

## **Working Paper 33**

# **Safety Regulation and the Mining Inspectorate – Lessons From Western Australia**

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## **Abstract**

This paper examines the role of mining regulation and its enforcement, principally in Western Australia. It begins by describing the activities of the Mines Inspectorate and then raising a series of concerns relating to the limitations of the regulatory status quo. In particular it examines the extent to which the Department of Industry and Resources (DoIR) inspectors rely on detailed prescriptive requirements to the detriment of performance and systems based approaches; the extent to which the DoIR audit process fails to monitor adequately the effectiveness of OHS management systems; the extent to which DoIR inspectors failed to consult adequately with worker representatives; the limitations of the inspectorate's current approach to enforcement action; and whether the inspectorate was sufficiently independent of the companies it regulated. It concludes with some broader reflections in response to the DoIR's vision of best regulatory practice, and by raising some practical issues concerning the lack of adequate regulatory resources.

## Introduction

For many years, the major mining states in Australia have maintained separate regulatory regimes to curb the incidence of work related injury and disease in that industry.<sup>1</sup> The justification for this approach has been that the hazards, culture and circumstances of the mining industry are sufficiently different from those of most other industry sectors as to merit the introduction of separate statutes and regulations.<sup>2</sup> The distinctive nature of mining regulation relates not only to the legislation itself, but also to inspection and enforcement, with some disturbing consequences which are the subject matter of this article.

The focus is on mining regulation and its enforcement in Western Australia, although there are some striking parallels with the approach to mining taken in Queensland<sup>3</sup> and, until recently, New South Wales.<sup>4</sup> The article argues that a failure to take account of developments in ‘mainstream’ OHS legislation has resulted in an approach to inspection and enforcement that falls so radically short of ‘best practice’ as to have seriously detrimental consequences for OHS. Although the implications of the British Robens Report of 1972 gradually influenced and shaped the mainstream OHS legislation of all the Australian jurisdictions and its enforcement,<sup>5</sup> it had far less impact on the mining sector.<sup>6</sup>

There could be no better or graphic illustration of the failings of mining inspection and enforcement in Western Australia than the findings of the Ministerial Inquiry on Occupational Health and Safety Systems and Practices of BHP Billiton Iron Ore (BHPBIO) and Boodarie Iron (BI) sites in Western Australia, handed down in November 2004.<sup>7</sup> Prompted by three deaths in three separate incidents in the Pilbara

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<sup>1</sup> *Occupational Health and Safety Act 2000* (NSW); *Coal Mine Health and Safety Act 2002* (NSW) and the *Mine Health and Safety Act 2004* (NSW); *Coal Mining Safety and Health Act 1999* (QLD); and *Mining and Quarrying Safety and Health Act 1999* (QLD); *Mines Safety and Inspection Act 1994* and Regulations (WA); and the *Mines Safety and Inspection Amendment Act 2004* (WA).

<sup>2</sup> See for example *Review of the Mines Safety and Inspection Act 1994, Final Report* (hereafter the Laing Report) Ch 2, Perth, January, 2003.

<sup>3</sup> Peter Shaw, *Review of Outcomes and Implementation of the Recommendations of the Report on the Inquiry into Fatalities in the Western Australian Mining Industry* (the Shaw Report), October 2000 [http://www.doir.wa.gov.au/documents/safetyhealthandenvironment/Shed\\_Safety\\_MOSHAB\\_ShawReport.pdf](http://www.doir.wa.gov.au/documents/safetyhealthandenvironment/Shed_Safety_MOSHAB_ShawReport.pdf) (accessed 17 April 2005); Neville Wran and Jan McClelland, *New South Wales Mine Safety Review* (the Wran report) [http://www.minerals.nsw.gov.au/\\_data/page/1798/Mine\\_safety\\_review\\_report.pdf](http://www.minerals.nsw.gov.au/_data/page/1798/Mine_safety_review_report.pdf)

<sup>4</sup> Mining inspectors in New South Wales, while traditionally taking a ‘softly softly’ approach, have in recent years adopted an adversarial and much more punitive approach, at least following fatalities. See in particular the prosecutions of individual mine managers following the Gretley disaster.

<sup>5</sup> See R Johnstone *Occupational Safety Law and Policy: Text and Materials* (2<sup>nd</sup> Ed), 2004, Ch 2. Thomson/Law Book, Sydney.

<sup>6</sup> Although the *Occupational Health and Safety Act 2000* (NSW) also applies to the mining industry.

