Preventing dust diseases: strengthening the protections for workers

Submission by the Australian Council of Trade Unions to the National Dust Diseases Taskforce Consultation Paper

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Introduction

Since 1927, the ACTU has been the only national confederation representing Australian unions. We have played a leading role in advocating for improved wages and conditions for Australian workers and have participated in the development of almost every regulatory measure concerning worker and trade union rights during that time. The ACTU consists of 43 affiliated unions and trades and labour councils from across the country, representing approximately 2 million workers from all major industries, occupations and sectors.

The protection and enhancement of every worker's fundamental right to a safe and healthy working life has always been, and remains, a core goal of the ACTU and its affiliates. The ACTU welcomes the opportunity to make this submission to the National Dust Diseases Taskforce.

The re-emergence of diseases such as silicosis and coal worker's pneumoconiosis are symbolic of the systemic failure of our regulatory system to prevent, identify, control and manage occupational diseases, and especially dust diseases, in Australia. It is estimated that over 5,000 Australians will die each year from diseases caused by their work.[1] Whilst many of these deaths are directly related to the failure to eliminate and control the use of asbestos, an increasing number of workers are dying due to diseases such as silicosis and other occupational diseases. It is a national disgrace that in a country as rich as Australia that in the last few years we have seen more than 250 workers diagnosed with silicosis and a further 111 diagnosed with dust diseases in the Queensland coal industry.[2]

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[1] Australian Bureau of Statistics, Cat. 6324.0 - Work-Related Injuries, Australia, Jul 2013 - Jun 2014 (Latest Issue) at least 531,800 Australians experienced a work-related injury or illness

GBD, Institute for Health Metrics and Evaluation, University of Washington. Tim Driscoll, ASEA Conference 2017estimates 4,000 deaths annually from asbestos related diseases

Tukala J, presentation *Cancer at work Work-related Cancer in EU*, ETUI Forum Brussels 16 December 2016

[2] 39 CWP, 39 other pneumoconiosis, 42 non-pneumoconiosis

It is also symptomatic of a failure of governments, both state and federal, to implement the recommendations of countless inquiries over the course of the last 20 years, and whilst we welcome the renewed attention that this subject is receiving with the establishment of the Taskforce, we caution against 're-inventing the wheel' when it comes to solutions. Many of the recommendations called for in this submission are not new, they have been recommended by multiple inquires and supported by numerous experts in both work health and safety and the medical profession.

The solutions to ***prevention and identification*** lie within the system of laws and regulations governing *work health and safety* and the role that workers, unions and regulators play in enforcing them. Whether it be bans on dry cutting, reductions to workplace exposure standards (**WES**) or improved awareness campaigns that highlight the dangers of exposure to dust, it is direct engagement and intervention in workplaces that our attention should be focussed on.

Whilst solutions aimed at the ***control and management*** of dust diseases also intersect with our work health and safety system, including our workers' compensation systems, it also extends to the broader heath system and its capacity to diagnose and track the outbreak of occupational disease. This includes the need for a government managed register of disease to ensure we are able to identify these outbreaks earlier and direct both preventative and control measures more quickly, through to the process that sufferers of disease are expected to go through in terms of seeking support and compensation.

This submission will focus heavily on the ***prevention and identification*** measures that governments can take to stem, and eventually eliminate, the growth and prevalence of silicosis and other dust diseases. It will highlight the importance of our work health and safety system to each of these elements. It will draw on a range of sources, with particular attention to those from Queensland, given the advanced state of the disease and research from that state with now in excess of 1,000 stone masons screened.

In preparing this submission, the ACTU has carefully considered the Discussion Paper and consulted with our affiliated unions. In light of the scope of the review, there may be a need for further information in relation to some of the recommendations made. We would be happy to provide further information on request, and we look forward to an ongoing constructive engagement with this important review process.

The ACTU supports the submissions made by individual unions and Trades and Labour Councils.

List of Recommendations

"Every bureaucratic obstacle will sadly result in more lives ruined and lost by a disease that should never be occurring."

The Lancet March 2019[3]

Given the urgency of current circumstances the ACTU calls for a suite of national actions to be implemented without delay. Some actions may take until the end of 2020 but should not be delayed by the tabling of the full report from the Taskforce.

National Prevention

Recommendation 1

Reduction of the Workplace Exposure Standard for respirable crystalline silica to 0.05 mgm/m3 by January 2020. The ACTU notes the general agreement to adopt health-based standards. The current impediment to a reduction to 0.02 mgm/m3 [the health-based standard] relates to some expressed uncertainty about quality of measurement. This issue can be resolved over the next 12 months which would enable a lowering to 0.02 mgm/m3.

Recommendation 2

The reduction of the Workplace Exposure Standard for Respirable Coal Dust to 1.5 mgm/m3 by January 2020.

[3] Kirby, T, Australia reports on audit of silicosis for stonecutters, www.thelancet.com Vol 393 March 2, 2019, quote attributed to Dr Edwards

Recommendation 3

All jurisdictions adopt a Regulation based on the Victorian Occupational Health and Safety Amendment (Crystalline Silica) Regulations 2019. These regulations formalise the current administrative directives in some jurisdictions which are aimed at controlling “dry cutting of engineered stone products”. The Victorian Regulations require:

an(?) employer or self-employed person must ensure that a power tool is not used for cutting, grinding or abrasive polishing of engineered stone at a workplace unless the use is controlled.

Note: Engineered stone is defined as *a manufactured composite stone material that contains resins and has a crystalline silica content of 80 percent or greater.*

Recommendation 4

By the end of 2020 a Regulation **be adopted** that requires the application of the hierarchy of control for silica and other inorganic dusts. This is to apply where elimination of the work is not feasible, e.g. tunnelling, demolition work. Many industrial activities produce high levels of respirable crystalline silica.

Recommendation 5a

A ban be implemented on the importation, manufacture and use of engineered stone with over 80 percent crystalline silica content i.e. using the definition from Occupational Health and Safety Amendment (Crystalline Silica) Regulations 2019:

Engineered stone means a manufactured composite stone material that contains resins and has a crystalline silica content of 80 per cent or greater.

Recommendation 5b

During 2020, whilst the preparatory work for a ban is being conducted, regulators and industry must develop a strategy to encourage the use of non-crystalline silica products as replacements

for engineered stone of greater than 80% crystalline silica. Our current health and safety laws provide the framework for such an approach.

Recommendation 6

Improved awareness campaigns – Investment in a broad-based community campaign around the dangers of silica coupled with specific targeted campaigns for employers and workers in higher silica industries.

Early Identification

Recommendation 7

Requirement for comprehensive health screening programs that extend to workers post exposure and retired workers. There will be a requirement to update the Silica Health Monitoring Guidelines currently issued by SafeWork Australia.

Recommendation 8

A review be conducted of the capacity of health professionals to conduct and interpret occupational lung health screening.

