

## **Human health and safety or cost/benefit analysis?**

In the aftermath of the Pike River Coal Mine disaster it is time to ask how the Government will continue to regulate health and safety in New Zealand. With the growth of self-governance in the occupational safety and health (OSH) arena, and a top Department of Labour official recently talking about replacing the term 'hazard' with 'risk' in legislation, we need to consider our priorities.

The regulation of safety in mining and Government resourcing in New Zealand has changed dramatically over the past few decades making it a crucial factor in the Pike River disaster. In 1992 sweeping changes were made with the introduction of the Health and Safety in Employment (HSE) Act which introduced performance regulation and the concept of 'practicable steps' and cost benefit analysis.

Never before had financial considerations been legislated into health and safety. The HSE Act replaced and repealed two more prescriptive pieces of legislation, both of which required periodic independent monitoring.

Under the Mining Act 1971 two union inspectors could be appointed to inspect a mine once every fortnight. It also required that every employee in a mine that became aware of the presence of inflammable gas "shall immediately withdraw from that place and inform his superior".

The Coal Mining Act 1979 allowed government inspectors to enter the mine at any time, day or night, and the owner was to afford all assistance. Inspectors could investigate any health and safety complaint.

The 1979 Act also prescribed other inspectors: the underviewer and the fireman deputy. These were required to "at least once in each working day, inspect every accessible cavity or 'dead end' where gas may accumulate within 90 metres of any working place [and] inspect every working place therein at intervals of not more than 5 hours."

After the 1992 HSE Act there were absolutely no mining regulations in place for seven years until the 1999 Health and Safety in Employment (Mining—Underground) Regulations. These regulations, however, are performance based and simply require employers to test for flammable gases 'as often as practicable', and they are to take 'practicable steps' in preventing ignition or combustion. All reference to independent inspectors had been removed and replaced with these vague obligations. A Code of Practice for mine safety remained in draft form until 2006.

The BP Deepwater Horizon oil disaster, where 11 workers were killed and the Gulf of Mexico catastrophically polluted, illustrates how things can go terribly wrong in a high trust, low regulation model.

The US Presidential Commission's report on the BP disaster found significant systemic failures with the non-regulatory environment. The industry's ability to serve as a reliable standard-setter was "compromised by its role as the industry's principal lobbyist and public policy advocate". The oil industry regularly resisted standards that would increase costs and its so called 'expert advice' was biased. Furthermore, decisions intended to save BP time and money created unreasonable risk, and the other companies involved had sacrificed safety to save money. The Commission warned that without significant reform in both industry practices and government policies another disaster could

occur. “Fundamental reform will be needed in both the structure of those in charge of regulatory oversight and their internal decision making processes to ensure their political autonomy”.

The terms of reference of the Royal Commission of Inquiry into the Pike River disaster set out a much narrower investigation than that into the BP incident. They mention the practices used or other steps taken at the mine for its operations and management in achieving compliance with the law or recognised practices. The employer’s ‘practicable steps’ are not prescribed in current law, which means a flexible computation will occur that looks at the owner’s financial and other resources balanced against risk.

Like the US Presidential Commission, the Pike River Inquiry should confront the systemic issues of government resourcing and authority, deregulation, so called ‘expert advice’, and performance versus prescriptive regulation. First and foremost, we should be asking whether our current ‘performance law’ is adequate. How would the previously prescribed regulations have protected mine safety? Will the Inquiry investigate whether government regulators lacked the authority, resources and expertise to prevent any safety lapse by the company? The terms of reference only apply to the resourcing of the administration and implementation of the current laws or recognised practices that apply to the mine.

In September a senior NZ Department of Labour official was reported in *Safeguard* magazine as saying he could foresee an opportunity to align ACC audits and performance in a way that could create some self-governance. He also said ‘risk’ will replace ‘hazard’ in the language we use, and could be included in New Zealand legislation.

A hazard is an identifiable danger (to people, in the OSH sense), while risk is about exposure, probability and the consequences (frequently used in a business management context). From the risk management (rather than safety management) perspective, a possible result is that an organisation could take risks that may cost a worker’s life or injury or illness, but save itself millions of dollars.

In the interests of ensuring the safety and health of New Zealand workers I would argue strongly against this policy direction. New Zealand doesn’t need to learn any more of the hard lessons associated with business priorities taking precedence over basic worker safety standards. We have to remember that our priority must be the safety of our workers.