<sup>7</sup> *Ministerial Inquiry: Occupational Health and Safety Systems and Practices of BHP Billiton Iron Ore and Boodarie Iron Sites in Western Australia and Other Matters*, Minister for State Development, Perth, November 2004 (hereafter “Ministerial Inquiry”) [http://www.ministers.wa.gov.au/brown/docs/features/BHP\\_Ministerial\\_Inquiry\\_Vol.pdf](http://www.ministers.wa.gov.au/brown/docs/features/BHP_Ministerial_Inquiry_Vol.pdf) (viewed 17 February 2005). It should be noted that the writer was OHS advisor to the Ministerial Inquiry and that the relevant material below is drawn primarily from Appendix 4 (the Gunningham Report). It must be

in a single month, all relating to the activities of BHP Billiton, the Inquiry provides some disturbing insights into the state of mining regulation and its enforcement in that jurisdiction. It may also provide broader lessons concerning the appropriate role of OHS inspection and regulation in other states that are currently conducting inquiries or making major changes to the role of their regulatory agencies.<sup>8</sup>

In terms of regulation and its enforcement, the focus of the report is on the performance of the Safety, Health and Environment Division (SHED) of the Department of Industry and Resources (DoIR) -also referred to as “the Mines Inspectorate” - which has the principal regulatory responsibility for OHS in the Western Australian mining industry. The agency administers the *Mines Safety and Inspection Act 1994* (WA) (hereafter MSIA) and the *Mines Safety and Inspection Regulations 1995* (WA) (MSIR).

### **The Regulatory Status Quo and Its Limitations**

While historically mine inspection has been the principal tool employed to assess the level of compliance with the MSIA, it is now considered important by the Department “to review the safety systems and procedures established by the mine managements through a more robust audit system.”<sup>9</sup> To achieve this, the Department now uses two types of audit. Management systems audits examine the way in which the safety responsibility of different parts of an organisation is handled across the management structure (horizontal audit). High Impact function audits scrutinise particular operational functions from their origins in management procedures and policies down to the point of physical application (vertical audits). How that inspection, audit and enforcement regime worked in practice, is the subject of the following sections.

#### **A focus on detailed prescriptive requirements to the detriment of performance and systems based approaches**

OHS law may incorporate four main and conceptually distinct types of standards. These are prescriptive, general duties, performance-based and systematic process-based standards. This classification is now well recognized.<sup>10</sup> A prescriptive approach tells duty holders precisely what measures to take and requires little interpretation on their part. Such a standard identifies “inputs”, that is, the specific preventive action required in a particular situation; rather than OHS outcomes. General duties (which form the basis of most OHS legislation of recent decades) set out general principles which duty holders must follow, such as ensuring health and safety as far as practicable. A performance standard specifies the outcome of the OHS improvement or the desired level of performance but leaves the concrete measures to achieve this end open for the duty holder to adapt to varying local circumstances. Systems based standards are process based (meaning they identify a particular process, or series of steps, to be followed in the pursuit of safety) and range from the requirement to

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emphasized that that in no way does this working paper draw upon any confidential information to which the author was privy.

<sup>8</sup> See the Shaw and Wran reports.

<sup>9</sup> W:WMED/inspect/Reports/Response/Gmi045In, 9.

<sup>10</sup> See E Bluff and N Gunningham, *OHS Regulation for a Changing World of Work*, Federation Press, Sydney, 2004, Ch 1.

identify hazards, and assess and control risks (found in many national standards) to the more ambitious requirement to engage in a systemic approach to OHS at organisational level.

As long ago as the British Robens Report of 1972 it has been recognised that there are substantial limitations to a prescriptive approach, not least that it tends to result in a mass of detailed law, difficult to comprehend and keep up to date, and that many problems “fall between the cracks” of the detailed regulations and are not addressed.<sup>11</sup> In contrast, general duties and performance standards have the virtues of establishing responsibilities in broad terms; of requiring duty holders to take OHS measures across the board, so far as practicable; and of encouraging them to address new hazards as they emerge. Because they are flexible, they facilitate innovation and least-cost solutions. The DoIR itself apparently accepts this view, stating in its submission to the Ministerial Inquiry that: “regulation should not be unduly prescriptive. Where possible it should be specified in terms of performance goals or outcomes”.<sup>12</sup>

But although the principal legislation - the *MSIA* - is a Robens-influenced statute, it does not unequivocally reject the previous prescriptive regime. On the contrary, an examination of the *MSIR* reveals that legislators have been reluctant to let go of the mass of highly prescriptive regulatory detail that Robens felt was so counter-productive.<sup>13</sup> The result is that the general duties in the *MSIA* have been largely superimposed onto existing prescriptive regulations, rather than replacing them.