Recommendation 9

The adoption and implementation of a National Notifiable Disease System, based on the *Queensland Health Notifiable Dust Lung Disease Register*, for all dust related diseases. Such a scheme to be operational by the end of 2020. Further work should be conducted for a future expansion of the scheme to all work-related lung conditions. [4]

Management and Control of Disease

Recommendation 10

By the end of 2020, every workers compensation jurisdiction should adopt the 2015 Safe Work Australia Deemed Diseases list with amendment to cover all silica related diseases.

Recommendation 11

The establishment of compensation funds to support those suffering from dust diseases such as silicosis and coal workers pneumoconiosis, and their families. These funds should be funded by particular industries, on the basis that 'you pay for the harm you cause'.

Recommendation 12

Improved workers compensation processes for sufferers of occupational lung diseases. This submission does not detail all the limitations in the current systems. Plaintiff law firms representing sufferers are best placed to outline the limitations of the system and recommendations for reform.

Background

The re-emergence of dust diseases such as silicosis and pneumoconiosis is a national disgrace. For a country such as Australia, which has the unenviable title as 'one of largest per capita burden of asbestos related disease' to now be facing the consequences of a failure to manage exposure to equally insidious substances such as respirable crystalline silica (RCS) and coal dust is as tragic as it is embarrassing.

This tragedy is further compounded when we consider the countless inquires and reports that have made the same repeated recommendations for reform, which governments, both state and federal have failed to implement.

A Failure to Act

In 2006 the Senate Inquiry *Workplace Exposure to Toxic Dust*[5] recommended improved data collection, consideration of mechanisms to improve health surveillance of employees, particularly those exposed to toxic dust, the expansion of the Surveillance of Australian Work Based Respiratory Events (SABRE) program to become Australia wide, the examination of the need for improvements in testing regimes for lung disease associated with exposure to toxic dust including the training of those conducting tests and equipment requirements and a national campaign to raise awareness of the hazards associated with toxic dust. The inquiry identified problems with the timeliness of changes to the regulatory regime, enforcement of the regulations and a lack of awareness by workers of the dangers of exposure to toxic dust. [6]

A 2010 report into road tunnelling and related operations by the Queensland Department of Justice and Attorney General noted the persistent lack of perception about the inhalational hazards which arise from dusts and the lack of a health and safety regulation dealing with

[5] Community Affairs References Committee, Workplace exposure to toxic dust, Senate, May 2006
[6] Ibid page xi

respirable crystalline silica [RCS].[7] The report noted that many workers were itinerant and moving from one tunnelling job to another, including across state boundaries[8].

A Queensland audit of a broad spectrum of construction and construction related industries in 2013 further identified workers being exposed to significant crystalline silica and in some instances "excessive exposure conditions". The report noted that the exposures standard for RCS was only one fourth as stringent as the recommendation from the American Conference of Governmental Industrial Hygienists.[9]

However, these insights and recommendations were not limited to RCS, but also in relation to other hazardous dust exposures such as coal. In 2016, following the re-emergence of coal workers pneumoconiosis (CWP), the Queensland Department of Natural Resources and Mines conducted a review of health screening of the Coal Mine Workers' Health Scheme. The review identified significant failings resulting in under diagnosis and under reporting of dust related diseases.[10]Further commentary on the re-emergence of CWP from Australian respiratory experts lamented the lack of a mandatory reporting system for occupational dusts diseases, the lack of national data on the prevalence of CWP and the failure for Australian coal dust exposure standards to reflect the international understanding of the levels of coal dust that cause disease.[11]

The 2017 Queensland parliamentary Inquiry into the *Re-identification of Coal Workers' Pneumoconiosis in Queensland* recommended an immediate reduction in the exposure

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[7] Workplace Health and Safety Queensland**,** Department of Justice and Attorney-General Report – *Tunnelling road header and related operations: dust conditions and their control,* July 2010.
[8] ibid Page 5
[9] Workplace Health and Safety Queensland, *Occupational dust and silica conditions in some Queensland construction and related industries*. Department of Justice and Attorney General, August 2013 page 3
[10] Review of Respiratory Component of the Coal Mine Workers' Health Scheme for the Queensland Department of Natural Resources and Mines, Final Report, Monash University in collaboration with School of Public Health University of Illinois at Chicago, 12th July 2016.
[11] Zosky et al, Coal Workers pneumoconiosis: an Australia perspective, Medical Journal of Australia, 204 {11} 414 – 418.

standards for both respirable coal dust and crystalline silica[12]. In the same year Cancer Council Western Australia[13] warned the community about the dangers of occupational exposures to dusts, including silica. Cancer Council WA estimated that silica dust is causing over 230 lung cancer cases each year across the country.

So thirteen years on from the 2006 Senate Inquiry, despite more than half a dozen state and federal parliamentary inquires, a similar number of reports from regulators, expert peer reviewed medical journals and advice, we have seen very little action, and **no nationally consistent actions** on prevention, early identification, health screening, a national scheme of notifiable dust diseases or management and control of the disease.[14]

It is not surprising that when one reflects on this that we are now facing an unprecedented outbreak of dust disease in this country - an outbreak that when considering the above warning was not only predictable but had just some of these measures been implemented nationally, preventable.

A Boom in Silica Exposures

The recent outbreak of silicosis in the engineered stone industry highlights just how little we have learned as a country when it comes to occupational disease, and in particular dust disease. It underscores the dilemma a nation obsessed with the latest fashion item at the expense of protecting the workers who make it.

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[12] *Black Lung White Lies,* Inquiry into the re-identification of Coal Workers' Pneumoconiosis in Queensland, Coal Workers Pneumoconiosis Select Committee May 2017

[13] Silica dust - the cancer risk tradies cannot see, October 2017. https://www.cancerwa.asn.au/articles/news-2017/silica-dust-the-cancer-risk-tradies-cannot-see/

[14] Significant change has occurred in the Queensland coal mining industry but there is still unfinished business – see Appendix 2

It is disturbing to think that the most apt comparison to the one we face today with engineered stone is the story about the obsession the world had in the late '90s and early 2000s with stone washed jeans. These jeans, manufactured in Turkey and other garment producing nations, were made by manually sand blasting jeans, at higher pressure, to produce the trendy distressed denim that teens, and even some adults, in the west craved [15]. The consequences were deadly. Thousands of garment workers working in dust filled factories were being diagnosed with silicosis, an incurable but preventable disease normally found in construction workers who had experienced prolonged exposure to RCS., These workers, like with those in the engineered stone benchtop sector, had been working for just months or a few short years. Further, like with stone washed jeans our stone benchtops are a mere fashion item, one where effective and safe substitutes are available. As with sand blasting of jeans, we should consider bans of the importation and manufacture of engineered stone.

'I have never seen such severe cases of silicosis in my professional life.'

Deborah Yates, Occupational Respiratory Physician

About two decades ago "engineered stone" became very popular for use in kitchen and bathroom "bench tops". Engineered stone is a manufactured composite stone material that contains resins and has a crystalline silica content of 80 percent or greater. Some material is as high as 95 percent silica.

