CHAPTER 5

Governance and management

Introduction

1. This chapter considers the governance of Pike by the board of directors and the consequential effects on health and safety at the mine. The chapter also deals briefly with the actions of executive managers. Their actions emerge in more detail in the subsequent chapters, which describe how the mine was managed.

Composition of the board

2. At 30 September 2010 the Pike board comprised John Dow, as chair, and five other non-executive directors, as listed in Chapter 4, 'Organisational structure'.

3. Mr Dow had retired following an international career in the metalliferous mining industry. He became a director of Pike in February 2007 and chairman in May 2007. Work had started on constructing the stone drive into the mine and a share market float was imminent. At the time of the explosion, the board had been looking to replace retiring directors with people who had underground coal mining experience.[1] Mr Dow provided the commission with written and oral evidence.[2] Antony Radford, a non-executive director, provided written evidence. Gordon Ward, an executive director and chief executive, refused to provide written or oral evidence to the commission but had provided evidence to the joint investigation.[3] Mr Ward had been on the board since July 2006 and resigned in September 2010. He moved to Australia where he was effectively beyond the commission's reach.

Executive management

4. For the purpose of its report the commission has found it useful to distinguish between 'executive management' and 'functional management' responsible for specific areas such as engineering or technical services. Executive management comprised the chief executive, the general manager and the operations manager. Those positions were filled at various times by Mr Ward, Peter Whittall and Douglas White, as explained in Chapter 4. Mr Ward and Mr Whittall played major roles in the company. Mr Ward was chief executive from January 2007 to September 2010. In his previous capacity as general manager of New Zealand Oil & Gas Ltd he had been responsible for the Pike River project since 1998. Mr Whittall was general manager from February 2005 until he succeeded Mr Ward in October 2010. Mr White was the operations manager from January 2010 and became general manager in October 2010.

Legal obligations of directors

5. Under the Companies Act 1993, Pike's board of directors was responsible for managing the company's business or affairs, or directing and supervising that management.[4] Under the health and safety legislation the company, as employer, was required to take all practicable steps to ensure the safety of its workers.[5] The legislation places no specific duty on individual directors to ensure the safety of workers. Directors may be prosecuted if the company has committed an offence under the legislation but only when they have directed, authorised, assented to, acquiesced in, or participated in the company's failure.[6]

Governance by the board

6. The commission adopts the following definition of governance: 'setting the strategic direction of the company and appointing and monitoring capable management to achieve this'.[7] The key point is that directors must not only lead but also monitor management and hold it to account.

7. A range of external guidance on good governance practice was available to help the Pike board to govern effectively. Comprehensive guidance on good governance practices was available from the New Zealand Institute of Directors.[8] This included the need for the board to systematically manage all business risks, to hold management strictly and continuously to account, and to ensure the company complied with regulatory requirements. Best governance practice on health and safety was also available from the UK Health and Safety Executive (the equivalent of the New Zealand Department of Labour).[9]

8. Three Australia/New Zealand Standards guidelines were also available for directors on governance principles, both generally and in respect of health and safety.[10] Governance principles are discussed in more detail in Chapter 28, 'Improving corporate governance', when considering recommendations for the future.

Pike's governance documents

9. The corporate governance manual included the board charter, the charter of the audit committee and the charter[11] of the health, safety and environment (HSE) committee.

The board charter

10. The charter described the responsibilities of the board. The 'managing director' was responsible for implementing strategy and managing operations. The board was responsible for 'reviewing and ratifying systems of risk management and internal compliance and control, codes of conduct, and legal compliance'. According to the charter, the board had overall responsibility 'for the company's system of risk management and internal control, and has established procedures designed to provide effective control within the management and reporting structure'.[12]

11. The charter described three committees that oversaw aspects of governance on behalf of the board: the audit committee (essentially financial), the remuneration committee and the HSE committee. The use of such committees is commonplace. The allocation of health and safety oversight to the HSE committee is in line with international thinking on health and safety and follows good governance practice.[13] The responsibility remains with the board and committees must report back so that other directors can raise questions.[14]

The corporate risk management policy

12. The board was responsible for annually approving the risk management policy[15] and monitoring the management of risks in the company.

