REPORT ON PROCEEDINGS BEFORE

STANDING COMMITTEE ON LAW AND JUSTICE

CORRECTED

LIFETIME CARE AND SUPPORT SCHEME AND 2018 REVIEW OF THE DUST DISEASES SCHEME

At Macquarie Room, Parliament House, Sydney on Friday, 25 January 2019

The Committee met at 9.00 a.m.

PRESENT

The Hon. Natalie Ward (Chair)

The Hon. Lynda Voltz (Deputy Chair)
The Hon. David Clarke
The Hon. Trevor Khan
The Hon. Daniel Mookhey
Mr David Shoebridge

The CHAIR: Welcome to the Standing Committee on Law and Justice inquiry into the 2018 Review of the Lifetime Care and Support Scheme and the Dust Diseases Scheme. Before we commence I acknowledge the Gadigal people, who are the traditional custodians of the land on which we meet. On behalf of the Committee I pay respect to the elders and present of the Eora nation and extend that respect to other Aboriginals present today. Today we will be hearing from a number of representatives, including non-government organisations, unions, medical professionals, lawyers and the regulator. I will now make some brief comments about the procedures for today's hearing. Today's hearing is open to the public and is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available.

In accordance with the Legislative Council's *Guidelines for the Broadcast of Proceedings*, only Committee members and witnesses may be filmed or recorded. While members of the media may film or record Committee members and witnesses, people in the public gallery should not be the primary focus of any filming or photography. I also remind media representatives that they must take responsibility for what they publish about the Committee's proceedings. It is important to remember that parliamentary privilege does not apply to what witnesses may say outside their evidence at the hearing. I urge all witnesses to be careful about any comments they may make to the media or to others after they complete their evidence as such comments would not be protected by parliamentary privilege if another person decided to take action for defamation. The guidelines are available from the secretariat.

There may be some questions that a witness could only answer if they had more time with certain documents to hand. In those circumstances witnesses are advised that they can take questions on notice and provide answer by Thursday 7 February 2019. Witnesses are advised that any message should be delivered to Committee members through the Committee staff. To aid the audibility of this hearing, may I remind both Committee members and witnesses to speak into the microphones. In addition several seats have been reserved near the loud speakers for persons in the public gallery who have hearing difficulties. I now welcome our first witness from the Australian Community Industry Alliance.

LYN FRANCO, Chief Executive Officer, Australian Community Industry Alliance, sworn and examined*:

The CHAIR: Do you wish to make a short opening statement before the Committee proceeds to questions?

Ms FRANCO: No, I do not have an opening statement.

The CHAIR: I note that you have not provided the Committee with a written submission, which is the usual course.

Ms FRANCO: No.

The CHAIR: We probably do need to hear from you in a sense of what your—

The Hon. LYNDA VOLTZ: I actually wanted to ask some questions about their structure. Perhaps we could go to that.

The CHAIR: Very well, if Committee members are happy to move to questions.

Mr DAVID SHOEBRIDGE: I actually think the suggestion of the Chair is really useful. A witness is before the Committee without a submission, we need to understand why they are here and who they are before we start the questions.

The Hon. LYNDA VOLTZ: We should clarify that you were actually invited to appear before the Committee?

Ms FRANCO: Yes, I was.

The Hon. DAVID CLARKE: Were you asked to give a submission?

Ms FRANCO: No, I did not.

The Hon. DAVID CLARKE: You were not asked to give a submission?

Ms FRANCO: No, I was not.

The Hon. DAVID CLARKE: How long has your organisation been in existence?

Ms FRANCO: Since 2005. We have attended previous hearings.

The CHAIR: Could you give the Committee a very brief outline about who you are, what your organisation does, what your appreciation of this statutory landscape is and any challenges that you feel you would like to bring to the attention of the Committee; we will then move to questions.

Ms FRANCO: Okay. The Australian Community Industry Alliance [ACIA] is a peak body for the community sector, both disability and aged care. Their main focus is around the delivery of quality services and supporting service providers to actually meet those expectations. That is done via a number of means: we have our own standard, which is endorsed by the Joint Accreditation System of Australia and New Zealand [JAS-ANZ], and has been in operation since 2008; and we also own the scheme—we are in our third edition of that. In our relationship with icare, the Dust Diseases Board and Lifetime Care and Support we work very closely on projects similar to what we are supporting, including the administration of the standard and scheme, which is a contractual requirement of any approved panel provider for services of attendant care. So that is our relationship. We continue to have that close relationship supporting providers so they can meet those higher expectations that are expected by participants in the community.

We have well over 100 members. They do not necessarily have to have that standard but they are members who seek to be supported. We have a number of guidelines that have provided leadership and support to members and the industry generally. Those 100-odd members—and it is increasing—basically represent about 150,000 attendant care staff. We have also worked over the last three years with the National Disability Insurance Scheme [NDIS], the commission and the Department of Social Services [DSS] to actually develop the national quality in safeguarding standards, which align very closely to our ACIS standard. So we see ourselves as leading in the quality space for the community sector as this point in time. Is that enough information?

The Hon. LYNDA VOLTZ: That is fine. Do you still receive funding from the Motor Accident Authority?

Ms FRANCO: Yes, we do. We still have a grant for the administration and consultation services because we see ourselves as an expert—all of our staff have significant operational experience in the sector; they have worked at senior and executive levels—and provide that level of advice not only to icare but also to the industry generally.

The Hon. LYNDA VOLTZ: How much do they provide for that funding?

Ms FRANCO: What do you mean?

The Hon. LYNDA VOLTZ: What is the grant?

Ms FRANCO: The grant is around $285.

The Hon. LYNDA VOLTZ: Do you get any other grants from the Government?

Ms FRANCO: No.

The Hon. LYNDA VOLTZ: You are a registered charity as well, are you not?

Ms FRANCO: Yes. No, we do not. We did receive funding for the project to develop those standards with NDIS and that has ceased at this point in time.

The Hon. LYNDA VOLTZ: Do you charge for the licensing service?

Ms FRANCO: Yes, we do.

The Hon. LYNDA VOLTZ: How do people become members? Is it just that they can join?

Ms FRANCO: Yes, they can. We have three different levels: organisational, affiliate and also individual members.

The Hon. LYNDA VOLTZ: Part of your role is to help implement Federal and State policies, is it not?

Ms FRANCO: Yes, we can do that.

The Hon. LYNDA VOLTZ: So when the standards are put forward, how do you arrive at the standards for the organisations that want the licensing?

Ms FRANCO: Predominantly research and obviously the legislation, as well as looking at industry trends at the time, but also looking at feedback and adverse events that have occurred. Basically we have followed a format that basically covers all aspects of a governance framework but applied that to the community sector. So we are looking at things like abuse and neglect, critical incidents, complaints management, human resource management, making sure that in the human resource management sector staff are skilled to perform the duties that they have been allocated to—an external auditing group will come and actually assess or look for evidence of compliance in those areas.

The latest edition, which I think is really important, has taken the next step in compliance for the industry—that is, looking at additional modules. When I am talking about that, we are talking about complex physical supports and as the industry grows we are looking at more and more complex services being delivered in the sector. So making sure that the evidence provided when an organisation is audited actually meets a certain level, which includes policy development, the appropriate person assessing the participant; the appropriate planning for that participant, and including the family and the participant in the choice of meeting goals and expectations; and looking at what happens when an incident happens—who does the staff member escalate that issue to, what is the action that should be taken.

The Hon. LYNDA VOLTZ: What about where there is a gap in the service? I assume you are working with Lifetime Care and Support under the State scheme?

Ms FRANCO: Work alongside them; I do not work for them.

The Hon. LYNDA VOLTZ: No, you work with them to implement—

Ms FRANCO: Yes.

The Hon. LYNDA VOLTZ: What happens when Lifetime Care and Support say, "This is the package and this is where you arrive at."? Do you also work up the tree to say, "That is not appropriate. We need more."?

Ms FRANCO: Yes, definitely. We are part of the consultation process—for instance, at the moment they have a policy coming out on restrictive practices, which is due to be launched in April.

The Hon. LYNDA VOLTZ: I am sorry, on?

Ms FRANCO: Restrictive practices: substance abuse, physical restraint—

The Hon. LYNDA VOLTZ: Aged care.

Ms FRANCO: And disability.

The Hon. LYNDA VOLTZ: It obviously happens in other sectors.

Ms FRANCO: Absolutely. They have already developed that policy. That has gone out to consultation to all members and also to the industry generally and their approved panel, but we have actually worked with them as well because there is reference to our documents, including the ACIS 2018 and also a couple of our guidelines. So there are a couple of guidelines in there to do with the response providers should take to adverse events, particularly around what their elected auditors should do as well—if when they are auditing they come across a situation how that should be reported, how that should transpire.

The CHAIR: I think we are across the structure sufficiently. The Hon. David Clarke will ask some questions?

The Hon. DAVID CLARKE: Thank you, Chair. Ms Franco, your organisation has been in existence since 2005, is that correct?

Ms FRANCO: That is correct.

The Hon. DAVID CLARKE: Has your organisation ever appeared before a committee?

Ms FRANCO: Yes, it has.

The Hon. DAVID CLARKE: Are you aware whether on those previous occasions the organisation made any written submissions?

Ms FRANCO: I cannot answer that. I can certainly take that on notice.

The Hon. DAVID CLARKE: You did not check to see?

Ms FRANCO: I certainly looked at the transcripts from 2017 and there are some statements in there from our founder, Ms Barbara Merrin, and also Danielle Bennett, and my predecessor. I will say that both Barbara Merrin and Danielle Bennett are advisers to the board. I did actually consult with Danielle Bennett but she did not allude to a previous submission just that they had attended the hearing.

The Hon. DAVID CLARKE: Why I am asking is that at the beginning I asked you whether you had received an invitation to make a written submission and I am advised that an invitation was sent to you?

Ms FRANCO: The invitation was sent but I was not aware that I was to make a submission. I did make contact to say, "What do I need to prepare?" but I was not advised that I needed to provide a submission for this hearing.

The Hon. DAVID CLARKE: Now that you are here, and you did not make an opening statement, is there anything in particular you would like to put forward to the Committee? Are you happy about the way the scheme is operating? Do you have any concerns? Would you like to make a statement now?

Ms FRANCO: I did actually speak to a number of providers before I came to this session just to get an understanding, both small and large, of how they are faring with working with Lifetime Care and Support and the Dust Diseases Board. On the whole the senior management that they come in contact with at icare are very good to work with, they are very easy to communicate with. They are still seeing that some areas of integration are still occurring between the different services within icare but that is still a work in progress. There is still some work to do particularly around the Dust Diseases Board in aligning with Lifetime Care and Support. I know that they are bringing a lot of their case management internally into their organisation and that is something that providers are seeing as a good thing because it is something that they had in the past and apparently that would provide better communication between provider, participant and icare themselves.

There still are some issues around the fee structure, particularly as the NDIS is now introducing an increase that will take effect from 1 February. Sometimes with the fees for providers, there may well be parity there but it is in a different context so maybe if that was clearer for providers they would not feel that the fees are a better structure within the NDIS than icare itself. There is still quite a lot of angst around the fee structure but it is in a different format so if you follow that format the parity may well be there between the two organisations.

The Hon. TREVOR KHAN: Can you explain the difference in format?

Ms FRANCO: With icare, they have a different type of fee structure. For instance, there is a service establishment fee, which is quite a generous service establishment fee. There are different levels of fees for different services. I will not profess to be expert in the fees but there is also another fee that supports organisations that do apply for ACIS, the certification renewal, which is quite generous. The fee structure that the NDIS has introduced is around a 5.6 per cent increase for complex services. Having spoken to a provider yesterday, he sees that covering a lot of the areas that were previous in place by the State Government, such as administration fees,

assistance with case management because, by default, providers do a lot of case management that they are not paid for. By the same token I spoke to another provider yesterday who had not claimed for a number of years the service establishment fee with icare. That is a lack of understanding around the fee structure. That provider has since gone to icare and they are about to pay that back pay to them, so that is very good on their behalf.

Mr DAVID SHOEBRIDGE: You have a national operation, is that right?

Ms FRANCO: We do.

Mr DAVID SHOEBRIDGE: When you look across the country how does Lifetime Care and Support in New South Wales compare to motor accident schemes dealing with catastrophic injuries in other States and Territories?

Ms FRANCO: I do not think I could answer that but I could certainly provide information and take that on notice.

Mr DAVID SHOEBRIDGE: If you could get that on notice, that would be useful. Are you aware of anything similar to Lifetime Care and Support operating in other jurisdictions?

Ms FRANCO: Yes, absolutely. We have relationships with Transport Accident Commission [TAC] in Victoria. They again have ACIA on their contract requirements for their panel, not solely as the only quality framework. We work closely with the Lifetime Care Authority in South Australia and also in the Northern Territory.

Mr DAVID SHOEBRIDGE: I think the South Australian scheme is very similar to New South Wales?

Ms FRANCO: Yes.

Mr DAVID SHOEBRIDGE: Are you aware of comprehensive no fault catastrophic injury schemes in other jurisdictions?

Ms FRANCO: No, I am not at this point.

Mr DAVID SHOEBRIDGE: In terms of the dust diseases benefits that are applied in New South Wales, are you aware of similar schemes that apply in other States or Territories, the comprehensive dust disease compensation for employees?

Ms FRANCO: No, not at this point in time. I am very aware of the Dust Diseases scheme though for New South Wales.

Mr DAVID SHOEBRIDGE: Sometimes it is good to step back and compare how the New South Wales schemes are operating compared to other jurisdictions and given that you are a national body it would be really useful to get your reflections on that—

Ms FRANCO: Thank you, yes.

Mr DAVID SHOEBRIDGE: —whether or not there are gaps in the New South Wales scheme that are filled in other jurisdictions or whether or not the New South Wales schemes may be models that you should be looking at to implement in other jurisdictions?

Ms FRANCO: Yes. We do not actually implement the scheme.

Mr DAVID SHOEBRIDGE: Advocate to implement.

Ms FRANCO: We do not even advocate; we work alongside and support the industry generally and providers.

Mr DAVID SHOEBRIDGE: So no part of your organisation is advocacy?

Ms FRANCO: Advocacy in supporting the industry in areas that they find challenging in providing quality service delivery, yes. We are on a number of reference groups, including the NDIS reference group, as well as the Lifetime Care and Support provider reference group. We are there to provide feedback, consultation, et cetera, from the provider sector.

Mr DAVID SHOEBRIDGE: Some of the discussion that was had over the last few years has been about separate accreditation for the NDIS, the Lifetime Care and Support and for statutory workers compensation schemes. Is that an issue that you are aware of?

Ms FRANCO: No, it is not an issue that I am aware of.

Mr DAVID SHOEBRIDGE: Are you aware of any of your organisations having multiple accreditations?

Ms FRANCO: Yes, I am, and we have worked with the auditors so that instead of having to be accredited, it is actually certified against different quality frameworks, that they are actually working hard to basically certify against multiple quality frameworks at the same time and I am seeing that with providers at the moment. For instance, we have at least, I think it is two providers that have gone through that have actually been certified against NDIS and also ACIS 2018.

Mr DAVID SHOEBRIDGE: What is ACIS?

The Hon. LYNDA VOLTZ: That is their licensing scheme?

Ms FRANCO: Yes.

Mr DAVID SHOEBRIDGE: What is it?

Ms FRANCO: It is the Australian Community Industry Standard and also the scheme.

Mr DAVID SHOEBRIDGE: Does being accredited or certified under ACIA give you automatic access to provide services to Lifetime Care and Support, to the workers compensation scheme and to the Motor Accidents Scheme in New South Wales?

Ms FRANCO: Yes, it does.

Mr DAVID SHOEBRIDGE: So there is nothing we should be looking at in terms of talking with State agencies about streamlining the certification process; that is all working fine?

Ms FRANCO: Yes, to our understanding.

The CHAIR: You referred earlier to some issues in relation to the fee structure. I might invite you, Ms Franco, if you would like, to provide a written submission with specific examples of that. You alluded generally to it being an issue . It might be helpful for the Committee if you are able to specify with some clarity what the issues are and perhaps some recommendations about how that might assist us, if you can come up with some proposed solutions?

The Hon. TREVOR KHAN: And, more importantly, it might assist their members.

The Hon. LYNDA VOLTZ: With your accreditation service, certification, when you performed that accreditation—I note that it is an ongoing process and you refine it—do you consult with government as part of that process?

Ms FRANCO: Yes, there is quite a broad consultation. We have an annual quality steering committee as well. So there is a very broad consultation with a number of different parties and auditors as well.

The Hon. LYNDA VOLTZ: Because essentially if it is to administer their schemes they would probably need to tick off on your certification if that is the standard which they want to apply to their schemes, I assume.

Ms FRANCO: Yes.

The Hon. LYNDA VOLTZ: How does that process of government approval of the certification happen?

Ms FRANCO: We have members on the quality steering committee that are consulted on the scheme.

The Hon. LYNDA VOLTZ: They are government members are they?

Ms FRANCO: State, yes.

The Hon. LYNDA VOLTZ: State representatives.

Ms FRANCO: Yes, from icare. They are consulted on it seeing as they basically utilise that standard.

The Hon. DANIEL MOOKHEY: In the quality framework that you have, what are the skills requirements that are imposed upon providers for their workforces?

Ms FRANCO: At this point of time they are basically supposed to demonstrate that whatever service the disability worker or support worker is assigned to that they are appropriately skilled to be able to deliver those particular services.

The Hon. DANIEL MOOKHEY: What is the definition of "appropriately skilled"? Does it interact with the ASQA framework? Do you require that they have a certain graduate certificate?

The CHAIR: What framework? Mr Mookhey, could you clarify the what framework?

The Hon. DANIEL MOOKHEY: The Australian Skills Quality Authority framework.

Ms FRANCO: No. That is left to the provider to provide that level of evidence and compliance.

The Hon. DANIEL MOOKHEY: Is there any minimum skills qualification that your framework applies for the workforce?

Ms FRANCO: No, not at this point in time, but it is certainly being looked into at the moment. We are doing quite a bit of work in that area to look at that requirement in particular, particularly around the complex services.

The Hon. DANIEL MOOKHEY: What about labour standards?

Ms FRANCO: Sorry?

The Hon. DANIEL MOOKHEY: Does your accreditation system call for the consideration of, for example, whether or not a provider is providing payments on labour standards, minimum wages?

Ms FRANCO: That is part of their contractual requirements with their individual funding. That is not part of the standards itself. When we are looking at the skill of the worker we are looking at the number of staff that are assigned to the participant. It is very much an individual assessment that is done and planned for with the client and their family. It is not something that we prescribe. As part of the standards, both participants and staff are interviewed as part of that whole certification auditing experience to make sure that there is the appropriate skills and service delivery to the participant.

Mr DAVID SHOEBRIDGE: And part of that in the appropriate skills is ensuring adequate wages are paid, particularly in the community sector, and one thing we do hear is that the wages are so low it is hard to attract and retain people with skill.

Ms FRANCO: Correct.

Mr DAVID SHOEBRIDGE: I suppose that is part of the implicit question of Mr Mookhey: are you looking at ensuring that there are adequate wages in the sector to attract and retain the skilled workers needed?

Ms FRANCO: I probably should have said at the beginning we are an apolitical organisation. We certainly do—

Mr DAVID SHOEBRIDGE: But decent wages is not a political issue. I am talking about getting decent wages to attract and retain the right workers.

The CHAIR: Mr Shoebridge, I will allow this to continue briefly, but we are straying now well beyond the terms of reference. I am happy to allow the questions but could you allow the witness to finish her answer before asking another question?

Mr DAVID SHOEBRIDGE: Sure.

Ms FRANCO: That is not part of our brief to be checking the organisation as part of the audit and also part of the standard. It is not part of the brief of the standard.

The Hon. DANIEL MOOKHEY: You have organisations that go through your accreditation framework that work in the aged care sector?

Ms FRANCO: Yes, that is true.

The Hon. DANIEL MOOKHEY: And they work in both schemes, the lifetime care and dust diseases, and presumably other work in the aged care sector.

Ms FRANCO: We do have some, yes, that is right.

The Hon. DANIEL MOOKHEY: To the extent to which issues have surfaced in the aged care sector, which, for example, have led to the calling of the aged care royal commission, how would your auditing framework detect that?

Ms FRANCO: I suppose the area that I see that is most significant is that the auditors are an external auditing group who also have oversight from JAS ANZ.

The Hon. DANIEL MOOKHEY: From where?

Ms FRANCO: JAS ANZ, which is the Joint Accreditation System of Australia and New Zealand. So there is that level of oversight externally. Also, not only that, as owners of the scheme we witness audits to make sure that the application of the audit is appropriate as it was intended.

The Hon. DANIEL MOOKHEY: Have any of your audits detected any of these issues before amongst any of the participants in your scheme? By the way, what is the coverage of your scheme? How much percentage of the industry is going through your accreditation framework?

Ms FRANCO: We have about 60-odd providers that go through our scheme. I would like to be able to go away and answer your question particularly in relation to the aged care side of things because we do feel quite strongly, as you would imagine, that our standard exceeds the level of compliance requirements that is currently the case.

The CHAIR: You might take that question on notice.

Ms FRANCO: Yes, I will.

The CHAIR: And you can respond to that in writing by 7 February together with the other written submission about fee structures. The Committee secretariat will advise you on those questions. If you can provide written answers by 7 February?

The Hon. DANIEL MOOKHEY: When you do discover an organisation which perhaps does not pass audit or if you audit and they have all of a sudden downgraded their status, how do you relate that information to icare or the LTCS, other providers in the scheme, and have you ever had to do that?

Ms FRANCO: With the first part of the question, there have been organisations that have failed to meet the requirements of the standard; they are not certified, they basically have a period of time, which is managed by the certifying body, to come up with an action plan. There are different levels of severity of non-compliance. We are aware of it—we are made aware of it by the certifying body that there is an issue, and the organisation is given a period of time to meet compliance requirements to the satisfaction of the certifying body. But if it was something that was a critical adverse event—a serious adverse event reporting—we would advise straightaway and so would the fund and we would advise the funding body. The certifying body would make sure that whatever that serious adverse event it is reported appropriately, we would be provided with a report and we would make a decision as to whether that certification should be suspended.

The Hon. DANIEL MOOKHEY: Have you ever done that?

The CHAIR: Thank you, Ms Franco. I am going to stop you there. We are on a very tight schedule today; we have a lot of witnesses. If there are further questions I invite members to provide them within 24 hours, as resolved by the Committee, or those who attended the Committee meeting.

The Hon. TREVOR KHAN: I am sorry to cut across but she was halfway through answering that last question.

The CHAIR: Mr Mookhey was about to ask another question. I will allow the answer to that question but then we will finish this evidence.

The Hon. DANIEL MOOKHEY: I am sorry, I was working off the assumption that we were going to 9.30 with the witness.

The CHAIR: The next witness is to start at 9.30 and we have a lot to get through today. I am just making it clear that we will not be running overtime with any witnesses. I invite you to finish that last question and then we will conclude the evidence.

The Hon. DANIEL MOOKHEY: The last question was: Have you reported that process that you just described?

Ms FRANCO: Not myself personally. We do deal with adverse events—

The Hon. DANIEL MOOKHEY: But your organisation.

Ms FRANCO: —of concern, and we work with the CBs to investigate those concerns and we inform Lifetime Care and Support if we have any concerns about an organisation. Generally though in the past they have been resolved without any issue, to my knowledge whilst I have been CEO.

The CHAIR: Thank you for coming along today and for providing information to this Committee. You have taken some questions on notice which we ask to be returned by 7 February. The secretariat will assist you with those.

(The witness withdrew)

*See correspondence received from Ms Franco on 25 February 2019 regarding clarifications to evidence.

BRIAN WOOD, Secretary, Motorcycle Council of NSW Inc., affirmed

The CHAIR: Do you have an opening statement you would like to make? We have received your written submission—thank you for that—and you can assume members have read that. Do you have anything you would like to add by way of a short opening statement to the Committee today?