In mid-2010, Australian doctors noticed an increase in young patients presenting with an aggressive form of silicosis. Previously most sufferers of silicosis were workers in construction, mining, quarrying and foundries who developed chronic lung damage after exposures of more

[15] Deadly Denim Report 2012, Clean Clothes Campaign https://cleanclothes.org/file-repository/resources-publications-ccc-deadly-denim.pdf/view

than 10 years. However, the new group were presenting with significant lung damage following less than five years of exposure.

Engineered stone products are imported into Australia. Fabrication for and fitting into commercial and residential buildings is often done by small to medium workshops where the owners are also exposed. For many overseas workers who work in these workplaces English is not their preferred language and/or they are not unionised. These workers often feel vulnerable and have not been the target of any health or safety campaigns. Without any source of information there was little awareness of the hazards involved.

Engineered stone importers should have been aware of the risks as similar "outbreaks" of disease have been observed in throughout Europe and Israel. Basic risk assessments required by our Work Health and Safety Laws should have revealed this hazard and directed duty holders to eliminate and control the risk. Early reports were published in 2002 in the medical literature. Much of the product is manufactured in Spain, Italy, Israel and China.

An increase in workers exposed to dusts is not limited to those working with engineered stone or the coal industry. In her Churchill Fellowship report Cole observed that Australia is also in the midst of a tunnelling work boom due to transport network construction with more tunnelling in the years 2016 to 2023 than the past two decades. Around 4,000 workers are required for each major tunneling project and there were seven major projects in 2018 alone.[16]

A 2013 Queensland audit reported levels of respirable crystalline silica at 22 times the current exposure standard of 0.1 mgm/m3.[17] Cole noted that tunnel construction workers have an *increased risk of developing silicosis, chronic obstructive pulmonary disease (COPD), adverse*

[16] K Cole, Investigating best practice to prevent illness and disease in tunnel construction workers, 2016 Churchill Fellow page 122

[17] Workplace Health and Safety Queensland, *Occupational dust and silica conditions in some Queensland construction and related industries*. Department of Justice and Attorney General, PN11527 Version 1 August 2013, figure 4, page 7

respiratory symptoms, double the rate of lung function decline than heavy smokers, asthma, general airflow limitation, and lung cancer, and thus represent a high-risk work group. [18]

It is also a mistake to ignore other industries such as inground construction work, general stone masonry and manual building demolition where levels of RCS have been measured up to six times the current exposure standard. [19]

What is clear from this short history is that workers from a variety of industries and across multiple states and territories have been exposed to hazardous dust levels causing disease and death. What is also clear is that these risks were identified by numerous investigations and reports by governments leading up to and including the recent outbreak of silicosis and coal workers pneumoconiosis. These reports repeatedly recommended measures that would have prevented these deaths. What remains unclear is whether these recommendations will continue to be overlooked or only partially implemented. What is needed is immediate national action to ensure these diseases are prevented, that those already exposed are identified and provided with early and accurate screening and that those diagnosed are provided with the necessary support in order to manage this disease. Critical to this is interventions in workplaces to eliminate and control dust hazards. We must tackle this challenge at its source. Whilst the following chapters of this submission repeat many of the recommendations that have been called for over the last 13 years, we also propose new initiatives aimed at eliminating these hazards from workplaces. We encourage the Taskforce to consider many of these recommendations for swift action and not to delay, and potentially risk further exposures.

[18] Ibid, Cole
[19] Ibid, Queensland 2013

A National Approach to Prevention

Workplace health and safety is a fundamental human right. Every worker should be able to go to work and return home safely and in a state of good health.

Protecting workers and other persons against harm to their health is enshrined in the objects of the Work Health and Safety Act [WHS Act]. When protecting workers and others, regard must be given to the principle that workers and others are given the highest level of protection as is reasonably practicable. [20]

The objects of the Acts include a role for unions and employer organisations in playing a constructive role in promoting improvements and for workers to be effectively represented and consulted with in relation to health and safety.[21]

The framework of health and safety laws is of overarching Acts which outline key obligations of duty holders and regulators; mandatory regulations for specific hazards where the risk control measures are known; codes of practice which are not mandatory but provide duty holders with clear advice on how to meet their obligations under the Act and numerous varieties of information such as guides, fact sheets etc which compliment any of the preceding legal instruments.

Duty holders under the Acts include but are not limited to manufacturers, suppliers and installers. The provision of advice, information, education and training to workers is a clear obligation of duty holders. [22]

With regards to the risks of airborne contaminants at work these must be managed according to section 19 of the WHS Act. A Person Conducting a Business or Undertaking [PCBU] must

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[20] Model Work Health and Safety Act, Section 3 Objects. Similar objects exist in the Victorian OHS Act 2004, Section 2.1.b includes the objective to eliminate, at the source, risks to health, safety or welfare
[21] Model Work Health and Safety Act, Section 19.3.
[22] Ibid Division 2 and 3

eliminate health and safety risks, and if this is not reasonably practicable, ***minimise*** those risks so far as is reasonably practicable. Regulation 49 requires a PCBU to ensure that 'no person at the workplace is exposed to a substance or mixture in an airborne concentration that exceeds the exposure standard for the substance or mixture'. This means that duty holders must ensure the airborne concentration of a hazardous chemical with a Workplace Exposure Standard [WES] does not exceed the corresponding WES value. Importantly, Regulation 50 requires a PCBU to carry out 'air monitoring' if the PCBU is either not certain that the relevant WES value has been exceeded, or if monitoring is necessary to determine whether there is a risk to health.

The WES list was first developed in 1995 and drawn directly from the list of occupational exposure limits published by the American Conference of Governmental Industrial Hygienists (**ACGIH**). Although there have been some revisions, the list largely remains the same.[23] In 2016, SWA commissioned a consultant to evaluate the WES list. The consultants found that toxicological knowledge and recommendations of airborne hazardous chemicals have 'advanced significantly' since the WES were first adopted, and that there are 'significant differences' in the policies used to determine an exposure standard value internationally, and that the evaluation process used to review and determine a WES must be 'timely, applicable to contemporary Australia and adaptable to advancements in toxicological knowledge'.[24]

An inadequate WES value means that workers may be exposed to hazardous substances without adequate controls in place, which may cause illness, disease or death. The severe personal and financial costs of such adverse health impacts on individuals, families, employers and the wider community have been well documented. Diseases resulting from hazardous exposures can be extremely serious and require expensive treatments. For example, Safe Work Australia concludes that the cost of treating a worker with mesothelioma is $82,378: significantly higher than the

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[23] Safe Work Australia, *Consultation regulation impact statement: Workplace exposure standards framework under the model work health and safety laws*, 1 August 2018 at p 21
[24] Ibid, p 25

average hospitalisation cost of $5,078.[25] The ACTU does not have an estimate on the costs of lung transplants, one of the treatment options for those suffering from accelerated silicosis, but the costs will be considerable.