Where does this leave the inspectorate? One might imagine that they would exercise their considerable administrative discretion, mindful of the benefits of the Robens approach, and with a focus on general duties and risk control.<sup>14</sup> However, it is clear from a perusal of the Mines Record Book entries (which incorporate inspectors’ reports) going back many years that far from adopting a broader general duty or performance based focus (or focusing to the extent practicable on risk assessment and control) the almost overwhelming concern of mines inspectors in the Pilbara is with very detailed breaches of highly specific regulations.<sup>15</sup> It is almost as though the inspectorate operates in a time warp in which the Robens Report and the legislation that has implemented that approach over the last thirty years had never existed. As a consequence of this approach it is impossible from reading the inspectors’ reports to have any sense of whether particular duty holders were complying with their broader duties to ensure health and safety (as distinct from breaching particular guarding or housekeeping requirements from time to time), or how effectively they approached the important task of risk control. More broadly, it is unclear how effective or

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<sup>11</sup> R Baldwin, C Scott and C Hood *A Reader on Regulation*, Oxford University Press, Oxford, 1998, 15.

<sup>12</sup> DoIR, *Submission to Ministerial Inquiry*, 18.

<sup>13</sup> This is acknowledged by the Laing Report op cit at para 367, where he states: “it is doubtful whether the Western Australian occupational health and safety system fully embraced the Robens view of regulations.”

<sup>14</sup> It should be noted that although the *MSIA* refers to risk control, it does not explicitly incorporate a risk control hierarchy. Arguably, it should do so.

<sup>15</sup> See Ministerial Inquiry, Appendix 4, sections 2.2.3; 3.2.3; 4.2.2; and 5.2.2.

otherwise their safety management systems might be, particularly in terms of implementation.

A response to these criticisms might be that the inspectorate does take account of the need for a broader systems base approach, through its program of OHS audits. But testing by results the practical application of the audit program left much to be desired. For example, one would imagine that the Booderie Iron facility (BI) would have been a high priority, given that it is a major hazard facility (albeit not formally classified as such) with a history of safety problems. Yet to date, only two HIF audits and a single management systems audit seem to have been conducted with regard to BI. The audits that have been conducted at BI are now rather dated and shed little light on contemporary safety systems and conditions. Nor is it clear whether BI modified its behaviour as a result of the audit or whether there was any follow up by the Department to verify whether improvements had been made. Moreover, the contents of a number of the audit reports also raise questions about their overall quality and appropriateness as a tool to improve OHS performance, with the commentary section of HIF audits (though not managements systems audits) frequently similar in attitude to the current prescriptive approach to inspections with all the limitations that implies.<sup>16</sup>

A further problem with the present prescriptive approach is that it does not distinguish between different sorts of organisations, but rather involves a largely mechanistic approach under which, seemingly, ‘one size fits all’. This is surprising given that documents supplied by the Department suggest a much more nuanced approach, using a five fold classification of enterprises, which implies a different inspection strategy depending upon how each individual organisation rates in terms of the leader-laggard continuum.<sup>17</sup>

Whether the limitations identified above are largely a consequence of the level of training, qualifications and expertise of the current inspectorate is not clear. On the one hand, DoIR claims that the greatest strength of the Mineral and Petroleum Services Group lies in the technical excellence and competence of its staff.<sup>18</sup> On the other hand, in its submission to the Laing Report, it acknowledged that “the increasing focus on performance-based safety systems requires greater emphasis on auditing safety and health management systems. As well as technical skills, therefore, the Mines Inspectorate now needs skills in risk management systems, safe systems of work, safety promotion, behavioural safety, and effective communication. This implies a broader mix of professional backgrounds than has traditionally been the case in mining.”<sup>19</sup> Certainly a report prepared by the Mines Occupational Safety and Health Advisory Board (MOSHAB) at the end of 1998 stated that that the inspectorate’s current skills base falls far short of what is required and that there is a

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<sup>16</sup> This consists of a set of numbered standards or ‘points’ to which a yes or no response is required.

<sup>17</sup> The five categories are: vulnerable; rule followers; robust; enlightened; and resilient.

