

Disaster at Pike River – TEACHING NOTE

Synopsis of case

On 19 November 2010, an explosion at New Zealand's newest coal mine caused the death of 29 men and sent shock waves around the country. The Pike River mine had been promoted as a best practice in everything from leading edge mining technology to environmental responsibility. In reality, as emerged in evidence at the 2012 Royal Commission of Inquiry into the Pike River Mine Tragedy, difficulties in construction had led to delays which put pressure on the company to prioritise getting into production at the expense of safety in a high risk industry.

How this case might be used

Pike River was an enormous event, both in impact and complexity. This case aims for breadth rather than depth across a range of issues. Connections can be drawn between them.

Teachers should probably check with a class whether students have any personal exposure to the case. Some will introduce new "facts" into the class that will need managing. Some students may be vulnerable to discussing the case.

The case can be taught from four perspectives, two of which this teaching note expands on:

Human resource management – how would you describe the HRM practices at the time of the disaster? As an alternative history, what could have been done before the accident that might have stopped the accident happening? How likely is this alternative history to have taken place?

Health and safety – what was the health and safety climate in the organisation? What lead to it, and what could have been done to have a better health and safety culture?

Governance – to what extent did the Board exert adequate governance over Pike River? Could it have been done better without stepping into managing the business?

Regulation – at the time of Pike River health and safety had a light handed regulatory regime, with the onus placed on individual companies to manage their own safety.

This teaching note was written by Dr Geoff Plimmer, Victoria University of Wellington. It has been prepared to accompany the case study *Disaster at Pike River* (2014-158.1 and 158.2). The use of teaching notes is restricted to authorised persons.

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How would, and how well, would an intelligent regulation system have worked for an organisation like Pike River?

Target audience

Senior public sector managers; post-experience and postgraduate students.
Possibly advanced undergraduates.

Suggested teaching plan:

Preparatory note: Decide whether this case will be taught as a one-off, or part of a course; in which case, where the case would be placed, what would precede and what would follow.

Teaching from a Human Resource Management (HRM) perspective

The *objectives* here are to:

- Analyse and evaluate HRM processes by describing the HRM practices at the time of the disaster
- Describe aspects of the HRM culture and status of HRM in an organisation
- Advise on HRM practices. As an alternative history, what could have been done before the accident that might have stopped the accident happening? How likely is this alternative history to have taken place?

This case could start by discussing some of the individual components of HR practices, like remuneration, training, induction.

A possible *opening question* would be to ask for a show of hands,

Who has ever worked at a place within very poor HR / unsafe practices?

Or

Who has started a new job, or taken up a new position in the past five years? Keep your hand up if you were given a good induction to the role. Keep your hand up if you got the training you needed. Who found really good, (and who found really bad) HR systems generally?

What would you have wanted to know and why? (Could take answers and sort them on the board so that they show things about management, training, reporting lines etc – in other words things you want to bring out in the following discussion).

Then a *transitioning question*

- How would you describe Pike River's HR at the time of the accident?
- HR practices – covering recruitment and selection, performance management, pay, training
- The HR culture and context – the underlying ethos and the drivers

These could also be charted on a white board, with a column for recruitment, selection, training and development, performance management and pay.

This discussion might bring out things like the possibility of Pike River being an employer of last resort (at least for some managers), perverse performance pay incentives, and weak training with poor “transfer” to the work environment.

A **clarifying question** could concern the culture and consequences before the explosion, where people discuss and describe Pike River culture and how it came to be?

A new whiteboard with headings of “consequences” and “culture”, where people could try to map the dynamics or inter-relationships between HR and culture might help. For instance, if people suggested chaotic and authoritarian, connections could be drawn between poor performance management of the CEO and unsafe practices, or poor training possibly leading to difficult recruitment. The high turnover of managers in its early days could be discussed in terms of its meaning and the signals it sends.

The culture and context could be discussed in terms of both bullying and a chaotic laissez faire management in a downward cycle. A useful discussion could take place about checks and balances to ensure safety and productivity, and the benefits of unions or other external feedback and accountability checks.

The **major question** concerns the redesign of HR, what would have been done in an ideal world, and what opportunities and barriers such a change faced.

HRM design choices can be discussed – the alternative history. The discussion could then centre on the type of barriers to achieving that change. Finally, the discussion might lead to the realisation that not all problems can be solved. It could include a discussion about what obligations HR practitioners have, including not be “boiled frogs” – slowly socialised or coerced into accepting unethical practices. A comparison of HR as a “profession” compared to accountancy or law could take place.