13. In its corporate governance disclosure statement filed with the New Zealand Stock Exchange in September 2010, the company described its risk management in reassuring terms:

> *Pike River has developed a framework for risk management and internal compliance and control systems which cover organisational, financial and operational aspects of the company's activities…*
>
> *Management is responsible for designing, implementing and reporting on the adequacy of the company's risk management and internal control system. The board requires that management reports to it on a monthly basis as to whether material business risks are being effectively managed, and to the Audit Committee and the Health, Safety and Environment Committee…*

The board has a Health, Safety and Environment Committee comprising two non-executive directors with mining and engineering experience… there is a strong safety culture which is fostered by management… detailed compliance programmes operate to ensure the company meets its regulatory obligations.[16]

Risk assessment

14. Risk assessment takes a number of forms and typically operates at different levels of a company. The basic concept is to identify risks faced by the company and assess their likelihood of occurring and their consequences if they do occur. To do this, the adequacy of the controls, or defences, intended to reduce likelihood or consequence have to be assessed and additional controls implemented if necessary. Finally, a decision is taken as to whether the risk is acceptable or not, and the risk is then managed. Risk assessment, which starts with the board, is an integral part of modern governance and a continuous process.

15. In Pike's circumstances, one could reasonably expect to see three interacting levels of risk assessment: corporate, mine site and specific proposal. The risk assessments at the corporate level, viewed by the board, should detail the major risks faced across the company, for example in the areas of finance, people and operations. At the mine, the major risks, such as ventilation, would be similarly documented and assessed by executive and middle managers and, depending on importance, would be summarised and included in the corporate-level risk assessment. Risks posed by specific processes or proposals, such as changes to the ventilation system, would be separately assessed at a detailed level by the relevant managers and experts, then summarised and included in the mine site assessment and, if necessary, the corporate assessment.

16. For a high-hazard activity such as underground coal mining, rigorous and continuous risk assessment, and subsequent management, are crucial at all three levels. According to Mr Dow, the board was 'keenly aware' of the risks posed by methane.[17] But the board had no effective framework for ensuring there was a systematic assessment of risk throughout the organisation. The board commissioned no third parties to carry out such an assessment.

17. The corporate risk management policy required an overall risk management committee but this was not established.[18] Mr Dow said Pike instead had committees that individually managed risk in specific areas. One was the HSE committee, which he chaired.

The challenges facing the board and executive management

18. In 2010 the board and executive management faced serious challenges, some of which had been apparent for years. The company had a history of not delivering on its promises. Coal production was years behind schedule and previous estimates of production capacity had to be severely reduced. Lack of revenue was driving the company to seek further funding. There were major problems with the advent of hydro mining, the company's main production method.

19. It appears that no one on the board had experience in the local underground coal mining industry. The business was new, with the mine still under development, as were its systems, including health and safety.

20. There was a rapid turnover of statutory mine managers and middle managers. Many workers were inexperienced. Morale and absenteeism were of concern. The company relied heavily on contractors and consultants. It had purchased equipment unsuitable for the difficult strata conditions encountered. Some key equipment and systems were unproven when production began. There was no suitable second egress for use by workers in an emergency.

Board meetings

21. The board met monthly, sometimes at the mine. The chief executive normally attended. Included in the monthly board papers was an operations report from the mine site, part of which was devoted to health and safety. Mr

Dow considered that 'quite a significant amount of the report focuses on the safety aspects of it and the board was getting quite a lot of good information'.[19]

22. The statistical information provided to the board on health and safety comprised mainly personal injury rates and time lost through accidents. Mr Dow was comfortable with the information provided to the board.[20] The information gave the board some insight but was not much help in assessing the risks of a catastrophic event faced by high-hazard industries. Pike had not developed more comprehensive measures which would have enabled the board and executive managers to measure what was being done to prevent catastrophes, such as the analysis of high-potential incidents (near misses which could have caused serious harm) and the steps taken to prevent their recurrence. The board appears to have received no information proving the effectiveness of crucial systems such as gas monitoring and ventilation. The nearest the board came to questioning management on such issues appears to have been on 15 November 2010, when the general manager, Mr White, attended his first board meeting and was questioned about safety systems. [21]

23. In describing his approach to governance, Mr Dow compared the difference between governance and management to the difference between 'church and state'.[22] The commission does not accept the analogy. Management operated under delegation from the board. Good governance required the board to hold management strictly and continuously to account.