Because of the re-emergence of diseases associated with RCS and RCD and their "outdated" current exposure standards, the review of the WES for those two dusts was bought forward and dealt with prior to other 600 substances on the WES list.

The ACTU noted in our submission that the case for lowering the WES for silica is clear. Current exposure levels are too high, and workers are developing serious and life-threatening illness as a direct consequence. Workplace exposure standards are, by definition, not always protective from health effects for all workers. [26] The ACTU supports the revised values acknowledging that this WES will not guarantee there will be no health effects on any workers, but rather that given the current state of technical knowledge the proposed level will significantly lower the risk of fibrosis and silicosis, if effectively monitored and enforced in workplaces.

A similar case was put for RCD [containing less than 5% quartz] following the principle that WES should be health based.

It is important to note that a WES does not guarantee the preservation of health. However, the adoption of health-based WES, as proposed in Safe Work Australia consultation document, does significantly increase the level of protection. SWA recommended a level of 0.02mgm/m3 for RCS to protect against fibrosis and silicosis and minimise the risk of lung cancer and a level of 0.9mgm/m3 for the most common forms of RCD to protect against CWP, PMF and COPD.

[25] Ibid, p 41
[26] ACTU, Safe work Australia Review of Workplace Exposure Standards – Respirable Silica and Coal Dust, April 2019

Recommendation 1

The ACTU recommends the reduction of the Workplace Exposure Standard for Respirable crystalline silica to 0.05mgm/m3 by January 2020. The ACTU notes the general agreement to adopt health-based standards. The current impediment to a reduction to 0.02mgm/m3 [the health-based standard] relates to some expressed uncertainty about quality of measurement. This issue can be resolved over the next 12 months.

Recommendation 2

The ACTU recommends the reduction of the Workplace Exposure Standard for Respirable Coal Dust to 1.5mgm/m3 by January 2020.

Improved Regulations

Other than for mining, none of our current general health and safety laws have specific regulations applying to any hazardous dusts other than asbestos. This in contrast to hazardous chemicals where duty holders are required to label, supply safety data sheets, manage risks according to the hierarchy of control and provide health monitoring.[27]

This anomaly was observed in the 2010 by the Queensland Department of Justice and Attorney General.[28] It was not rectified with the introduction of the WHS Act and Regulations but could arguably be addressed under Recommendation 3 in the 2018 Review of the Model WHS Laws which calls for continuous assessment of emerging hazards to identify if there is a need for new regulations.[29] It is important to understand that unless there is a specific regulation, managing

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[27] WHS Regulations Chapter 7 Hazardous chemicals
[28] Ibid, 2010: *In a legislative compliance assessment sense, the occupational health risks and their control are judged on a pragmatic use of Sections 27 and 27A of the Workplace Health and Safety Act 1995 which deal with discharging obligations and managing risk where no regulation is made. This arises because the RCS to which workers are exposed is not subject to the Workplace Health and Safety Regulation 2008 – Part 16 Hazardous Substances, simply because the silica does not fulfil the status of a hazardous substance because it does not come to the workplace accompanied by a material safety data sheet (Regulation S 198).*
[29] Review of the model Work Health and Safety Laws – Final report, December 2018

risks to health and safety according to the hierarchy of control is inferred rather than an explicit requirement of health and safety laws.[30]

The audits by many regulators have uncovered serious breaches of the general duty of care. All regulators have issued prohibition and improvement notices dealing with very high-risk practices of dry cutting when working with engineered stone. [31] Other high-risk activities, such as working at heights or entry into confined spaces prescribe the risk control measures necessary to protect health and safety. Given the known risks and the measures to minimise those risks, hazardous dusts must be dealt with in a similar manner.

The Victorian government has recently recognised this problem and introduced a regulation prohibiting the use of power tools on engineered stone without controls. Other jurisdictions have not accepted the full gravity of the problem and are relying on general duties – which as the current situation demonstrates, have been a failure.

Recommendation 3

The ACTU recommends that all jurisdictions adopt a Regulation based on the Victorian Occupational Health and Safety Amendment (Crystalline Silica) Regulations 2019. These regulations formalise the current administrative directives in some jurisdictions which are aimed at controlling "dry cutting of engineered stone products". The Victorian Regulations require:

an(?) employer or self-employed person must ensure that a power tool is not used for cutting, grinding or abrasive polishing of engineered stone at a workplace unless the use is controlled.

[30] WHS Regulations, Regulation 32
[31] https://www.abc.net.au/news/2019-09-16/silicosis-surge-prompts-call-for-ban-on-engineered-stone-product/11516138

Note: Engineered stone is defined as *a manufactured composite stone material that contains resins and has a crystalline silica content of 80 percent or greater.*

Lack of specific dust regulation [excluding asbestos]

Despite the incurable nature of dust diseases, the well-known health effects of dust exposures and the known risk control measures, there is no specific regulation for hazardous dusts. This is unacceptable. In the USA, OSHA has clearly outlined rules to lower exposures to respirable silica. These rules provide clear directions on the control measures to be undertaken for various tasks. The OSHA rules on silica exposures were subject to a 20-year campaign by industry attempting to disallow these rules.[32]

In the Australian context there is the ability to mandate that workers and others are protected from hazardous dusts using the same framework as for other high-risk activities i.e. Regulation 34 to identify hazards, Regulation 35 Managing risks to health and safety and Regulation 36 Hierarchy of Controls. These regulations require the duty holder to take such steps to eliminate risks as are reasonably practicable and if it is not reasonably practicable, to minimise those risks according to the hierarchy of control. The hierarchy progressively applies the principles of substitution, isolation, implementation of engineering controls, administrative controls through to the use of personal protective equipment. A combination of the controls may be used to minimise risks if a single control is not sufficient for the purpose.[33]

Many industrial activities cannot be prohibited, or the use of silica eliminated such as, for example, in tunnelling or demolition work. However, other measures in the hierarchy of control

[32] https://www.osha.gov/silica/SilicaConstructionRegText.pdf
https://portside.org/2018-01-06/worker-safety-experts-court-ruling-silica-dust-limits-huge-victory
[33] Regulation 36

can be applied. The generic approach in a general dust reduction regulation could be designed as follows:

- Substitution: Where possible, use materials with no or lower percentage crystalline silica content.
- Isolation: separate workers from equipment that produces respirable silica dust through the use of sealed environments such as glass partitions, provision of cabins for operators of heavy mobile plant etc.
- Engineering controls such as whole of workplace ventilation; water suppression of dust; use of local exhaust ventilation; wet dust slurry management via use of guards, plastic flaps and brush guarding; management of wet waste.
- Administrative controls such as prohibition of dry sweeping methods or compressed air; cleaning of contaminated surfaces and contaminated garments.
- Suitable respiratory protective equipment such as powered air purifying respirators, RPE must be reasonably comfortable for the wearer.

