

# **PUBLIC SUBMISSION COVER SHEET**

**Please note that this submission will be repeated as a part of the broader CFMEU Submission**

## **NATIONAL REVIEW INTO MODEL OCCUPATIONAL HEALTH AND SAFETY LAWS**

**Submission by the Construction Forestry Mining and Energy Union -  
Mining and Energy Division**

### **INTRODUCTION**

1. The Mining and Energy Division of the Construction Forestry Mining and Energy Union (CFMEU), represents workers in the coal and metaliferous mining industries, as well as workers in coal ports, and power and oil and gas industries.
2. It is the intention of this submission that it be read in conjunction with the broader Construction Forestry Mining and Energy Union (CFMEU) submission, but for this submission to deal specifically with those elements of the Review that go to Questions 7, 8 and 9 respectively contained within the Review Panel's "Issues Paper" issued May 2008.
3. It is concerning that within the Issues Paper, while noting that mining specific legislation exists in the jurisdictions of Queensland, New South Wales and Western Australia, and notes that work is being undertaken to achieve consistency in mining OHS legislation across all jurisdictions through the National Mine Safety Framework process, the Panel raises the concern that while the NMSF may achieve consistency within the mining industry, there remains the possibility of inconsistency between mining and other

industries and that " *This would be an issue for businesses operating in both sectors.*"

4. This submission reminds the Panel of its own words contained in the introduction section of the "Issues Paper" - "...*the paramount reason for OHS legislation is to protect the health and safety of persons undertaking or affected by work...*". These are indeed both noble and entirely accurate words. It is not the purpose of OHS legislation to do anything other than to protect workers. It is not intended to make business more or less cost effective, more or less productive, nor more or less internationally competitive, but these may well be outcomes of the development and implementation of the best OHS legislation that has as its reason for being, the provision of that protection.
5. This submission will call for a continuation and where appropriate, extension, of Industry specific OHS legislation, but will particularly concentrate on such a continuation or extension of Mining specific legislation.

## **HISTORY OF MINING SPECIFIC LEGISLATION**

### **Queensland**

6. In Queensland, the first Mining Act was promulgated in 1898. This Act, which was made specifically exempt from the operation of general work place health and safety legislation, applied to both Coal and Metaliferous mines and was followed by the Mines Regulation Act in 1910.
7. A separate Coal Mining Act was introduced in 1925 and this followed on from the Royal Commission into the Mt Mulligan disaster, which occurred 19th September 1921 in which seventy-five (75) men and boys were killed in an explosion.
8. In the 1925 Act, and as a direct consequence of the Mt Mulligan explosion and Royal Commission, provision was made for:-
  - the appointment of Mines Inspectors who must have practical mining experience,
  - the recording of mine deputy safety inspections in individual reports,
  - specifically designed and "permitted" explosives and rules for their use in coal mines,
  - the use of safety lamps or electric camp lamps for lighting for individual miners and the banning of naked lights,
  - rules for the application of stone dust,
  - the establishment of Mines Rescue Stations in all mining districts, and
  - rules for air flow and the use of ventilation fans.
9. Following the Royal Commission into the 13th October 1954 disaster at Collinsville, in which seven (7) miners were killed in a Carbon Dioxide outburst, the 1925 Act was further amended to require Mine Deputies to undertake statutory examinations for qualification and before appointment and for Deputies to carry flame safety lamps and gas detectors during inspections.
10. On 31st July 1972, an explosion occurred at the Box Flat colliery at Ipswich. Seventeen (17) miners died in the explosion and an eighteenth (18th) died some two (2) years later as a direct consequence of injuries received. Legislative change to the 1925 Act and/or Regulations as a consequence of this disaster, and the Mining Warden's Inquiry which followed it, included:-
  - the introduction of personal filter self rescuers (emergency breathing devices) for all underground miners,
  - the introduction of Gas Chromatographs on the surface of all underground mines for the analysis of mine gas samples,