<sup>18</sup> DoIR, *Submission to Ministerial Inquiry*, 55.

<sup>19</sup> Laing Report, op cit, para 720.

‘manifest failure’ to carry out essential regulatory functions “*at all levels to the level of competency required.*”<sup>20</sup>

The DoIR might benefit considerably from examining the Victorian experience, where the then Central Investigation Unit’s “attempt to develop uniformly high quality investigations was initially hampered by antagonism from inspectors schooled in the traditional approach to investigation and enforcement ...[a] difficulty overcome from 1998, when specialist investigators were brought together in the Investigations Unit and were responsible for all investigations.”<sup>21</sup> It should also be noted that a variety of other measures, including re-training and the use of a manual explaining how to approach the general duties and establishing procedures to demonstrate practicability under those duties, were implemented to achieve change. It may be however, that unless the fundamental issue of resources and pay scales is addressed, that such measures would only have limited success. The issue of resources is revisited in the final section.

### **A failure to consult with workers representatives on a regular basis**

It is widely recognised that competent, well trained and well-motivated safety and health representatives, will add value to the minerals industry by assisting in the industry’s approach to reducing accident and injury rates and eliminating fatalities. However, they can only play this role if they are empowered to do so, and part of such empowerment comes (or should come) from their interactions with Departmental inspectors.

Yet in the Western Australian mining industry, there is reason to believe that safety representatives have not to date made as valuable a contribution as they might potentially have done. For example, the MOSHAB Safety Behaviour Study Survey of 2002 identified a need to develop a strategy to promote the role of Safety and Health Representatives (SHR) across the industry, and programs for the implementation by the industry to improve the effectiveness of SHR in mines.<sup>22</sup> A number of recommendations of the Laing Report also relate to SHR, including expanding the role of representatives to enable them to issue provisional improvement notices.<sup>23</sup> Yet despite recognition of the value of SHR and of their importance in empowering workers and improving safety, the past record of the inspectorate in this regard is a generally poor one. A perusal of past inspection reports suggests that it has been common for inspections to take place without consultation with any relevant safety representatives, that only in a minority of cases are safety representatives explicitly informed of an inspection, and only in an even smaller minority of cases do they actually take part in such an inspection. Certainly there is a trend towards greater consultation – more recent reports are much more likely to refer to consultation with a SHR than older ones, or to representatives being asked to assist in responding to a

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<sup>20</sup>J Torlach, “Mines Fatalities Inquiry – Western Australia – Opportunities and Initiatives <http://www.grc.org.au/files/docs/speeches/torlach.html> 6, summarising the MOSHAB Report.

<sup>21</sup> R Johnstone *Occupational Health and Safety, Courts and Crime*, Federation Press, 2004, p82.

<sup>22</sup> MOSHAB subsequently endorsed the formation of a working group to consider and report on strategies and means to enhance the role of, and participation, by, safety and health representatives in the WA minerals industry.

<sup>23</sup> Laing Report, *op cit*, 153, 154.

questionnaire in systems based audits – but even today such consultation is hardly routine.

However, it should be acknowledged (i) that there may be practical difficulties in meeting with representatives at fly-in/fly-out and shift work operations and (ii) that the Department is aware of the issue and has made a commitment to “improve communications between the inspectorate and the industry, particularly the direct statutory representatives of the workforce on safety and health matters so that adequate consultation between the parties is ensured.”<sup>24</sup> Nevertheless, it is questionable whether it is satisfactory to assert that: “it is not possible to be definitive [about whether inspectors consult with safety representatives] as this may well vary from inspector to inspector, from mine to mine and from SHR to SHR.”<sup>25</sup> On the contrary, it might be argued that rather than merely encouraging inspectors to meet with SHRs whenever practicable, they should be directed to do so, a practice that is well accepted in many other jurisdictions.<sup>26</sup> Formal provision might also be made to ensure that a SHR has an opportunity to raise safety concerns privately with an inspector, and for ensuring that the complaints register, which appears to be in some disarray, is kept up to date and in a form where it can provide an effective tool for alerting the inspectorate not only to particular safety concerns but also to patterns of safety problems.