Mr WOOD: Yes, I would like to make an opening statement. I would like to take this opportunity to thank the Committee for being able to appear before you this morning. I would also like to correct some of the comments that we made in our written submission regarding how the Lifetime Care and Support Scheme [LTCS] levy is calculated. It has only just come to our attention very recently that the method has changed from being a percentage of the compulsory third party [CTP] premium to now being a fixed dollar, so this method of calculation is far more equitable, particularly for those who, for whatever reason, are with an insurer with a higher CTP premium than other insurers. They were being, I guess, double charged by virtue of the fact they were paying a higher CTP premium and therefore a higher LTCS premium or levy.

Since that was introduced on 1 December 2017 it has been reviewed on 1 July 2018 and again on 15 January 2019. The State Insurance Regulatory Authority [SIRA] provided me with a spreadsheet of the dollar amounts for each class and each regional area so I would be able to make a comparison. While there was no change for cars or motor cycles on 1 July 2018, as of 15 January 2019 the LTCS component went down by $3. It is not a large amount but it is still a reduction and it is at odds with a claim by SIRA that motor cycles are not paying sufficient into the LTCS scheme. Compared to the class 1 cars, small capacity bikes are paying around about $80 less. The larger capacity motorcycles are paying around about $30 more, except for those in country areas, which are paying about $75 more in the larger capacities. The levies for the medium-capacity bikes are in the order of between $30 less and about $20 more.

The Hon. LYNDA VOLTZ: You said the higher-capacity bikes were paying $30 more and country $75?

Mr WOOD: The higher-capacity bikes, except for those in the country, are around about $30 more than a car in the same regional area.

The Hon. LYNDA VOLTZ: And $75 for the country?

Mr WOOD: In the country areas, yes, $75 more. Those large capacity bikes in the country are paying $136.71, which is a bit unusual because in the other classes the highest levies are for metro vehicles, not for country vehicles. So that is also reflected in the CTP premium and I am not aware as to why that particular class is at odds with those other classes, but it is certainly a question we will be asking SIRA when we next meet with them.

Mr DAVID SHOEBRIDGE: What is the difference between a regional premium for that class of motor cycle and a city premium? You said it is $136 for the regions?

Mr WOOD: Yes, and $89.96 for a metro large capacity motor cycle.

The Hon. LYNDA VOLTZ: Does that collate with the figures of where the risk is?

Mr WOOD: I guess that becomes a bit difficult as to where the risk is. As I say, it seems unusual why country large motorcycles are the most expensive whereas in other classes it is the metro so you would think the risk would still be why someone with a large capacity motorcycle is more likely to have a LTCS claim than someone in the city would.

Mr DAVID SHOEBRIDGE: Mr Wood. I am sure your opening submission will then go to the issues about road surface and not–at-fault motorcyclists?

Mr WOOD: Yes.

Mr DAVID SHOEBRIDGE: Maybe part of the answer lies there.

Mr WOOD: I guess the other comments I wanted to make in the opening statement were to expand on what we said about the Safe System approach. This Safe System approach is where the road authorities accept that they have a responsibility to provide a safe system. The safe-system approach is a key element Towards Zero, which is the desire to have a road toll of zero by 2056. If we are going to achieve a zero road toll then obviously the road authorities need to be able to provide a safe road network. Unlike other forms of insurance, CTP and the LTCS levy are compulsory and there is no mechanism by which you can tailor that insurance to the individual needs to obtain best value.

With comprehensive car insurance the benefits of the payout can be adjusted to adjust the premium that you pay, so again you can adjust that, tailor it so that you are getting good value for money. In my case I have opted not to take comprehensive insurance for many years, but rather take out third party property insurance and that over the years has proved that it has been the best value for money for me. In taking out insurance you are authorising the insurance company to act on your behalf, so the insurance company in many cases does not pursue claims or costs from other insurance companies—this is referred to as knock for knock. This knock-for-knock agreement simplifies recovery costs among insurers and over time attributes fairly evenly the cost among the insurers.

The rationale for this agreement is economic and administrative efficiency. Sometime ago I crashed as a result of gravel being left on the road after the local council repaired a pothole As I had third party property insurance this enabled me to pursue the council for compensation for damage to my bike, in which I was successful. Had I had comprehensive insurance it would have been very unlikely that the insurance company, for economic efficiency, would have pursued the council for compensation. So the costs for that would not have laid with the council—which had responsibility for causing the crash—it would have been taken up by the holders of the insurance policy. Had I been injured in that case the cost would have been borne by either the CTP or the LTCS schemes, whereas really the responsibility for that crash lay with the local council so if there were a claim under CTP, the costs should have been borne by the council not by the holders of CTP policies.

Civil liability legislation allows road authorities to not be held responsible for the cost of crashes. However, this legislation predates the Safe System approach to road safety. If road authorities are to provide a safe system then they need to be able to, I guess, take responsibility for their actions. One way of doing this is to hit them in the hip pocket by pursuing them for injuries. I am aware of a crash where the Roads and Maritime Services [RMS] took responsibility. This occurred in the driveway of a service centre on the M1. While the claim was being handled through the CTP scheme, the RMS were to reimburse the CTP scheme.

So the costs in this case were borne by the RMS, not by CTP policies so if it could occur in this particular case I see no reason why it could not be applied in other similar cases, not only with CTP but also for LTCS. I would like to urge that the Committee encourage the LTCS authority to purse those costs where there is another road authority that has responsibility for the crash. I would also like to urge the Committee to pursue the fact that road authorities have a responsibility in this area in bearing the costs for crashes and also that the LTCS authority pursues those costs. In closing, I thank you for this opportunity to appear before the Committee on a matter of great interest to our members.

The CHAIR: Thank you for taking the time to make a written submission and for appearing today. I am sorry to hear about your accident and I hope you have recovered.

Mr WOOD: It was some time ago. I had some bruising, but that was my only injury.

The CHAIR: The terms of reference do not allow the Committee to look at particular claims, and you are obviously not asking it to do that. However, members are interested in your experience. In your written submission and in your opening statement you have referred to introducing claim recovery from road authorities. I am interested to know whether you have any basis or evidence to support the cost benefits of doing so.

Mr WOOD: I say in our written submission that it has been estimated that about 20 per cent of crashes involve some form of road defect.

The CHAIR: Yes, you did say that, but I am interested in the other end. You referred to cost recovery from, for example, Roads and Maritime Services [RMS]. Is there any indication of what the cost would be? It is a broad recommendation, but I would like to know whether there is any information about whether cost recovery is achievable.

Mr WOOD: I do not have any evidence of the cost. The particular case for which Roads and Maritime Services took responsibility was under the compulsory third party [CTP] scheme and you can claim up to six months of wages. So she was in the scheme for up to six months. That would be several thousand dollars of that claim. Of course, those who have appeared in the LTCS are far more seriously injured, so the costs of that scheme would be significantly more.

The Hon. TREVOR KHAN: This is about achieving a behavioural change through them bearing the cost. That is the essential point, is it?

Mr WOOD: Yes, that they meet their obligations under the Safe System that they have a responsibility to provide; that is, they have a responsibility to provide a safe road network. At the current time they hide behind the Civil Liability Act to say they were not aware of it. Gravel on the road or a pothole usually do not appear overnight. A lot of the gravel is the result of the road surface breaking down. As an asset manager, the road

authority should be aware of the condition of its asset. It should therefore know that if a road surface is coming to the end of its life it is likely to produce loose gravel. We know that they can repair a pothole, but then probably after a period of wet weather it usually reappears. If they have repaired a pothole they should know it is likely to reappear. They should not be able to say they did not know. If they are saying that, they are not meeting their obligations as an asset manager.

The Hon. TREVOR KHAN: You have me partly persuaded with regard to where the roads authority has taken an active step. I remember being involved in an inquest many years ago where the Roads and Traffic Authority, as it then was, had laid down gravel just before Christmas on a stretch of the New England Highway and a number of cars subsequently went off the road. In the case of my client's son, he travelled into the path of another vehicle and was killed. That was an active-step exercise in failure of signage and the like. I hear what you are saying about potholes, but they can spring up fairly quickly. If you create a liability in those circumstances, I do not think it will have much of an educative effect on the road authorities. I do not think it is possible for them to respond quickly enough to every pothole appearing on a road in New South Wales.

Mr WOOD: Roads and Maritime Services has road inspectors.

The Hon. TREVOR KHAN: Not that many.

Mr WOOD: It is my understanding from correspondence with RMS that it inspects major State roads once a week. That is fairly quick.

The Hon. TREVOR KHAN: But there are more than major State roads in New South Wales.

The Hon. LYNDA VOLTZ: Most roads are the responsibility of councils.

Mr WOOD: Yes, 80 per cent of roads are council roads and councils have a number of employees. Some councils also have reasonable car pools and council employees are driving those cars. While they are out and about driving around they should be looking for road defects and reporting them. They do have a means of inspecting roads fairly regularly. We certainly encourage riders to report road defects to road authorities. I have reported a defective inspection cover that was the responsibility of Sydney Water, and it took several weeks to repair it. It has a requirement under the Roads Act to have inspection covers flush with the road surface. This one was in the middle of the lane on a corner.

The Hon. DAVID CLARKE: Are you saying that someone who works in the accounts department at the local council would be under an obligation to report and possibly negligent for defects in the road system?

Mr WOOD: Yes, because safety is the responsibility of all employees in many organisations. Employers have responsibility for safety in industrial workplaces, but the employees are also responsible. If council employees spot a road defect while they are on council business, I do see any reason that they cannot report it.

The CHAIR: I am not sure that is within the purview of the terms of reference.

Mr DAVID SHOEBRIDGE: I went for ride with my daughter this morning down one of the rear lanes. It was a horror show of potholes and has been for a couple of years, so I am emotionally committed to your project. As a plaintiff torts lawyer during my career, I am also emotionally committed. Like the Hon. Trevor Khan, I had frustrations with the nonfeasance rule in particular. However, there are complex public policy considerations that find their way into the Civil Liability Act—section 45, section 43A and those parts of the Act. I think one talks specifically about road authorities and another more generally about statutory authorities. If we were to adopt your proposal—that is, holding road authorities accountable—we could not do that without having a broader hearing to look at the broader public policy issues. Do you agree with that?

Mr WOOD: Yes, it is a complex issue. However, my point is that they have signed up to this Safe System approach; they have said they have a responsibility to provide a safe road network. If they are not meeting those obligations, what is the point of having that approach and what is the point of having a Towards Zero goal if the basis of providing a safe road network will not be achieved?

Mr DAVID SHOEBRIDGE: You have persuaded some members of the Committee that there is a good public policy position in having responsibility and liability lie with people who can fix things. That part is unarguable. However, we then come to the point of—

The Hon. LYNDA VOLTZ: Reality.

Mr DAVID SHOEBRIDGE: —the funds available, particularly for regional councils, which can have very extensive road networks. If they do not have the funds to build and to maintain their networks and we add an additional legal liability for the damage that is occasioned by not having the funds to maintain them, you can see a spiral effect—

The Hon. DAVID CLARKE: Legal potholes, to coin a phrase.

Mr WOOD: But no doubt councils were aware of that when they signed up to the Safe System approach.

Mr DAVID SHOEBRIDGE: I think you might be giving more agency to councils than they have when the State Government rolls out a Safe System approach. If councils thought that came with a legal liability when they failed to fix potholes, I think they would have run 100 miles—provided it was safe. Do you see how those public policy issues operate?

Mr WOOD: Oh, yes; but, again, if the Government has signed up to the Safe System approach, then I guess they have got to provide the funds and other resources to implement that.

Mr DAVID SHOEBRIDGE: If we are going to go down that path, should we not then be looking at complex things such as financial assistance grants from the Commonwealth that underwrite regional councils for their road networks. We would have to look at State funding for councils for their regional road networks. Maybe that is something we should do in a future inquiry on motor accidents and lifetime care and support.

Mr WOOD: Yes.

The Hon. DANIEL MOOKHEY: Mr Wood, in respect of the Safe System approach that you advocate for, are you aware that—

Mr WOOD: I am not advocating for that approach. It is one that has been adopted.

The Hon. DANIEL MOOKHEY: Okay. I accept that point. But you are aware that that originated as a desire to effectively replace a complex and litigious system with a cooperative system that effectively works on a supply chain basis? That is your understanding? And do you accept that in that system the whole concept of the Safe System is that you are liable for matters that you can control.

Mr WOOD: No. I think the Safe System approach is part of Towards Zero—to reduce or get the road toll down to zero.

The Hon. DANIEL MOOKHEY: Indeed. But the basic principle is that responsibility to provide a Safe System is allocated in terms of your ability to control the factors in the system, which is a cornerstone of occupational health and safety law that you have just cited as being an example that you called for.

Mr WOOD: There has been a recent inquiry into the National Road Safety Strategy.

The Hon. DANIEL MOOKHEY: Of course there has.

Mr WOOD: It made the point that we should not be making a safer network. We have got to make a safe network.

The Hon. DANIEL MOOKHEY: But do you see that perhaps the councils might see a tension there. If you apply the liability as you would state it on them, they would say that there are many factors outside their control that really does affect their ability to provide the Safe System. Do you accept that?

Mr WOOD: I can see there are difficulties. If they believe that, then they should be discussing with the State Government about the Safe Systems approach.

The Hon. DANIEL MOOKHEY: Do you understand that in a Safe System approach they would equally argue that there are obligations on the rider as much as there are on the people who are above them?

Mr WOOD: Yes. There is an obligation on the rider.

The Hon. DANIEL MOOKHEY: To the extent to which a no-fault scheme is really designed to avoid such conflicts within the chain so that we actually focus on the outcome, do you see that perhaps were we to embrace the literal definition that you are advocating that we might perhaps be encouraging a conflict between the councils and the riders for them to effectively engage in the blame-sheeting approach, which the Safe System is designed to avoid?

Mr WOOD: Yes, and we need to find a mechanism by which we can avoid that—in the same way the compulsory third party [CTP] scheme has been changed to remove a lot of that conflict to make it easier and cheaper to be able to get compensation.

Mr DAVID SHOEBRIDGE: But, Mr Wood, your position at the moment is there is no conflict because the rider cops the blame every single time and the council and the roads authority gets out of it.

Mr WOOD: Yes.

Mr DAVID SHOEBRIDGE: That is a solution to the conflict problem, but it is a solution that always paints the motorcycle rider as the culprit, which is not fair in the circumstances.

Mr WOOD: I think there is a shared responsibility; so, yes, if there are circumstances regarding perhaps speed and other issues then, yes, the rider has to take their responsibilities for the costs that they incurred. But where there is a case of—in my case it was a result of one single pothole that the council had repaired.

Mr DAVID SHOEBRIDGE: And had misfeasance, in so far as they had left gravel on the road.

The Hon. TREVOR KHAN: Indeed.

Mr DAVID SHOEBRIDGE: As opposed to nonfeasance, where they had not dealt with an empty pothole. That is the difference in your case.

Mr WOOD: Yes.

Mr DAVID SHOEBRIDGE: They had actively done something which had negligence associated with that as opposed to not fixing something.

Mr WOOD: Yes, but I am also arguing that if there is a pothole there the council just cannot say, "Oh, we didn't know about it." They should be making more of an effort to know about this, yes, there was a pothole, or if there is gravel.

Mr DAVID SHOEBRIDGE: If you drive around parts of Lismore, residents spray-paint the edge of the pothole with high visibility spray paint, and that is one way of getting council to find out about it and to warn other road users.

Mr WOOD: Yes.

The Hon. DANIEL MOOKHEY: But you would accept that effectively establishing an absolute liability on a council authority or other authority would be as absurd as establishing it purely on the rider as well.

Mr WOOD: Yes. I think there is a shared responsibility but the council or the road authorities need to be taking up more of these responsibilities.

The CHAIR: Five minutes remain.

The Hon. LYNDA VOLTZ: Can I go back to the difference in levies paid by country and city cyclists based on the capacity of bikes. We have had this issue before about motorbike capacity and really the difference between 250 and 500 or a thousand these days with the nature of bikes, has it been any explanation of why there is that difference?

Mr WOOD: Under the CTP scheme, it is really the difference between the ability of the bike to have a pillion because the pillion costs are the most expensive in that CTP scheme.

The Hon. LYNDA VOLTZ: But that is not normally based on the capacity of the bike, is it?

Mr WOOD: The capacity then reflects the size of the bike and its ability to carry a pillion. With something like a 250, you could carry a pillion; but most of them do not because of the fact that it is not that comfortable and it affects the performance of the bike far more than it does others. Many riders buy cruisers so that the pillion can have a nice comfortable ride.

The Hon. LYNDA VOLTZ: But that is the basis of it. Your understanding of it is that it is the capacity to carry a pillion.

Mr WOOD: It is the major cause for the costs in those higher capacity bikes.

The Hon. LYNDA VOLTZ: The difference between city and country—having ridden bikes I have always found the city a lot more dangerous than the country on a bike.

Mr WOOD: Yes, but you will find that a lot of the bikes being ridden in the country are people from the city out enjoying a recreational ride. The cost then goes back to, because the bike is registered in Sydney, against the Sydney registered bike.

The Hon. LYNDA VOLTZ: So country riders have a much higher levy you were saying—$75 on the higher capacity?

Mr WOOD: Yes, in the highest capacity.

The Hon. LYNDA VOLTZ: As opposed to 30 in the city?

Mr WOOD: That was the difference.

The Hon. LYNDA VOLTZ: Yes, that was the difference.

Mr WOOD: That was the comparison between a car class 1.

The Hon. LYNDA VOLTZ: What I am trying to get to is why the country high-capacity is larger than the city.

Mr WOOD: That I cannot answer. It is a question I would say we are going to ask the State Insurance Regulatory Authority [SIRA] when we next meet with them, which I think is on 8 February.

The Hon. LYNDA VOLTZ: It occurred to me that one of the issues may be the difference, in fact. That is where the road maintenance issue probably does come more to the fore once you get off the city roads.

Mr WOOD: Yes, but the other difficulty is the number of vehicles in each particular class. It may well be that there have been some large claims in that particular category and therefore that is why those premiums are still high.

Mr DAVID SHOEBRIDGE: And the speed of the accidents, if you are driving on country roads compared to driving on city roads. There is poor road maintenance, speed of accidents and you are going to have probably more like the catastrophic injury, I would imagine.

Mr WOOD: Yes, usually as a result of the higher speeds involved.

The Hon. LYNDA VOLTZ: And that would align with the data that you guys are looking at?

Mr WOOD: Yes.

The CHAIR: If there are no further questions from Committee members, thank you for coming along today. I believe you have not taken any questions on notice, but if there are any further questions by Committee members they will be submitted to you in the next 24 hours.

Mr DAVID SHOEBRIDGE: I just have one question to put on notice, which is about unregistered bikes. I am not asking you to answer it now but I am asking you about any events you have had in terms of roping in unregistered bikes, particularly dirt bikes, and what the response has been.

Mr WOOD: No. We have had no success in that area.

Mr DAVID SHOEBRIDGE: All right. But if you want to add anything to that on notice, please feel free, Mr Wood.

Mr WOOD: Okay.

The CHAIR: Thank you, Mr Wood. Should you do so, the Committee is under fairly tight time constraints and I ask if you could provide those answers as quickly as possible and at the latest by 7 February. The secretariat will assist you with those questions and answers, if that is necessary. Thank you for coming today.

Mr WOOD: Okay. Thank you.

The CHAIR: The Committee will adjourn briefly for morning tea and resume at 10.15.

(The witness withdrew)

(Short adjournment)

MARK MOREY, Secretary, Unions NSW, affirmed and examined:

NATASHA FLORES, Work Health and Safety and Workers Compensation Industrial Officer, Unions NSW, affirmed and examined:

BEN KRUSE, Legal and Industrial Officer, Construction, Forestry, Maritime, Mining and Energy Union, affirmed and examined:

The CHAIR: Thank you all for appearing before the Committee today and for your written submissions, which the Committee members have read. Ms Flores, would you like to make a short opening statement?

Ms FLORES: Yes. Unions NSW welcomes the invitation to appear before the Standing Committee on Law and Justice in this Lifetime Care and Dust Diseases review. Unions NSW made a submission late last year in the Lifetime Care and Dust Diseases review based on recommendation No. 1 of the first review of the Dust Diseases Scheme, which was published in August 2017. We decided to focus on this because we felt that this was of greatest concern to us given the risk at the moment to our members and workers in general. Recommendation No. 1 stated that "the relevant Minister urgently convene a task force of industry, regulatory and workforce representatives to review safety standards in the manufactured stone industry and consider regulatory changes necessary to protect workers in the industry."

The task force was established in 2018 and Unions NSW, along with the Construction Forestry Maritime Mining Energy Union [CFMMEU], and now the Australian Workers' Union [AWU], have been participating in these new meetings. While we have found these meetings to be a valuable opportunity to discuss the issues, the concerns and the obstacles faced, and also a good learning opportunity, as we enter 2019 we remain extremely concerned for the safety of people working in these industries. Our first concern is around the current exposure standard. We would like to see this reduced from 0.1 milligrams to 0.025 milligrams to match that of the United States—we have raised this in our submission.

We are also concerned that the exposure to respirable crystalline silica [RCS] is not often known, given the requirement under the Work Health and Safety Regulations around air quality testing is only required where there is uncertainty as to whether the airborne concentration exceeds the exposure standard order to determine if there is a health risk. We also know that monitoring this is costly and it is more than likely that a small business will not undertake this unless it is mandatory or less costly. Unions NSW has also argued that more screening needs to occur to ensure work that is likely to develop the disease or at the early stages are removed from this environment in time to prevent any terminal prognosis.

Unions NSW understands that controls can be put in place to greatly minimise the risk of exposure. However, the reality is that much of this work—that is, the installation of kitchen and bathroom bench tops containing very high levels of silica—is conducted by very small businesses, often migrant workers, who work in domestic residences throughout Sydney. Many of these workers would be under enormous pressure to get the jobs completed quickly, so these time pressures lead to shortcuts. These workers are also invisible—they are very, very hard to find. While we are very pleased that SafeWork NSW has made visiting relevant businesses a priority, we also have concerns that SafeWork NSW does not have the staffing capacity to adequately police this. In reality, it would take an enormous number of field-based inspectors to be able to adequately police this issue whilst also investigating the usual complaints, accidents and incidents that occur daily across New South Wales.

Recently we have been made aware of a new product. The new product: Geoluxe, is apparently an engineered stone product made of 100 per cent minerals and zero resin, which is the component used to bind quartz together in products like caesarstone. We understand that further information is available at *www.geoluxe.com*. We have the manufacturer's safety data sheets and it presents ranges of silica from a minimum of 7 per cent to 25 per cent maximum. Obviously more research and investigation should be undertaken on this product but ,on the face of it, it looks as though there are alternatives available to the traditional engineered stone products currently used. We would encourage this Committee to consider recommending that further research be undertaken into new products like Geoluxe. Thank you.

The CHAIR: Mr Morey, would you like to make an opening statement?

Mr MOREY: No, I am fine.

The CHAIR: Mr Kruse, would you like to make an opening statement?

Mr KRUSE: Yes. I give apologies for our president Rita Mallia. We have an urgent industrial matter on this morning so apologies for her not being able to attend.

The CHAIR: I understand. For the benefit of those watching the broadcast, I appreciate you all combining your time and appearing together as one unit today. Thank you.

Mr KRUSE: Our submission addresses the emerging silicosis crisis, which was a significant focus of the Standing Committee's first review of the scheme in August last year. In September last year the Construction Forestry Maritime Mining Energy Union [CFMMEU] health and safety representatives [HSR], which are our delegates—these are the workers who actually perform this work—passed a resolution calling for the elimination of products such as manufactured stone benchtops that have high levels of silica—the types like caesar stone, all of which are imported into Australia. Our HSRs emphasize that exposure is not just limited to the employees who are working directly with these products—these will be the small contractors who are setting the kitchen benchtops in place in domestic settings and the like.