- modern fire fighting equipment, including foam generators to be available underground, the upgrading of Mine Managers' qualifications and responsibilities, and
  - improved stone dust legislative requirements.
11. Following the Kianga Disaster on 20th September 1975, in which thirteen (13) mineworkers were killed, further legislative changes were made to the coal mining Acts in both Queensland and New South Wales that saw:-
- the introduction of explosion-proof barriers,
  - a requirement for a barometer (to measure changes in barometric pressure affecting ventilation underground) to be available on the surface of each underground mine,
  - a requirement for the provision of continuous carbon monoxide (CO) monitoring and recording of gas ratios and trends, and
  - the requirement for the construction of preparatory seals, to enable rapid sealing of underground sections in the event of a heating or a fire.
12. The Moura No 4 disaster, which was an underground explosion on 16th July 1986 and which resulted in the deaths of 12 mineworkers, and the subsequent Mining Warden's Inquiry, ultimately resulted in the Act and/or regulations being further amended to provide for:-
- the banning of flame safety lamps from underground mines,
  - the banning of aluminium alloys from use underground,
  - continuous gas monitoring from all sections of the mine with readings for same to be available on the surface of the mine,
  - safety induction training to be compulsory for all mineworkers, and
  - secondary extraction plans to be developed and approved by the Mines Inspectorate.
16. Finally, the 7th August 1994 disaster at Moura No 2 underground, in which eleven (11) mineworkers were killed, led to further dramatic amendments to the Queensland Coal Mining Act. Indeed, a review of the 1925 Act, with its numerous amendments as already pointed out above, was underway at the time that the disaster occurred and the then Minister for Mines and energy in Queensland, Mr Tony McGrady, directed a cessation of that review, whilst the investigation and subsequent Mining Warden's Inquiry into this disaster was carried out. Following the completion of both, the review was recommenced with a commitment from the Queensland Government that all of the recommendations and suggestions emanating from the Inquiry would be addressed and implemented, where necessary, as part of the recommenced Act review. The Act review process ultimately saw a legislative requirement for:-
- risk based Safety and Health Management Systems including specific identified Principal Hazard Management Systems to be developed at each mine in consultation with mineworkers,
  - Spontaneous combustion and gas management training for all underground mineworkers,
  - simulated emergency exercises to be conducted annually at each mine, and at State level at a selected mine,
  - a Ventilation Officer to be appointed at each underground mine and for such a person to be in full charge of all aspects of ventilation at the mine,
  - oxygen self rescuers to be supplied for each mineworker, inertisation equipment to be purchased and maintained by the Rescue Service, and support systems, including rapid sealing and re-entry provisions on the surface, to be available at each mine for use from a safe location,

- statutory officials certificates/qualifications no longer available for life, but valid for a maximum period of five (5) years,
- sealing plans to be developed and persons to be withdrawn from the mine after sealing while the atmosphere behind the seals spans through the explosive range,
- supervisors to be trained and be competent in communication, risk management and such other competencies as determined by the Advisory council.

## **New South Wales**

17. Perhaps not surprisingly, as the other major coal mining State in Australia, New South Wales (NSW) has seen separate industry specific legislation develop over a lengthy period of time, and in most cases as a consequence of a litany of deaths and serious injury from industry specific hazards and as a consequence of Inquiries an/or royal Commissions into same.
18. The Coal mines Regulation Act 1912, was followed by the Coal Mining Act 1973, followed by Coal Mining Regulation Act 1982 and finally the Coal Mine Health and Safety Act 2002 (CMH&SA2002), supported eventually, by the Coal Mining Health and Safety Regulation 2006 (CMH&SR2006). The Act and Regulations combine the requirement to develop health and safety management systems and major hazard management plans through a process of consultation with mineworkers. Hazards associated with the carrying out of various activities are required to be subjected to formal risk assessments and a broad outline of what is required to be addressed in each plan is contained in the Act and Regulations. The employer must provide proof that the consultation has in fact been carried out.
19. The major hazards identified in the legislation in NSW, and arising as a direct consequence of fatalities and consequent inquiries are:-
  - Strata failure, which has been the identified cause of two hundred and seventy (270) fatalities in both NSW and Queensland, has resulted in recommendations that strata failure must be identified as a major hazard and controlled (Clause 32 CMH&SR2006).
  - Inrush of water into underground workings, the cause of four (4) fatalities at Gretley Colliery and one (1) at Tahmoor Colliery, led to recommendations that mines must identify all sources of potential inrush. The CMH&SR2006 provides at cl33 for all mines to have an inrush management plan.
  - Gas outbursts have been the cause of twelve (12) fatalities in the Southern District Coalfields and led in 1994 to the Chief inspector of Coal Mines, pursuant to powers under section 63 of the then Act, to issue a notice requiring all mines to have an Outburst Management Plan in place. The CMH&SR 2006 at cl 29(b)(vi) lists outbursts as a major hazard, which must be subject to a Major Hazard Management Plan.
  - Fires and explosions have been identified as the cause of well in excess of 350 deaths in mines in both Queensland and NSW. Again recommendations have resulted in requirements for mines to identify all potential sources of fire and explosion, dust explosion and spontaneous combustion, and as a consequence clauses 35, 36 and 28(b)(vii) of the CMH&SR 2006, list fire and explosion, dust explosion and spontaneous combustion, respectively, as major hazards and requires them to be the subject of a Major Hazard Management Plan.
  - Incidents involving surface and underground transport have been the cause of nearly one hundred (100) fatalities in the NSW and Queensland underground and open cut sectors, with fifty nine (59) of these occurring in NSW underground mines alone. This has led to a requirement, pursuant to clauses 30 and 31