#### **A failure to take appropriate enforcement action**

Experience of OHS regulation internationally suggests that the most effective enforcement approach is for regulators to steer a course between the extremes of tough sanctions (which in any event require the inspectorate to have more resources than are available to Australian inspectorates) and over-reliance on advice and persuasion. The challenge is to develop enforcement strategies that punish the worst offenders, while at the same time encouraging and helping employers to comply voluntarily. Ayres and Braithwaite, for example, argue for an enforcement pyramid which employs advisory and persuasive measures at the bottom, mild administrative sanctions in the middle, and punitive sanctions at the top. Regulators should start at the bottom of the pyramid assuming virtue – that business is willing to comply voluntarily. However, where this assumption is shown to be ill-founded regulators should escalate up the enforcement pyramid to increasingly deterrence-orientated strategies.<sup>27</sup>

In Western Australia, it would appear that prosecution is regarded as a tactic of last resort, generally to be reserved for occasions giving rise to death or serious injury, and that the Department operates almost exclusively in the lower reaches of the enforcement pyramid outlined above. That this is the case is not apparent from the Department’s Enforcement and Prosecution Policy, which states that: “Enforcement is an essential element in controlling or regulating activities and gaining compliance

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<sup>24</sup> Mines Safety Branch, Business Plan 2004/05 15.

<sup>25</sup> DoIR, *Submission to Ministerial Inquiry* 8.

<sup>26</sup> See R Johnstone op cit, 510-511.

<sup>27</sup> See Ayres & Braithwaite *Responsive Regulation*, OUP, UK, 1992, Ch 2, Gunningham & Johnstone, *Regulating Workplace Safety*, 1999, OUP, UK. Chs 4, 6 and 7).

with statutory requirements. This is done by detecting breaches, bringing them to the attention of the alleged offender, requiring corrective or preventative action, applying penalties (directly or through the courts) and providing deterrence.”<sup>28</sup>

One key question that the Policy addresses is when the Department should decide it is appropriate to prosecute. The Department will exercise its considerable discretion consistent with the Enforcement and Prosecution Policy, which states that the need for any further enforcement action after an offence has apparently occurred will be determined using the following criteria (and applying stated principles<sup>29</sup>): seriousness of breach, failure to comply with either a legal direction or notice, culpability, level of broad public concern, due diligence procedures in place, voluntary action taken to mitigate any harm, cooperation and willingness to take remedial action, need for both specific and general deterrence, precedent that may be set by failure to take enforcement action, enforcement measures necessary to ensure compliance and failure to notify.<sup>30</sup> The statement lists a number of circumstances in which, if there is sufficient evidence, DoIR will prosecute.

Little objection can be taken to the principles stated above. Nevertheless, it must be noted that in practice, the level of prosecutions would appear (on the basis of the very limited information provided by DoIR) to be very low. Notwithstanding very frequent identification of breaches by the inspectorate, there is very little evidence of any formal action being taken, beyond the giving of directions on some occasions.<sup>31</sup>

This concern about inadequate levels of enforcement by DoIR is not new. The Laing Report pointed to “the apparent downward trend in enforcement activity”<sup>32</sup> while noting that “a review of other material, including the level of compliance reflected in audits, suggests significant compliance failures continue and it may be surmised that the Department is not maintaining its previous level of enforcement activity.”<sup>33</sup> If, as it would appear, this remains the case today then it is a matter of considerable concern, in terms of achieving best safety outcomes. For as Laing also pointed out: “what is fundamental of course, is that those who are unwilling to comply with their safety and health obligations understand that prosecutions will be taken if there is a failure to comply with the Act”.<sup>34</sup> Such an approach at the tip of an enforcement pyramid is essential for reasons of both specific and general deterrence, and is

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<http://www.doir.wa.gov.au/safetyhealthandenvironment/726632F71F06404593BFE3760495DEB0.asp>  
accessed 3 Feb 2005.

<sup>29</sup> In summary these are: objective, proportionality and responsiveness, transparency, consistency, targeting, due process and natural justice, cost-effectiveness and policy compatibility.

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<http://www.doir.wa.gov.au/safetyhealthandenvironment/726632F71F06404593BFE3760495DEB0.asp>  
accessed 3 Feb 2005.

<sup>31</sup> Note that the power to issue directives under section 22 of MSIA to mine management to take certain corrective actions or to stop unsafe activity/equipment and withdraw persons from potentially hazardous areas directives are recorded in Mine Record Books and in the Mine Record Book database.

<sup>32</sup> Laing Report op cit para 764.

<sup>33</sup> Ibid.

<sup>34</sup> Laing Report op cit para 771.

demonstrably “an effective means of securing compliance”.<sup>35</sup> The penalties contemplated under the 2004 Mines Safety and Inspection Amendment Act, *coupled with significantly greater enforcement* could be anticipated to have a positive effect on safety outcomes in the mining industry.