In large residential and commercial building projects the dust that emanates from the installation of these products affects all workers in the vicinity where the work is being carried out. The message from SafeWork NSW to our members is that dust exposure can be adequately addressed through the use of controls. However, even on these large building sites involving big corporate "person conducting a business or undertaking" [PCBUs]—in other words, anyone who has a control over the safety of that workplace— our HSRs report that the work is commonly performed bysmaller contractors. There is a haphazard approach to the use of controls on the sites and the result is that our members continue to be exposed to this task. In the smaller domestic settings, as has just been pointed out, there is even less likelihood that the controls that should be put in place will be put in place. We have also identified there is uncertainty about the data supporting the adequacy of the controls recommended by SafeWork NSW.

The small entity compliance guidelines that are being used to guide the control standards are based on studies conducted in the United States, and to my knowledge there have not been independent studies here to make sure they are actually appropriate. As you have just heard, it is clear that the workplace exposure standards are grossly out of date and, of course, they link to the requirements in the Work Health and Safety Regulations about when monitoring occurs. So there is a really urgent need to address those. Given the continuing inadequacies regarding the use of controls and lack of knowledge about what safe exposure actually is, we are concerned that the current regulatory approach essentially is left up to the employer or the person in charge of that workplace to decide whether or not there should be monitoring.

The regulations need to be amended to make sure that monitoring occurs regardless of when dust work is carried out. I participate on the Manufactured Stone Industry Taskforce, which the Government is running, and the push back we are getting in that context is that monitoring is expensive to do, so this is the issue. If we are going to use a control-based approach, that can really only operate effectively if you monitor all of this work and that is just not going to happen. It is too expensive and to be quite frank people just do not do it. Our members are acutely aware that this is the case; control-based approach does not work and we need to get back to the principal rule with work health and safety and that is: if you can eliminate the hazard, you do so. If there is a hole that you might fall down, you fill the hole up, you do not put a barrier around it. You get rid of it. This sort of dust exposure should be treated the same: Get rid of the source of the dust.

None of the manufactured bench tops used in Australia are made here; they are all imported, yet the overseas-based commercial manufacturers have a very significant and continuing influence in promoting a control-based approach in forums such as the Manufactured Stone Industry Taskforce because they are concerned with protecting their profit margin. This is a bit like—it is a lot like—the experience with James Hardie and asbestos. If we look back in time, we are with silica exposure now where we were with asbestos in the fifties and sixties. The exception is that back then Australia had a huge investment in the mining and manufacture of asbestos products so it was a huge cultural and economic change to actually say, "We have got to get rid of this stuff". These manufactured stone bench tops, which are 90 per cent silica, are all imported.

There is no reason why we should not actually be developing a local industry here to grab hold of this market worldwide and our businesses can be exporting Australian manufactured products which are safe, not unlike the ones Ms Flores spoke about. We could export that worldwide and actually get in at the beginning of what is going to be a growth industry. We have also pointed out that we need more investment in lung buses. We need more medical screening and it is quite clear, and the Thoracic Society said and everyone supports a national register the dust diseases but the reforms are moving too slowly. You have national involvement with this, you have a national inquiry into workplace exposure standards and national work health and safety regulations but it is our workers in New South Wales who are dying from these diseases. We have young people who are affected. We say we need to take some urgent action at the State level to address an urgent problem.

The CHAIR: We will see how we go for time, address questions as they arise on the topics and if I feel the need to allocate time I will do that separately.

The Hon. TREVOR KHAN: Can I just ask a couple of questions first?

The CHAIR: Yes.

The Hon. TREVOR KHAN: As to this Stone Lux product, why is that perhaps a safer product than the imported product, the caesarstone and the like?

Ms FLORES: The Geolux?

The Hon. TREVOR KHAN: Yes, sorry?

Ms FLORES: There are much smaller quantities of silica in that. The caesarstone products have very, very high levels of silica. This product has much lower levels. The silica is the problem so if we can use products with much lower levels, but the problem is in terms of the manufacturing side of things silica works very well because of its durability. You can have lots of different colours; obviously lots of people like to have different coloured bench tops. It is also less porous.

The Hon. TREVOR KHAN: It stains less and the like.

Ms FLORES: It stains less, it is more hygienic. I think if we can find or develop—and I am sure the science is certainly capable of it and it looks as though we are heading in that direction—a way of having a product that has reduced levels of silica but still meets the requirements that the consumer wants, then I think we should certainly be looking into that. Certainly companies such as caesarstone should be doing that. I would encourage companies such as caesarstone, and within our task force meetings I do believe that they are looking at some of these products but I do not believe that they are doing that at the speed with which we believe they should be.

The Hon. TREVOR KHAN: I am not trying to minimise this in any way but one of the charts we were given by icare is a chart that identifies silicosis as running at roughly 7, 8, 9 consistently each year. Do you know what I am talking about?

Mr KRUSE: I know exactly what you are getting at but do you want to finish your question?

The Hon. TREVOR KHAN: I am just wondering because we have talked about it in the sense of an explosion of this?

Mr KRUSE: Yes.

The Hon. TREVOR KHAN: Again I am not trying to minimise this in any way because obviously I was involved in the last inquiry but I expected to see some sort of uptick particularly as the use of this stone has become more and more frequent in households and the like?

Mr KRUSE: Yes.

The Hon. TREVOR KHAN: Why are we not seeing it in the figures?

Mr KRUSE: If you look at the Thoracic Society submissions, there is a real concern that the actual incidence has been massively underreported. In Queensland—and it is addressed in our submission—in the last 12 months there actually has been a massive increase in the number of reported cases. Because of Queensland's experience with black lung disease they have become very focused on this and so they are actually looking for the results. In New South Wales it is not a reportable disease. If you go to the doctor and you do not have silicosis, the doctor does not have to give a mandatory report and most workers will not want to have a mandatory report of this disease because once you report that you have got it, the most likely outcome is that you will lose your job because it is unsafe for you to continue to work in these dusty environments if you have the disease.

I think even icare accepts that the figures that are being reported did not reflect the actual state of the issue. I would be very careful to base any response on the current data that is available. The disease is hidden and that is why we need the mandatory reporting mechanisms, more screening to ensure that people actually do get the care and we can actually map where the disease is prevalent.

The Hon. DAVID CLARKE: You say there are figures from Queensland however. You said there is a massive increase?

Mr KRUSE: Yes.

The Hon. DAVID CLARKE: What sort of increase percentagewise; just a rough idea?

Mr KRUSE: I can take that on notice. I do not want to rat through my submissions now.

The Hon. TREVOR KHAN: I think icare can give that because I have already asked them about Queensland.

Mr KRUSE: There were 20 cases reported in about three months at the end of last year.

Mr DAVID SHOEBRIDGE: Twenty cases in the last quarter?

Mr KRUSE: Yes.

The Hon. LYNDA VOLTZ: And is part of that also to detect the disease if you are not sure from the CAT scan or from the X-ray that you actually need a lung biopsy? Is that playing into part of the diagnosis of silicosis?

Ms FLORES: This is probably more something you would be asking the thoracic specialists but from our discussions with them they definitely have concerns around the current screening methods and are telling us that those methods are inadequate.

The Hon. DANIEL MOOKHEY: My question is potentially to start to tease out the scale and magnitude of incidents and the supply chain. My understanding of the stone masonry industry is that the way it works is that it is imported, it is cut, it is installed. Is that a simplistic way of describing it?

Ms FLORES: Yes.

Mr KRUSE: That is right. The manufacturers are very keen to show the engineering and other controls that they have in place in the factory settings. Manufacturers encourage the installers to bring the stone back to the factory setting for adjustments to be made but that does not happen in practice.

The Hon. DANIEL MOOKHEY: My familiarity with this particular supply chain is because effectively one of the cutting places is right around the corner from where I live. We are talking about which class of worker is exposed. We are talking about firstly, the stonemasons who are cutting it in the factories or recutting it from the manufacturer and the people who are installing it. How many people are we talking about at those two levels?

Mr KRUSE: In the small domestic setting it is likely to be—and I do not have a lot of exposure to this because our members tend to mainly come from the larger commercial settings—it is the installers themselves, which are small subcontractors, a lot of non-English-speaking background, the Korean community is heavily involved in this.

The Hon. DANIEL MOOKHEY: So unskilled labour.

Mr KRUSE: Yes, largely unskilled, self-taught.

The Hon. DANIEL MOOKHEY: Transient?

Mr KRUSE: Yes. They will then be exposing other people on those sites such as carpenters and builders. When we get into the large commercial settings, these big businesses and major corporations, the experience of our members, as our health and safety representatives [HSRs] are telling us is happening, is that the builders, who have overall control of these sites, are really not terribly focused on policing these controls. So you might have a small subcontracting entity come in and a couple of non-English-speaking background, unskilled labourers start cutting this stuff up on a commercial site where there are hundreds of people working and there is dust everywhere and it is not controlled, so not only are the workers who are installing this exposed but also our members who passed the resolution to say we have got to get rid of what they describe as this putrid product; they are exposing everyone on that site.

Mr DAVID SHOEBRIDGE: Some people have suggested that part of the answer might be having wet cutting on site and requiring if you are cutting on site you can only do it with wet cutting where you are applying water and dampening down the dust as you cut.

Ms FLORES: We have certainly heard that. Particularly when the task force began, the move was we need to ensure that all cutting is wet cutting, and this is the situation in the United States, this product is supposed to always be cut wet. That is possible in some situations. If it is back at the factory where it is cut to fit the bench you can do that. One of the problems is that if it is taken out to the building or it is taken out to the house it often does not fit—

Mr DAVID SHOEBRIDGE: It has got to be trimmed down.

Ms FLORES: —and then it needs to be trimmed down. Obviously, wet cutting is not happening in that situation. We have also heard through this task force, and you have to understand that there is a morning tea and we talk and chat amongst the different specialists and in one of those morning teas it came up that it is possible—and this is just coming out of the United States and we do not have a lot of research—that possibly wet cutting does not prevent this. So initially we were quite yes, wet cutting is the answer, but now we are unsure and we believe that more research needs to happen, particularly in the United States where it is always usually cut wet.

The Hon. TREVOR KHAN: I do not doubt what you say but do you know of any papers that have been done that have analysed this?

Ms FLORES: I do not, and I have tried to look. As I said, this is anecdotal around the morning tea table discussion and I think this was someone from SafeWork that mentioned this.

Mr KRUSE: The SafeWork inspectors who have attended the task force have been absolutely adamant that wet cutting is not necessarily the answer.

The Hon. TREVOR KHAN: Why is that?

Mr KRUSE: I understand that there is emerging evidence from the US, as Ms Flores was just saying, to say that exposure can occur from wet cutting as well.

The Hon. TREVOR KHAN: I am sure it can but—

Mr KRUSE: There are not enough studies. Most of the work in this area is coming from studies that have been conducted by the manufacturers themselves; they have an interest in ensuring that the product is regarded as safe. Asbestos is safe when it is wet and moulded into place. This is what we keep getting back to.

The CHAIR: You can eat asbestos, you just cannot breathe it.

Mr KRUSE: You can eat it. It is a fantastic product to eat—the problem is it kills you.

Mr DAVID SHOEBRIDGE: I remember chewing on it as a kid.

The Hon. DANIEL MOOKHEY: The dietary uses of asbestos are interesting, but the question I am asking you is getting to the extent of the point that you were making about whether or not a controls-based approach can practically work when you get that part out of the supply chain. The other question I was going to ask is to what extent does the notorious problem in the building industry of the phoenix effect have on whether or not these small subcontractors are able to control their environments?

The Hon. TREVOR KHAN: Point of order—

The Hon. DANIEL MOOKHEY: I withdraw the question in that sense. If we are attaching the liability at that low level can you describe whether or not that control approach is communicable down the supply chain to the point where a small subcontractor who is installing my kitchen bench can be subjected in a practical way to these control devices that the task force is thinking about? That is a better way of putting it.

Mr KRUSE: If we look at the data, again in our submission we have quoted some of the data that SafeWork inspectors have put forward to the task force. They are going out and doing more inspections of these smaller installers and manufacturers, but they cannot get to all of them. I am a member of the Dust Diseases Board, and I do not purport today to speak on behalf of the Dust Diseases Board, but the board has initiated a process and encouraged the Government to take up advertising in radio and in the newspapers in community languages to try and address this issue towards those populations who just might not be aware of the controls. If you see the correspondence from the board to the Minister, the board has recommended that the Government look at the use of alternatives to high-silica products. It did not go so far as to say to ban them, but if you have got the Dust Diseases Board saying we need to look at alternative products, the reason being that we just cannot be assured that these small installers will ever get the message and even if they do get the message they just might not apply the controls.

The Hon. DANIEL MOOKHEY: You made the parallel before about asbestos and that an economic incentive was created around asbestos. All these approaches that you have described about controlling the risk, advertising to market populations, inspections, they were all rolled out for asbestos for a long time before we eventually went, "It's not going to work". Why should we have more confidence that it will work with silica as it did for asbestos and therefore the elimination strategy that you are calling for, tell us about whether that is better to invest in than control?

Mr KRUSE: We have no confidence that the controls will be applied. That is why our delegates have called for the elimination of the product and it is why, particularly where we met with the Minister recently and pointed out if the Liberal Party represents the business community here is an opportunity for Australia to be ahead of the game, develop a product which is technologically advanced and safe and export this to the world.

The Hon. DANIEL MOOKHEY: You said there is pushback in the task force. In your opening statement you said that when these arguments were laid out at the task force there was pushback. Who is pushing back?

Mr KRUSE: SafeWork.

The Hon. DANIEL MOOKHEY: On what basis?

Mr KRUSE: SafeWork are very firmly of the view that the issue should be able to be addressed through controls. In my personal view SafeWork have been captured by the business community and this task force have been captured by the manufacturers.

Ms FLORES: They argue that silica is in everything, and it is—it is in sand, it is in stone, it is everywhere. Their argument is you cannot get rid of it because it is everywhere. That is one of the things that we have found when we were on the task force that they have come back with: it is in sand, it is in granite, sandstone, flint, slate—

The Hon. DANIEL MOOKHEY: Is it as concentrated in all those forms as it is in caesarstone?

Ms FLORES: Caesarstone is a manufactured product which uses high concentrations. It is different. It is the fact that it is the dust that is just all over the place. If you go into a lot of workshops in Sydney—these are just anecdotal, and our colleagues from the Australian Workers' Union [AWU] are not here at the moment—they have stories of, particularly in the tunnelling at the moment, excessive amounts of dust. We have spoken to the Minister about this and, to be fair, the Minister has taken on board these concerns and SafeWork has been in touch with me to talk to the relevant unions about what can be done. The AWU tell us that when there are diligent site managers on site the controls that are in place do work. When they are not on site, so if you have a site manager who is in a hurry, wants to get the work done quickly, then those controls do not happen and you are just working in—you know, we have seen some photos and we have shown those to the Minister, you can barely see a metre ahead of yourself.

The Hon. DANIEL MOOKHEY: That is always the nature of supply chains to economic incentives.

Ms FLORES: That is correct. In theory, I think if all controls are in place, yes, you can minimise or even eliminate almost, but these controls are not going to be used in these very small operations and there is absolutely no way that you can police the domestic use or the domestic households out there—the thousands and thousands of houses that are getting renovations done daily. It is just impossible.

The CHAIR: Do you have something to add to that?

Mr KRUSE: If you do not mind, I would like to return to the issue about our concerns with Safe Work's involvement in this area. We met recently with the Minister to complain that the task force has become a politicised body. The task force was recently asked to provide an interim report to the Government about the work that it is doing. It was also given the opportunity to advise the Minister on proposed reforms to go to Marie Boland, who is conducting the Safe Work Australia review of the regulations. The Construction, Forestry, Maritime, Mining and Energy Union [CFMMEU] indicated that as representatives on this task force that we wish to have our members' views about the banning of the high silica products put forward as a proposal. The response of the task force to that was to have that proposal subject to a vote of members on the task force. I have never participated on a working party, a sort of fixing things type group before, where the members of the task force actually vote on outcomes. We were outvoted by the large number of industry representatives on the task force and so our recommendation did not actually get reported at all.

We had to write separately to the Minister and we had to write separately to Marie Boland, who was conducting the regulation review, to ensure that our view was put forward. It is very clear to us that the people running the task force are doing everything they can to ensure that the views of our members—and it is our members who do this work, it is 50 HSRs passed this resolution at our offices to have this product eliminated—to ensure that the views of the workers on this issue are actually reported to the Government and taken into account. The Minister has told us that this politicisation of the task force will stop, but I suppose it reflects the fact that there are problems with it. In fact, the membership of the task force is being reviewed to bring on a lot more employer and industry reps. Our advice is to be careful about what you hear in terms of recommendations from the task force because it is not necessarily reflective of the views of all those members.

The Hon. TREVOR KHAN: I think the problem is that we are unlikely to hear, at least in this Committee form, of that because we are on the edge of this issue dealing with the dust diseases part of it, not where you are, which is essentially in the guts of it. I think the whole problem with this at the moment is that we are not going to have the opportunity of hearing from representatives.

The Hon. DANIEL MOOKHEY: We are too removed from the supply chain.

The CHAIR: But we have your submissions.

Mr DAVID SHOEBRIDGE: We will get some guidance from SIRA and from icare, I am sure.

The Hon. TREVOR KHAN: I know, but it will only be a partial picture that we get.

Mr DAVID SHOEBRIDGE: When you approached Safe Work and you say, "Obviously what we should be doing is eliminating the risk" and given that when you look at the hierarchy of responses, Safe Work's own statute and all of its material says, "That's what you should first of all do, eliminate the risk" how does Safe Work respond to that and say, "No, no, instead we are going to put in control measures"?

Ms FLORES: "Where reasonably practicable" so they use that. That is part of the law which is the sort of get-out-of-jail card.

Mr KRUSE: Yes, and our submission focusses on this sort of wilful blindness that is attached to this whole issue. There are the regs—I can't point you to the section—but it only requires that monitoring occur where the person in charge of this work is not certain on reasonable grounds that there is a risk. If you don't actually monitor you don't know that there's a problem and you're unaware of the risk. The recommendations about what the appropriates responses are for the controls are sort of based on studies in the United States and, as far as I can see, no-one is doing any work to see what the actual exposures are for wet cutting, dry cutting, cutting under various circumstances.

Mr DAVID SHOEBRIDGE: Have you had reported to the task force whether or not there have been any actual prosecutions for unsafe work?

Mr KRUSE: There have been inspections and Safe Work has increased the number of inspections. There have been improvement notices issued and there have been a significant number of improvement notices issued, but, I think, less than a handful of prohibition notices to actually stop the work being done, and zero prosecutions to my knowledge.

Mr DAVID SHOEBRIDGE: Mr Morey, given the extent of this as a work, health safety issue, what is the view of Unions NSW about the absence of any prosecutions?

Mr MOREY: I think it is like with most of these things, there is a level of frustration for us as a movement. It is difficult, (a) to identify the problems, (b) to get those raised in the particular forums, and, (c) to have any ability to force the regulator to actually take those steps to actually lead to a prosecution.

Ms FLORES: Sorry, can I interrupt. We have obviously contributed to the submissions last year to the model work, health safety Act and one of the problems in the Act is it is very difficult to prosecute. Since we lost, the onus is on us to prove, or Safe Work to prove, that the person conducting a business or undertaking [PCBU] undertook all avenues possible. Since we lost that onus of proof we obviously also can't prosecute as unions ourselves; we can only prosecute categories one and two where the Director of Public Prosecutions does not want to prosecute. Otherwise that just leaves category three, the sort of more minor issues. There have been no union prosecutions since the new laws came into place. I had a quick look the other day at the Safe Work prosecutions for last year. There were very few and even Safe Work will tell you that it is not easy to prosecute. The burden of proof is just too difficult.

Mr KRUSE: Do you mind if I add to that? We pointed out in our submission that one of the issues is that Safe Work really is not answerable to anyone, except perhaps to this body here.

The Hon. TREVOR KHAN: They are not answerable to us; not in this inquiry.

The CHAIR: No.

Mr KRUSE: They are answerable to no-one and so in our submission we talked about the Burrell Creek asbestos. This is a State Government RMS road project on the South Coast. Our officials turned up and found asbestos everywhere and people breaking it up without any controls in place at all. The inspector was asked to come down. He sort of poked around and said, "Don't worry about it." So we did an internal review. The employees, in an area of high unemployment, were absolutely too scared to put in a complaint themselves and no HSR on site, or not one that was willing to do anything. So we submitted an application for an internal review and they came back and said, "No jurisdiction. We won't answer to you." So we went to the Industrial Relations Commission and the Government solicitor was instructed to come down and say, "The commission doesn't have the jurisdiction to deal with this complaint."

Mr DAVID SHOEBRIDGE: So a vast amount of resources were spent on killing off even addressing the complaint let alone addressing it.

The Hon. TREVOR KHAN: I am sorry, I am going to make the point again—

The CHAIR: I am sorry, I have let it run—

The Hon. TREVOR KHAN: We are dealing with an inquiry into two bodies. This is quite outside the terms of reference, even though it is interesting.

Mr KRUSE: It is interesting.

The CHAIR: In the interests of all of us getting on nicely this year, I have let it run, but I am afraid I am going to have to rein it in to the terms of reference, as is my obligation. And I have some questions, which I would like addressed. Will you comment about your experience with the so-called lung bus? We have spoken about how things were not done well in the past and with a view to trying to do things better. I hear your concerns; I am not trying to minimise them. I would like to hear of your experience with the lung bus. In a perfect world we would have lung buses everywhere and monitoring everywhere, but as a first step will you give the Committee some information about your experience with that please?

Mr KRUSE: The task force reports have more focus on resources for the Lung Bus, and it is going to smaller work sites. It is my understanding that access to the Lung Bus is subsidised for smaller employers. The larger employees pay a fee but the smaller ones do not, which is great. However, the concern is that the demand for the use of this resource is much greater than what is available. In our submission we have indicated that there needs to be more funding. I have also raised that matter through the Dust Diseases Board.

Mr DAVID SHOEBRIDGE: Maybe it is doing testing with providers other than the Lung Bus. As I understand it, Insurance and Care NSW [icare] is looking at that and is having testing done by people other than those running the Lung Bus. Do you have any thoughts on that?

Ms FLORES: I do not think the Lung Bus can adequately test the number of people who need to be tested. Absolutely that needs to happen.

Mr DAVID SHOEBRIDGE: Have you spoken about what that model might look like?

Mr KRUSE: We have proposed that there be more government funding to provide more lung buses. We have not looked at other alternatives. We should not forget that this must go hand in hand with mandatory reporting. Doctors are in a terrible position. They are seeing patients who they know have this disease and it is not required to be reported; reporting is not mandatory. As a result it does not appear in the statistics.

Ms FLORES: Of course, the problem is the workers' fear of being tested and being found to have it.

Mr DAVID SHOEBRIDGE: It is an end-of-career tunnel.

Ms FLORES: Absolutely; it is a major concern to us. I do not have the answers at the moment. However, I can certainly understand why someone would hesitate to be tested if that meant their career was about to end and they would have no way to keep a roof over their head.

The Hon. TREVOR KHAN: But there is another factor in that, is there not? A male with a mole growing on his back will put off doing anything about it. They do not get it checked because the easy way to avoid the news is not to have it examined.

Ms FLORES: Correct.

The CHAIR: But in terms of proactivity, sending a bus out to the workplace, particularly to smaller businesses that may not be able to afford to have everyone to take a day off for testing despite that being ideal, could be a problem. My understanding is that it is also difficult in rural and regional areas. Can you comment on that aspect?

Mr KRUSE: It is absolutely a good idea and there needs to be more of it to ensure that these resources get to as many workplaces as possible.

The CHAIR: In the event that the bus turns up and everyone is tested—

Ms FLORES: They have to get tested. They all get on the bus.

The CHAIR: But they might say they would rather sit it out; they would rather work.