respectively on the CMH&SR 2006, for surface and underground transport to be the subject of Major Hazard Management Plans.

- The improper use of explosives has been the cause of eleven (11) fatalities in the industry in both States and has resulted in requirement in cl 37 of the CMH&SR 2006 for the use of explosives to be dealt with by a Major Hazard Management Plan.
  - Finally, airborne dust has long been recognized as a danger to particularly underground mineworkers, both as an inhaled contaminant giving rise to appalling diseases such as pneumoconiosis and silicosis, and as a potential source of explosive fuel, and has resulted in cl 38 of the CMH&SR 2006 listing airborne dust as a major hazard and requiring it to be subject of a Major Hazard management Plan.
20. Additionally, a number of matters, the cause of death and serious injury and the subject of various inquiries, are now required to be addressed as part of the mine's requisite Health and Safety Management System.
21. Arising from six fatalities attributed to asphyxiation in NSW mines, recommendations were made that mines must design and control ventilation in an underground coal mine to control gas management, spontaneous combustion, airborne contaminants and render harmless any inflammable gases. Clause 21 of the CMH&SR 2006 requires a Ventilation Management Plan as part of the mines Health and Safety Management System.
22. Arising from nineteen (19) fatalities in NSW from electrocution, Cl 19 of the CMH&SR 2006 provides for mines to incorporate an Electrical Engineering Management Plan as part of the mine's Health and Safety Management System.
23. And arising from a total of one hundred and twenty six (126) fatalities in both underground and open cut mines in both States attributed to the operation of mechanical equipment, pursuant to Cl 20 of the CMH&SR 2006, each mine's Health and Safety Management System must contain a Mechanical Engineering Management Plan and must make provision for the acquisition, inspection and testing, maintenance and repair, competence of persons dealing with such equipment and safe work procedures.

## **RATIONALE FOR MINING SPECIFIC LEGISLATION**

24. While it is perhaps trite to state that Mining is an inherently hazardous industry, it is worth pointing out, for the purpose of reminding people who have perhaps not ventured on to an open cut mine site, or been underground, the circumstances of working in such a place that make the work environment both inherently hazardous and unique. Following is a short summary of some of the more significant unique hazards.
25. At **open cut mines** heavy mobile mining equipment, like rear dump trucks with a carrying capacity of up to four hundred (400) tonnes (vehicles the size of a three storey building), operate in and around and interact with light vehicles (cars and four wheel drives) and operate in close proximity with near vertical drops and on steep slopes.
26. Given the rates of extraction at modern open cut mines, geological conditions change quickly and this, combined with pits of up to seventy five (75) metres depth, with

spoil piled to similar heights, geological instability can be and is encountered near working areas both at day and night. It is of course typical for mines to operate around the clock and it is not possible to give daylight-like illumination to all working areas given the size of the mines. The larger mines stretch for up to eighty (80) kilometres in strike length.