Meetings of the board's health, safety and environment committee

Composition, mandate and meetings

24. The HSE committee, which was to report to the board, consisted of Mr Dow as chair and another director, Professor Raymond Meyer. According to its charter, the committee was to assess management's effectiveness in providing leadership in health, safety and environment matters; review with management the company's strategy and performance in these areas, 'including receiving reports on any significant incidents and measures arising from them to avoid future incidents'; consider and review the identification and management of health, safety and environmental risks as part of the company's overall risk management system; and 'monitor compliance with legal and statutory obligations'.[23]

25. The HSE committee was to meet every six months but by the time of the explosion it had not met for 13 months, with the exception of the board meeting of 15 November when it questioned the general manager on health and safety. Mr Dow said that this was because the board as a whole was taking more interest in health and safety.[24] No meetings of the HSE committee had been scheduled for 2011, in contrast to meetings of the board.[25]

Obtaining information

26. In Mr Dow's view, health and safety were the responsibility of the health and safety manager,[26] who had charge of the corporate safety management plan, and the mine manager. The health and safety manager presented information to the committee when it visited the mine. Mr Dow did not consider the committee needed to obtain information from other managers.[27] If they wished to raise concerns with him they had the opportunity to do so, for example at company dinners or barbecues.[28] Mr Dow considered that neither the board nor the committee felt it necessary to obtain further information or seek independent advice on health and safety. The HSE committee recommended that third-party audits of the safety management systems should be done but did not require this when senior management considered they should be deferred until the systems had been bedded down.[29]

Warning signals

27. In 2010 there were obvious warning signals that things were amiss. These included two third-party reviews that an alert chair and board would have found very revealing. The first review was a comprehensive risk survey by Hawcroft

Consulting International, commissioned by Pike's insurers. The second was a review of legislative compliance conducted by Minserv International Ltd (Minserv).

The Hawcroft risk survey 2010

28. Hawcroft is a specialist risk assessor for the insurance industry, carrying out over 150 insurance risk surveys annually at over 150 mining/processing operations around the world. Their risk survey at Pike covered underground, coal processing and surface operations.

29. In its 2010 report on Pike, Hawcroft repeated its 2009 recommendations that a 'broad-brush' risk assessment of the operation was needed, in order to develop a risk register and determine core hazards.[30] The report also identified that a number of specific risk assessments were outstanding on such vital matters as windblast, gas ventilation and hydro mining. Hawcroft rated the risk of a methane gas explosion as 'possible'. The Hawcroft review also commented on the need for timely and effective action on incident reports.

30. Mr Dow said that although the board was aware of the review, he had not read the report and the board had neither considered it nor been briefed on it.[31] Mr Dow considered the matters raised would be appropriately dealt with by management at the mine.[32] The Hawcroft report was not, in his view, something that would normally come to the board or its HSE committee.[33]

31. Mr Dow added that the site managers were responsible for bringing the issues they considered important to the board's attention. These people were very competent and the board had every confidence in them.[34] There were plenty of opportunities for site managers to bring safety concerns to his attention in both formal and informal situations,[35] and he was surprised that they had not done so.

The Minserv legislative compliance audit 2010

32. In the course of eight visits to the mine between February and April 2010, David Stewart, an experienced mining consultant and principal of Minserv, conducted a legislative compliance audit.[36]

33. In August 2009 Mr Dow had been approached by a professional colleague who expressed concern about aspects of the Pike River mine, including training and culture. Mr Dow discussed this with Mr Stewart. Mr Stewart said that Mr Dow was concerned about the turnover of senior managers, difficulties in recruiting good managers, morale and the failures to meet production targets.

34. Mr Stewart told Mr Dow that the management team needed help from someone entirely familiar with New Zealand regulations and conditions, and the starting point should be a legislative compliance audit.[37] Mr Dow referred Mr Stewart to Mr Whittall.

35. Mr Stewart's review identified serious problems with safety critical systems.[38] Among these he noted that:

- the instrumentation of the main fan was not compliant with regulations;
- there was no remote gas monitoring systems in the mine connected to the control room;
- the ventilation structures (stoppings and doors) were inadequate and training on construction was needed;
- the stoppings needed protection from blast damage caused by shot-firing;
- there was a lack of information about ventilation air flow;
- there were obstructions and debris in the main returns leading to the Alimak ventilation shaft;
- there were no stone dust barriers;
- the ventilation shaft was impractical as a second egress;
- intershift reports by mine deputies were inadequate; and

- the methane gas drainage line alongside the main access road in Spaghetti Junction was at risk of damage by mobile equipment.