One significant obstacle to effective enforcement may well be the reluctance of the inspectors themselves to bring prosecutions, given their lack of experience and relative training in this regard. Again, the need to train inspectors in prosecution requirements and processes was noted by the Laing Report,<sup>36</sup> but it is not apparent from the documentation available that the Department has done so.

Finally, the importance of taking some form of enforcement action short of prosecution in appropriate circumstances must also be emphasised. There is convincing international evidence demonstrating that significant reductions in individual site level injury rates follow inspections which are *coupled with some form of penalty* (administrative notice etc).<sup>37</sup> However, routine inspections without any form of enforcement have no injury reducing effects.<sup>38</sup> The researchers’ conclusion is that the imposition of formal action focuses managerial attention on risks that would otherwise have been overlooked. Many of the most obvious such penalties have not been available to the inspectorate (on-the-spot fines, improvement and prohibition notices) and the principle tool currently available – giving directions – has apparently been used less than in the past.<sup>39</sup>

However, it should be noted that the *Mines Safety and Inspection Amendment Act 2004* introduces new provisions relating not just to improvement and prohibition notices but also to enforceable undertakings, community service orders, publicity orders and restoration or remedial orders. However, even with such new powers, their impact will depend crucially on the willingness of the inspectorate to invoke them.

### **The risk of regulatory capture**

A number of aspects of the DoIR’s behaviour – its approach to inspections, its approach to enforcement, its failure to consult with safety representatives on a regular basis, and the perception (disputed by DoIR<sup>40</sup>) that it informs employers in advance of

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<sup>35</sup> Wright M et al 2004, *Building an Evidence Based for the Health and Safety Commission Strategy to 2010*, Health and Safety Executive Research Report, 196, HSE Books.

<sup>36</sup> Laing Report op cit para 774.

<sup>37</sup> W Gray and J Scholz “Does Regulatory Enforcement Work?” *Law and Society Review*, 27:1: 177-215, 1993 192 and A Hopkins *Making Safety Work*, Allen and Unwin, 1995, 90, cited in N. Gunningham and R. Johnstone, *Regulating Workplace Safety*, 1999, OUP, UK.

<sup>38</sup> S. Shapiro and R. Rabinozitz 1997, “Punishment versus Cooperation in Regulatory Enforcement: A Case Study of OSHA” *Administrative Law Review*, 713. Baggs, Silverstein and Foley 2003 “Workplace Health and Safety Regulations: Impact of Enforcement and Consultation” *American Journal of Industrial Medicine*, 43, 483.

<sup>39</sup> Laing Report op cit, para 469.

<sup>40</sup> In its response to questions from Mr Ritter the Department has stated that its “policy on prior notice of inspection visits, both generally and in the Pilbara is what it has always been. It is not the policy generally for inspections to be notified in advance. The Department is aware of the perception that inspections are always notified in advance by the inspector. However, as Laing quite correctly identifies...there are other reasons why advance notice of the intention to visit may well be given”.

its intention to inspect their premises – all raise the possibility that it has become too close to the industry it is responsible for regulating.<sup>41</sup> The implication is that DoIR has been ‘captured’ by the regulated industry and functions in a manner which is unduly sympathetic to their interests.

There is insufficient evidence available in the documented materials to reach a considered view on this question of regulatory capture. What can be noted is that (i) there is a perception of capture on the part of some Trade Unions and employees; and (ii) the position of the inspectorate within a Department of Industry and Resources which has principal responsibility for ensuring the productivity and economic success of the regulated industry provides fertile ground for industry capture. As regards (ii), such a conflict of interest was the very reason that in the United Kingdom responsibility for the regulation of North Sea Oil was removed from the Department of Energy to the Health and Safety Executive, following the Piper Alpha disaster in which 167 people lost their lives.<sup>42</sup> In a similar vein, the UK mines inspectorate also became part of the Health and Safety Executive following the enactment of the Health and Safety at Work Act.<sup>43</sup>