27. Another unique feature of the open cut sector is the massive amounts of explosives used in each "shot". Because of the size and depth of the mines, it is not unusual for up to three hundred (300) tones of explosives to be used in a single "shot" and for large mines to fire such shots up to three (3) times a week.
28. In **underground mines** the issues and hazards are more starkly unique than those associated with working conditions encountered in any other workplace.
29. The perhaps obvious issues of ensuring an adequate supply of fresh air to mineworkers engaged underground, as well as using proper ventilation systems across significant distances of underground roadways to ensure dust and gas control, as well as balancing air pressures around previously worked and now sealed areas, means ventilation systems are inherently unique to underground coal mines and to a lesser extent in underground metal mines. (Metal mines would not normally be exposed to explosive gas and dust.)
30. Spontaneous combustion (self heating) of coal in mined out areas is a phenomenon almost exclusively encountered in coal mines, and while it can be an issue in open cut mines, the hazards of spontaneous combustion in an open air environment are perhaps obviously far less significant than those if it occurs underground where there is a real possibility of explosive mixtures of methane gas being present.
31. Gas outbursts from pressure of gases (methane or carbon dioxide predominantly) built up either from depth of mining or geological structures that occur within the coal seams.
32. Strata control issues arising from mining and natural pressures occurring at depth.
33. Emergency response (ambulance, etc) to areas where normal equipment cannot be used.
34. Issues with the atmosphere in which mineworkers are required to work, travel or may be required to initiate self-escape and the use of explosives and electrical equipment in such potentially contaminated (by gas and coal dust) atmospheres.
35. And finally the operation of large and powerful heavy equipment in confined spaces, with often limited visibility, and with limited access for technologically advanced devices, which might otherwise be utilised in a less hazardous environment.

### **Nature and Form of Current Mining Specific Legislation**

36. Both the Queensland and NSW coal legislation are a mixture of prescriptive requirements and enabling provisions.
37. Prescriptive requirements are those that relate primarily to technical requirements such as permissible gas levels and the reporting of certain high potential incidents to the Inspectorate, many of which have been incorporated in the legislation as a result of recommendations arising from fatalities and resultant investigations thereof. Many

of these have been highlighted earlier in this submission and are not unnecessarily repeated here.

38. The enabling provisions cover a range of matters such as the conduct of inspections; the development of Safety and health management Systems at the mine through the use of consultation and formal risk management processes; the development of standard operating procedures for defined hazards and hazardous tasks; and by allowing mines to follow "recognized standards" or by controlling such hazards in a way which achieves a similar level of risk.
39. The Act and the Regulations in both jurisdictions were developed utilizing risk management ideals and principles, and in Queensland the legislation adopts the concept of the achievement of an "acceptable level of risk". In NSW the legislation is subordinate to the Occupational Health and Safety Act, an Act that purports to place an "absolute" duty on the employer to provide a safe place of work. There remains much controversy over the veracity of this "absolute" duty, given that the "reasonable excuse" defence is permitted. However it is the view of the CFMEU that either the Queensland provisions or the NSW provisions are reasonable and either would be acceptable as a model for this aspect of the law.
40. In both jurisdictions (and particularly in the case of NSW where the broad duty applies as discussed briefly above), the coal legislation requires the development and recording of management structures and, while defining and/or specifying some specific positions, imposes roles, responsibilities and obligations on key management positions within those structures. Additionally, both pieces of legislation empower either the Coal Mining Safety and Health Advisory Council (Qld) or the Coal Competency Board (NSW), to recognize and/or determine and/or publish, the required competencies required to be held by persons holding positions called up or nominated in the legislation.
41. As mentioned previously, a feature of both jurisdiction's legislation is that Operator's are required to ensure that Safety and Health Management Systems are developed through consultative processes at each mine and both Acts have a feature of specifying Principal Hazard Management Plans or Major Hazard Management Plans to be developed to address the risks associated with specific hazards that are recognized as existing at mines. Again, the detail has been dealt with previously in this submission and is not repeated here.
42. An additional common feature of both jurisdictions' legislation is the establishment of formal tripartite consultation provisions. In Queensland, the Act specifies the establishment of the Coal Mining Safety and Health Advisory Council and specifies the Council's role and obligations. In NSW both a Mine Safety Advisory Council and a more specific Coal Safety Advisory Council are established.
43. In both cases the bodies are representative of people who work in the Industry and who have experience in Health and Safety matters as they affect mineworkers. In both cases the bodies are required by the legislation, to give advice the respective relevant Ministers o the effectiveness of the Acts, to review the Acts and regulations and to assist and give advice on the development of strategies and standards for improving health and safety outcomes in the Industry.
44. The legislation prescribes certain information and data must be collected and provided to the Inspectorate for the development of an Industry specific database to assist in following trends in incidents and to allow for the making and distribution, by the Inspectorate of safety alerts based on industry information provided. The latter are

