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Submission for the State Development, Natural Resources and State Development, Natural Resources and Agricultural Industry Development Committee

I thank the committee for the opportunity to provide a submission into the — INQUIRY INTO THE MINERAL AND ENERGY RESOURCES AND OTHER LEGISLATION AMENDMENT BILL 2020. I note that my submission is limited to the scope of issues surrounding Mining Safety associated with the Bill.

Background Information

I am a safety and health professional and run a business consultancy in respect of safety and health. I have approximately 30 years of experience in both the public and private sector associated with the administration and management of work safety. I currently serve as the Consultant Editor of the Australasian Mine Safety Journal and run a social media site with more than 45,000 followers from the Australian resources sector. Those resource sector workers engage with the site approximately 300,000 times per month.

Over the last twenty-four months I have witnessed and reported on, a range of incidents in the resources sector in Queensland. I speak with families who have lost loved ones in tragic mining accidents on, at least, a weekly basis and I hear feedback from mineworkers across the State of Queensland through social media contacts on at least a daily basis.

At the outset I wish to state to the Committee that I am a supporter of industrial manslaughter legislation as a deterrent to recklessness and wilful acts that endanger the safety and health and Queensland mineworkers however, I do not support the current proposed regulations on the basis of two issues.

- Firstly, that the Bill will ***strengthen safety culture in the mining industry***;

- Secondly, that the Bill fails to provide adequate defences under law that would normally be available to those who were charged for indictable offences.

I proposed to address the first issue as I believe that the Queensland Law Society submission received by the Committee addresses most, if not all of my concerns.

Objectives of the Legislation

According to the explanatory notes the principal policy objectives of the Bill relate to a priority of the Queensland Government in respect of Safety and Health in the Resources Sector.

The Minister for Natural Resources Mines and Energy, the Honourable Dr Anthony Lynham has introduced the existing Bill to "strengthen the safety culture in the resources sector by introducing industrial manslaughter offences in the *Coal Mining Safety and Health Act 1999*, the *Mining and Quarrying Safety and Health Act 1999*, the *Explosives Act 1999* and the *Petroleum and Gas (Production and Safety) Act 2004*"

The Bill further seeks to *strengthen the safety culture* through requiring that persons appointed to critical safety statutory roles for coal mining operations must be an employee of the coal mine operator.

What is the 'safety culture' in Queensland mines?

Over the past twenty plus years a range of safety professionals and academics have conducted extensive research and, sought to quantify what are the characteristics of a good safety culture across a range of industries. Researchers have also developed a variety of methods for measuring and quantifying culture as an initial component of providing cultural 'interventions' (Hale, 2010) to enhance safety in workplaces.

In the State of Queensland, it is my understanding that there is an assortment of existing assumptions held by the Queensland Government in respect of industry culture. These assumptions have underpinned a move to implement regulatory reform yet, the assumptions appear to be untested and unsupported by statistically significant evidence.

On the surface at least, the assumptions appear to rely on anecdotal and hearsay information received by a range of influential parties that appear to be driving the industrial manslaughter agenda together with changes to the roles of statutory officials. An agenda that appears 'thinly veiled' in evidence on methodologies associated with improving safety culture and improving safety in the industry.

What is good safety culture?

In one of the prominent safety culture researchers works, Hale (2000) "*elements for a good culture for safety*" editorial titled *'Culture's confusions*' Hale (2000) offered the following list of eight "elements for a good culture for safety:"

- The importance, which is given by all employees, but particularly top managers to safety as a goal, alongside and in unavoidable conflict with other organisational goals; e.g. whether actions favouring safety are sanctioned and rewarded even if they cost time, money or other scarce resources;

- Which aspects of safety in the broadest sense of the word are included in that concept, and how the priority is given to and felt between the different aspects;

- The involvement felt by all parties in the organisation in the process of defining, prioritising and controlling risk; the sense of shared purpose in safety;

- The creative mistrust which people have in the risk control system, which means that they are always expecting new problems, or old ones in new guises and are never convinced that the safety culture or performance is ideal. If you think you have a perfect safety culture, that proves that you have not. This means that there must be an explicit provision for whistleblowers. A role for health and safety staff in very good organisations may be as a professional group constantly questioning and seeking the weak points in the prevailing culture;

- The caring trust which all parties have in each other, that each will do their own part, but that each (including yourself) needs a watchful eye and helping hand to cope with the inevitable slips and blunders which can always be made. This leads to overlapping and shared responsibility;

- The openness in communication to talk about failures as learning experiences and to imagine and share new dangers, which leads to the reflexivity about the working of the whole risk control system. If coupled with a willingness only to blame in the case of unusual thoughtlessness or recklessness, this can drive a responsible learning culture;

- The belief that causes for incidents and opportunities for safety improvements should be sought not just in individual behaviour, but in the interaction of many causal factors. Hence the belief that solutions and safety improvement can be sought in many places and be expected from many people;

- The integration of safety thinking and action into all aspects of work practice, so that it is seen as an inseparable, but explicit part of the organisation (pp. 12-13);

Hales research and others have demonstrated that there are definable factors for determining 'safety culture' and there are known strategies and 'interventions' for improving culture that exist at both a macro and micro level (albeit some have known weaknesses).

So, on the basis of these issues highlighted by Hales do we really understand what the culture of the Queensland Resources Sector actually is before the Queensland Parliament embarks on significant legislative reforms to address safety culture? Do we understand the safety culture on specific mine sites where accidents have killed mineworkers? Do we understand the macro culture of the Queensland mining industry let alone the micro cultures within industry sites?