36. Mr Dow did not ask for Mr Stewart's reports. He did not require the board or the HSE committee to be briefed on them. He told the commission: 'Mr Stewart was engaged to help the management team deal with the issues. He was engaged by them, the reports went to them. I didn't consider that it was necessary for them to come to me as well and Mr Stewart testified that he didn't expect them to come to me either. I had a subsequent oral conversation with him to ask how it had gone'.[39] There does not appear to have been a comprehensive management response to all the issues raised in Mr Stewart's reports. The health and safety manager, Neville Rockhouse, did not see them.[40]

Serious incidents at the mine

37. Mr Dow was asked to comment on a range of high-potential incidents at the mine in the month or so before the disaster.[41] A sample of these was summarised in schedules prepared by the commission.[42] Although Mr Dow was referred to only a few incidents, these were enough to show that over a five-day period in October 2010 there were six occasions when methane was over 5% of the air. Mr Dow viewed these as 'a series of operational incidents that are very much the prerogative of the onsite management team … In due course I would expect the board to have been advised at its next meeting'.[43]

38. Mr Dow was then referred to a number of earlier incidents, including one on 23 June 2010 that concerned dangerous recirculation of air. A mine deputy had attributed this to inadequate ventilation, inadequate leadership and supervision, inadequate engineering, inadequate maintenance, safety rules not enforced and poor stoppings. When Mr Dow was asked, 'Would the committee not have wanted to verify for itself whether those matters had been remedied or not?', he answered, 'No, as I've said on a number of occasions these are operational issues on site … it's a management issue to follow up.' [44]

39. Mr Dow accepted that the schedules presented to him showed many high-potential incidents were not reported to the board. But he did not accept that the systems were not working and said he was comfortable with the reporting.[45]

Challenges facing executive management in 2010

40. The challenges faced by the executive management, and how they handled those challenges, are described in some detail in Chapters 7 to 12, but some general comments are made now. Although they are described in mining industry terms, the issues also relate to the generic management problems faced in other enterprises – strategy, planning, risks, systems, information and people.

41. Executive managers had to translate the board's strategic direction into operational plans but had difficulty in preparing a comprehensive, long-term operational plan because of continual changes in the mine design and production schedules.[46]

42. Executive managers, like the board, focused on production and earning revenue. As noted in paragraphs 14 to 17 of this chapter, risk management was undeveloped at Pike. The risk of catastrophe was not identified by executive management and was not reported to the board. The warnings in the Hawcroft reports that risk management needed improvement were not heeded. Similarly, there was no comprehensive response to the Minserv legislative compliance audit. A number of other reports from consultants on safety critical issues, such as methane management and ventilation,[47] were not properly addressed by the time of the tragedy.

43. The mine's health and safety management systems, including vital systems such as ventilation management, methane drainage, gas monitoring and hydro mining, were still under development at 19 November 2010, as discussed in Chapters 7 to 12.

44. The management information systems were also undeveloped and vital information was not brought together, summarised and analysed for executive managers. For example, as is clear in Chapter 7, 'Health and safety management', key information on health and safety incidents in the mine was available but was not handled systematically and so did not result in a comprehensive response.

Conclusions

45. The board's focus on meeting production targets set the tone for executive managers and their subordinates. The board needed to satisfy itself that executive managers were ensuring that its workers were being protected. After all, the company was operating in a high-hazard industry. The board needed to have a company-wide risk framework and keep its eye firmly on health and safety risks. It should have ensured that good risk assessment processes were operating throughout the company. An alert board would have ensured that these things had been done and done properly. It would have familiarised itself with good health and safety management systems. It would have regularly commissioned independent audit and advice. It would have held management strictly and continuously to account.

46. Mr Dow's general attitude was that things were under control, unless told otherwise. This was not in accordance with the good governance responsibilities. Coupled with the approach taken by executive managers, this attitude exposed the workers at Pike River to health and safety risks.

47. Focused on production targets, the executive management pressed ahead when health and safety systems and risk assessment processes were inadequate. Because it did not follow good management principles and industry best practice, Pike's workers were exposed to health and safety risks.

The future

48. In Chapter 28, 'Improving corporate governance', and Chapter 29, 'Improving management leadership', the commission discusses governance and executive management more generally, identifies the lessons that the Pike River tragedy holds for directors and executive managers in high-hazard industries, and makes recommendations for the future.