seen to be vitally important in quickly bringing potentially hazardous matters to the attention of the broader industry to assist in ensuring that controls are put in place to prevent a re-occurrence. A recent review of the Industry's health and safety statistics in the Queensland jurisdiction, found that it is one of the few industries that collects such information and that the level of collection is one of the highest in Australia. This data also shows that the Queensland industry, records amongst the lowest LTIFR and Fatality rate in the world amongst mining countries. For example the *Queensland Mines and Quarries Safety Performance and Health Report 2005-2006*, confirm the following statistical results for the total mining industry:-

Event	01/02	05/06
Lost time Injuries	403	308
Days lost	5701	6352
Hours Worked (millions)	48.4	73.5
Employees	18957	33132
Disabling Injuries	620	515
Permanent Incapacity	7	4
Fatalities	2	2
LTIFR	8.3	4.2
Severity Rate	118	86

Similar consistent improvements in key indicators are confirmed by referencing, for example, Coal Services Pty Limited *Lost Time Injuries and Fatalities NSW Coal Mines*, available via Coal Services web site.

All of this statistical information supports the argument that Industry specific legislation, based on obligations and risk assessment tools and strategies, coupled with prescriptive legislation for known and principal hazards, is having a positive effect on OHS outcomes.

45. Specific legislative requirements also exist for the compulsory investigation and reporting of injuries and incidents. The Queensland Act for example requires that medical treatment injuries, high potential incidents and fatalities be the subject of reporting and investigation by the mine and by the Inspectorate. The legislation gives powers to various persons to become involved in those investigations and requires that such persons hold specific accident investigation and causal analysis competencies. The legislation also requires that mineworkers be advised of these incidents and workers representatives have powers to investigate such incidents as well as having the power to stop operations if they hold a reasonable belief that a continuation of the operation would lead to an unacceptable level of risk.

#### **Industry Check Inspectors/ Industry Safety and Health Representatives**

46. To the CFMEU a crucial feature of the coal mining specific legislation in place in Queensland and New South Wales, is the provision of union nominated and funded safety representatives. In Queensland they are titled as Industry Safety and Health Representatives and in NSW Industry Check Inspectors, but the common colloquial term is "Checkie" and that term will be used in the balance of this submission.
47. Under both pieces of State legislation, "Checkies" have the power have the authority to enter any coal mine for the purpose of conducting a safety inspection to assess the level of risk to the safety and health of mine workers.
48. "Checkies" have the power to review documents and to review the safety management system in place at a mine and to report on its effectiveness.

49. They have the power to direct that operations cease if they are of the view that a continuation of the operation may place mine workers in danger.
50. In the case of both Site and Industry Safety and Health Representatives under the Queensland legislation, it is available to the Minister to remove a representative from office if the Minister considers the representative is not performing the representative's functions properly. A similar provision arises under the New South Wales legislation in respect of Site Check Inspectors and it is considered that the Minister could exercise similar power in respect of a person appointed an Industry Check Inspector.
51. Site Safety representatives have been recognised by the Queensland legislation since the early 1900's and Industry Representatives, appointed by the Union since 1938. The positions have been available under New South Wales' legislation for similar timeframes. Despite this history, and despite the criticisms of and opposition to Union appointed safety representatives alive and well in the employer community, no person appointed as such a representative by the union has ever been removed or suspended from office, by a Minister. This confirms, in the Union's view, that union appointed safety representatives are more than capable of properly performing their roles, without, as some employers promulgate, being used by unions as industrial and/or political stalking horses.