This framework can then be used to develop industry specific supporting Codes of Practice.

Recommendation 4

The ACTU recommends that by the end of 2020 a Regulation **be adopted** that requires the application of the hierarchy of control for silica and other inorganic dusts. This is to apply where elimination of the work is not feasible, e.g. tunnelling, demolition work. Many industrial activities produce high levels of respirable crystalline silica.

Applying the hierarchy of control to the use of engineered stone

The number of cases of silicosis is evidence that those supplying and using engineered stone have failed to protect people's health.[34] Audits conducted by regulators have identified widespread noncompliance with health and safety laws. Risk control measures have been ineffective[35] despite claims by the industry:

> *AESAG is confident silicosis can be successfully addressed through this cooperative approach because engineered quartz surfaces are perfectly safe when cut according to current workplace regulations and the recommended safety standards.*[36]

As explained above, current workplace regulations do not prescribe how to cut engineered quartz surfaces. The media release is also at pains to point out that manufacturers and suppliers are not the employers of customers who purchase product or workers diagnosed with silicosis. There is no reason to dispute this claim, but there is an omission as manufacturers, importers and suppliers do have obligations under health and safety law.[37]

ASEAG *Australian Good Practice Guide for fabrication of engineered quartz surfaces* was not published until 2018.[38] The Guide refers to regulations but does not detail what those are. It also refers to the use of wet manual tools which have been shown to be inadequate in suppressing dusts in audits - *Water suppression was being used as the primary dust control.* The

[34] Ibid, as of September at least 250 workers diagnosed with silicosis
[35] Findings Report: Phase one audits of engineered stone benchtop fabricators in South East Queensland, Office of Industrial Relations, Workplace Health and Safety Queensland December 2018 noted; *The results of monitoring indicated that water suppression alone was not always sufficient to ensure the safety of workers, especially when using grinders to cut stone.*
[36] Australian Engineered Stone Advisory Group, *Industry Action on silicosis*, Date: 30 May 2019
[37] WHS Act division 3
[38] http://www.aesag.com.au/media/1025/engineered-quartz-surfaces-good-practice-guide.pdf

results of monitoring indicated that water suppression alone was not always sufficient to ensure the safety of workers, especially when using grinders to cut stone [39]

In September 2019, to supplement the Guide, the ASEAG commenced the roll out of an accreditation scheme in 2019. It is not known if this is a state based or national system.

Costs underestimated

Engineered stone product has been marketed for its smart clean look, ease of maintenance for the end user and the fact it is relatively cheap to install. However, the cost effectiveness of engineered stone is predicated on:

- The lack of effective upstream dust control methods, as shown by regulator audits. The ACTU understands that some workplaces are investing in equipment where workers are separated from dust by glass enclosures using automated processes. This equipment is much more expensive than individual power tools.
- A lack of effective control measures during fitting and re-modelling on site. There has been little if any effective dust monitoring done during the fitting stages of bench tops. Due to the variability in work sites e.g. access, size, shape, ventilation and the ability to use dust suppression techniques, generic measures can be hard to use. Effective measures similar to those required when removing legacy asbestos are beginning to be used e.g. physical barriers to separate dust producing tasks.

[39] Phase one audits engineered stone benchtop fabricators in South East Queensland, page 7

- A lack of health monitoring of workers, at the employer's expense. If industry had been screening workers and acted upon the findings, the current "spike" should have been prevented through earlier detection and subsequent review of risk controls

The framework of health and safety laws requires that risks must be controlled as is reasonably practicable. Reasonably practicable as defined in Section 18 of WHS Act requires the consideration of five factors:

1. likelihood of hazard/risk occurring,
2. degree of harm,
3. what persons ought reasonably to know about eliminating or minimising risk,
4. the availability and suitability of ways to eliminate or minimise risk, and after considering these factors, whether the cost is grossly disproportionate to the risk, and
5. after considering these factors, whether the cost is grossly disproportionate to the risk

Applying the 'reasonably practicable' test to work with engineered stone shows that the likelihood of production of a well-known hazard - respirable silica - is **high and** the degree of harm is **high** [40]. There are risk controls that can minimize, but not remove, the risk of harm. When considering the costs of implementing effective controls, the regulatory framework clearly states that cost is only one of the factors to be considered; cost includes the cost of doing nothing (i.e. injury or death, resulting workers compensation claims) and the potential *saving*s (fewer incidents, injuries and illnesses, potentially improved productivity and reduced staff turnover). Further, SafeWork Australia's guidance on reasonably practicable states that "*although the cost of eliminating or*

[40] Recent health surveillance of workers in the artificial stone benchtop industry in Queensland has revealed alarmingly high rates of accelerated silicosis with approximately ***one in three workers in the industry being diagnosed.*** Both RACP and TSANZ expect these rates to be the same across Australia https://www.racp.edu.au/news-and-events/media-releases/call-for-regulators-to-address-public-health-crisis-in-the-artificial-stone-benchtop-industry

minimising risk is relevant in determining what is reasonably practicable, there is a clear presumption in favour of safety ahead of cost.[41]

It is easy to keep costs down if the equipment used is cheaper than is needed to eliminate the silica hazard, and the appropriate health surveillance has not been provided to workers. The current cost effectiveness of engineered stone product is based on considerable cost shifting from the private enterprise to the suffering of individual workers and their families and our taxpayer funded health system.

Additionally, many less hazardous materials exist and are easily available - for example natural stone, marble, timber, laminates and manufactured stone containing amorphous rather than crystalline silica – that are likely to require less rigorous application of risk control measures.[42]

In February 2019, the Queensland Government requested that the Federal Government consider control of importation of engineered stone.[43] The NSW Legislative Council on 26th September 2019 passed a motion calling on the Government to immediately consider the viability and impact of a state-wide ban on manufactured stone products.[44] A similar proposition was put to the Federal Minister for Health by one of the ACTU representatives on Safe Work Australia members group, Andrew Dettmer, National President Australian Manufacturing Workers Union.[45] In his response The Hon Greg Hunt, Minister for Health indicated a request had been sent to Safe Work Australia to *"consider the merits of putting in place importation controls on engineered stone products".*[46]

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[41] https://www.safeworkaustralia.gov.au/system/files/documents/1702/guide-reasonably-practicable.pdf
[42] For example https://www.bettastone.com.au/
[43] https://www.parliament.qld.gov.au/documents/hansard/2019/2019_02_27_WEEKLY.pdf , page 420
[44] NSW Legislative Council Hansard – 26 September 2019
[45] Communication available on request. November 2018
[46] Communication available on request, December 2018

As far as the ACTU is aware there is no publicly available material outlining the considerations of Safe Work Australia or the relevant government departments on the matter.