A **final question** could concern HR systems and implications for other workplaces.

The role of unions could also be discussed. In what situations could unions be pro - or anti - productivity? How important is it generally to check and balance management behaviour, particularly when governance and regulations are weak?

The discussion could extend to the **health and safety climate**, and the role of HR in it.

Objectives are to:

Understand the idea of safety climate and its relationship to other aspects of organisational life, such as productivity and HRM.

A useful opening quote on safety climate is by Zohar (2010):

“Safety climate perceptions should ... focus on the nature of relationships between safety policies, procedures, and practices, taking into account that often times rules and procedures associated with safety compete with those associated with other domains (e.g. safety vs. productivity or efficiency). From an employee standpoint, it is the overall pattern and signals sent by this complex web of rules and policies across competing domains that ultimately must be sorted out in order to discern what role behavior is expected, rewarded and supported. This argument suggests that safety climate perceptions should move beyond a focus on safety in isolation toward a more

comprehensive evaluation that captures at least some of these competing domains (p.1518).

A fruitful **opening question** could be: *How did the behaviours of staff at Pike River shortly after the explosion paint a picture of their performance and attitude towards critical event management? (This should provide a number of leads that could be put on the board for following discussion).*

A **transition question** could centre on:

What were the attitudes to safety at organisation, management and individual levels?
What did they share and how did they differ? What was distinctive to the mining culture?

A **clarifying question** could centre on “How did they relate to other aspects of the organisation, such as productivity and efficiency?” Classes might discuss the internal consistency and coherence of safety messages and behaviours, across the organisation.

- Health and safety is often described as being good for productivity. What are the ways they could conflict and what are the ways they could complement each other?

A **major question** could concern “How did health and safety relate to HR practices and other features of the organisation”? Classes may discuss the contracted workforce and perverse pay incentives. Classes might also discuss why workers did not speak up, and there was so little resistance to bad safety practice in the organisation, and how such low standards became normalised. A discussion could ensue about how to manage the tensions between health and safety, with productivity; or turn them from a conflict into a synergy.

In high risk environments, it is seen as a core competency to be able to follow a clear plan and react calmly and quickly in a crisis. What role can a) recruitment and b) training play in developing this competency?

Mine safety experts often talk of a “triangle of safety” in which ownership of and responsibility for health and safety is taken by the Government, by employers and by workers. What did this look like at Pike River?

In the Hansard report of the 12 November 2013 parliamentary debate on the Health and Safety (Pike River Implementation) Bill, Kevin Hague (Green, West Coast) refers to Dave Feickert a mine safety expert who talks about “... the fact that successful mining industries – those that are safe – have this thing called the triangle of safety, where there is responsibility taken for health and safety in the mine by the Government, by employers and by workers.”

Possible student assignment:

1. In a discussion about her book on the Tragedy at Pike River, Rebecca Macfie talks about how the workers were all aware that it was dangerous to go down the mine, but their focus was more on the new machinery which was unreliable. “They thought there would be an accident, someone might even be killed, but they did not think there would be an explosion.” Why do you think workers had these beliefs? Design an HR system for a new underground coal mine on the west coast.

From Hansard, 12 November 2013, Damien O'Connor, Labour – West Coast Tasman: “I speak from some experience having been a shift delegate at a mine in Western Australia. I was responsible for shutting down the mine when it was too unsafe. When dust got to a point when we could not operate safely, then I had to stop operations. It is not an easy job for any individual to stop operations – to intervene and say; “This is unsafe, we should stop work.” There is huge pressure not just from the employer, the foreman, or the leading hand, but also from fellow workers who, particularly are on a bonus system, say, “Oh, come on, let’s get on with it. Look, it’s OK – it’s not that unsafe.” The pressure comes from everywhere on the individual, the site representative, who is going to make a judgment on health and safety issues.”

References and recommended reading

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New Zealand Parliament, Hansard, 12 November 2013, http://www.parliament.nz/en-nz/pb/debates/debates/50HansD_

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<http://pikeriver.royalcommission.govt.nz/Volume-One---Proposals-for-reform> accessed 24-0302014 and <http://pikeriver.royalcommission.govt.nz/Volume-One---Recommendations>

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