#### **External/Independent Commentary**

52. The Union of course could be, although it would be inappropriate to so do, accused of bias and seeking to further or protect its own interests in seeking a continuation of Industry specific OHS legislation to apply to mining generally, but to coal mining in particular. The union however appears to be well supported in this position from a number of external and clearly independent authorities.
53. No less an agency than the International Labour Organisation, an agency of the United Nations, recognizes that the unique OHS issues associated with mining warrant a specific and separate Convention dealing with safety and health in mines.
54. Convention C176, Safety and Health in Mines Convention, 1995, deals specifically and solely with OHS measures to be adopted by signatory Countries, and in the preamble, does so notwithstanding and recognizing the existence of other ILO conventions dealing with OHS matters, in particular we point out ILO C155, Occupational Safety and Health Convention, 1981.
55. In the Report by Coroner D J Jones in the matter of Inquests into the deaths of three miners at Renison Bell Tin Mine in Tasmania, handed down Wednesday 21st May 2008, a series of comments, highly critical of the attempt to provide appropriate OHS laws to cover the mining industry are made. The paragraphs hereunder are the same paragraphs as appear in the formal report:

362. At all relevant times the applicable legislation relating to occupation health and safety at mines in Tasmania was the Workplace Health and Safety Act 1995 and Workplace Health and Safety Regulations 1996 (hereinafter referred to as "the Act"). The Tasmanian legislation, unlike mainland states, does not have "mines specific" OH&S legislation. This means that the same standards apply to all workplaces, regardless of the danger or complexities of the tasks carried out. This would be an acceptable legislative infrastructure, provided the legislation could be drafted to be applicable to all industries, but mining, in my view, is not an industry which readily falls under a general umbrella of workplace health and safety. (Emphasis added)

363. Section 9 of the Act establishes general duties of care for employers to ensure (so far as is reasonably practicable) that employees are kept safe from injury and risks to health. The duty is more specifically particularised, but not to a prescriptive level. There is also a general duty on employers who are in a position of management or control over a workplace to ensure that the workplace is safe from injury and risks to health. The duty of the employer is also extended to contractors and their employees to ensure that they do not carry on work in a manner that the employer reasonably believes would place the health or safety of any person at risk.<sup>147</sup>

364. Under s10 employers are to appoint a responsible officer, who must, under s11, perform the duties of the employer at the workplace.

365. This scheme represents a departure from the pre 1995 position, in which OH&S legislation detailed prescriptive or specification standards, supplemented by further detailed technical specification standards in regulations, as was the case in respect of the previous Mines Inspection Act 1968 and regulations.

366. I infer that the prescriptive approach was considered to have short comings, so the more general approach was adopted. I acknowledge that the general duty approach should not be denigrated; it is appropriate that employers are required to be subject to general duties of care. The issue is whether the mining industry in Tasmania is sufficiently regulated.

367. It is important to understand that regulatory action is not confined to a choice between generality and prescription. There are four broad ways in which the industry may be regulated, viz,

- a. Prescription;
- b. General duties;
- c. Performance standards;
- d. Systematic process standards.

These need to be considered as tools for achieving a suitable regulatory mix for the purpose of encouraging compliance with and, when necessary, enforcing the law.

368. The Tasmanian legislation relies solely on general duties. In my view, and it is highlighted by the death I am investigating, this is an undesirable state of affairs.

(Emphasis added) The existing Tasmanian legislation clearly fails to meet the situations so tragically illustrated in these inquests. The shortcomings of the Tasmanian system have been recognised by others.

369. In his book, *Mine Safety, Law Regulation Policy*, Neil Gunningham summarised the Tasmanian position succinctly when he said at page 10:

*“Tasmania, through the Workplace Health and Safety Act 1995 (Tas), addresses general duty requirements but lacks adequate provision for OHS management systems, provisions specifying key positions within the mine management and supervision structure, provisions specifying safety and health policy for a mine, and a variety of other mine-specific requirements. Tasmania also lacks mine-specific regulations. The final report of a review of Tasmanian OHS legislation was published in early 2007. This too provides an opportunity for substantial legislative change.”*

56. As the Tasmanian Coroner saw fit to make a specific reference to the comments of Professor Neil Gunningham, Director of National Research centre for OHS Regulation at ANU, it is not considered necessary to further embellish this

submission with commentary attributable to him. Suffice to say, that Professor Gunningham is an internationally recognized expert in the field and his comments concerning the capacity for mine specific legislation containing mine specific management and supervisory structures, OHS management systems etc should not be ignored.

