence clearly was that he wanted to, he wasn't satisfied early on that there

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had been anything of the magnitude that we're aware of. Now that's regrettable but we can't turn the clock back and I can't go beyond his evidence.

5 **COMMISSIONER HENRY:**

The second question is regarding, you've touched on it, the question of reporting structures. I remember when he was here I think he was asked about what kind of information system he had and he seemed to rely very much on going around and talking to people. He didn't seem to have any kind
10 of integrated information system that told him what was going on in the mine.

MR HAIGH:

Well I think there was the, there was the committee which was initially, which was taken over by Mr Ellis in October I think when he joined which had been
15 previously organised or run or chaired by Mr White and it was through that system there was a reporting back and it wasn't just casual reporting of just finding out, like chatting to people. That was much more structured and it continued to be is my recollection from the evidence but without, for whatever reason, Mr Ellis passing on this information where there were deficiencies
20 which were known to the committee at that point, including ventilation issues, and I think that included spiking, where this wasn't passed on to him and he would've expected that this would have been done. So I don't think it's quite as casual as you suggested because there was a system and that as the essence of it as I recall and there were the incident reporting and I'm just
25 trying to recall what other methodologies existed for his being made aware of the position but there was, I think he was reliant upon managers but there were these managerial meetings and where there was reporting back but, wrongly, he wasn't advised of these issues after Mr Ellis took over. I don't think I can answer it any more than that, sir.

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COMMISSIONER BELL:

Mr Haigh, Mr White was the statutory mine manager, he was also the quasi ventilation officer or whatever you want to call it, he was acting in that role

even though it wasn't part of his job description. He went down the mine two to three times a week, in your words a minute ago, what puzzles me is, and he does talk to people, he talks to managers and deputies and the people that he meets underground, why didn't he pick up that the ventilation system
5 wasn't working properly, as has been given in evidence here and as Mr White admitted to himself when he was here last time. That's what puzzles me. Why didn't he pick up there was a problem with the ventilation?

1705

MR HAIGH:

10 My recollection is that he was aware of specific ventilation issues that arose and dealt with them accordingly. I think if you were asked Commissioner Bell whether he anticipated that the problem was to the magnitude that required a complete revamping of the ventilation system, well my only comment on that is that his evidence that he believed, particularly after the installation of a new
15 fan, that ventilation was adequate and that there was – it was monitored and the air fed into different working areas at the times that he thought it was required. So I'm not sure that it's fair to say that – well, I understand your question, I can only answer it that he dealt with each specific issue that he was aware of as it arose but if you asking was there a general grand plan to
20 implement major changes, I don't think he was questioned about that or if he did I may have intervened.

COMMISSIONER BELL:

He was there for 10 or 11 months based on starting in January and up until
25 the 19th of November. Employment in the mining industry as you're aware Mr Haigh, is a very short duration anyway, people come and go all the time. Why didn't he just leave, why didn't he leave before this matter happened if these things were there, that he knew about them to some degree? Why didn't he just leave?

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MR HAIGH:

Well I'm not sure what you're referring to when you say, "he knew about them," so I'm not going to address that. What I can say though is that there

were – he had considered leaving before the correspondence that was produced here and in fact as I recall there was some earlier discussions with a head hunter for want of a better word. But I think that’s – the inference to be taken from your question is a bit unfair because in his correspondence he said
5 he thought he could continue to make a difference. He wasn’t just going to walk away and where there were differences, he was going to stay and try and change it so I don’t think you can say that it would’ve been proper just to walk away because it was then if there were problems they were landed on someone else and someone who may not have been efficient as he was at
10 remedying the problem.

COMMISSIONER BELL:

You mentioned stone dusting and that was one of Mr White’s issues that he did improve. The trouble was all the samples that were tested actually failed
15 so it didn't actually improve at all.

MR HAIGH:

Well I don’t recall that evidence.

20 **COMMISSIONER BELL:**

Well I mean that’s in the evidence and Mr White admitted it when I asked him last time that it didn't work.

MR HAIGH:

25 Well I can't remember the times that the question related to. What I do remember is that when he started he introduced a system of each shift stone dusting at the end of the shift and the mine was wet at that time and as it was drying out it became obvious that the system had to be upgraded and all I can say is that that’s exactly what he was doing after discussions with Mr Poynter
30 shortly prior to the 19th of November.

COMMISSION ADJOURNS: 5.09 PM