Australia was able to effectively ban the importation and use of all forms of asbestos, from December 31st, 2003. Like asbestos, working with engineered stone can cause incurable diseases and the in-situ product will be remodelled and refashioned creating a risk for decades to come with the potential for future generations to be exposed to hazardous dust. It is not cost effective or morally defensible to replicate the problems Australia has with legacy asbestos, which is costing millions to remove and manage. Given our nation's experience, it is hard to justify why similar mistakes are being made with respirable crystalline silica from nearly "pure" silica products [greater than 80%].

We just can't continue to let young Australian workers die just so we can have cheap, fashionable kitchens. [47]

The mechanics of a ban on the importation and use of engineered stone with high silica content need to be discussed.

Recommendation 5a

The ACTU recommends that a ban be implemented on the importation, manufacture and use of engineered stone with over 80 percent crystalline silica content i.e. using the definition from Occupational Health and Safety Amendment (Crystalline Silica) Regulations 2019:

Engineered stone means a manufactured composite stone material that contains resins and has a crystalline silica content of 80 per cent or greater.

[47] https://theconversation.com/engineered-stone-benchtops-are-killing-our-tradies-heres-why-a-bans-the-only-answer-126489

Recommendation 5b

We recommend that during 2020, whilst the preparatory work for a ban is being conducted, regulators and industry must develop a strategy to encourage the use of non-crystalline silica products as replacements for engineered stone of greater than 80% crystalline silica. Our current health and safety laws provide the framework for such an approach.

Improved Awareness

The indications are that many workers and small business owners have not been aware of the dangers of silica dust. If the risk is not perceived to be high it is highly unlikely risk control measures will be implemented. The ABC report of September 2019 highlights that some workers would have left the industry had they known the risks, whilst others remain reluctant to be checked, due to the effect a diagnosis will have on their incomes and families – a form of denial. [48] This replicates the dilemmas experienced by coal workers in the Queensland.

The ACTU acknowledges the recent improvement in the information available to workers and employers/PCBUs. The extent of uptake in the target industries is likely to be variable and it is essential that various communication strategies and platforms will be required. Often face to face communication will be necessary to facilitate change, as in the experience of one regulator follow up workplace visits indicate that achieving lasting change in work practices can be difficult.[49]

[48] https://www.abc.net.au/news/2019-09-16/silicosis-surge-prompts-call-for-ban-on-engineered-stone-product/11516138

[49] Personal communication

Recommendation 6

The ACTU recommends improved awareness campaigns – Investment in a broad-based community campaign around the dangers of silica coupled with specific targeted campaigns for employers and workers in higher silica industries.

Early Identification

One area of systemic failure has been the detection of those with signs of disease. Early detection is of importance given the incurable nature of silica related diseases and the asymptomatic nature of early disease.

The WHS Regulations require PCBUs must provide health monitoring for workers if they are carrying out ongoing work using, handling, generating or storing crystalline silica and there is a **significant risk** to the worker's health because of exposure. [emphasis added][50]

The fundamental problem with this approach is that if a PCBU decides that no significant risk exists, health monitoring will not occur. Given the general lack of awareness and the perception that few risks are associated with silica dust, it is not surprising there is a lack of health monitoring and therefore a failure to detect disease early. This flaw does not exist in the Asbestos Regulations.

Safe Work Australia has produced Guides for PCBUs/medical practitioners and workers outlining the minimum health monitoring requirements for crystalline silica. In the USA, the OSHA silica rule requires *that chest X-ray are to be interpreted by a NIOSH certified B reader, and that cases should be reported to the local or state health department.*[51] As currently written, the Silica Health Monitoring Guidelines do not refer to NIOSH certified B reader. This was one of the

[50] https://www.safeworkaustralia.gov.au/silica
[51] NIOSH Science Blog October 29, 2019

deficiencies identified in the Queensland coal mining health screening programs. That program now has clear guidelines for the Coal Mine Workers' Health Scheme.[52] An agreed national approach, like Clinical Pathways Guideline, should be introduced for **all** crystalline silica exposed workers.

Lack of nationally consistent approach to lung screening

Since the re-emergence of silicosis, jurisdictions have been providing free health screening [an obligation that should be met by the PCBU/employer and further evidence of cost shifting]. However, there are anomalies between the jurisdictions with some workers being able to access screening more easily than others. There is no reason why a worker in NSW should have different access to screening than a worker in Queensland.

In NSW, free lung screening is available for employees working for employers who have received an improvement notice from SafeWork NSW.[53] This contrasts with the free health screening in Victoria for 1,400 stonemasons as well as 1,000 in Queensland. At the end of October 2019, the Queensland program had screened 1,000 stonemasons exposed to RCS form engineered stone:

186 people have been diagnosed with a work-related condition: 25 have a diagnosis of progressive massive fibrosis, 10 have a respiratory condition that is not silicosis, 151 have silicosis.[54]

Continued health screening is essential as deterioration in health status does not necessarily cease on removal from exposure to silica dust: *The rate of change in lung function deterioration for workers with accelerated silicosis is on average 10 times faster than the normal age-related*

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[52] Queensland Department of Natural Resources, Mines and Energy, Coal Mine Workers' Health Scheme (CMWHS) Clinical Pathways Guideline

[53] https://www.icare.nsw.gov.au/employers/employer-obligations/lung-screening-service/working-safely-with-crystalline-silica/

[54] https://www.worksafe.qld.gov.au/silicosis/background-to-silicosis

deterioration. Even in the absence of further exposure, silicotic nodules may continue to develop and coalesce resulting in the development of pulmonary massive fibrosis (PMF). If a worker has had sufficient exposure to silica dust, the disease may even become first evident after the worker has left the industry.[55]

Given the vagaries of workers compensation schemes this is likely to become problematic for many [see Management and Control of Disease].

Recommendation 7

The ACTU recommends that there be a requirement for comprehensive health screening programs that extends to workers post exposure and retired workers. There will be a requirement to update the Silica Health Monitoring Guidelines currently issued by Safe Work Australia.

Medical expertise

The reviews of the Queensland coal mining industry health surveillance programs highlighted a lack of expertise amongst those engaged to conduct the screening and interpret results. It is unknown whether such difficulties are restricted to Queensland. The Taskforce should review the various reports into that system and explore if the relevant findings can be extrapolated nationally. It is worth noting there is a lack of specialist occupational medical expertise employed by regulators. Such expertise would greatly enhance the capacity of regulators to make informed decisions on health monitoring/screening programs etc.

[55] https://www.racp.edu.au/news-and-events/media-releases/call-for-regulators-to-address-public-health-crisis-in-the-artificial-stone-benchtop-industry

Recommendation 8

The ACTU recommends that a review be conducted of the capacity of health professionals to conduct and interpret occupational lung health screening.

How many

Governments and regulatory agencies do not act unless the problem is identified and **quantified.**

The Australian Work Health and Safety Strategy 2012-2022 bases its targets on workers compensation claim numbers. These statistics are particularly unreliable in quantifying the prevalence of work-related diseases such as those of the respiratory system. These diseases have a latency between exposure and symptoms or signs of disease. The causation can be under diagnosed and workers or ex workers do not utilise claims under workers compensation due to its limitations. Additionally, if the person does not meet the definition of a worker, the person will be required to seek compensation from suppliers etc, which can be particularly difficult to establish. Others may develop disease post- retirement.