## **Conclusion**

57. The National Mine Safety Framework (NMSF) process is continuing and the Ministerial Council on Mineral and Petroleum Resources (MCMPR) has adopted three (3) of the seven (7) identified strategies in principle. It is arguably unfortunate that a tripartite steering group established in 2006, which has been responsible for the significant body of work completed to date, was not put in place as the vehicle for the Framework development in the first instance. However it is submitted that this process, which has employer, employee and all Government support, should be permitted to finalise its work - it has a tentative end date of October of this year - and then its success or otherwise, both in improving OHS in mining and making life easier for business can be evaluated. It is inappropriate to simply suggest that the NMSF will not deliver satisfactory outcomes for all concerned with the mining industry before it has been completed and implemented.
58. While there is a doubt as to the veracity of statistics collected, at least in the Queensland mining jurisdiction, arising from a recently conducted audit, nonetheless the published figures, which are extensive by any industry standard, and are available via the Department of Mines and Energy web site, do show a continuing decline in injury statistics since the introduction of the new Queensland legislation in 2001. Those statistics are an indication at least, that the legislation in its revised form, is working to create improved OHS outcomes for workers in the mining industry. That in itself is a cogent and powerful argument to support no fundamental alteration to the nature and specificity of mining legislation.
59. The foregoing largely establishes the basis for the union's specific responses to the questions 7, 8 and 9 contained in the Panel's Issues paper. But to summarise and condense and succinctly provide a response to each we submit as follows:

*Q7. Should the model OHS Act maintain the status quo in each jurisdiction regarding industry specific safety legislation? If so, what provisions should be made for establishing the relationship between the model OHS Act and industry specific legislation?*

At worst, the model OHS Act should maintain the status quo in respect of industry specific legislation in NSW, Queensland and Western Australian. However, and particularly based on the report by the Tasmanian Coroner, either the Tasmanian Act and therefore the Model Act would need to contain specific and detailed mining specific provisions, or, provision should be made in the Tasmanian Act and therefore the Model Act, for jurisdictions to be able to exempt mining from the general OHS Act and provide for mining specific legislation, developed within the parameters being developed through the auspices of the NMSF.

*Q8. Alternatively, should a model OHS Act incorporate all industry specific safety legislation? If so, how and to what extent (e.g., could industry specific issues be dealt with in regulations, codes of practice or guidance material under the model OHS Act)?*

No. Experience, and in particular that highlighted by the Tasmanian Coroner,

supported by experts such as Professor Gunningham, and recognized by the ILO, strongly supports the development and implementation of mining specific OHS legislation, developed with input from people with specific and detailed experience in the field.

*Q9. Should the model OHS Act contain provisions for improving coordination between safety regulators within jurisdictions? If so, what should be provided?*

The union would submit that this is a machinery/administrative matter that does not need to be dealt with by legislation. It ought to be obvious and simply a good management process to improve co-ordination between regulators with different skills, experience and industries to administer, but who hold a similar broad responsibility to oversee, regulate and improve OHS performance.

60. While outside of the specific confines of questions 7, 8 and 9 of the Panel's issues paper, the CFMEU respectfully suggests that as opposed to considering whether or not the mining industry specific legislation should be retained and as a consequence of the review, there is a valid argument, given the statistically confirmed improvements in OHS performance in particular in NSW and Queensland, for the review to consider extending some of the more obvious differences between mining legislation and general OHS legislation. To this end, we would urge the panel to seriously consider proposing that the new model law incorporate the concepts of Industry Safety and Health Representatives (Qld) and Industry Check Inspectors (NSW) dealt with in paragraphs 46 to 51 inclusive in this submission, and the data recording and collection requirements of the legislation, dealt with in paragraph 44.