Ms FLORES: It is not avoidable. If the bus turns up, all the workers are tested. There is no avoiding. It is ideal.

The Hon. TREVOR KHAN: Does anyone know how long the test takes?

Mr KRUSE: No.

The Hon. TREVOR KHAN: How many people can they bung through this bus?

The Hon. LYNDA VOLTZ: I assume it involves a CAT scan.

The Hon. TREVOR KHAN: They would not be doing CAT scans on a bus.

The CHAIR: There are some details in the icare submission about this. It has some outlines.

Mr DAVID SHOEBRIDGE: This would be useful to explore with the Thoracic Society of Australia and New Zealand.

Mr KRUSE: Yes.

Ms FLORES: That is definitely its space.

The Hon. DANIEL MOOKHEY: What is the age profile of the people we are talking about? You are talking about careers ending.

Ms FLORES: One of the frightening things is that we are looking at a lot of very young people dying of this. I do not have those statistics.

The Hon. DANIEL MOOKHEY: Are we talking about 30-year-olds or 40-year-olds?

Ms FLORES: The media did a few things last year and that got this issue out in the public.

The Hon. DANIEL MOOKHEY: I am going to ask icare about the actuarial advice it has about the length of the liability the scheme will incur.

Ms FLORES: One of the first major media stories focused on a young man in his early 30s or even late 20s. One of really horrifying things is that we are looking at very young men dying. However, I cannot tell the Committee the age range.

Mr DAVID SHOEBRIDGE: It is dependent on exposure as an apprentice and thereafter.

The Hon. DANIEL MOOKHEY: And time of detection and when they present. We will be asking icare how it assesses it and how it ensures there is enough money for them. Do you have any information that we could put to icare?

Mr KRUSE: The data referred to in our submission shows that, as opposed to asbestosis and lung diseases, silicosis has a much quicker onset. If you have 10 years of exposure in the industry, there is a very high risk. With asbestos, the latency period tends to be much longer. The member about whom I had to do a referral to our lawyers is a 31-year-old with a de facto partner and two dependent children who worked at a stonemasonry company with other young men and who worked with caesarstone. He has been referred with the onset of silicosis. That is what we are concerned about; this is a disease affecting young people. The signs we are seeing in Queensland are that it is on the increase. It is not being reported properly in New South Wales, so we simply do not know how much it has increased here.

The Hon. TREVOR KHAN: Is there mandatory reporting in Queensland?

Mr KRUSE: I am not sure, but it is affecting younger workers.

The CHAIR: Is there mandatory reporting in the United States?

The Hon. TREVOR KHAN: They would not have mandatory reporting of anything.

The CHAIR: That is my question. We are looking to the United States for standards and research.

Mr KRUSE: I am not aware of that.

The Hon. DANIEL MOOKHEY: Is the morbidity rate and the time until death from silicosis comparable to asbestosis?

Mr KRUSE: I think you should ask the doctors.

The CHAIR: I am not sure that is within their purview.

Ms FLORES: I think you should talk that the Thoracic Society because—

The Hon. DANIEL MOOKHEY: Are you talking about it being within my purview or their purview? It is certainly within my purview because it relates to the actuarial liability.

The CHAIR: No, I am saying that I do not think that these witnesses are capable of answering that.

The Hon. DANIEL MOOKHEY: That is okay.

Mr DAVID SHOEBRIDGE: I do not understand why we have not already changed the exposure rate standard. It seems to me that everyone agrees—

Mr KRUSE: Absolutely.

Mr DAVID SHOEBRIDGE: —that the .025 milligrams per cubic metre standard applied in the United States is the one we should apply in Australia. We have been talking about this for 18 months or two years. Why has the standard not been changed?

Mr KRUSE: Inaction.

Ms FLORES: Good question.

Mr KRUSE: Very. The practical effects are huge. We are in dispute with WestConnex about missing data. We have mentioned this in another inquiry. It is data on monitoring—

The CHAIR: Again, I caution you that that is not within the terms of reference of this inquiry.

Mr DAVID SHOEBRIDGE: But it is. It explains the resistance.

The CHAIR: I would like to hear from the witness.

Mr KRUSE: Thank you. I come back to the issue at point; that is, the workplace exposure standard. If the standard is 0.1 then you do not get a red flag until you get to 0.5 and it is not reportable until it exceeds zero.

The Hon. TREVOR KHAN: That assumes monitoring is being done.

Mr KRUSE: Yes. That is a practical example of a major infrastructure project where the red flags are not coming up and the mandatory reporting of incidents is not occurring because the people performing the work are complying with the existing standard, which we all know to be wrong.

Mr DAVID SHOEBRIDGE: Have you raised this issue with the task force? I think you all may have been on the task force at different times—you very sensibly delegate. What happens? We all agree that the standard should be changed. When will it change?

The Hon. TREVOR KHAN: Is that a matter for the task force? Is that what it is looking at?

Mr KRUSE: The task force is charged with making recommendations about how to stop the problem. Apart from the politicisation issues, it is meant to be a practical fixing-type job. Everyone on the task force agrees that it must change. A national review is occurring, but it is moving even more slowly than the State Parliament inquiries.

Mr DAVID SHOEBRIDGE: Could New South Wales move and adopt a standard here?

The Hon. TREVOR KHAN: No, it is a national standard.

Mr DAVID SHOEBRIDGE: I am asking the witnesses. Could New South Wales move to adopt a standard and perhaps push the nation along?

Mr KRUSE: We make specific recommendations about some of the regulations. We say that it would be appropriate for the State Government to move to amend the workplace exposure standards here, to fix the fact that you can be wilfully blind about whether there is a risk, and to amend the regulations to ensure that where dusty work is been carried out air monitoring occurs rather than relying on someone being aware without the information being available. Because of the urgency, we think action needs to happen now and it should be happening here.

Mr DAVID SHOEBRIDGE: While there are model work health safety laws, there is nothing that actually prevents New South Wales from promulgating a higher standard in the regulations.

Mr KRUSE: Absolutely.

Mr DAVID SHOEBRIDGE: What about even something as simple as the New South Wales Government saying that on all Government sites—

The Hon. TREVOR KHAN: This is getting so far away from the terms of reference.

Mr DAVID SHOEBRIDGE: No. It is not because of the process of tunnelling and other major sites.

Mr KRUSE: Write it into the contracts.

The Hon. TREVOR KHAN: Look, there are terms of reference for these inquiries.

The CHAIR: I am going to stop it there. There are separate inquiries into those matters. The Hon. Lynda Voltz has a question.

The Hon. LYNDA VOLTZ: Could you please take this question on notice? From a cursory glance, it looks as though Queensland amended legislation in 2018 to have mandatory reporting for both coal pneumoconiosis and for silicosis.

The Hon. TREVOR KHAN: Do you have that there?

The Hon. LYNDA VOLTZ: I did. I just looked it up.

The Hon. TREVOR KHAN: I am not disagreeing.

The Hon. LYNDA VOLTZ: What I am asking him to take on notice is whether he can check whether that is correct for Queensland and whether any other States are also doing that. It looks like Western Australia may have done something.

Ms FLORES: I think Victoria is moving in that direction.

The Hon. LYNDA VOLTZ: If you could take a look, take the question on notice, and come back to us on whether any States have done that and confirm whether Queensland has done that, that would be good.

Mr KRUSE: Sure.

The Hon. TREVOR KHAN: If you are looking at the other States, I would be interested to know, for instance—the United States is such a fragmented jurisdiction, it is hopeless—whether jurisdiction such as the United Kingdom [UK]—

The Hon. DANIEL MOOKHEY: The European Union [EU].

The Hon. TREVOR KHAN: Yes, the EU, although they may be one and the same.

Mr DAVID SHOEBRIDGE: There are standards in place in places like British Columbia in North America, which apparently have high standards applying to silicosis. There may be some useful Canadian legislation or United States of America States' jurisdictions or provincial jurisdictions.

Mr KRUSE: Sure.

The CHAIR: Thank you all for attending the hearing today.

The Hon. TREVOR KHAN: Expansive, but interesting.

The CHAIR: Some questions have been taken on notice. We are under some tight time frames for this Committee to report, so we would appreciate receiving your answers as soon as possible but at the latest by 7 February. The Committee staff will be in touch with you in regard to those questions and your answers. Thank you very much.

(The witnesses withdrew)

JOANNE WADE, Practice Group Leader, Slater and Gordon, representing the Australian Lawyers Alliance, sworn and examined

GERARD McMAHON. Partner, Turner Freeman Lawyers, representing the Australian Lawyers Alliance, sworn and examined

The CHAIR: Does either of you have an opening statement you would like to make to the Committee before we begin questions?

Ms WADE: Yes. I do. I appear today, along with my colleague Gerard McMahon, on behalf of the Australian Lawyers Alliance [ALA]. I welcome the opportunity to give evidence to the standing Committee's second review into the 2018 functioning of the Dust Diseases Care Scheme. For the sake of clarity, Mr McMahon and I will not be making any comments on the Lifetime Care and Support Scheme. I confirm we both represent the ALA, which is a national association of lawyers, academics and other professionals who are dedicated to protecting and promoting justice, freedom and the rights of the individual.

The ALA estimates our 1,500 members represent up to 200,000 people each year across all States and Territories in Australia. The ALA promotes access to justice and equality before the law for all individuals, regardless of their wealth, position, gender, age, race or religious belief. We have made some written submissions to the review that are dated 2 November 2018 and I refer to those submissions. Mr McMahon and I will be dealing with separate parts of the submissions. I would like to highlight in my opening that one of our submissions is to consider expanding the definition of dust diseases. I note this issue was also discussed extensively in the 2017 review.

The Hon. TREVOR KHAN: It was.

Ms WADE: The ALA supports the call for a review of the definition of a dust disease from the 14 diseases listed in the 1942 Act. The list was written in 1942 and in our view is outdated, given that the industries have moved on. The ALA supports the calls from the Thoracic Society to review the list of scheduled diseases. The ALA notes this will require research into which diseases should be on the schedule and it will also require actuarial advice and recommendations in relation to the costings if those diseases are to be added. It will also involve engaging with stakeholders for their expertise on those occupational dust diseases. The ALA also submits that those diseases should include occupational asthma, chronic obstructive pulmonary disease [COPD] from dust exposure, and the aggravation of pre-existing asthma. At present, those people diagnosed with those diseases are not able to obtain compensation through the Dust Diseases Care Scheme, but they do have rights under the Workers Compensation Act.

I also note that 95 per cent of the dust disease care cohort deals with asbestos-related diseases, as do Gerard and I, I think, in our respective practices. The majority of our work is related to asbestos-related diseases. I also wish to touch on the issue you have just been talking about in relation to silicosis and progressive massive fibrosis from caesarstone cutting and manufactured stones. This is continuing to rise. In particular, I can talk about three cases that I have recently had. They were all men aged 39, 40 and 41 respectively, employed as stonemasons in factories that were manufacturing the cutting of caesarstone benchtops for kitchens or bathrooms. Each of them was diagnosed with silicosis and progressive massive fibrosis. Such diseases are fatal. They were immediately told that they had to cease work in those occupations and they could not be exposed in a dusty occupation.

Having worked to their entire lives as stonemasons, leaving school aged 15, it is very difficult for those people to retrain into a different occupation. All of them have life expectancies of between probably eight and 10 years. Each of those different factories were dry cutting the kitchen benchtops. I have seen photos from one factory in particular from one of my clients where the layers of dust were appalling. I understand that WorkCover went out to investigate and the investigator would not even step into the factory, the dust was that bad. The ALA submits that more education of the community is needed in relation to the dangers of cutting caesarstone, as well as the risks that are involved. In the previous hearing they mentioned that silicosis and progressive massive fibrosis can come on after only having worked 10 years in the end; that is my experience as well. In relation to those risks, we also submit that WorkCover should be doing more inspections of those factories and more education. As to the balance of the ALA submission's on the icare scheme and the tribunal, I defer to Mr McMahon.

The CHAIR: I am not downplaying the importance of what you are saying but there are two things to consider. First, we have to deal with the terms of reference of this Committee—which you referred to at the end of your statement—namely, a statutory review of these two schemes. I am happy to hear generally about those issues but equally we cannot inquire into individual cases.

Ms WADE: I just raised those three as examples of stonemasons.

The CHAIR: The Committee understands that but just so you are aware. We need to be careful not to stray from the terms of reference.

Mr McMAHON: I am known for my brevity, so if it seems brief it is just me. The Dust Diseases Authority issue is fairly well dealt with in the submission but there are just a couple of extra points I wanted to make on reflection. Firstly, the administration of the scheme itself works pretty well. I, and no doubt Ms Wade, only find out about negative experiences because the authority deals with the worker the claimant directly so we hear about the difficulties. The complaints you tend to hear about are slow reimbursement of expenses and the like. I have to say over time the administrative staff have been responsive to those concerns. There was a period where it was taking six or seven months to obtain a Medicare refund of $700 or $800 and that sort of thing, but that seems to have gone.

A matter I find a little bit concerning is that the Committee may know the authority provides certain grants for research. If one looks to the most recent report of icare it will be seen that something like $2.6 million in grants have been made to practitioners at the University of Western Australia, whereas grants of just over $900 thousand have been made to New South Wales researchers. I find that a little bit concerning because these are premiums being paid by New South Wales employers and we should have the quality researchers in New South Wales who can use that money. In fact, I know a couple of grants have been made to oncologists who are looking at treatment in relation to malignant mesothelioma and it may be—I know that the people at the University of Western Australia have been engaged in research for a long time—that the response of the authority might be, "We are going to give the money where the expertise is." I think it is fair to say that we should be fostering that here, as opposed to giving the money to another State.

The CHAIR: We can certainly ask them about that.

The Hon. TREVOR KHAN: They are probably watching now so they will be on notice.

Mr McMAHON: No doubt they have a response.

The Hon. TREVOR KHAN: They will.

Mr McMAHON: You know, this is New South Wales and we pay the money.

Mr DAVID SHOEBRIDGE: I think it is 50 per cent funded from investments and 50 per cent from levies at the moment, and that varies over time.

Mr McMAHON: But the source funding is—

Mr DAVID SHOEBRIDGE: It has all come at one point or another—

Mr McMAHON: Yes, from employers in this State. Segue to another issue: the old rights of appeal under the Workers Compensation (Dust Diseases) Act against decisions of the authority. It is very rare that those rights are exercised and there are a couple of practical reasons for that. One of them, which seems to have got buried in the sands of time, is that if you go back in time when the Compensation Court of New South Wales existed, the appeal was made to that court and the governing Act of that court said that the court could not make a costs order unless there were exceptional circumstances—we are talking about litigation that is vexatious, without merit. Once the court was abolished the right of appeal is now to the New South Wales District Court and in the governing Act of that court—

The Hon. TREVOR KHAN: Costs follow the court.

Mr McMAHON: Exactly. Now it is invariably the case that any appeal against a decision of the authority is going to involve complex medical issues. There are a series of cases. My firm was involved—going back probably 10 years ago now—in the causation of lung cancer and whether the widows of waterside workers should receive lump sum compensation when they had been smokers. There was a prolonged hearing—I do not know what the costs were off the top of my head but they would have been in seven figures all up. Now there is no way on God's earth that a worker is going to appeal to the District Court and face an adverse costs order like that—practically speaking it ain't gonna happen. The problem with that is, it lets a lot of adverse decisions go through to the keeper, so to speak, because they do not have the money to challenge it. I think that could be looked at—you could obviously introduce some legislation that took care of that. The other thing too is that the judges of the Dust Diseases Tribunal have a pretty good background in the medical issues that arise in these cases. I would have thought that is the more appropriate venue for decisions of the Dust Diseases Authority to be adjudicated, as opposed to the District Court.

Just a couple more things. The authority considers it is bound by the WorkCover guidelines when it comes to impairment issues. That works fairly well in most cases because the most serious dust disease cases—we are talking lung cancer, mesothelioma—are people who have got gross disability. There is no argument that

they might need homecare, assistance around the home. The problem arises when you look at the benign cases where the disability is much lower—it comes to those only who qualify for home assistance where the whole person impairment is 15 per cent. When it comes to deciding disability, the medical assessment panel do not apply the whole person impairment regime imposed by the American Medical Association—they have a more liberal approach to it. In other words, someone who has got a 10 per cent disability as a consequence of some benign asbestos disease or silicosis, they do not have a 15 percent whole person impairment.

It is a little bit problematic but some of these people have comorbidities on top of their asbestos disease coming from a generation where smoking was commonplace. Often their overall disability will be higher but the asbestos disease component may be under the threshold, so there is a need for some flexibility in the guidelines. I think when it comes to assessing those kind of needs there could be a bit more flexibility adopted when looking at those cases down the chain a bit. That is all I have to say. I am happy to respond to your questions. I did have something to say about the operation of the Dust Diseases Tribunal in the submission; I recognise that is not squarely covered in the terms of reference. The only reason I put that in there is, unlike workers compensation benefits where a worker generally has a choice between statutory compensation and common law, these are quite different—these are kind of hand in glove.

The CHAIR: You helpfully made that point in your submission, which is quite right.

Mr McMAHON: Yes.

The CHAIR: I take you back to your second last point where you suggested some flexibility in that space. Can you elaborate on what you think the answer is?

Mr McMAHON: Sure.

The CHAIR: We are all dealing with a scheme and we need a cut-off somewhere. What is the suggested change you are proposing?

Mr McMAHON: I cannot be completely confident about the timing but I think it was either 2004 or 2007 that the old board started to implement the WorkCover guidelines for looking at these things. Prior to that it was simply a matter for the medical assessment panel internally to make a decision and they would be guided by reports from a general practitioner or the treating specialist. So it was not a question of whether you got X per cent or Y per cent; it was simply a question where the needs of that individual were reasonably attributable to—

The CHAIR: The discretion of the medical board.

Mr McMAHON: Exactly.

The Hon. DAVID CLARKE: I have a question to whoever would like to answer it and it follows on from comments the Chair just made. You referred in your organisation's submission to legislation and regulations governing common law claims commenced in the Dust Diseases Tribunal, which we have touched on in previous inquiries. You expressed concerns about delays causing hardship to plaintiffs whose claims to compensation are not finalised prior to their deaths. Does your organisation have any concrete proposals on this issue?

Mr McMAHON: The straight answer to that is no because it was seen by us to be slightly outside the terms of reference but I can make some suggestions about it because it is the area that I practice in day in, day out. The problem is that the regulations that govern these claims were set up after the Jackson inquiry with the intention that there would be a framework for the resolution of the cross-claims at the same time as the plaintiff's claim. So typically, for example, if you had someone who was exposed to asbestos at the State Dockyard at Newcastle they would sue the employer, which is essentially the State of New South Wales.

Under the old scheme that claim would be dealt with by the tribunal and resolved without reference to the cross-claims. That would be resolved some time down the track. The concern was to avoid incurring unnecessary legal costs, that this regulatory framework that we have now would basically front-end load the scheme, involve the cross-defendants at the start so everyone who was going to contribute to settlement would be there at mediation and the thing would go away without walking into a courtroom. Theoretically that works okay. The problem is that if you get someone who is diagnosed with mesothelioma they may be, to the naked eye, looking okay one day and in four or five weeks they are dead.

The CHAIR: You are at a bedside hearing then.

Mr McMAHON: Now under the time frames—and I did bring some examples—that apply, if I sue the State Dockyard and it does not issue a cross-claim if I sue it today, then I will get to mediation some time in late March. As soon as they file cross-claims, what happens is that pushes out to mid-April. If they then request a time in which to file cross-claims, it pushes out to late April and then in some cases early May. I will give an example. I had a guy who was in that position just before Christmas. The treating specialist gave him a two-year life

expectancy and obviously his claim could be completed within the parameters of the legislation because his matter would go to mediation probably in late March. He was dead two weeks later. Now, I suppose one might say there was nothing you could do about that.

The Hon. DAVID CLARKE: That is why I want to cut in. You have raised concern. Instead of you having to do it off the cuff, would you like to take this issue on notice—

Mr McMAHON: Certainly.

The Hon. DAVID CLARKE: —and come back to us with the proposals that your organisation has in mind to deal with this specific issue of hardship and the issue of common law claims not being finalised prior to the death of the plaintiff?

Mr McMAHON: Yes. Look, just off the cuff, one of the things you would probably do is deal with them and the malignant claims far differently.

The Hon. TREVOR KHAN: Sorry, what does that mean?

Mr DAVID SHOEBRIDGE: Fast-track it.

Mr McMAHON: Yes.

Mr DAVID SHOEBRIDGE: Super fast-track it?

Mr McMAHON: Super fast-track where he did not have extra time for cross-claims. Realistically if you sue the State Dockyard or most of the institutional defendants, they all know who the suppliers are. It is a question of pressing a button on a word processor and a cross-claim flies out.

The Hon. DAVID CLARKE: Without putting you on the spot on this issue, perhaps you would like to take it on notice and come back with some specific proposals that your organisation has in mind?

Mr McMAHON: Yes.

Mr DAVID SHOEBRIDGE: It is partly addressed—I know it is not fully addressed—by the procedures the court has to basically have a bedside hearing to take the evidence and ensure that the plaintiff's evidence is all captured, is it not? It is partly resolved by that?

Mr McMAHON: Partly resolved but from a practical point of view the problem with that is that once you expedite a claim, legal costs go up without it making any material difference to the result to the plaintiff. That is the problem I have with it.

The Hon. TREVOR KHAN: Could you explain that a bit more?

Mr McMAHON: Sure. There is the provision to remove the claim from the claims resolution procedure if you can show that the plaintiff is likely to die prior to the timetable for completion but what that means is that I, as a plaintiff's lawyer, prepare an affidavit; I brief a barrister. People trot up to Newcastle and they take the plaintiff's evidence and come back and it may or may not be resolved in the plaintiff's lifetime. In fact, once you get to that point the chances are the plaintiff is going to be dead before the claim is finalised anyway. What you need to do is have a super fast-track when none of that happens. You see, under this system—

The Hon. TREVOR KHAN: Again, what is that super fast-tracking?

Mr McMAHON: What I am getting at is just to compare what happens now with what happened back then.

The Hon. TREVOR KHAN: Sure.

Mr McMAHON: Now, the plaintiff's story is in the form of a statement of particulars supported by statutory declaration. You get a full statement from the plaintiff. It is not a question of knowing or having to ask questions about how you were exposed; it is all there. Under the old system the defendant requested particulars and I would answer them on behalf of them. You would not have that firsthand account but it is actually there now. In a sense there is no real need to cross-examine a plaintiff about it. In fact, most of the cross-examinations I have seen go to factors that are not relevant to the exposure, for example, economic loss. You could have a super fast-track which did not involve the issue of cross-claims or a limited time in which to do it and just compress the time frame. You could take it to a judge of the tribunal at the outset to get that done or you could do it by regulation.

Mr DAVID SHOEBRIDGE: To be honest I am surprised that in the tribunal you still have to put on a full motion and brief counsel in order to get an expedited hearing. I would have thought there would be some kind of simple in-chambers application that would be heard by a registrar?

Mr McMAHON: It is funny you say that because before the so-called claims resolution process [CRP]—this is before about 2005—if I had an urgent case I would simply ring the judge's associate and say, "This is what's going on. I will see you tomorrow morning. Tell the other side" and we would turn up.

Mr DAVID SHOEBRIDGE: Yes, because that seems to me to be expensive and relatively futile. I would imagine it is not contested. If you have the medical evidence your client is about to die, it is hardly going to be a contested motion; it is just going to be a question of practicality and finding the best way?

The Hon. TREVOR KHAN: Look, apart from that observation, was that subject to abuse? Is that why it fell out?

Mr McMAHON: I do not think it was ever abused. The people who practise in the area tend to be—it is a small group.

The Hon. TREVOR KHAN: I am not accusing anyone; I am trying to work out why it changed.

Mr McMAHON: I think it was just a function of the aftermath of the Jackson inquiry—

Mr DAVID SHOEBRIDGE: The new rule.