For reasons of long latency and lack of coverage by workers compensation schemes, it has been necessary to establish and maintain the Asbestos Mesothelioma Registry [and its predecessors].

Submissions to the 2006 Senate Inquiry demonstrated a broad consensus for reliable national data collection. The Senate report noted *that there is need to improve data collection. Without reliable data, the true extent of dust-related disease is unknown, trends cannot be identified in a timely manner and decision-making by government, industry, unions and the medical profession is hampered.*[56]

[56] Community Affairs References Committee, Workplace exposure to toxic dust, Senate, May 2006, page 22,23,60

Respiratory experts, epidemiologists and civil society groups representing sufferers of disease have all called for a national system of notification. The Queensland government was able to pass amendments to the Public Health Act in late 2018 which came into effect in July 2019. The preparatory work has been done - each jurisdiction should be able to replicate this approach with minimal obstacles.

In a statement on the contribution of work exposures to respiratory diseases, the American Thoracic Society concluded that Workplace *exposures contribute substantially to the burden of multiple chronic respiratory disease..... This burden has important clinical, research and policy implications*[57]. The Society estimates the population attributable fractions for asthma is 16%, for chronic obstructive pulmonary diseases 14% and 13% for chronic bronchitis.

Without any data it is difficult to quantify the population attributable fraction of work to chronic lung disease. An extension of a notifiable lung disease to non-dust diseases would contribute positively to awareness, risk perception and subsequently reduction of work exposures.

Recommendation 9

The ACTU recommends the adoption and implementation of a National Notifiable Disease System, based on the *Queensland Health Notifiable Dust Lung Disease Register*, for all dust related diseases. Such a scheme to be operational by the end of 2020. Further work should be conducted for a future expansion of the scheme to all work-related lung conditions.

[57] Blanc, P et al, *The Occupational Burden of Nonmalignant Respiratory Diseases*, American Journal of Respiratory and Critical Care Medicine Volume 199, Number 11 June 2019

Management and Control of the Disease – Supporting Sufferers

Most workers compensation systems include a list of diseases that are deemed to be work related, called 'Deemed Diseases'. The effect of this is to reverse the onus of proof such that a worker with the disease, who has been exposed to the relevant exposure, is assumed to have developed that disease because of the exposure, unless evidence can establish to the contrary.

In 2015 Safe Work Australia published a revised Deemed Diseases list updating very old lists. The 2015 list does not explicitly mention working with engineered stone in the list of high-risk occupations or industries and refers to a minimum of five years exposure.[58] The List was developed using the following criteria: a strong causal link between the disease and occupation exposure; clear diagnostic criteria and the disease comprises a considerable proportion of the cases of that disease in the overall population or in an identifiable subset of the population.

The Australian evidence of accelerated silicosis in engineered stone workers exposed to respirable crystalline silica was published after 2015 and was therefore not considered.

The ACTU believes this threshold of a minimum of five years needs to be reassessed given the occurrence of accelerated silicosis in workers with short term exposures. Additionally, the current list excludes scleroderma. It should be noted that it is likely increases in silicosis cases will be accompanied by an increase in scleroderma given the estimated population attributable risk is approximately 30%.[59] As such the exclusion needs to be reassessed for all diseases.

[58] Page 56, 65 ibid
[59] Blanc P, et al, The Occupational Burden of Nonmalignant Respiratory Diseases, Am J Resp and Clinical Care Medicine Vol 199, Number 11 June 2019

Recommendation 10

The ACTU recommends that by the end of 2020, every workers compensation jurisdiction should adopt the 2015 Safe Work Australia Deemed Diseases list with amendment to cover all silica related diseases. [60]

Workers compensation systems are inadequate

Many industries have ignored and failed to provide hazard information to their workers. Flawed risk control measures, and the failure to detect early signs of disease, has left many sufferers and their families facing enormous long-term health and financial problems. Some sufferers have no redress to workers compensation schemes or access to monetary assistance when facing forced early retirement or a change in occupation because of ill health. Many who persist in work where exposure continue face the prospect of further deterioration of their health. In fact, like many with work related chronic disease, they often end up on New Start payments, as access to the Disability Support Pension has been severely restricted and workers compensation payments both for medical and like expenses are often time limited; a matter made worse following the recent changes in NSW.

For these reasons' funds need to be established to support sufferers [and their families] who have been diagnosed with work related dusts diseases. Funds need to be financed by industry and used to support victims and their families for: for lost wages and ongoing income support, travel costs for medical consultation testing and treatment; rehabilitation costs – it is noted that more can be done to improve rehabilitation services [from the experience of Queensland miners]; counselling services; specialist research into best practice diagnosis and treatment of dust diseases; coverage of out of pocket expenses for treatment services.

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[60] https://www.safeworkaustralia.gov.au/system/files/documents/1702/deemed-diseases.pdf

Such funds need to be administered by tripartite bodies ensuring transparency to both industry and the public.

Recommendation 11

The ACTU recommends the establishment of compensation funds to support those suffering from dust diseases such as silicosis and coal workers pneumoconiosis, and their families. These funds should be funded by particular industries, on the basis that 'you pay for the harm you cause'.

Workers compensation systems are flawed

Dust related diseases are an example of chronic diseases caused by work exposures that are ignored or poorly recognised by workers compensation systems. This is due to a number of factors, including but not limited to underreporting, under diagnosis, difficulty in establishing causation for the purposes of eligibility to make a claim, long latencies, lack of awareness of links to work exposures, and negative outcomes for future employment.

There is currently a wide disparity in compensation processes available to workers suffering silicosis across jurisdictions. In some jurisdictions, access to common law rights for impacted workers has been eroded over the years. For example, in at least one jurisdiction, there is a requirement to establish "serious injury" prior to commencing proceedings for common law damages which can be problematic for dust disease sufferers because the laws specifically refer to asbestos related disease to the exclusion of other dusts diseases.

Recent government screening programs have meant that silicosis is being diagnosed earlier, which is overwhelmingly a good thing. It gives people a chance to eliminate dust exposure at an earlier stage and seek medical treatment to manage their disease. However, once diagnosed, this enlivens potential limitations complications. If a stonemason has six years to bring a claim from diagnosis, but their condition is not classified as a "serious injury" at this time, they run the risk that they may be considered statute barred.

A comparison of each jurisdictions access to benefits and benefit structure is beyond the scope of this submission but ensuring appropriate access to justice for injured workers should be at the forefront of the Taskforce's considerations in 2020.

Recommendation 12

The ACTU recommends improved workers compensation processes for sufferers of occupational lung diseases. This submission does not detail all the limitations in the current systems. Plaintiff law firms representing sufferers are best placed to outline the limitations of the system and recommendations for reform.