ENDNOTES

1 John Dow, transcript, p. 3900.
2 Ibid., pp. 3891–4156.
3 Gordon Ward, Police/DOL interview, 29 September 2011, INV.03.28891.
4 Companies Act 1993, s 128.
5 Health and Safety in Employment Act 1992, s 6.
6 Ibid., s 56.
7 David Walker, A Review of Corporate Governance in UK Banks and Other Financial Industry Entities, 26 November 2009, p. 23, http://webarchive.nationalarchives.gov.uk/+/http://www.hm-treasury.gov.uk/d/walker_consultation_261109.pdf
8 Institute of Directors in New Zealand, Principles of Best Practice for New Zealand Directors: The Four Pillars of Board Governance, 2010, https://www.iod.org.nz/Publications/TheFourPillarsofGovernanceBestPractice.aspx
9 Institute of Directors and Health and Safety Executive, Leading Health and Safety at Work: Leadership Actions for Directors and Board Members, October 2007, http://www.hse.gov.uk/pubns/indg417.pdf
10 Standards Australia and Standards New Zealand, Risk Management – Principles and Guidelines (AS/NZS ISO 31000:2009), 20 November 2009; Standards Australia and Standards New Zealand, Occupational Health and Safety Management Systems – General Guidelines on Principles, Systems and Supporting Techniques, (AS/NZS 4804:2001), 15 November 2001; Standards Australia and Standards New Zealand, Occupational Health and Safety Management Systems – Specification with Guidance for Use (AS/NZS 4801:2001), 15 November 2001.
11 Pike River Coal Ltd, Corporate Governance Manual, 1 June 2009, DAO.037.00002.
12 Ibid., DAO.037.00002/5.
13 Health and Safety Executive (UK), Leading Health and Safety at Work, October 2007, http://www.hse.gov.uk
14 Securities Commission New Zealand, Corporate Governance in New Zealand Principles and Guidelines: A Handbook for Directors, Executives, and Advisors, March 2004, p. 13, http://www.fma.govt.nz/media/178375/corporate-governance-handbook.pdf
15 Pike River Coal Ltd, Corporate Risk Management Policy, DAO.001.09450.
16 Pike River Coal Ltd, Corporate Governance Disclosure Statement, September 2010, NZX2292/6.
17 John Dow, transcript, p. 4028.
18 Ibid., p. 4000.
19 Ibid., p. 3905.
20 Ibid., p. 4031.

[21] Pike River Coal Ltd, Excerpt from PRC Board Minutes, 15 November 2010, DAO.014.00448/1.
[22] John Dow, transcript, p. 3991.
[23] Pike River Coal Ltd, Corporate Governance Manual, 1 June 2009, DAO.037.00002/30.
[24] John Dow, transcript, p. 4012.
[25] Ibid., p. 3956.
[26] Ibid., p. 3984.
[27] Ibid., p. 3993.
[28] Ibid., p. 4080.
[29] Ibid., pp. 3947, 3992.
[30] Hawcroft Consulting International, Pike River Coal Limited, Pike River Mine – Risk Survey – Underground, CPP & Surface Operations: Final Report, July 2010, DAO.003.08710.
[31] John Dow, transcript, p. 4005.
[32] Ibid., p. 3983.
[33] Ibid., p. 3989.
[34] Ibid., p. 3984.
[35] Ibid., p. 3922.
[36] David Stewart, Pike River Compliance Audit – Ventilation, 11 February 2010, STE0004.
[37] David Stewart, transcript, p. 3324; John Dow, transcript, p. 3927.
[38] David Stewart, transcript, pp. 3326–34.
[39] John Dow, transcript, p. 4007.
[40] Neville Rockhouse, transcript, p. 4251.
[41] John Dow, transcript, p. 4034.
[42] For example: Royal Commission on the Pike River Coal Mine Tragedy (Katherine Ivory), Summary of Pike River Coal Limited Deputy Statutory Reports for March and October 2010, November 2011, CAC0115/15–17; Royal Commission on the Pike River Coal Mine Tragedy (Katherine Ivory), Summary of the Reports of Certain Incidents and Accidents at the Pike River Coal Mine, November 2011, CAC0114/10–30.
[43] John Dow, transcript, pp. 4035–36.
[44] Ibid., pp. 4037–38.
[45] Ibid., pp. 4040–41.
[46] Petrus (Pieter) van Rooyen, transcript, pp. 5181–83; Petrus (Pieter) van Rooyen, witness statement, 27 January 2012, PVR001/54–55, paras 320–24.
[47] For example: Drive Mining Pty Ltd, Pike River Coal Limited – Gas Drainage Assessment, 15 May 2010, DAO.001.04811; Comlek Electrical Engineering Contracting Ltd, Report on Ventilation System – History & Current Status, 31 March 2010, DAO.003.05885.