Mr McMAHON: —and I think it was seen as a way of keeping the legal costs down because the same thing happens now; it is more formal. You have to have a motion, then some evidence. They have loosened that up a little bit in recent times, I should say.

Ms WADE: Can I also add that in relation to getting a bedside hearing, a recent requirement that we also need to provide evidence on is the fact that the plaintiff is not comfortable with video link evidence because most of these plaintiffs are in their 70s and 80s; they are elderly. The court now requires evidence as to why video link is not appropriate and instead are actually going to the bedside, which adds extra evidence—

The Hon. TREVOR KHAN: Why is video link not appropriate? I have heard 70 or 80, but there are many traumatic circumstances where, for instance, women give evidence via video link. Why is it not a suitable criteria?

Ms WADE: A lot of these elderly people are hard of hearing, they have other comorbidities. They are on their deathbed. Some of them are in hospital. Some of them are literally unable to get out of bed.

Mr DAVID SHOEBRIDGE: Incubated.

The Hon. LYNDA VOLTZ: Have respiratory failure.

Ms WADE: Yes. They are on oxygen 24 hours a day. All of those reasons mean you cannot get them to a courtroom where there is an appropriate video link.

Mr McMAHON: To give a concrete example, I had one exactly like that, going back to about October. He was 66 but he had advanced mesothelioma. He was not very well and lived at South West Rocks and we were requested to provide evidence that he could not travel. The problem was that the nearest facility was Port Macquarie, which if you are healthy is not that far away, and if he was in good physical condition he would have been able to go.

Mr DAVID SHOEBRIDGE: We all need to understand that to go to a video link you have to go to a facility that provides it. If a video link could come to a hospital bed that would be fine—

The Hon. TREVOR KHAN: David, I know how video link works, believe it or not.

Mr DAVID SHOEBRIDGE: —but if you have someone in hospital you do not want to trot them out to the nearest video link.

The Hon. TREVOR KHAN: It is a competing exercise. If you are getting a judge to a bedside hearing, you are taking him or her out of the system for a period of time?

Mr McMAHON: Exactly.

Mr DAVID SHOEBRIDGE: Appoint more judges.

The Hon. TREVOR KHAN: There is an issue of competing resource use?

Mr McMAHON: Yes.

The Hon. TREVOR KHAN: We are rolling out VideoLink very extensively over the State for a reason, and one of them is to facilitate these things.

The CHAIR: Maybe the middle road is VideoLink at the bedside, not having to drag them to a facility.

The Hon. TREVOR KHAN: I do not know if it would provide sufficient quality of things. In a lot of hospitals they have got VideoLink facilities in the hospitals and they use them all the time.

Mr DAVID SHOEBRIDGE: For their surgeons, yes. Could I ask about funeral expenses? One of the issues you raise is that there is only $9,000 payable for funeral expenses under the Dust Diseases Scheme, and obviously that is insufficient to meet funeral costs now. What is the process for getting that bumped up? Is that set by regulation?

Mr McMAHON: Yes, it is set under WorkCover guidelines, from memory.

Mr DAVID SHOEBRIDGE: If we were to put a recommendation to remedy it, it would just simply be a recommendation that the WorkCover guidelines for funeral costs be revisited.

Mr McMAHON: Be increased.

Mr DAVID SHOEBRIDGE: And it should meet the reasonable costs of a funeral. That should be the aim of it.

Mr McMAHON: Yes.

Mr DAVID SHOEBRIDGE: Are there any other areas where there are obvious inadequacies in the schedule of payments?

Mr McMAHON: No, I do not think so. I think it is squarely at the funeral expenses.

Mr DAVID SHOEBRIDGE: I heard earlier that you support the recommendation from the Thoracic Society, which is that the Government undertake a review of the spectrum of diseases covered by dust diseases to ensure it conforms with international standards of attribution of causality in the field of occupational lung diseases. Are they the terms of the recommendation that you will be supporting?

Mr McMAHON: Yes.

Mr DAVID SHOEBRIDGE: In terms of the expenditure of the fund on research your issue is not with the quantum of expenditure on research or the fact that they are expending it on research or even the subject of the research, it is just simply where that has been done. Is that right?

Mr McMAHON: Exactly.

Ms WADE: I should add to that. In New South Wales we have the Asbestos Diseases Research Institute based at Concord, which is a fantastic facility where research is undertaken in relation to asbestos-related illnesses.

The Hon. TREVOR KHAN: Can I just go back to this question of expanding the list? The practical implications of expanding the list from your perspective is what? Because I can remember having this argument with a former Chair behind closed doors as to what it was. What do you see as the practical implications of expanding the list?

Mr McMAHON: It will be easier to conduct a claim simply because the various definitions that apply to what are dust diseases at the moment are such that, for example, if someone is working in an aluminium smelter and they contract an occupational asthma disease or one of the variants, there is an argument about whether the dust that caused it was aluminium dust or something else. It gives rise to this huge technical argument about what the cause of the disease was. I have been involved in these things so I have had some background in it. It overcomplicates things to high hell, to be frank. So it just makes it straightforward.

The Hon. TREVOR KHAN: And straightforward to what end? The person has their rights to workers comp.; they do not have a right under the Dust Diseases Act to make a claim. What is the practical implication of the difference?

Mr McMAHON: The practical implication is that you are under a different compensation regime and that is why these things have remained the way they are, in my view. So effectively you would have unrestricted common law rights.

The Hon. TREVOR KHAN: I and the Chairman previously disagreed because it really came down to expanding that group of workers who would have an opportunity to common law rights. That is it, is it not?

Mr DAVID SHOEBRIDGE: And someone is going to pay for that and there is a cost issue. Has anybody had a look at the actuarial concept?

Mr McMAHON: No, I have not. I do not know anyone who has.

The Hon. TREVOR KHAN: We may have had this argument last time. I was not concerned about the cost issue. What I was concerned about was essentially creating a class of workers with a different set of rights to another class of workers, and this was, in a sense, a way of opening up that jurisdictional issue.

Mr DAVID SHOEBRIDGE: We already have that. The question is whether the existing class based upon post-war definitions is the right one. That is the argument, is it not?

Mr McMAHON: Yes, exactly.

Mr DAVID SHOEBRIDGE: And that is why you would need to have multiple stakeholders in the review.

Mr McMAHON: Exactly.

The Hon. TREVOR KHAN: What sort of dust diseases do you now perceive, or do you perceive any of the old ones? There was bagassosis and various ones. We do not really have a pulp industry anymore.

Mr McMAHON: No, and that is exactly what has happened. I have had a couple of byssinosis cases—cotton dust cases—aluminosis cases, but we are talking about probably 5 per cent over time.Either the industries have gone offshore or in some cases safety standards have increased dramatically. You have got to remember the latency periods you were talking about earlier, people with asbestos disease have had frequent exposure over a long period of time when standards were quite different and the latency period means that they are getting sick now, whereas with these other diseases the latency period can be quite short; they are getting sick within a short time of the exposure, particularly occupational asthma cases.

But some of these cases are where they are now simply by error, if I could put it that way, or no-one has thought about it. If you go back before the introduction of the 2002 workers comp. reforms, occupational asthma cases were dealt with by the Dust Diseases Tribunal because the causative substance was a particulate matter, which gave the tribunal jurisdiction. The 1987 Act still applied, but that is what has happened; the definition at that level has changed and these people have been left out. I suppose it comes down to as a matter of policy whether you think a severely compromised respiratory system should be compensated under one regime or another.

The Hon. TREVOR KHAN: Or should have access to common law rights.

Mr McMAHON: Yes, absolutely.

Mr DAVID SHOEBRIDGE: Whether or not the severely compromised lungs were caused by a particulate or by some other, it seems a kind of arbitrary basis upon which to hand out compensation.

The CHAIR: Causation.

Mr DAVID SHOEBRIDGE: We are talking about you can be exposed to fumes at a workplace—

The Hon. LYNDA VOLTZ: And chemicals and gases.

Mr DAVID SHOEBRIDGE: —or chemicals and gases, which causes chronic occupational asthma, there is an argument about you are probably not covered. If you are exposed to particulates then you are covered.

Mr McMAHON: Exactly.

Mr DAVID SHOEBRIDGE: That seems arbitrary.

The Hon. TREVOR KHAN: It is equally arbitrary, if you get down to it, if you fall under the scheme now and you have got access to common law rights, but if you have your foot chopped off you may not get access to common law rights. That is arbitrary, let us face it.

Mr DAVID SHOEBRIDGE: There is an elegant solution to that that we do not need to discuss now.

The Hon. TREVOR KHAN: I know what the elegant solution is and I am not going there.

Mr DAVID SHOEBRIDGE: We are talking lungs. It would reduce legal costs, it would reduce dispute costs, it would make things quicker if lungs go down here and all lung conditions go down here.

Mr McMAHON: This is a result of history. It is because all the diseases that we are traditionally dealing with are caused by particulate matter. Most welding rod cases have some particulate matter as well, but that is why we are where we are.

Mr DAVID SHOEBRIDGE: Is there any State statutory scheme where a pension is paid or a statutory weekly sum is paid where there has been an arrangement with the Commonwealth for pension benefits to still be payable, particularly for recipients who are over the age of 65?

Mr McMAHON: No.

Mr DAVID SHOEBRIDGE: What we should be trying to do on a federation level is not have this stupid argument where we bounce back and forth about whether or not you receive a State-funded statutory pension or a Commonwealth-funded statutory pension; if you get a Commonwealth-funded statutory pension you keep your pension benefits but if you get a State-funded statutory pension you lose your benefits.

Ms WADE: It is a problem for some people suffering from dust diseases because when they get the dust disease care pension they have to go along to Centrelink and tell them "I'm now getting this pension". Centrelink takes away dollar for dollar what they were getting and if they lose their age pension they lose all those extra benefits with the health care card, the reduction on rates, and then they say "I'm worse off".

The CHAIR: Which you raised in your submission.

Ms WADE: Yes.

Mr DAVID SHOEBRIDGE: Do you think it might be useful to have a recommendation that the New South Wales Government explore this issue with the Commonwealth Government to try to retain those associated pension benefits when someone goes onto a dust disease pension?

Mr McMAHON: Absolutely.

Ms WADE: Yes.

Mr McMAHON: That would have cured the problem, in effect. I mean you would still have the inconvenience of having to get an income from two sources and perhaps having to put in a tax return when you haven't done one for years to get the tax paid on the New South Wales benefit back, but what people are really scared about is they just don't want to lose that health card. They don't want to lose those additional things—they are worth about $2,000 or $3,000 a year.

Mr DAVID SHOEBRIDGE: If the Commonwealth Government understood its own self-interest, it would be keen to do this because it shifts people off the pension and puts them onto the State.

Mr McMAHON: Exactly.

Ms WADE: That's right.

Mr DAVID SHOEBRIDGE: There is kind of mutual self-interest in this.

Mr McMAHON: Yes. There are some people who won't make an application to the dust disease authority because of the perceived negative affect on their pension. It's probably not a rational view, but we are talking about people who are in their 80s or late 70s.

The Hon. LYNDA VOLTZ: It may or may not be. We had a similar case with TPIs. When they get their TPI they come off their pension. They lose their pensioner concession card, which means instead of paying $2.50 for a bus they are paying—they lose their car registration, they lose their rates and all those rebates. It can be thousands of dollars.

Mr McMAHON: That's true. What I didn't say about that is that the people who are resisting the application, some of whom have very serious illnesses like mesothelioma, for example, and the medical benefits that the board can provide them would overwhelm any of that and the reality is that they have a very limited life expectancy, so that's what I'm kind of getting at. An elderly person is more worried about having that certainty than perhaps making an application to get their medical benefits covered 100 per cent, so that's what I was kind of driving at. But what you're saying is dead right.

The Hon. LYNDA VOLTZ: But it is a mindset. My uncle had mesothelioma and he is on the Dust Diseases Board and he is the Department of Housing, so it affected a whole range of stuff. In his mindset, "I'm going to a public hospital anyway. Where's the difference?"

Mr McMAHON: Exactly.

Mr DAVID SHOEBRIDGE: In terms of the appeal rights for decisions from the authority, you say they are currently to the District Court.

Mr McMAHON: Yes.

Mr DAVID SHOEBRIDGE: Have you had discussions with anybody from the authority or anybody from any government agency about getting it to the tribunal?

Mr McMAHON: No, I haven't.

Ms WADE: No.

Mr DAVID SHOEBRIDGE: Do you know if that has ever happened?

The Hon. TREVOR KHAN: Well, you have—us.

Mr DAVID SHOEBRIDGE: You are having discussions with us. It seems like common sense and there may well be a reason for it that I am not aware of. But it does seem like common sense.

Ms WADE: The judges of the tribunal are judges of the District Court and they do hear other District Court cases. They would be best placed to hear the residual jurisdiction appeals.

The Hon. TREVOR KHAN: How many of them are there?

Mr McMAHON: There's three now. They all used to be judges of the Compensation Court. When that was abolished they were transferred to the District Court. There was that natural crossover, I guess, not so much now.

The Hon. TREVOR KHAN: How much would this appeal work add to their workload?

Mr McMAHON: I don't think very much.

Ms WADE: No, not very much. I'd say I've have had probably only three or four matters go to appeal.

The Hon. TREVOR KHAN: How long have you been in practice in this area?

Ms WADE: Over 20 years.

Mr McMAHON: I have had sweet B-A, to be honest, but part of the reason is that—

The Hon. TREVOR KHAN: I think it is F-A.

Mr DAVID SHOEBRIDGE: Hardly any I thought you would say.

Ms WADE: The issues comes back to the cross issue as to workers not wishing to take those appeals.

Mr McMAHON: Exactly.

Ms WADE: But when they do take an appeal—

The Hon. TREVOR KHAN: Let me rephrase my question to both of you: How many do you think you would have had if there was not a cost implication?

Ms WADE: I would still say not that many.

Mr McMAHON: Yes, I agree with that assessment. You are tending to talk about causation issues; nine out of 10 times they are straight forward. You might be talking about whether someone is actually a worker or not—again pretty straight forward. There is the odd case, whether you are a contractor, whether you are a worker but it doesn't arise that often.

Mr DAVID SHOEBRIDGE: Most people who I talk to who practise in the area respect the medical panels and the skills of the authority.

Mr McMAHON: Exactly.

Mr DAVID SHOEBRIDGE: So it is not like there is a high degree of scepticism. As a general rule people have confidence in the authority and clearly do not want to challenge it.

Mr McMAHON: Exactly. We are not opening the flood gates by any means.

Mr DAVID SHOEBRIDGE: But there should be an accessible and reasonable right to challenge because that obviously makes for better decision-making.

Mr McMAHON: Exactly.

The Hon. TREVOR KHAN: Can I just ask one thing. In those shops were any of your three employees involved in wet cutting or was it all dry cutting?

Ms WADE: One factory did have wet cutting, but the factory owner only let his son do the wet cutting.

Mr DAVID SHOEBRIDGE: That kind of sums up some of the issues doesn't it? Thank you.

The CHAIR: Are there any other questions from Committee members? Thank you so much for coming along today. Those questions that you have taken on notice, I ask that you return them as quickly as possible, and

at the latest by 7 February. We are under a tight time frame to report. The Committee secretariat staff will be in touch with you about those questions on notice.

(The witnesses retired)

(Lunch adjournment)

ROD SMITH, Awareness and Support Coordinator, Bernie Banton Foundation, sworn and examined

The CHAIR: Welcome to the 2018 Review of the Lifetime Care and Support Scheme and Dust Diseases scheme. Mr Smith, do you have an opening statement to make to the Committee?

Mr SMITH: I realise that most members of the Committee were here at the first review. For those who were not and those watching and listening, I have a long history in this space. I have been involved in the support side of things since my late wife was diagnosed with multiple forms of mesothelioma in 2008, and I have been heavily involved in running support since February 2010. I joined the Bernie Banton Foundation in January 2012, six years ago. Since then we have had a significant increase in the number of people we support. We support close to 500 people in New South Wales alone. We also support people online and in other demographics across Australia and New Zealand. Our home demographic is New South Wales and most people we support here have a connection to Dust Diseases Care.

I was instrumental in having the Cancer Council write, and I was a co-author of, the first mesothelioma booklet, which was dedicated to my late wife in 2011 when it was launched. I am also a co-author of the current Cancer Council mesothelioma booklet entitled "Understanding Mesothelioma". I am a member of the expert group that advises the Australian Government on the Australian Mesothelioma Registry, which is now run by the Australian Institute of Health and Welfare in Canberra. I am also a member of the Dust Diseases Board. Other than that, I have qualifications in social work and counselling. My late wife and I spent 30 years running a reasonably successful business with 550-odd clients in Victoria, mainly in the air conditioning and refrigeration industries, transport and cranage.

The Bernie Banton Foundation is primarily about supporting people. It is what we try to do to the best of our ability rather than spread ourselves too wide. We advocate very much for clients or patients—it depends what you want to call people who have been affected. We are totally apolitical; we do not have an interest in politics unless it will benefit the people we support.

The CHAIR: Thank you for providing a written submission, which is helpful to the Committee. You have raised the issue of accessing medical records. One of my frustrations as a lawyer was the time it took to get those records. You say that while the process has been overhauled and streamlined and it is now more user-friendly, one of the contributing factors to delays is obtaining records. Do you want to comment further?

Mr SMITH: It is much as I said. Many of the people who contact us have false diagnoses. They are told by their general practitioner that they have "asbestos on the lung". That is the favourite term and I mentioned it in my submission. When it gets down to Dust Diseases Care and civil litigation, which previous witnesses have mentioned, it becomes extremely frustrating. We have had people diagnosed on a Monday and die the following Saturday after a bedside hearing on the Friday. It is sometimes that close to the wire.

We will ring up and have a good whinge about why this is happening. I regularly raise it with Dust Diseases Care liaison officers and our legal representatives on behalf of clients. The biggest problem is getting hold of even a written diagnosis and all of the medical history from hospitals, and in particular public hospitals, I believe. That has been told to me by solicitors and people in Dust Diseases Care. They say they simply do not have the medical records; they are still waiting for them. It is very big problem.

In some cases it is not so prevalent when someone is going really well after six months. However, in other cases it is literally the difference between a person being able to give evidence or not. With a case in the civil arena, it is the difference between a case being mounted or brought before the Dust Diseases Tribunal or not before they die. Of course, that makes a difference to the payouts to those left behind.

The CHAIR: I know I have gone to a very specific issue but that is because it is a bugbear of mine that there is that difficulty and that delay. I do not quite know what the answer is, but would you say that that is the major problem? You have referred to it, which is why I picked up on it, but is it the major cause of delays, or are there other delays? I see that in other ways the system has been streamlined and from the part that the scheme can control there has been quite a lot of progress in making it more efficient and faster for people to put in an application and those sorts of things, but it is those other areas that seem to be holding it up. Is this the main one?

Mr SMITH: I think it is one. The other bugbear that I have—and I am glad you have asked me, to be honest, because I did not put it in the submission—is that there seems to be an inequitable link between information given to Dust Diseases Care and information that is accessible to defendant lawyers in the Dust Diseases Tribunal cases. We regularly have a problem where the lawyers—and many would say rightly so and in many cases I would say rightly so—have not actually processed a claim or a registration to Dust Diseases Care because the defendant lawyers can actually access that information and use it against the client, if that makes sense.

The Hon. TREVOR KHAN: How do they do that?

Mr SMITH: You might be able to tell me more but as far as I know—and I was actually shocked to find out—the defendant lawyers in a Dust Diseases Tribunal claim, and we are talking about a civil claim, can actually subpoena the information from Dust Diseases Care, which is beyond me how that is allowed. But that is apparently allowed.

The Hon. TREVOR KHAN: But when the record is subpoenaed, it is subpoenaed to the court.

Mr SMITH: Yes.

The Hon. TREVOR KHAN: Both parties have access to that material.

Mr SMITH: They do.

The Hon. TREVOR KHAN: As long as they read it.

Mr SMITH: As long as they read it, but the problem is—

Mr DAVID SHOEBRIDGE: What is the material that you say should be protected from the defendant in those circumstances?

Mr SMITH: You have two different—like, when it comes to a registration for Dust Diseases Care, it is all about work history whereas with the Dust Diseases Tribunal, it can be work history, it can be history as they are growing up—people as they are growing up—and so forth. If there are multiples in there, then it is felt, I believe—and I am not a lawyer but I believe it is felt—that the information given to Dust Diseases Care can be used against the client in some cases because Dust Diseases Care, or the dust diseases board, whatever you want to call it, is only really considering work situations.

The Hon. DANIEL MOOKHEY: When you say misused, do you mean by the defendant for the purpose of contesting liability?

Mr SMITH: Yes. Yes, very much so. Anything that is written down as far as a person's history goes can very much be used by the defendant lawyers.

Mr DAVID SHOEBRIDGE: But I would have thought there would have been an obligation to traverse your work history in both proceedings. Obviously, one of the things that would be relevant in the civil claim, in the tribunal, would be whether or not there is a cross-claim or some contribution from another defendant. Therefore, you are going to have to have the work history.

Mr SMITH: I do not think the work history is the problem there. I think what actually happens is that because Dust Diseases Care—and, again, I am not a lawyer—is only interested in work history.

Mr DAVID SHOEBRIDGE: But if that is the material being subpoenaed in the tribunal, I do not understand the theoretical issue. There may be practical issues that I am missing; there may well be, but I do not understand the theoretical problem.

Mr SMITH: By what I am told—

The CHAIR: I think we are going down a rabbit hole, which is probably of my making, I am sorry. You are dealing with five lawyers here.

Mr DAVID SHOEBRIDGE: What were you being told?

Mr SMITH: Basically what I am told is that, because it can be accessed, the less that is put down about what happened can make big differences to the payout. To me, I just find it incredibly unbelievable that anyone can access information given to the Dust Diseases Care.

Mr DAVID SHOEBRIDGE: I understand the argument. It may make individuals more guarded in what they give to the Dust Diseases Care [DDC] if they think it can be subpoenaed at a later point.

Mr SMITH: Yes. That is basically it.

The Hon. DANIEL MOOKHEY: Just to follow that up, can I ask this: Given that second degree exposure is the fastest growing claims for asbestosis—that is, the partners, wives, and people who have had non-work-related exposure—to what extent does that change this?

Mr SMITH: I think it very much changes the point of view. What we are going to see with Dust Diseases Care is that we are going to have, I believe—and we are already seeing it—fewer asbestosis claims, et cetera. You are going to see more and more.

The Hon. DANIEL MOOKHEY: It is not workers who are necessarily presenting. It is often people who are connected to workers.

Mr SMITH: No, no. People who are connected to workers cannot actually go to Dust Diseases Care.

The Hon. DANIEL MOOKHEY: A friend of mine recently passed as a result of mesothelioma aged 36 because in the primary school at the time they were removing asbestos and he caught it 30 years later. They are the type of people we are talking about.

Mr DAVID SHOEBRIDGE: No. They go to the tribunal, not the authority.

Mr SMITH: They go to the tribunal.

The Hon. DANIEL MOOKHEY: I understand. What I am asking you is this: The problem that you alluded to before about the subpoenas onto the Care because it is work-related, to what extent is that diminishing because people who are presenting in civil courts are not necessarily presenting for work-related claims?

Mr SMITH: Certainly, if that is the case; but we are still seeing a huge number of work -related claims.

The Hon. DANIEL MOOKHEY: Of course we are.

Mr SMITH: Eventually we will start to see that balance tip over where Dust Diseases Care becomes less relevant, if you like, because it cannot be accessed by many people who are still being diagnosed.

Mr DAVID SHOEBRIDGE: Those secondary exposure claims are tort claims that are brought down in the tribunal, not statutory-based reporting.

Mr SMITH: That is right—such as my late wife. Her father brought it home on his clothes.

The CHAIR: Mr Smith, if we are finished on that topic, I would like to move you into one specific area. However, at the outset I want to say that I am sorry for your loss of your wife.

Mr SMITH: Thank you.