Conclusion

The “re-emergence” of preventable incurable work-related dust diseases has occurred because of systemic failures in the scope, application and enforcement of our workplace laws. Those with duties under the laws have ignored their obligations which has kept these diseases “silent”. Consequently, the regulators who are required to enforce the laws have not been aware of the breaches until it is too late. Our health systems have been unable to see trends in disease incidence which could have alerted authorities earlier to the failings in work health and safety due to the lack of an effective system of notification. Shamefully these failures were predictable. Strong consistent threads of what should have happened can be found in the recommendations and advice from many inquiries over the decades. These have been ignored by industry and governments, federal and state.

There are other silica exposed industries and high-risk dust industries, outside of engineered stone bench tops, which likewise fail to control exposures or monitor the health of their workers. This is not just about silicosis as the systematic failings apply to all work-related dusts and occupational disease in Australia.

The ACTU is sure that if our 12 Recommendations are adopted industries will become healthier, costs will decrease for workers and employers and the burden on our health system will be alleviated.

It is vital that this Taskforce not repeat the mistakes of past inquires. This submission outlines a number of initiatives that enjoy broad support and can be implemented immediately. Every day that passes more workers are being exposed to dangerous levels of hazardous dust that are exacerbating existing disease and developing new ones.

We thank the Taskforce for the opportunity, and we look forward to further engagement in our shared mission to eliminate dust diseases from Australia.

Appendix 1 – Consultation Paper Questions

1. From your experience, what are the issues that are underlying the increasing rates of accelerated silicosis in Australia?

Background section which highlights the nations failure to act on the recommendations from respiratory medicine experts, parliamentary inquiries and expert reports and audits. This includes a lack of risk perception and awareness in the relevant industries.

National Approach to Prevention section which outlines proposals for

- More protective Workplace Exposures Standards for RCS and RCD
- Regulation to prohibit use of power tools on engineered stone unless the use is controlled
- Health and Safety Regulations to address hazardous dusts
- Ban on importation and use of engineered stone product with a content greater than 80% crystalline silica
- Lack of risk perception and awareness in industry

2. Please describe ways we could collect information that could help to understand the problem better, so practical solutions can be developed.

Early Identification section outlines proposals for improved health surveillance and the adoption of a mandatory national occupational lung disease register.

3. Are there any gaps in the current protections for workers? If so, what are they?

National Approach to Prevention and Appendix 2 outline some of current failings and propose regulatory reform which would increase protection for workers. That regulatory reform is addressed in Recommendations 1 5.

4. Where you have seen good practice, what do you think caused this practice?

The ACTU has received feedback about improvement in work practices at some stone bench top sites [see discussion Costs underestimated]. Additionally, there are efforts to improve dusts control in tunneling operations, some of which are under discussion through the Major Infrastructure Consultative Committee Silica Working Party, under the auspice of SafeWork NSW.

5. Where you have seen poor practice, what do you think were the barriers to preventing good practice?

Many barriers are the result of lack of awareness and risk perception, failure to regulate and enforcement regulation and a breach of duty of care, and the relevant health and safety laws by entities along the supply chain. These issues are outlined in section on **Lack of specific dust regulation**, **Cost underestimated** and **A Boom in silica exposures**.

6. Who do you think is impacted by this current situation and who should be involved in the potential solutions?

The submission does not explicitly deal with this question, but it is implicit in our answers that workers and their unions must be consulted, represented and be partners in potential solutions. It also must be understood that exposure to silica, and indeed other hazardous dusts goes far beyond the stone benchtop industry. We believe the Taskforce should also be concerned dust exposure the following industries and sectors (this list is not exhaustive):

- Tunnelling
- Manual building demolition
- Stone masonry
- Inground construction work
- Concrete block production
- Brickwork and clay products
- Fibre cement cutting
- Concrete block laying
- Concrete grinding
- Quarrying and mining
- Foundries
- Specialty metal fabrication

In addition to these specific industries there is miscellaneous dust exposure in a range of other industrial processes.

7. Please outline any examples of current work, projects, research or research proposal you may be aware of occurring across the sector related to accelerated silicosis, or occupational lung diseases more broadly, that you would like the Taskforce to take into consideration in its review.

The ACTU does not have the expertise to comment on medical research and refers to the Taskforce to submissions made by expert groups such as Lung Foundation, the Thoracic Society, academics and a research program currently under way at the NSW Centre for Work Health and Safety.

8. Are there any other issues you wish the Taskforce to consider as part of its review?

The ACTU believes it is imperative that the Taskforce is not limited to the stone bench top issue. A failure to address the broader question of all occupational lung diseases runs the serious risk of replicating the mistakes we have outlined in the section **Failure to Act.**

In 2020 the Taskforce needs consider access to justice for injured workers, activities to encourage use of non-crystalline silica products and the implementation of a ban on the use of high-risk crystalline silica products.

Appendix 2 - Black Lungs White Lies Inquiry into the re-identification of Coal Workers' Pneumoconiosis in Queensland, Coal Workers Pneumoconiosis Select Committee May 2017

Below are some Recommendations from the inquiry that the ACTU understands have not been fully adopted:

Recommendation 1

There should be a truly independent Mine Safety and Health Authority, established as a statutory authority and body corporate, with responsibility for ensuring the safety and health of mining and resource industry workers in Queensland.

Recommendation 2

The Mine Safety and Health Authority should be established under its own legislation as a 'unit of public administration' for the purposes of the Crime and Corruption Act 2001 and a 'public authority' for the purposes of the Right to Information Act 2009.

Recommendation 19

An Occupational Exposure Limit (OEL) for respirable coal dust (including mixed mineral coal mine dust) should be set requiring duty holders to ensure a 'coal worker' is not exposed to atmosphere containing respirable dust exceeding an average concentration, calculated under AS 2985, equivalent to the following for an 8-hour period — • for coal dust – 1.5mg/ m3 air, and • for silica – 0.05mg/m3 air. Section 89 of the Coal Mining Safety and Health Regulation 2001 should immediately be amended to give effect to this recommendation. Consideration should then be given to relocating the OEL provisions within the Coal Mining Safety and Health Act 1999.

Recommendation 25

Real time personal dust monitors, such as the Thermo Scientific PDM3700, should be assessed having regard to the scientific information already available world-wide, and if possible certified for use in underground coal mines as soon as possible.

Recommendation 26

An industry working group including coal mine operators, unions and government should be tasked with exploring the use of real time personal dust monitors as a compliance tool, including canvassing amendments to Recognised Standard 14 on monitoring respirable dust in coal mines, to enable the use of real time personal dust monitors for compliance monitoring and reporting.

Recommendation 31

Section 119(1)(b) of the Coal Mining Safety and Health Act 1999 and section 116 of the Mining and Quarrying Safety and Health Act 1999 should be amended to remove the requirement for industry safety and health representatives to give 'reasonable notice' to the mine operator before the power to enter a mine site is exercised.

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