I suspect not. It is my observation that the basis of the Bill to strengthen safety is culture is largely grounded on 'hearsay' evidence gleaned by the Queensland Government through the conduct of some of its' activities. Some reports by the Department of Natural Resources Mines and Energy's senior management have eluded to evidence gathered in safety resets, evidence provided by the Brady Report (which does not assess or contribute to the debate on safety culture) or even evidence provided through accident investigation conducted on the range of fatalities.

The author believes that the Brady Review provided some evidence of historical causal factors associated with fatal accidents in the industry, but aspects of safety culture associated with the sites where workers died was out of scope of the review and, I suspect, may have been considered in an ad-hoc approach by the Department's own investigators who, over many years, have provided a range of methodologies for investigating and reporting into deaths in the industry.

Accordingly, the lack of evidence to support wholesale changes to industry ***'safety culture'*** is not supported by the Brady Review or other significant evidence sources.

We must understand the culture in order to improve it

As a critical step towards improving safety culture in the Queensland mining industry, the Queensland Government should first quantify, among other things, the existing safety culture and safety sub-cultures that exist between companies, between sites and indeed between teams in the industry.

Professor Andrew Hopkins, one of Australia's leading thought leaders on health and safety, has been outspoken on the *"Johnny come lately"* approach to safety culture Hopkins (2015) in a book review of one of Australia's leading work safety researchers works highlighted.

> *"It is fashionable to identify a defective safety culture as the root cause of accidents. Those who use the term often assume that the way to tackle this problem is to change the way workers think about safety, by winning their hearts and minds*
>
> *But this is bound to fail, unless organisations themselves change the way they do business. There is a good reason for saying this. The culture of the workplace is largely a reflection of what leadership wants or tolerates.*
>
> *It will only give greater emphasis to the control of catastrophic risk if leaders pay systematic attention to the way such risk is managed, and if they reward relevant behaviour, for example, the reporting of near misses and warning signs.*
>
> *Culture is better seen not as an explanation but as a description. It is 'the way things are done around here', and the way things are done around here is largely determined by top leadership."*

In order to assist in understanding safety culture, there are a range of available safety culture assessment tools that are commonly used by human resources and safety professionals.

It is probable that these tools may inform us that there are variances in '***safety culture and safety climate'*** between companies, mine sites and within teams across the industry. Safety culture assessment tools, like a range of other evidentiary based information gathered by regulators, can contribute to the evidence to support a range of regulatory reform.

To embark on macro levels reforms without an effective methodology or depth of understanding of the micro issues at hand is both fraught with danger and ultimately risks failure of the reforms to improve safety in the industry.

To fail to employ a holistic, considered approach to mine safety regulatory reform that encompasses quantifiable evidence amounts to poor governance and at its worst mismanagement of governmental processes. Evidence gathered should, at the very least, quantify key drivers of safety in the mining industry and encompass issues such as:

- Safety culture and climate;
- Past incident causation (including limitations of engineering standards and existing regulatory processes);
- Impact of accidents and incidents on families and communities;
- Legal precedents and case law;
- Regulatory impact analysis;
- Engineering and technological changes impacting or likely to impact the future of the industry.

Understanding the extent of mining safety issues facing the Queensland mining industry safety is no doubt complex but without due consideration of the drivers for safe performance, the industry will be left with a fragmented, ineffective legislative instrument that will fail to achieve its' original intent.

What is the purpose of this legislation anyway?

My experience in health and safety as both a practitioner and consultant informs me that the primary purpose of health and safety legislation (irrespective of the sector) is to create safer workplaces where workers remain free of injury, disease or risks to life.

In order for safety legislation to be effective it must have outcomes that deliver tangible benefits in conditions for workers at the 'coal face' not political benefits that seek to appease families who have lost loved ones.

In recent months when I have spoken with Queensland families who have lost loved ones, they have told me of their concerns about delays in regulatory processes, the lack of transparency of investigations and of being extricated from processes. Most of all they have told me that they want to ensure that the incident that claimed the life of their loved one, can never happen again in the industry.

Those that have argued for the current changes to the MINERAL AND ENERGY RESOURCES AND OTHER LEGISLATION AMENDMENT BILL 2020 appear to want administrative conveniences – like wanting to harmonise legislation and wanting those who were responsible for incidents get "*what's coming to them"* for the death of mineworkers. While these may be warranted arguments, they are largely counterintuitive to improving safety, irrespective of the industry group.

Good safety practice involves gathering evidence (though understanding and quantifying lessons learned from incidents), applying engineering controls and

standards to prevent recurrences, providing adequate responses to families and deterring rogue operators through effective penalties and 'public shaming' for their offences.

In my view the Bill, has failed to address the tenets of good safety practice and appears largely based on a reactionary approach to a range of tragic incidents in the Queensland mining industry.

An evidence-based approach to quantifying and understanding safety culture, implementing engineering controls and ensuring that the legislation and the work of the mining safety regulator is likely to a significantly impact on mining safety is what Queensland needs and what the families of our fallen miners deserve at this time.

John Ninness

Note: Some of the information contained in this submission has been sourced from *Organisational Culture: A Search for Meaning Core Body of Knowledge for the Generalist OHS Professional*, Second Edition, 2019. Information was first published by Dr David Borys, an Independent safety educator and researcher.

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