The CHAIR: Thank you for the work you are doing in this area. It was remiss of me not to acknowledge that. I would like to do that on behalf of the Committee because it is important. The ongoing work you are doing with clients is important also. Importantly, part of that is their experience of this process, as you rightly recognise.

Mr SMITH: Yes.

The CHAIR: It is a small thing, but a huge thing to these clients—the phone line. You have talked about that. That seems to have experienced some problems that seem to have been rectified or are being rectified. Would you care to comment on that? I believe icare is aware of that. I think it is very important with this demographic that they are able to communicate. They cannot email and do other things, or they are less able to email and do other things.

Mr SMITH: Exactly right.

The CHAIR: Will you comment on that and the status of that now in your clients' experience?

Mr SMITH: I think the status of it now is—I do not think I could actually say it in words in a public forum. It is a new system. It certainly has its advantages, I guess. If we go back, the original system got superseded by a Skype-based internet system that was deplorable. Recently—I think in October or November; November I think it was—a whole new system has gone in. The problem we were having is that you just could not get hold of anyone. You get put in a loop, as I have said in the submission. That has now been overcome. The problem we now have—

The CHAIR: They have attempted to rectify that by putting this new system in.

Mr SMITH: They put a new system in and the new system now—and also with new dedicated operators—about what we now have, from my own personal point of view, for example, is that there is still no—the decision was made, I believe, that you could not leave a message. You had to actually talk to someone, which on the surface would seem pretty good. The last system, if you got caught in the loop, you could be there forever and just forever. But I think now the new system is better for, let us say, random people, or people with no new connection. I think the phone is getting answered more quickly, but there is still no way of leaving a message. What happens now is that if I actually contact a direct phone line to a liaison officer, and that liaison officer is already on a call, for example, I will then get put in a loop until either the call centre worker answers it—

The Hon. TREVOR KHAN: As in put on hold?

Mr SMITH: Put on hold, or the next available liaison officer answers it. There is no opportunity, even though I know exactly who I want to talk to and only want to talk to that person, to leave a message. I might be on hold for five minutes or 10 minutes, depending on the time of day and the pressures of the work happening. Now if the liaison officers hangs up from a call and there is someone there—there is another call in the system—then they just quickly take it. Then you have to explain what you want to the other liaison officer and say, for example, "Can you get Jenny to ring me?" That liaison officer will then have to send an email to Jenny to get Jenny to call me back when that person is available.

Mr DAVID SHOEBRIDGE: Was that not partly in response to a good many complaints that messages were being left and not responded to?

Mr SMITH: I think it was because they were not seeing the messages from what I actually saw.

Mr DAVID SHOEBRIDGE: So the response is to make sure that you speak to a person—

The Hon. TREVOR KHAN: It is almost a damned if you do and damned if you do not.

Mr SMITH: Yes, it is.

Mr DAVID SHOEBRIDGE: I would have thought there would be real benefits in speaking to a person.

Mr SMITH: The only problem that I think we are starting to see is that if you—I agree with what you are saying but the system now is because I believe there are two call centre workers, if you like, answering the phone and if they are tied up talking to someone then it goes to the next liaison officer. So if that person has been on the phone for 10 minutes or half an hour with someone and needs to write down notes or something, the phone is immediately pretty well ringing straight again for a call that has no connection to their workload or their caseload or anything else. I can only see that it must be almost putting those liaison officers in a constant, I guess, vibe of answering the phone.

The CHAIR: The Committee put some questions to icare ahead of time and in response to your submission they were specially asked about that. They said they have increased the number of client liaison officers from four to eight. So there are eight people dealing with 195 workers and 53 dependents et cetera. Do I understand your evidence to be that once you get a client liaison officer you have got a specific person you can contact and that is working well?

Mr SMITH: Yes.

The CHAIR: You cannot necessarily get through straight away but the allocation of a specific person has helped.

Mr SMITH: It is fantastic, and the ones who have that—it is only the new clients who will actually have it.

The CHAIR: Since September 2017.

Mr DAVID SHOEBRIDGE: Have they started rolling it backwards with the expansion of the client liaison team?

Mr SMITH: No, because it is getting bigger all the time. I think the problem we have is when it launched in September 2017 the first four liaison officers obviously had no backlog of clients and they got to a point where they were totally overwhelmed. I remember talking to a number of the upper echelon, if you like, of Dust Diseases Care about the need to double the staff because every day their workload was getting bigger and bigger.

Mr DAVID SHOEBRIDGE: Can we cut to the chase here and say your recommendation is that everyone gets access to the customer or client liaison team member?

Mr SMITH: Yes, very much so.

Mr DAVID SHOEBRIDGE: That is your recommendation?

Mr SMITH: Yes, and the staff should just be kept basically going up because what I believe at the moment, I do not know—perhaps you have access to this information, I do not—but it does not seem that there is actually an upper limit of clients put for each liaison officer. That is not as easy as it may sound because, even like with the foundation, we can hear from people under circumstances every day and then not hear from them for months on end because they do not need us. Then another crisis will come to the fore and so on. We see the absolute difference between the people who have a liaison officer and those who do not. We are seeing, thanks to an icare-funded program that the foundation launched 18 months ago where we are getting brochures into doctors' surgeries, an enormous amount of what I call new-old clients coming through—that is, people with file numbers that indicate they have been in the system for 20 years and so forth who have actually seen our brochures and

said, "Have not heard from Dust Diseases Care for 15 years or something and my health is a lot worse." We are starting to get a lot more of those coming in and I am hearing from the liaison officers that they are starting to get a lot more people coming in. I think the system is working well in the intent of the system; the problem is going to be to keep that system available and not burn out the liaison officers. That is my own, I am looking in—

The CHAIR: Just to clarify those numbers: There were four liaison officers and there are now eight liaison officers dealing with 195 plus 53 plus 202 further applicants, but the pre-September 2017 long-term customers who have not been allocated customer liaison officers are 3,978.

Mr SMITH: Right.

The CHAIR: So those numbers back up what you are saying—namely, that there a lot.

Mr SMITH: There is a huge amount. I do not know the exact answer to that, but I do know that it is to me distressing at times to talk to liaison officers who I know are very much under stress.

The CHAIR: So we need more of those. Is your organisation picking up the others and somewhat dealing with that?

Mr SMITH: We are still regularly getting, yes. We are on call 24/7. I mean both Karen Banton and I are on holidays at the moment, if you like, because our board told us that we had to.

Mr DAVID SHOEBRIDGE: Karen is sitting behind you, clearly not on holidays.

Mr SMITH: Look I will be honest, I have been in this space 10½ years and never had a holiday from it. Karen has now been in it 20 years and never had a holiday from it. It is very hard to just say, "Yes, we are going." We have in the last four weeks cut down a lot of the, let's say, the business side of the foundation but it is impossible to cut down on the helpline side when you have people who need you.

The Hon. TREVOR KHAN: I take you back to the liaison officers. We know that newer clients are being allocated to a particular liaison officer on the way through but I take it those liaison officers also deal with the cohort of unallocated people?

Mr SMITH: Yes, but they are not actually given those clients if you like or they could be, maybe.

The Hon. TREVOR KHAN: I am just trying to work out—and you will not be able to answer this—but there would be a percentage of their time committed to the allocated clients and a percentage of their time committed to the unallocated clients.

Mr SMITH: That is exactly right. Now a percentage of their time is taken in answering phone calls basically as a receptionist.

The Hon. TREVOR KHAN: I am just trying to work out from the allocated to unallocated numbers of liaison officers that we talked about if there needs to be a tenfold increase in the number of liaison officers or whether over a period of time the existing number of liaison officers, perhaps with additional ones, would cope with an allocation of the unallocated files?

Mr SMITH: If you look back at September 2017 each of those four newly positioned people had zero clients, now we have got eight people dealing with—was it 200 and something?

Mr DAVID SHOEBRIDGE: But the numbers probably do not tell you the story because I would imagine—I have not had a look myself—in the first 12 months of a claim there is going to be a lot more communication in bedding it down, then in most cases the work would tail off unless a crisis hit at some other point. I doubt it is about numbers; it is probably more about overwork.

Mr SMITH: I think you are dead right in that it goes in ebbs and flows—it depends on the client. If a client, for example, has mesothelioma and is a very short tenure that person may, let's say, be in need of support or needs to be talking to a liaison officer every single day. Whereas you might have someone with asbestosis who has not progressed, or had not, and they are now going through a crisis and has gone from 10 per cent disability up to 40 per cent or 50 per cent. That person and their carer may need to be talking the whole time. So getting that balance I think it will need to be—I guess where my concerns are, it would seem to me that the liaison staff are being asked to be everything to everyone whereas I feel more people should be just put on. No, I mean, the pressure of KPIs in support should never be applied. I do not believe KPIs, for example, have any place whatsoever in the support gender. I think they are absolute rubbish.

The Hon. TREVOR KHAN: Are you saying that KPIs are being applied?

Mr SMITH: I believe they are. I believe KPIs are being applied. I have been told that the new phone system is being put in place for the exact numbers of callers and how long every one is. At one point I believe the aim was to ensure that everyone was only on hold for no more than two minutes or something.

The Hon. TREVOR KHAN: Do you think that is unreasonable, that there be an expectation that clients be attended to quickly?

Mr SMITH: No, I do not think it is at all but I think it is unreasonable to tie in the liaison staff into this because if you are constantly on the phone—and we find this problem ourselves; we operate basically out of a home office. We do not have any money to have staff as such, so I can be on the phone for two or three hours to a newly diagnosed family and have five or six calls waiting to be attended to, which will all have left messages. So I actually find myself in the rush to attend to people you know you need to talk to and you do not then necessarily write everything down that you should.

You do not necessarily document everything the way you would like to, so you get further and further behind. You do not do your KPIs, which I have to do to justify funding, so you get further and further behind. The pressure just mounts up on you and I cannot for a second believe that the liaison staff are not. This is only from the outside, looking in, in dealing with these staff. I have said this all the way along that there should not be a figure put on the number of liaison staff. It should be put very much on how they are coping. They should be listened to on how they are coping because when it first started the staff had the flexibility, that if someone rang up, to guide them through and help them fill out an application form, for example. I doubt whether they do now because they are going to see their screen flashing that there is a call waiting to be answered.

The CHAIR: I am sorry to cut you off but we are out of time.

Mr SMITH: Really; that has gone quick.

The CHAIR: I know. We have a very full schedule today and I apologise for that. We would like to spend more time but we appreciate your written submission. Is there anything else you would like to add briefly?

Mr SMITH: I think we have covered it all. I am really pleased to say that the dust diseases care of today is a long way from what it was back in 2015, I believe. There is far more access. I think my closing statement in the submission says it all. We need to ensure that dust diseases care stays supporting people and does not become a business model.

The CHAIR: Thank you, Mr Smith. I do not think you took any questions on notice so we thank you very much for your time today.,

Mr SMITH: Thank you.

(The witness withdrew)

DEBORAH YATES, Senior Staff Specialist in Respiratory Medicine, St Vincent's Hospital, and Associate Professor, University of New South Wales, sworn and examined

The CHAIR: Thank you for appearing today at this review of the Lifetime Care and Support Scheme and Dust Diseases Scheme. Thank you also for the written submission. I do not know that you are the author of that submission.

Associate Professor YATES: Yes.

The CHAIR: It has Alan Glanville in here.

Associate Professor YATES: We did it collaboratively.

The CHAIR: Thank you for providing that; it is very helpful for the Committee. Did you have an opening statement you would like to make or are you happy for us to go straight to questions?

Associate Professor YATES: I will be brief because there is a relative amount that needs to be discussed. Just to give you a bit of background, I am a respiratory physician originally trained in the United Kingdom with qualifications in occupational medicine as well and I worked in the United Kingdom with the Pneumoconiosis panel, which is probably the oldest established system in the world with regard to compensating for occupational lung diseases. I am currently also involved in a number of different research collaborations, particularly with the Black Lung Centre of Excellence at the University of Illinois at Chicago. I also have a role as the Co-Chair of Coal Mine Dust Lung Disease (CMDLD) Collaborative Group in Queensland, which has been very much instrumental in reviewing the procedures with regard to the pneumoconiosis outbreak in Queensland. In addition to that I am on the Silicosis Taskforce for New South Wales and I am also very committed towards developing a standardised national approach towards diagnosis and treatment of occupational lung disease within Australia.

Mr DAVID SHOEBRIDGE: Did you want to speak to a couple of your points? There is the medical assessment panel issue and the classification of lung diseases. They are two issues that jump out from your short but really informative submission. Do you want to start addressing those?

Associate Professor YATES: Certainly. I come from the health point of view and as such my focus is diagnosis and prevention rather than primarily compensation. I start with diagnosis. In the last 25 years there have been a lot of changes with regard to respiratory medicine, particularly with understanding basic disease othophysiology. That has included occupational lung disease, and the spectrum of occupational lung disease has vastly widened. I think it is fair to say that Australia is not as advanced as some other areas with regard to the spectrum of occupational lung diseases and essentially we in the Thoracic Society think this needs to be expanded to conform to international best practice.

The Hon. LYNDA VOLTZ: The big differences are in the international standards?

Associate Professor YATES: Yes, occupational asthma and occupational chronic obstructive pulmonary disease [COPD]. It is usually associated with cigarette smoking but data now suggests that 30 per cent to 40 per cent are actually not associated with cigarette smoking but very clearly associated with dust and environmental exposures.

Mr DAVID SHOEBRIDGE: And occupational asthma is one of those issues where you have an argument currently, do you not, about whether or not it is by particulates, chemicals or gases, is that right?

Associate Professor YATES: No, not strictly. In fact, occupational asthma can be caused by dust, fumes or vapours. The actual particulate matter or whatever is not necessarily relevant. It is a very broad spectrum of different diseases. Now we call it work-related asthma and there is a specific subtype called occupational asthma. Essentially our position is that we feel that the spectrum of disease-related occupations needs to be expanded to meet twenty-first century criteria.

The Hon. TREVOR KHAN: Could you just say that again?

Associate Professor YATES: We think that the spectrum of diseases recognised as due to occupational exposures needs to be expanded in order to meet the twenty-first century criteria.

The Hon. TREVOR KHAN: So what is the implication of that in terms of what we are doing? I am not being rude in that regard. You are talking at it from a medical point of view, a diagnosis point of view. The question is: If I take those words at face value, Mr Shoebridge would say that therefore means the number of diseases that should be dealt with under the Dust Diseases Act should be X, so I am just wondering if the leap that Mr Shoebridge would seek—and I am not being rude to him—

Mr DAVID SHOEBRIDGE: It is probably fair to say that I would want to expand them.

The Hon. TREVOR KHAN: I am just wondering if X follows Y in what you say.

Associate Professor YATES: Yes, it does. We think that the number of diseases is much smaller than the lobby view and in addition to that that the number of cases of occupational disease is vastly under-diagnosed in Australia.

The Hon. LYNDA VOLTZ: And that is reflected in the difference in the international standard and what we have here.

Associate Professor YATES: Exactly.

The Hon. TREVOR KHAN: Accepting that they are diagnosed as an occupational lung disease, and again getting back to part of the argument that was had with the lawyers, the relevance of that is that if it is diagnosed and accepted as being an occupational lung disease then it would be covered under the Workers Compensation Act.

Associate Professor YATES: Yes. I should add that in the UK, occupational asthma has been on the industrial disablement benefit since the late eighties—I was partially instrumental in bringing that in; I was appearing on a committee at that stage—and occupational COPD is accepted, for example, for coalmine lung diseases and there is a push for silica also, silica exposure in an absence of silicosis also to be associated with COPD. The spectrum that is recognised here is out of date, in our eyes.

Mr DAVID SHOEBRIDGE: Your view is we should review occupational lung diseases and the focus should be on whether or not they are acquired in the course of an occupation rather than particular mechanisms. Is that right?

Associate Professor YATES: Yes.

Mr DAVID SHOEBRIDGE: There are issues you have about the current way in which diagnosis is made under the medical assessment panel. Can you deal with that?

Associate Professor YATES: Certainly. I should add I was the deputy chair of the medical authority for 10 years and I know all the workings of it fairly well. I also worked in that capacity in the UK. So I know how the other systems worked. The difficulty, I think, is related to the fact that in Australia we have got into an area of complacency and that wa really well shown in Queensland where when they reviewed the system they found that the systems that were in process for doing X-rays for lung function and for acting on those results were very bad, and one of the reasons for that was partly because the medical profession were very poorly trained in that regard.

The Thoracic Society have been trying to improve the training in this particular area and we run a course, which is currently supported by icare, which is done on alternate years to improve education in that regard. But there is a dearth of practitioners who have any experience or real knowledge of occupational lung diseases and we would like to expand that. I think there should be a standard procedure for knowing what people should be qualified for when they apply for the medical authority; there is no quality control audit of those particular decisions and, again, the decision-making processes are not necessarily in conformity with what is the international situation with regard to diagnosing these diseases.

The Hon. TREVOR KHAN: So who do they apply to? You said when they apply for—

Associate Professor YATES: Patients when they apply for a disablement.

Mr DAVID SHOEBRIDGE: I thought you were talking about the makeup of the medical assessment panel.

Associate Professor YATES: Yes, sorry, absolutely you are right.

Mr DAVID SHOEBRIDGE: So I assume they apply for dust diseases care.

Associate Professor YATES: Yes. I do not know how they actually applied for the position on the medical authority but I can tell you how I was. I was just approached and asked.

The Hon. TREVOR KHAN: You would say you were a suitable person to be approached and asked.

Associate Professor YATES: I believe in meritocracy and advertisement widely. I do not believe in the being approached and asked, no; I believe in advertisement. As far as I know, these positions are not widely advertised. In the Thoracic Society we have a system to advertise these positions. The Board position is advertised but the individual membership is not advertised, to my knowledge.

The CHAIR: But you were appropriately qualified, which is what I think you were getting at.

Associate Professor YATES: Yes.

The CHAIR: Your qualifications made you an appropriate person to approach amongst other appropriately qualified people.

Associate Professor YATES: Yes.

Mr DAVID SHOEBRIDGE: I suppose we should ask icare about the processes and the procedures and the scrutiny they have and the qualifications for getting people on the medical assessment panel. I take it the Thoracic Society would be happy to sit down and talk with them about that.

Associate Professor YATES: We certainly would be, yes.

The Hon. TREVOR KHAN: Have you approached them?

Associate Professor YATES: No, not on this specific issue.

Mr DAVID SHOEBRIDGE: Flowing from that, you suggest there should be a review of the last two years' decisions to see if they are consistent, if nothing else.

Associate Professor YATES: Yes, because one of the problems that the patients have, which I think is partly due to lack of communication, is that they do not understand the difference between having a diagnosis and having a disablement. So when they have a diagnosis they think that that means that they are necessarily going to be sick and get a pension. Yet there are criteria for disablement which are totally appropriate but these criteria may not necessarily be exactly the same that are internationally applied and are those which patients will understand. For example, I have a patient who has hard metal pneumoconiosis and if you look at his lung function it is actually quite good, but the reason it is quite good is because he had very good lungs to start with.

So unless you have measured the baseline you cannot see the change over time. There is a move internationally towards going away from single measurements of lung function towards looking at serial measurements of lung function, which give you a much more accurate assessment of the degree of disablement and using other tests that will highlight the incapacity in a young person. The way in which disablement is assessed really just needs to be reviewed in order to make sure that it is appropriate to the modern situation and that it is actually clear to the patients because they find it very difficult to understand.

The Hon. TREVOR KHAN: When I read your recommendation of looking at the last two years I took from that that you had a criticism that there were bodgy assessments done in that two-year period.

Associate Professor YATES: Not particularly two years, no.

The Hon. TREVOR KHAN: But that is not the conclusion. I was wrong.

Associate Professor YATES: Two years is just enough numbers to get an appropriate review. I could also add that on the Pneumoconiosis panel we had a regular review of all the cases and usually over every year and we also had a regular audit facility; for example, any decision that was made was audited by an objective other panel, so, say, one in 10 was looked at, and then if, for example, an individual doctor had not been in conformity with the guidelines then they were asked about it and it was all brought in line. In addition to that there was a medical appeal tribunal, which I think is something which has been considered before in this sort of forum, which, again, acts as an independent non-litigious group, which is a group of three senior doctors who can assist with making a final decision and it makes it easier for patients and to do it rapidly rather than through a legal forum.

Mr DAVID SHOEBRIDGE: Your submission seeking a reform, a modernising of the way the lung functioning test is done, is not revolutionary; this is bringing New South Wales into the twenty-first century. Is that right?

Associate Professor YATES: That is exactly right.

Mr DAVID SHOEBRIDGE: Queensland just moved that way for their pneumoconiosis.

Associate Professor YATES: I should add that a lot of our comments are generated because of the information that we have been getting in Queensland. In Queensland what has happened is they have instituted training for lung function testing for spirometry, and we in the Thoracic Society offer a course for that.

The Hon. TREVOR KHAN: Sorry?

Associate Professor YATES: Forgive me for being technical. When you measure lung function you get someone to breathe out and you can do either a test called spirometry, which is you only get to breathe out fast and you keep on going for six seconds, and/or you can do what they call full lung function, which is where

you measure the amount of gas left in the lung after you have breathed out and the rate at which gas is transferred across the lungs, and you measure slightly different things. Over the last 20 years there have been very large studies internationally which have beautifully documented exactly how to do these tests and there have been very good predictive values so that we can say in an individual person, depending on their age and sex and height and racial group, what their lung function should be. This is not rocket science; this is now extremely mainline science.

The Hon. DANIEL MOOKHEY: It is rocket science to us.

Associate Professor YATES: We think that the system needs to take into account these changes which have really helped a lot with patient care and have now been implemented in Queensland and similarly with radiology, for example, we used to just do chest x-rays, but now we are moving more and more to doing high resolution CT scans, which give you an excellent view of the internal anatomy.

The Hon. DANIEL MOOKHEY: Before you go too far in the story, when you say it is being done now in Queensland, who mandated it to be done in Queensland?

Associate Professor YATES: The Department of Mines.

The Hon. DANIEL MOOKHEY: When?

Associate Professor YATES: Over the last—

The Hon. TREVOR KHAN: Eighteen months?

Associate Professor YATES: Yes, 18 months.

The Hon. DANIEL MOOKHEY: As a result of that decision are you saying that the level of data that is now coming from Queensland is much greater than before?

Associate Professor YATES: The quality of the data that is coming through is much better.

The Hon. DANIEL MOOKHEY: Are you saying therefore New South Wales can rely on that data in the absence of any comparable New South Wales data as a way in which to judge whether we are likely to face the same issues in this State?

Associate Professor YATES: I think it is a valid comparison, yes.

The Hon. DANIEL MOOKHEY: Should we be applying in New South Wales the same rules they have been applied in Queensland?

Associate Professor YATES: I think we should.

The Hon. TREVOR KHAN: Just on that point, what changes would that mean should be adopted in New South Wales. I am sorry to interrupt.

The CHAIR: No, it is quite right to tie that up.

Associate Professor YATES: With regard to the lung function testing, the people who perform the lung function testing at the Dust Diseases Board who, I think, are respiratory trained already, would need to be accredited. They would need to undergo the training process and get that re-accredited, revalidated every few years. The predicted values that are applied to the lung function testing should be the standardised ones that are now accepted by the global lung community. The chest radiographs should be performed according to the International Labor Organisation [ILO] protocol and the issue of whether there should be a high resolution CT scan performed in addition should be objectively and carefully examined because there are very good data demonstrating that the newer techniques diagnose disease earlier and better.

Mr DAVID SHOEBRIDGE: We have icare coming in next. If we were to say to them, "Would you mind sitting down in the next fortnight or month, whenever you can first arrange it, and meet with the Thoracic Society to try to nut these things out?" and they said "yes" would you be happy to be in that meeting?

Associate Professor YATES: Yes, certainly.

The Hon. TREVOR KHAN: Or at the very least, how many points were there then?

Mr DAVID SHOEBRIDGE: It is all covered neatly in the submission.