Whether the mines inspectorate should be similarly distanced from DoIR, in which it is currently located, and placed with WorkSafe WA is an open question. This is certainly not the first time that separation has been considered. For example, in recommending the amalgamation of the former Department of Minerals and Energy with the Department of Resource Development, the Reviewers noted “there is a need to separate clearly the regulatory/administrative resources function of the Department of Mineral and Petroleum Resources from the promotional/facilitation functions.”<sup>44</sup> The DoIR position is that there is a separation of the regulation and facilitation functions into the Mineral and Petroleum Services (MPS) and Investment Services groups respectively, and that this allows for explicit avoidance of potential conflict between regulation and facilitation. It also notes that “the most recent reports and reviews of the Government sector have further reinforced the merits of retaining all resource related roles in one agency.”<sup>45</sup>

On the other hand, one submission pointed out that the corporate structure of the Department states: “As the lead economic development agency, the Department of Industry and Resources is focused on developing the State’s industry and resources. This focus, together with the objective of achieving sustainable prosperity for Western Australia and its business partners, is driven by the Department’s business and strategic planning groups.”<sup>46</sup> This might well give the impression that OHS comes a poor second to promoting the state’s resource industry.

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<sup>41</sup> For example, see Laing Report op cit, 75.

<sup>42</sup> Cullen, Lord (Chairman), *Piper Alpha Inquiry* (HMSO, London, 1990).

<sup>43</sup> See [www.hse.gov.uk/mining/legislat.htm](http://www.hse.gov.uk/mining/legislat.htm) accessed 7 Feb 2005.

<sup>44</sup> DOIR response to Ritter Inquiry 17.

<sup>45</sup> DoIR, *Submission to Ministerial Inquiry*, 7-8.

<sup>46</sup> <http://www.doir.wa.gov.au/aboutus/D51363F2CA014057994CB134C8BF1C9D.asp> accessed 7 Feb 2005.

## Where Next: the DoIR and Best Regulatory Practice

The DoIR submission to the Inquiry acknowledges that “As industry and community expectations change over time, the development of regulatory systems requires a process of ongoing improvement to ensure that regulation is efficient, effective, and maintains community confidence.”<sup>47</sup>

In its submission, DoIR envisages best practice safety to be:

not in enacting more prescriptive legislative regimes but through legislation that introduces new concepts in approach to safety and health within the mining industry. These concepts include:

- Duty of care obligations that span from Directors’ boardroom to individual workers;
- The use of risk management systems to control the inherent hazards and possible consequences of mining activities;
- A statutory requirement for each operation to have a formal Safety Management System in place; and
- Involvement in safety management processes by employees, employers and regulators.<sup>48</sup>

The present writer would not disagree with the broad thrust of this approach. Rather, what is striking is the gap between the present practices of the inspectorate ‘on the ground’ and the DoIR vision. As indicated in the previous section there are a number of ways in which this gap might be narrowed. But three broader points must be made.

First, as DoIR recognises, the journey from prescriptive standards to best practice regulation, does not end with the Robens-based general duties, but continues through to the development of a systems based approach to regulation (and in some circumstances to the introduction of a Safety Case regime). The argument that is now widely made by regulatory theorists and policy analysts is that most accidents are not simply due to the failure of technical measures, but usually involve an organisational or management failure, and that the best way of addressing such failure is a *procedure* oriented approach rather than a prescriptive one, which seeks to encourage companies not only to design their own self-regulatory processes but also “to engage in self-evaluation of those processes as an integral part of their broader regulatory requirements”.<sup>49</sup> This is consistent with the thrust of the Laing Report, which refers to the need for “more explicit statements of risk management obligations under the Act and with reference to safety management systems”.<sup>50</sup>

Second, such a systems based approach will only be effective if those systems are effectively implemented, for otherwise there is a severe risk of ‘paper systems’ and a tokenistic approach to the regulatory requirements. That is, it is only if the self-regulation and risk-management of the industry is closely scrutinised by government

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<sup>47</sup> DoIR, *Submission to Ministerial Inquiry*, 7-8.

<sup>48</sup> Ibid.

<sup>49</sup> Ibid.

<sup>50</sup> Laing Report op cit para 432.

with the threat of more direct intervention if it fails, that it an enterprise is likely to take effective action.<sup>51</sup> On this model, what is needed is a form of “meta risk management” or “meta-regulation” whereby government rather than regulating directly, risk-manages the risk management of individual enterprises; or, put differently, engages in independent risk assessment on basis of information supplied by the companies. As Christine Parker argues, the role of legal and regulatory strategies under this approach is to add the ‘triple loop’ that “forces companies to evaluate and report on their own self-regulation strategies so that regulatory agencies can determine the ultimate objectives of regulation are being met”.<sup>52</sup>