The Hon. TREVOR KHAN: Well at least in terms of questions on notice, icare would need—I assume they are listening—to be able to answer as to the validity of each of the propositions just put.

Mr DAVID SHOEBRIDGE: Yes, by 7 February.

The Hon. DANIEL MOOKHEY: Just to close this out, just as a contextual matter to Queensland, this result has generally been applied to the coal industry of Queensland. Is that correct?

Associate Professor YATES: Yes.

The Hon. DANIEL MOOKHEY: And to coal workers?

Associate Professor YATES: Yes.

The Hon. DANIEL MOOKHEY: Who else is required?

Associate Professor YATES: In practice, the problem has arisen in coal workers but now, as you can imagine, the silicotics that abour at a very very much higher level.

The Hon. TREVOR KHAN: Is that someone suffering from silicosis, is it?

Associate Professor YATES: Yes, and in fact, you are probably aware of the really awful epidemic of artificial stone silicosis, which has been affecting Queensland, in particular—

The Hon. TREVOR KHAN: Why?

Associate Professor YATES: Why? Because there is a new occupational exposure, which involves cutting of stone benchtops. You know all those beautiful stone benchtops that we see in the kitchens?

The Hon. TREVOR KHAN: Including my kitchen, I might add, and bathrooms.

Mr DAVID SHOEBRIDGE: Why Brisbane and not Sydney?

Associate Professor YATES: Exactly. I believe it happens in Sydney as well. We just have not looked for it.

The Hon. DANIEL MOOKHEY: As a result of the introduction of these standards or others in Queensland the problem is surfacing far more in a way which can be officially recorded. Is that your evidence?

Associate Professor YATES: Yes. Two reasons: firstly, it is being noticed because those numbers have increased. It is now being looked for in this particular industry. Secondly, the improvements in standards have allowed the diagnosis and the increased awareness.

The Hon. DANIEL MOOKHEY: Is there any reason why we should think that if we were to apply the same rules in New South Wales we would not see the same spike?

Mr DAVID SHOEBRIDGE: The witness has already answered that as "yes".

Associate Professor YATES: The answer is I think we would see exactly the same thing.

The Hon. TREVOR KHAN: You would have a better idea, but we have the lung bus that trundles around in New South Wales. Was Queensland doing any of that?

Associate Professor YATES: No. Queensland has brought individual occupational physicians and sent them off for specific testing using the accredited places.

The Hon. TREVOR KHAN: I understand that, but they have had a spike. At least in part that spike is as a result of the black lung issue that arose two years to 18 months ago so they have worked. Is the current spike that is occurring in Queensland as a result of essential reform that has occurred there, firstly?

Associate Professor YATES: No. The spike that has occurred in silicosis is very clearly because of the new exposure, progressive silicosos. The spike that has occurred in coal in pneumoconiosis is because of long latency diseases. The exposures occurred 20 to 30 years ago, so it has just been recognised. It is not a real spike, it is an unrecognised spike.

Mr DAVID SHOEBRIDGE: But in terms of the silicosis there are two factors at play together. One is the greater exposure because of the expansion of the manufactured stone industry and that is causing the disease.

Associate Professor YATES: Yes.

Mr DAVID SHOEBRIDGE: But we are finding out about the disease and the numbers are becoming apparent in Queensland and not in New South Wales because? That is what we are asking you to answer. A similar industry development in both—

Associate Professor YATES: Yes, because we have not looked for them. The first case that was described in New South Wales—we described it—and we have a number of cases which have been referred to lung transplantation team and then subsequently to the lung transplantation service at St Vincent's. They have

never had any occupational exposure testing or screening at all. So I believe that there will be other cases there that have not been looked for. With regard to icare, and the silicosis task force, they have been trying to look for them, but unfortunately it has become diluted by looking at the whole load of silicotics as opposed to just that particular group.

The Hon. TREVOR KHAN: You are going to have to help us there. What does that mean?

Associate Professor YATES: Silicosis occurs with a wide variety of different occupational exposures. The majority of them occur with things like tunnelling or construction roadwork, mines, boring and so on. This is the usual group which the dust diseases care have looked at for many years. The artificial stone silicotics have only very recently emerged. I think the first case that they saw was the one that we referred to them, who now has had a transplant for it. SafeWork has been trying to get them screened, but they have been addressing all of the people who have been potentially exposed to silicosis and they have not looked specifically and concentrated particularly on the artificial stones. As far as I know from the silicosis task force the number that had actually only been examined is 19. And yet there must be a workforce of, we have estimated in the region of about 4,000 or 5,000.

The CHAIR: Can I try to clarify? In Queensland they specifically went fishing for that particular thing.

Associate Professor YATES: Yes.

The CHAIR: When is why they have been identified more? That is your evidence.

Associate Professor YATES: Yes.

The Hon. TREVOR KHAN: How many people have been diagnosed in Queensland, do you know?

Associate Professor YATES: I am not quite sure. I am reluctant to—

The Hon. TREVOR KHAN: That's alright. You can take it—

Associate Professor YATES: Over 100 and predictions are from a region of about 800 or 900. Yes. There is a case-finding rate of 30 per cent of complicated silicosis, which is a really progressive which kills you, basically. I have a 42-year-old who has silicosis from this cause who is dying at this moment. He is trying to get a transplantation. He has been exposed in New South Wales over the past 15 years.

Mr DAVID SHOEBRIDGE: When you were talking about the lung bus and what is happening in Queensland, you said something about sites or places that are accredited as a testing mechanism. Can you explain what means?

Associate Professor YATES: Yes. I mean places that have had accreditation in spirometry. In other words the Thoracic Society training and ensuring that it is done according to the right way. And then an ILO-accredited radiology practice. In other words, the x-ray is taken in an appropriate way, or the CT scan is taken in an international appropriate way and it is read by a radiologist who has undergone specific ILO training.

Mr DAVID SHOEBRIDGE: There are a number of those facilities identified and accredited by the Queensland authority and they are being subsidised for the test. Is that how it works?

Associate Professor YATES: Yes, and—

The Hon. TREVOR KHAN: Sorry, can I just get you to go back? Are you say x-ray first and then CT, or is CT— ?

Associate Professor YATES: The standard at the moment is x-ray, but the x-ray needs to be done according to those objective specifications. If it is done with the wrong technique it will not pick up the early disease at all. Specifically with progressive silicosis the data suggests that CT probably should be looked at first.

The Hon. DANIEL MOOKHEY: You said the task force has decided not to focus on artificial—

The Hon. TREVOR KHAN: I do not think that is quite what the witness said.

The Hon. DANIEL MOOKHEY: That is what I want to clarify. Is that what you are saying?

Associate Professor YATES: I do not think they have been trying not to do it. They have been trying to address silicosis as a whole, which is most appropriate. However, from a health point of view, they have understandable difficulties with finding exactly the workplaces that need to be screened. We think they need to look at all the places where artificial stone is manufactured, processed or used and ensure—make it mandatory—that the workers are screened. That is not happening now.

Mr DAVID SHOEBRIDGE: Part of why they focus on that industry is that those other industries—quarrying, mining and tunnelling—

The Hon. TREVOR KHAN: Madam Chair, I would like members to consider extending this session by 15 minutes. I do not think the representatives from icare will take the full amount of time allocated to them. We seem to have a love-in with them each time they appear.

Mr DAVID SHOEBRIDGE: I think some of this will be relevant. I suggest that we extend the session by 10 minutes.

The CHAIR: It appears that members are agreed.

Mr DAVID SHOEBRIDGE: The reason for focusing on inspections at manufactured stone workplaces is that in other industries—mining, tunnelling and so on—where silicosis occurs they are aware of it and have put measures in place. They are probably not as critical to get into as manufactured stone workplaces. Is that one of the reasons?

Associate Professor YATES: There are a few reasons. As far as we know, the risk with artificial stone is much, much greater. The silica levels are 1,000 times greater than in traditional industries. Also, the type of silicosis that we are seeing is new and is rapidly progressive, and it is occurring in young people. The data from Queensland shows that this is an emerging crisis.

Mr DAVID SHOEBRIDGE: And we need to act now.

Associate Professor YATES: We need to get onto it very quickly. To be fair to the task force, I think they have been trying to concentrate on education and dust exposure levels. That is reasonable, but I am involved in health and I want to ensure people do not get disease.

The Hon. DANIEL MOOKHEY: Can you tell the Committee what is the task force's intention in dealing with this rapidly emerging crisis?

Associate Professor YATES: It is concentrating on an education campaign, which has started. There is a publicity campaign and a conference will be held in May. But, as far as I know, there is no intention to do individual case findings.

Mr DAVID SHOEBRIDGE: It sounds to me that the education program is working in part because one boss said in earlier evidence that he would allow his son only to do wet cutting but he would allow all the other workers to do dry cutting..

The Hon. TREVOR KHAN: If you were in court you would get smacked for that.

The CHAIR: That is anecdotal evidence.

Associate Professor YATES: I think education is really important. I am not in any way—

Mr DAVID SHOEBRIDGE: But it cannot begin and end with education.

Associate Professor YATES: The problem is that we know the levels have been far too high, so measuring them now is very important but it is a bit late. By the time people get to the point where they need a transplant we really know there is a problem. We need to look at people in this specific industry to find out exactly how many there are and to stop them from getting any further exposure.

The Hon. DANIEL MOOKHEY: Is that desire translating to the task force and are they doing it?

Associate Professor YATES: Their point, which is valid, is that they are involved with regulation. The Department of Health has also been involved in the task force. However, as you can imagine, this requires a fairly major commitment from other areas. Safe Work Australia is involved in regulation of the workplace and in asking for health checks but not in ensuring they happen.

Mr DAVID SHOEBRIDGE: What about the naphtha standard? I am frustrated by the fact that everyone agrees that the exposure standard should be changed from 0.1 milligrams per cubic metre to 0.025 milligrams.

The Hon. TREVOR KHAN: That was a submission that we received.

Mr DAVID SHOEBRIDGE: No. I want to ask the witness whether anyone on the task force disagrees with that and why has it not happened.

Associate Professor YATES: I do not think anyone disagrees. But I think the reason it has not happened—and I agree—is that a proper objective review of all the evidence to ensure it is the appropriate standard has not been done because in practice it is very difficult to get as low as that.

The CHAIR: Why is it difficult?

Associate Professor YATES: Because of the technology involved in getting dust levels as low as that in every situation. It has not been examined for artificial stone. I think it would be relatively easy to do it, but I am not an occupational hygienist and I may be wrong. I do think it is practical, but as you can imagine this has major implications, for example, for changing workplaces.

The Hon. DANIEL MOOKHEY: To whom are you referring to?

Associate Professor YATES: I am talking about the tripartite committee that includes occupational hygienists and representatives of employers, unions and health—

The CHAIR: The task force?

Associate Professor YATES: Yes.

The Hon. DANIEL MOOKHEY: Feel free not to answer this question. The Committee has heard evidence from trade union representatives who said that perhaps the views of industry are dominating at the expense of everyone else and that they are motivated by economic incentives above all else. Do you wish to comment?

Associate Professor YATES: I would be reluctant to comment. I think the representation has been relatively balanced. However, I also think we are in an urgent situation. The workers are very vulnerable and something urgent must be done. Yes, if necessary, it might include involving industry in something that will be really effective.

The Hon. DANIEL MOOKHEY: Is your view about the urgency the consensus of the task force or is it disputed?

Associate Professor YATES: I think that on the whole people understand it.

The Hon. TREVOR KHAN: Are you saying that in terms of the manufactured stone industry the problem should be carved out—apologies for that phrase—of the general issues being considered by the task force and dealt with separately, or should the task force be given a term of reference to deal specifically with the manufactured stone problem?

Associate Professor YATES: It is supposed to be looking at the manufactured stone problem already.

The Hon. TREVOR KHAN: That is what I thought.

Mr DAVID SHOEBRIDGE: That is what the Committee recommended.

The Hon. TREVOR KHAN: I am not certain what terms of reference were given to the task force.

Associate Professor YATES: The problem is that Safe Work Australia is concerned with regulation of dust levels and on the health side we are concerned with disease happening quickly and trying to prevent it urgently. I am not part of the Royal Australasian College of Physicians and the Australasian Faculty of Occupational and Environmental Medicine. We work collaboratively and we take a uniform approach, which is to prevent disease happening quickly. That is a priority for all involved. I think it is fair to say we feel that the health implications are so important and urgent that a case finding study needs to be conducted now.

Mr DAVID SHOEBRIDGE: People's lives are at risk. Surely we should adopt a precautionary approach. Perhaps the standard should not be 0.025. Should we make the standard 0.025 and then do the research given what is at stake?

Associate Professor YATES: I can see that argument. But the problem with dust regulation is that it does not work. People do not do it; you can legislate as much as you want. My patients never measured any level; they knew nothing about it.

The Hon. TREVOR KHAN: Especially if they are in a shed at the back of Tamworth or wherever.

Associate Professor YATES: The majority of people working in this environment are non-English speaking and they are terrified of authorities. You can legislate as much as you want, but my patients never measured any level. They knew nothing about it altogether.

The Hon. TREVOR KHAN: Because they are in a shed in the back of Tamworth, or wherever it was.

Associate Professor YATES: Yes. The majority of the people who work in that sort of environment are often non-English-speaking and they are terrified of authorities. You can regulate as much as you want, but in order to actually get at the problem you have to mandate examination for these people, make it free, and find them.

Mr DAVID SHOEBRIDGE: And the national registry is surely part of that?

Associate Professor YATES: As you probably realise, we—and when I say "we", I mean the RACP/TSANZ/AFOEM—have very strongly supported this. In fact, we suggested it in the first place.

Mr DAVID SHOEBRIDGE: Did the task force support it?

Associate Professor YATES: The task force has supported it, yes.

Mr DAVID SHOEBRIDGE: Is it here yet?

Associate Professor YATES: No.

Mr DAVID SHOEBRIDGE: Why not?

Associate Professor YATES: It has been discussed at the Council of Australian Governments [COAG]. We are hoping that it will come. We need support for this at every possible level, and funding.

Mr DAVID SHOEBRIDGE: Is it urgent?

Associate Professor YATES: Yes.

Mr DAVID SHOEBRIDGE: Who should pay?

Associate Professor YATES: Every State and the Federal Government.

The Hon. DANIEL MOOKHEY: Thank you for politely pointing out our impotence as well.

The CHAIR: On that note—I tried to wrap it up before we got that, but we got there—thank you for appearing.

The Hon. LYNDA VOLTZ: You guys have to know when to let go.

Mr DAVID SHOEBRIDGE: I think the point was that the magic standard will not work and a whole lot of other preventative stuff is required.

Associate Professor YATES: Yes.

The CHAIR: We have gone over time. Thank you very much for your written submission and for your time today. We are very appreciative.

Associate Professor YATES: Thanks very much.

The CHAIR: I think there may have been questions taken on notice. If there are, we ask that you return answers as quickly as possible and at the latest by 7 February. We are under some time pressures for this Committee.

Associate Professor YATES: Thank you.

The CHAIR: The Committee secretariat will be in touch about that.

Associate Professor YATES: Can I just add that if there are any further questions, we as a group of physicians would be very happy to help.

The Hon. TREVOR KHAN: I can imagine, subject to what happens after the election, there might be another inquiry.

(The witness withdrew)

JOHN NAGLE, Chief Executive, icare, sworn and examined

NICK ALLSOP, Acting Chief Financial Officer, icare, affirmed and examined

CHRIS KOUTOULAS, Interim Group Executive, Care and Community, icare, sworn and examined

SUZANNE LULHAM, General Manager, Care, Innovation and Excellence, Care and Community, icare, sworn and examined

The CHAIR: I welcome everybody. I thank our witnesses for coming along today to the 2018 review of the Lifetime Care and Support Scheme.

The Hon. DANIEL MOOKHEY: The nineteenth.

The CHAIR: No. The title of the inquiry is the 2018 review of the Lifetime Care and Support Scheme and Dust Diseases Scheme.

The Hon. DANIEL MOOKHEY: It does feel like 2018 too.

The Hon. TREVOR KHAN: We are just late.

The CHAIR: We are in the new year. Thank you Mr Mookhey. The Committee welcomes the witnesses. If members keep interjecting, we will stay here until six o'clock tonight.

Mr DAVID SHOEBRIDGE: As long as this stays in 2019, I am happy.

The CHAIR: All right. Don't tempt me. Does any witness have an opening statement to make to the Committee before we commence questions? We have your written submissions and additional answers to questions provided today. If you would like to make an opening statement, go ahead.

Mr NAGLE: I have just a brief statement, if that is okay, Chair. Thank you, Chair and Committee members. The key schemes in the icare business are the areas that make icare unique in the insurance arena and help us to define our role as a social insurer. We focus on outcomes for injured people, not profit. These are about low-volume injuries but they are high-need high cost and they involve a long time frame. Our youngest participant joined us at six months from a road injury. With modern lifespans, we could be looking after that individual for more than 100 years. In many cases the future staff of icare that will look after that individual need not have even been born yet.

The challenges we have are adjusting to an ageing cohort who are starting to face impacts from age-related diseases as well as their injury, plus ageing families, supporters and an ageing workforce. We are also looking at the change in the compulsory third party [CTP] scheme that will be coming forward in 2020. We will bring further challenges from a cohort who have been engaged in an adversarial insurance industry and they will be moving to a system that is designed to support them. We are very conscious of cultural changes that will have to be required as you make that move.

In the dust disease area, we continue to have claims that are due to latency from the past or more recent workplace practices. We continue with our work to educate and support employers and workers who may be impacted. Our focus is utilising all the lessons from across icare and attempting to utilise our scale to control costs and maximise support. But at times we are hampered by legislation being by individual scheme, even if we are dealing with common injuries or issues. While generally pleased with our progress, we are aware that the ever-changing needs of our customers, advances in medical treatments and increased community expectations for transparency and support. We are also acutely aware that the long-term nature of these schemes requires us to focus on financial sustainability to ensure current and future customers can be supported. We do welcome the opportunity to update the Committee on our activities. Thank you.

Mr DAVID SHOEBRIDGE: Do you know what I would love? When we get your very modern position descriptions, I would love a small explanation about what you actually do. The position described by Ms Lulham sounded nice, but I was not quite sure what you did. Would it be possible to find out what you did?

The Hon. TREVOR KHAN: Well ask the question.

Mr DAVID SHOEBRIDGE: That is the question. What does each of you do, so we know where to direct our questions?

The CHAIR: I am not sure that is within the terms of reference.

Mr KOUTOULAS: I look after the care schemes. I look after both of the lifetime care and the dust diseases and the workers care program.

Ms LULHAM: I also have a role across lifetime care, workers care, and dust diseases care. It is very much in that service development and delivery space.

Dr ALLSOP: Currently, I am managing the accounts for icare, so I am performing the functions of a financial officer.

Mr DAVID SHOEBRIDGE: And that is for each of the schemes?

Dr ALLSOP: Yes, every scheme.

Mr DAVID SHOEBRIDGE: I think we know what you do, Mr Nagle.

Mr NAGLE: I try to make them do the work that they are meant to do.

Mr DAVID SHOEBRIDGE: Keep them honest.

Mr NAGLE: Correct.

The Hon. DANIEL MOOKHEY: Are you still the actuary?

Dr ALLSOP: Not at the moment. We have an interim chief actuary while I am the interim chief financial officer.

The Hon. DANIEL MOOKHEY: Congratulations.

Dr ALLSOP: Thank you.

Mr DAVID SHOEBRIDGE: Let me begin with the Dust Diseases Scheme. I do not know if you heard but I take it you have read the evidence from the Thoracic Society and some of the concerns they have about diagnosis criteria and the like. Does any witness want to address that broadly before we ask more specific questions?

Mr NAGLE: I think from an icare perspective, we are very conscious of the interest in silicosis. In the information we have provided, you can see that our claims numbers are quite stable. However, we are conscious that this could be an emergent latent scenario. Chris Koutoulas could give you more detailed answers.

Mr KOUTOULAS: Diagnosis of a dust diseases quite integral to the whole process under the scheme. We need that diagnosis. We need that certification. The important thing is, given the nature of these illnesses and the malignancy of a lot of the diseases, we want that diagnosis to occur as soon as possible. The timeliness is really critical and the accuracy is just as critical in picking that up.

Mr DAVID SHOEBRIDGE: The thoracic society said that they are not confident of the basis upon which the diagnosis is currently being done by the medical assessment panel, they are not confident about the kind of lung functioning tests, they are not confident about the training for the radiographers in terms of the X- rays and they are not confident about the criteria upon which CT scans are done and, given that package of concerns, they are very concerned about the numbers not reflecting reality. As a stress test on that, they say what is happening in Queensland in the industry is pretty much identical to what is happening here, or nothing materially different, yet there are vastly greater numbers in Queensland where they have more sophisticated diagnosis tests.

Mr KOUTOULAS: There are two elements to this. The health screening—the actual screening of the lung capacity, the disease and so forth—in terms of the diagnostic process that we follow, and that we apply, consists of lung function testing, spirometry and so forth, an X-ray and a medical examination by a respiratory physician.

The Hon. TREVOR KHAN: That is not all done on the bus, is it?

Mr KOUTOULAS: It can be, yes. It is, yes, as well as the clinic in the central business district here. All that complies with the International Labour Office [ILO]. There is a radiographer who takes the X-rays and the X-rays are then sent to a radiologist who is compliant with ILO standards. All of the spirometry test, the lung function test, is also compliant with relevant standards.

Mr DAVID SHOEBRIDGE: Are the people who are doing these tests accredited by the Thoracic Society of Australia and New Zealand [TSANZ] because that was one of the asks?

Mr KOUTOULAS: The tests do follow the Thoracic Society of Australia and the European Respiratory Society, so it does sort of comply with various standards. Are they specifically accredited through TSANZ? No, I do not believe so.

The Hon. TREVOR KHAN: Why not? I am not here to put you on the griller but is there a reason why they would not be?

Mr KOUTOULAS: I think our medical assessment panel, which is the independent body that is formed by the respiratory physicians who make the diagnosis on the certified diseases, is quite comfortable with the evidence coming through, the medical information that is coming through on the testing. We do undertake additional tests, which I believe are being recommended by TSANZ in Queensland, for example—so the use of the DLCO I believe it is called, which is a gas transfer testing.

Mr DAVID SHOEBRIDGE: They are saying both should be done.

Mr KOTOULAS: Yes, and the B-readers.

Mr DAVID SHOEBRIDGE: And there is more than one way to do the spirometry—

Mr KOTOULAS: The lung function test, yes.

Mr DAVID SHOEBRIDGE: There is a good way and a bad way—well, there is an old way and a new way?

Mr KOUTOULAS: I think there is, but we do the DLCO where we notice or pick up something. Where the panel does see an abnormality or some issue it will refer that we conduct a DLCO. I guess it is really about what is required at an initial screening relative to how it progresses.

Mr DAVID SHOEBRIDGE: According to the thoracic society, in the absence of having TSANZ accredited laboratories, when they reviewed the spirometry testing in Queensland it was found that it did not meet uniform, acceptable criteria in the context of occupational health screening. Do you have any reason to think that what is happening in New South Wales now is different to what was happening in Queensland before the reform?

Mr KOUTOULAS: We are pretty confident that we are providing quite a robust diagnosis process and a robust screening process.

The Hon. TREVOR KHAN: With respect, that is not necessarily a response to the question. Do you want to put it again?

Mr DAVID SHOEBRIDGE: I am sure if we had asked the Queensland authorities before they did the review they would have said, "We are comfortable we have a robust system in place" but a review found that was not so. What is materially different between what is happening in New South Wales now and what was happening in Queensland before the review that would give us comfort to say it is okay?

Mr KOUTOULAS: I cannot comment on what was going on in Queensland previous; I am not intimate with the detail of their testing or screening processes.