But this leads to the third issue. Under a meta-regulatory approach (and under what, in Safety Case terminology is often referred to as a “goal setting” regime) the regulator’s role is not to specify the individual action but to oversee the development of the process safety program. The problem is that enforcement is likely to be much more difficult in a goal-setting regime than under a prescriptive one with considerable judgment and skills required on the part of the inspector. Not only does the role of the inspectorate shift in emphasis from that of conventional inspection of the premises and plant to that of audit of the management system (a shift already under way within the inspectorate but with substantial limitations in its present form), but the inspectorate has now not only to rely on its judgment of the management system but must validate that judgment by detailed examination of its implementation in specific contexts.<sup>53</sup>

To return to an earlier point, inspectors trained to operate under a prescriptive approach are ill-suited to adapt to a meta-regulation/systems based approach. Experience with the Safety Case regime as it has applied to Australian off-shore oil confirms the need for highly skilled inspectors with risk analysis skills and a capacity to scrutinise the detailed requirements and operation of Safety Management Systems. As one highly experienced former Safety Case regulator points out: “Safety Case is produced in the knowledge that it will be scrutinised by a competent and independent regulator ... the operator will carry out the process of preparing the Safety Case in a rigorous manner, in the knowledge that if it is not done properly it will be challenged by the regulator. This competence is also essential if the installation operator and ... those who may be affected by the installation are to have confidence in the judgements made by the regulator”.<sup>54</sup>

Again the Victorian experience is illuminating. In 1998, recognising that it had serious problems the Victorian WorkCover authority “undertook a major upgrade of its field staff to optimise their role as agents of change in Victoria’s workplaces.”<sup>55</sup> It

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<sup>51</sup> This is consistent with Laing Report op cit para 432.

<sup>52</sup> See generally, C Parker, *The Open Corporation*, Cambridge UK, 2003.

<sup>53</sup> Torlach “The mining inspectorate, through is evaluation of project management plans, and the ongoing program of systematic auditing of mining operations, has the capacity to maintain pressure on each enterprise to develop and maintain these fundamental processes [of risk management] at the required levels” [above](#) n xxii, 7.

<sup>54</sup> P Wilkinson, “Safety Cases: Success or Failure?” NRCOHSR Seminar Paper 3 [http://www.ohs.anu.edu.au/publications/pdf/seminar\\_paper\\_2.pdf](http://www.ohs.anu.edu.au/publications/pdf/seminar_paper_2.pdf) (viewed 17 February 2005).

<sup>55</sup> Victorian WorkCover Authority, *Annual Report*, 1998-99, 19.

upgraded the qualifications and salaries of field staff, declared all field staff positions vacant and sought to recruit “multi-skilled adaptable, health and safety professionals who can help workplaces create the solutions that will produce sustainable change”.<sup>56</sup>

All this comes back ultimately to the issue of resources. The DoIR is not alone in referring to serious resource constraints.<sup>57</sup> This is a familiar theme not only in Western Australia but also elsewhere.

## **Conclusion**

A review of the materials submitted by DoIR, and of their inspection and audit reports and other material made available, suggests that the major problem lies not in the DoIR’s view of best practice regulation or how to achieve it, but in the very large gap between what DoIR aspires to do, and what its inspectors do ‘on the ground’.

From the numerous and serious limitations of current inspectoral practices it is reasonable to conclude that a major part of the problem is a substantial mis-match between the skills and culture of the current inspectorate, and the skills and culture that are needed to achieve the Department’s aspirations and which are necessary to achieve any significant improvement in OHS performance and injury outcomes in the mining sector. It is readily apparent that the current salary scales, and level of staffing are inadequate to attract the sorts of inspectors that would be necessary to undertake systems based or ‘meta-regulation’. Without a substantial injection of additional funding, the extent of change within Departmental practices is unlikely to be sufficient for it to play its necessary and important role in reducing work related injury and disease.

Mining regulation in all the major mining States has fallen very substantially behind best practice (although the legislation itself is now catching up). The DoIR might well benefit from identifying better ways to set priorities, from invoking a much broader range of compliance tools, and from improving the effectiveness of different enforcement and voluntary compliance strategies.

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<sup>56</sup> Ibid.

<sup>57</sup> It should be noted that the Laing Report found that there are “around 75 staff of the Department engaged in safety and health related activities, with at least 32 being mining inspectors. In comparison there are around 50 active WorkSafe inspectors to service the remaining 96-97% of workplaces.” op cit para 54.