The Hon. TREVOR KHAN: Could I just interrupt you there? If a spike has now been identified in Queensland in terms of diagnosis, then the question of what Queensland was doing before and what they are doing now becomes relevant. The question of what New South Wales is doing now compared to what Queensland is doing now becomes relevant. Have we got a better result in New South Wales because the system is doing a better job and therefore identified or is our system failing to pick up what some people would say is a developing problem—indeed, some would say crisis? The question is: Are we just missing it or is it not here?

Mr KOUTOULAS: My understanding is that the health monitoring was not happening at all in Queensland so I think that is probably attributing to the spike or increase in identification of those cases.

The Hon. TREVOR KHAN: I think I was told they have identified 100 or thereabouts, at least in terms of the figures that you handed to me yesterday or whenever we met. I am not denying that fact.

Mr DAVID SHOEBRIDGE: I do not think it is a secret.

The Hon. TREVOR KHAN: We were allowed to, except for Mr Mookhey who could not be found. On those figures we have got silicosis of all causes at eight or nine a year. If Queensland can pick up 100—10 times what we seem to be identifying in a year—perhaps my maths is wrong but less people live in Queensland. If they have found 100 in a year and we are picking up eight or nine, even with better long-term assessment, it strikes me that there is an inconsistency there in some way.

Mr NAGLE: If I may? I think possibly the best way to answer the question is to take it on notice and come back to you with some detail on what we have done about validating the testing regime that we have developed because it is done in consultation with medical advisors. We can have our chief officer respond to the question in more detail if you like.

The Hon. TREVOR KHAN: Mr Nagle, you know that we have always accepted that you have come before these committees and given us good evidence.

Mr NAGLE: Yes.

The Hon. TREVOR KHAN: This is an issue that we had in 2017 in the last inquiry and it has come back. Quite frankly, I think the evidence has been more compelling today than even in 2017, so for all of us on this Committee it remains troublesome.

Mr DAVID SHOEBRIDGE: One of the concerns that the thoracic society has is about the criteria for people being put on the medical assessment panel. They see it as opaque. There are no open applications that are tested for people to get on the medical assessment panel. Do you have a response to that?

Mr KOUTOULAS: The medical assessment panel is identified or formed through nominations from the relevant parties. Under the legislation the medical assessment panel is to comprise of medical specialists representative of workers and representative of employers. So when the appointments are due to come up we write to a whole series of worker-related associations and employer-related associations seeking nominations for appointment to the panel.

Mr DAVID SHOEBRIDGE: The question is: What is the criteria? Once you get the nominations do we have publicly available, clearly identifiable criteria? Because that seemed to be one of the concerns.

Mr KOUTOULAS: It is definitely experience in the area. So experience with the diagnosis, the treatment of dust diseases, experience around respiratory diseases and occupationally related illnesses.

The Hon. TREVOR KHAN: Do you advertise?

Mr KOUTOULAS: No, we go via the representative groups and they then—

Mr DAVID SHOEBRIDGE: Because the statute says it is a nomination process from the various bodies.

Mr KOUTOULAS: Yes.

Mr DAVID SHOEBRIDGE: Would you be open to meeting, sooner rather than later, with the thoracic society?

Mr KOUTOULAS: Absolutely.

Mr DAVID SHOEBRIDGE: Because we are having a mediated discussion between you and them now. It might be better if you sit down and directly have a chat sooner rather than later?

Mr KOUTOULAS: Sure.

Mr DAVID SHOEBRIDGE: Who do they contact?

Mr KOUTOULAS: Me.

Mr DAVID SHOEBRIDGE: What is icare's view on a national register for occupational diseases including silicosis?

Mr NAGLE: We support it.

Mr DAVID SHOEBRIDGE: Why has it not happened?

Mr NAGLE: We can only support it until it happens. We are supportive of the register but we are only one party to getting it underway.

Mr DAVID SHOEBRIDGE: In New South Wales is there anybody not supporting it?

Mr NAGLE: Not that we are aware of.

Mr DAVID SHOEBRIDGE: So if there is some reason that there is a delay in getting a national one started, should we start collecting it at a State level, say, tomorrow?

Mr KOUTOULAS: I think that would be beneficial. However, as Dr Yates mentioned, it has to be a combination of authorities and Health involved in the process for it to be useful because we have tried this in the past, just within work-related, and it was very difficult to get, first, the reporting and, second, the richness of the data and compliance with it. I think if we can start at a broader level, even statewide, as long as we have got inputs from all the relevant parties—

Mr DAVID SHOEBRIDGE: But you will need that whether or not it is a State one or a national one?

Mr KOUTOULAS: Absolutely.

Mr DAVID SHOEBRIDGE: We could start implementing that. There is no rational barrier not to start implementing it as soon as possible?

Mr KOUTOULAS: I think on acceptance from all the relevant parties, yes.

The Hon. DANIEL MOOKHEY: Let us move to Lifetime Care and Support. With respect to service providers under Lifetime Care and Support, is it correct that you contract out some of those functions?

Ms LULHAM: Yes, we contract out to most of our service providers.

The Hon. DANIEL MOOKHEY: How many do you have?

Ms LULHAM: There would be thousands but we have a variety of arrangements and it has been a risk-based approach. For those service providers that we rely on very heavily or we feel could be a potential harm to either us or the participant, we actually have panels of providers, so we have a panel of attendant care providers, for instance, and there are about 35 or 40 different providers on that panel.

The Hon. DANIEL MOOKHEY: Can you describe your methods of compliance with a whole bunch of standards that I am sure you do apply?

Ms LULHAM: Yes. In that instance there is the Australian Community Industry Standard [ACIS] that they have to comply with. They have to reach that even before they can get on to our panel. We have what we would call a half-yearly reporting requirement.

Mr DAVID SHOEBRIDGE: That is the acronym we need to feed into this morning's transcript. The ACIA does an ACIS?

Ms LULHAM: And that is the standard that we contracted with a number of years ago to develop for that industry and that is the standard on which they then based the development of the quality framework that they now use for the National Disability Insurance Agency [NDIA], so that is that one. Separate to meeting that, there are then different reporting requirements that we put in place as well, as well as things like critical incident reporting. One of the things that we are about to roll out is a separate auditing program for ourselves as well, some of those things that we think are not quite picked up in the ACIS standard.

The Hon. TREVOR KHAN: Such as?

Ms LULHAM: Some of the stuff that is more around the training, perhaps the specific competencies of workers. We have developed competencies around brain injury and the delivery of services to people with a brain injury, so how they are rolling those out—

The Hon. DANIEL MOOKHEY: That is presumably because with the demography of those you care for half of them have brain injuries?

Ms LULHAM: Three-quarters of them have a brain injury, so for us it is brain injury, brain injury, brain injury.

The Hon. DANIEL MOOKHEY: Then why is that not included as part of the ACIS?

Ms LULHAM: ACIS is a very broad standard has to meet everyone's types of needs. They have some layering in that standard. As we make decisions as we move forward in terms of where the NDIS quality framework sits with our scheme, we might get them to develop some slightly higher competencies around brain injury, spinal cord injury and maybe even around palliative care.

The Hon. DANIEL MOOKHEY: You mentioned you receive and act on critical incident reports. How many have you received, what were they and what did you do?

Ms LULHAM: We do not receive a lot.

The Hon. DANIEL MOOKHEY: That is nice to know.

Ms LULHAM: Yes. We would receive five to six a year perhaps and we investigate them. We either hear about them from the attendant care agency, case managers or sometimes from families as well or all three at the same time. The first thing we do is contact our participant and their family to find out what has happened in that case and conversations go on there. We talk to our case managers out there and we also talk to the attendant care provider.

The Hon. TREVOR KHAN: What is the nature of these critical care incidents?

Ms LULHAM: They could be a whole raft of things. We have had some over the last 12 months where there was an allegation that one of our participants assaulted one of the care workers so that was a critical incident. We have had another one where the family remove the participant from one of the homes because they discovered that he had some material that they did not agree with. It could be a raft of things. We had another one where there was an allegation that one of the attendant care workers was using drugs on the premises, so those sorts of things, and in that instance that was followed through and that attendant care worker was removed from the program.

Mr DAVID SHOEBRIDGE: Before I forget and before we close the door on dust diseases, there were two things—is that all right?

The CHAIR: I did not close the door; Mr Mookhey did. I certainly did not. We had not closed the door on dust diseases at all.

The Hon. DANIEL MOOKHEY: In the last review we were talking about the alignment between these accreditation standards, enforcement standards and audits standards with the NDIS, which at the time was still emerging and the NDIA was still emerging. I think we provided a specific recommendation about the need for the two of them to be closely aligned. Can you update us: How did that go?

Ms LULHAM: Well, they are closely aligned because the NDIS standard was based very much on us.

The Hon. DANIEL MOOKHEY: Yes, we were specifically worried that it would lead to yours lowering as opposed to them coming up to you?

Mr DAVID SHOEBRIDGE: And parallel accreditation?

Ms LULHAM: At the moment they are so aligned that you can do an audit that will allow you to meet both of them. The feedback we are getting—and I have to say it is only anecdotal feedback—is that our standard is perhaps a little bit higher and harder because, as you can see, to get a national standard you actually have to get agreement and consensus across a whole range of bodies and our standard without a doubt is focused a little bit more on that very severely injured group as well. The reason why we have continued with our standard at the moment is that when our last contracts came into play the national standard was not there. As we review our next contracts we will be making decisions then about how we align with the quality framework, the NDIS, but the NDIS framework only applies to services purchased by the NDIS.

The Hon. DANIEL MOOKHEY: Yes, of course, which is logical.

Ms LULHAM: Yes. The idea is about aligning them. We cannot actually rely on them to enforce them.

The Hon. DANIEL MOOKHEY: Yes. The purposes of providers who provide services under both, I can understand why there would be a need for parallel—

The Hon. TREVOR KHAN: But the problem is that your cohort of clients or patients has a specific range of needs which is not identical to the NDIS, is it?

Ms LULHAM: No. Ours is a very niche group of needs whereas the NDIS, as you can imagine, is anyone who has got a disability, so they have to be broad.

Mr DAVID SHOEBRIDGE: By definition your patient base is going to be all catastrophically injured?

Ms LULHAM: Yes.

Mr DAVID SHOEBRIDGE: Therefore, you may need higher standards to deal with that. I was just concerned that your evidence was suggesting that when you review the next round of contracts—

The Hon. TREVOR KHAN: You will drop them.

Mr DAVID SHOEBRIDGE: —you might be adopting the national standard which will be lower?

Ms LULHAM: We may but if we did do that, and it is a really big if at this stage because I need to follow up on the comments that there has already been a slight watering down in theirs compared to ours, is that we would then do specific competencies around brain injury, spinal cord injury and palliative care.

The Hon. DANIEL MOOKHEY: When will you be making that decision?

Ms LULHAM: The new contracts have only been in play for about 14 months so we have got another 18 months.

Mr DAVID SHOEBRIDGE: I am not quite sure what specific competencies would mean in practice but does that mean you would say: "Well, if you want a contract, you have to meet this standard and this

accreditation, which is the national standard but then we also want you to address A, B, C and D". Is that how it would work.

Ms LULHAM: Yes. You would need to meet the overall standards but on top of that we would say, "If you wanted to provide services to people with a brain injury, you have to have this as well".

The Hon. TREVOR KHAN: And what is "this"?

Ms LULHAM: This could be different sorts of risk frameworks, different training programs for their staff. That would be particularly around things like challenging behaviours, those sorts of things. Already at the moment with our panel of attendant care providers you cannot do everything. Some people put up their hand just to do brain injury, some spinal cord injury and some dust diseases, so they can already say, "Well, this is where I am expert. I do not want to do the other", and that is usually around the governance frameworks they have, the training programs they have for their own staff and things like rostering and those sorts of things as well.

The Hon. DANIEL MOOKHEY: A concern has been expressed about the explosive growth in demand for disability workers because of the NDIS, which is it is leading to a lowering of standards amongst the workforce itself and there needs to be comparable investment in skill building. Of course that is an NDIA debate but the question is: Is it causing workers under your scheme to shift or is there an increased demand for that workforce and if so how are you responding? Equally, are you seeing workers coming back the other way who perhaps do not have the same skills? What standards are you putting into the accreditation system to make sure that the people working under your system are properly trained, remunerated and looked after as well?

Ms LULHAM: In terms of the remuneration—it is not within the standard but it is within our contract with them—they have to comply with any of the fair wage and—

The Hon. DANIEL MOOKHEY: New South Wales Government policy.

Ms LULHAM: All of that, and even if they outsource that they still have to comply, they are responsible for whoever they—

The Hon. DANIEL MOOKHEY: So you have got contractor responsibility in your contracts?

Ms LULHAM: Yes.

The Hon. DANIEL MOOKHEY: And enforceable to your contract chain?

Ms LULHAM: Yes.

The Hon. TREVOR KHAN: How do you ensure that?

Ms LULHAM: That will be one of the things that we might look up when we start doing those audits ourselves.

The Hon. DANIEL MOOKHEY: That is very interesting.

Mr DAVID SHOEBRIDGE: It is more than interesting, it is good.

The Hon. DANIEL MOOKHEY: On notice, any further information you can provide about that would be really helpful. The second part of my question was in terms of the influx of people within the sector and whether or not it is creating any concerns that you might have about skill levels and, as well, are you losing workers to the NDIS, because I imagine your workers are highly trained and experienced?

Ms LULHAM: Our workers are the workers of the attendant care providers. It is something we are keeping an eye on. At the moment we are not noticing an enormous pressure in that space but we are anticipating that there will be some. There have always been areas where it has been hard to get workers anyway. The northern beaches of Sydney, it is very hard to get workers, and way down on the far South Coast. It has not changed, but I think that we are expecting that it will become more difficult. There is some, once again, anecdotal feedback from the attendant care providers that it is not that they cannot get the workers but they have to spend a lot more time training them up; they are not coming in skilled that they might have in the past. So they are not getting the depth that they used to get when they were advertising for workers. But that is anecdotal. We are anticipating, I guess, pressure in that space.

The Hon. TREVOR KHAN: That, in part, reflects the point we are at in the employment cycle/unemployment cycle as well in that you are starting having to drag, in a sense, people into the sector. That would be about it, would it not?

Ms LULHAM: It could well be.

The Hon. DANIEL MOOKHEY: Stop everyone from exiting is the other one.

Ms LULHAM: With the programs that we run they are usually pretty big programs. Our average program is 55 hours a week and they go up to four to eight hours a day. A provider will usually advertise for staff specifically for that program; they will have others that they can draw on. So if you have got someone who is an elderly Greek man they will try and have some Greek workers in that program, or Chinese, something like that; they are recruited around that specific person as well. They will usually try and have some people from that community—not the whole program because that creates other problems.

Mr NAGLE: It is also worth noting that we have also invested in connected homes. In many cases people need long-term care but there are some things that they can start doing through themselves. We have done a couple of models with Alexa so people can turn their lights off and on, open their door, close their door, and get more control of their life, but it also takes some of the pressure off the attendant care providers.

Mr DAVID SHOEBRIDGE: What is the amount that the scheme is spending on retrofitting homes? Is that a significant cost so that people with brain injuries or spinal injuries can get around their home?

Ms LULHAM: When someone is really injured and they come out of hospital we will usually do a home modification at that point in time. The range is enormous—it could range from something as little as $15,000 for some ramps and some rails to up to a couple of hundred thousand dollars. To put in that sort of home automation that Mr Nagle is talking about is around $15,000 to $30,000, and that is that thing where you can say, "Alexa, please turn on my television, turn on the lights", those sorts of things.

The Hon. TREVOR KHAN: Obviously Alexa is Amazon, but where has the technology come from that has allowed you to introduce that? Is that something you have developed yourself, your commercial self—

Ms LULHAM: It is what you go down to JB Hi-Fi and buy.

The Hon. DANIEL MOOKHEY: I have got it in my office. I ask it to turn on my music.

Ms LULHAM: The technology is based on that, that is why the price of it has dropped so much. Our issue is not so much access to that technology; it is access to the therapy staff who can put it in a home. There are only one or two of them who have got those skills. So that is another area we are working on.

Mr DAVID SHOEBRIDGE: My question was whether or not the scheme has engaged with proposals to change the Australian home building standards to make universal accessibility part of home building so all new homes are built to be accessible. There was a discussion paper put out by whatever the authority is that does the national building standards which are applied in New South Wales and their paper said that to meet basic accessibility standards means an additional $5,000 or so in the construction costs of a new home but to retrofit is, on average, in the order of $120,000 per home. It is probably a hard ask but did you engage at all in that, because it is not only for people who are catastrophically injured it is for an ageing population as well?

Ms LULHAM: No, we did not put in any specific submissions into those standards, but we are obviously very supportive of them, and it is the ageing population that is driving it.

Mr DAVID SHOEBRIDGE: In fact, as your cohort age as well I assume those costs are increasing. Do you have any projections about what those costs will be over time?

Ms LULHAM: To be honest, the amount we spend on home modifications is not really–I do not know if I am allowed to say this—that great in comparison to what we spend on attendant care and some of the other things.

Mr NAGLE: It is proportionate.

Dr ALLSOP: We absolutely project the expected future costs for our participants, making sure that we try to anticipate their ongoing future needs, be that around modifications, be that around care delivery, those sorts of things. But we are predicting, as Mr Nagle said, in some cases 100 years into the future for these participants.

Mr DAVID SHOEBRIDGE: So ideally we would be building accessible housing stock so you would not have to pay for the modification in 2060.

Dr ALLSOP: That would be great.

The CHAIR: Can I move to some issues that arose from evidence earlier today? I would just like to put some of these to you so you have the opportunity to respond either now or on notice if you prefer. Lyn Franco spoke with us this morning and raised the issue of the fee structure differences between the Lifetime Care and Support fee structure and NDIS services. As I understand it, her evidence was that there are ongoing issues because of the disparity in those fee structures. I do not know if you would like to have the opportunity to consider that or whether you are able to provide a response to that now.

Ms LULHAM: I can provide a response now. Up until fairly recently our fees had been fairly close together although theirs were higher in some areas and we funded things that they did not fund. From 1 February they are putting out a new fee structure that includes fees for attending—

The CHAIR: NDIS is putting that out?

Ms LULHAM: Yes. That includes what they are calling a complex, which they have got now but very complex, which is raising that, and that will increase the disparity between the NDIS and our fee. Our fees will be reviewed in July, which is when we do our fee review; so we will be doing a piece of work between now and then looking at those fees and what we need to do to make sure that we are not going to be losing workers, for instance, to the NDIS and those sorts of things.

The CHAIR: I think her concern was that the current fees as well as those that you flagged will be increased. So you are looking at both?

Ms LULHAM: We will be looking at both. The other thing we have done recently, which is why people might be talking about the complexity, we pay for some things—like if you want to set up a program we can pay people $1,000; we also pay a loading for case complexity in terms of for the person doing the organising. We have had very little take-up of those extra fees over the last few years. Over the last 12 months we really went out and said to people, "Don't forget to charge that". Some of those fees have increased by about 176 per cent, but even though they have been there all the time a lot of the providers thought they were new.

The CHAIR: Why do you think they did not take that up previously? They just did not know that it was there?

Ms LULHAM: They just did not know. I think the people that did the care programs were different to the people in the accounts area.

The CHAIR: So you have taken on a proactive role to educate them so that they know that?

Ms LULHAM: Yes. The last 12 months there has been a big increase in those other types of fees, yes.

The CHAIR: Do I understand your evidence to be that that could have been perceived as an increase?

Ms LULHAM: It could have been perceived as an increase in complexity, I think is what she said.

The Hon. TREVOR KHAN: Did you hear her evidence?

Ms LULHAM: Yes.

The CHAIR: Mr Nagle, just on a different issue, the Motorcycle Council of NSW raised in its written submission—I do not know if you have had a chance to look at that—and also today a novel idea of recovering some costs from the roads authorities where, for example, they have an obligation to look after roads and if there is a pothole or gravel on the road and an accident is caused because of that and where compensation is paid that it then be recovered from that roads authority. I want to give you the opportunity to respond to that either now or on notice if you would like. I do not know if you have had the chance to consider that.

The Hon. TREVOR KHAN: There was not universal agreement with the proposition, I might add.

The CHAIR: No, I am not saying we are necessarily going to recommend it, which is why I said it was novel.

Mr NAGLE: I think I prefer to take that one on notice and consider the logic.

The CHAIR: I think it is important that the Committee has a response to that. I think we know what the response will be.

Mr DAVID SHOEBRIDGE: And if you could point out the councils you want to bankrupt in regional New South Wales. I kind of support the move, but we have to work out how to fund it.

The Hon. TREVOR KHAN: Indeed. I know of at least one council that did go bankrupt because of a series of litigation arising out of roadworks. It was the Nundle Shire Council.

The CHAIR: I think he cited one example where there had been recovery from RMS, but I am not sure that this is a universally supported proposal. We would like your response to it.

Mr NAGLE: Barely supported.

The CHAIR: I refer to the customer experience for icare, which is obviously at the centre of everything we are doing. Will you talk to us about some improvements that you have made? I know you have briefed some

of us and you have taken some questions prior to the hearing, but could you comment on improvements to the customer experience in terms of timing, accessibility and so on?

Mr NAGLE: Absolutely. I might ask Mr Koutoulas to add some additional comments.

The CHAIR: To put that in some context, given the previous hearing and the recommendations that were made, what you have done to implement those recommendations?

Mr DAVID SHOEBRIDGE: Both schemes?

The CHAIR: I am still looking at Lifetime, but I am happy for you to deal with both, if you like.

Mr NAGLE: Certainly. The creation of icare has really allowed us to scale all of our expertise and I suppose buying power, in many respects, to apply our best ability to improve customer experience. So everything we do we actually measure as we go. We engage with our customer. We engage in customer design. We ask them what the pain points are. We then talk them through what we see as solutions. We then implement those solutions and then track their responses. But in many cases what we have been able to do is move away from just concentrating purely on process, which is what the old organisations used to do to really focus on the customer and what is the right outcome for that customer. By doing that we have managed to use our existing staff, our existing SMEs who have the knowledge and understanding of the issues, and just empower them to make faster decisions. I think Mr Koutoulas probably has some further comments.

Mr KOUTOULAS: In terms of faster decision-making it is really around two areas. It is around decision-making in eligibility and access to the scheme, and then it is decisions around access to the actual care and support services. If I start with dust diseases, the improvements have been quite substantial. We have sped up the process of eligibility determinations down from 136 days to 42 as at the middle of—

The CHAIR: How have you done that?

Mr KOUTOULAS: In a couple of ways. Really reducing the application form itself from 14 pages to two. It is not waiting until a completed form was signed and fully detailed to be sent in to commence the process.

The Hon. TREVOR KHAN: When was it taking 136 days on average to determine one of these?

Mr KOTOULAS: It was a couple of things.

The Hon. TREVOR KHAN: No. When?

Mr KOUTOULAS: Pre-September 2015.

The Hon. TREVOR KHAN: That is horrendous.

Mr DAVID SHOEBRIDGE: That was not being complained about at the time; it was just kind of the accepted time period because it was thought to be complex. Turns out you can do it quicker.

The Hon. TREVOR KHAN: It's a long time, isn't it?

Mr KOUTOULAS: Yes. We have triaged some of the more pressing malignant cases; so where we do identify that there is a potential malignancy we will liaise and work with lawyers so where there are parallel proceedings we will just work with them and get as much information as we can to speed up the process and not necessarily have to succumb the individual to a lengthy industrial history or workers' history process. Online application forms, so 24/7 and that was following the recommendations from the last hearing. We have implemented that and that has brought a new avenue. Applications over the phone, but also proactive follow-up now. We have implemented the customer liaison single point of contact function. So for new applicants coming through they are appointed a dedicated contact and so that facilitates the whole navigation and follow-up process quickly.

The CHAIR: I will deal with that. We have had some evidence about that, which I will ask you about.

The Hon. TREVOR KHAN: You knew what was coming, didn't you?

Mr KOUTOULAS: Yes, I did.

Mr NAGLE: We have also done quite a bit of work across all of our schemes around natural language. We have most of our key forms and explanations around the process in eight key languages. We are talking to SBS Radio at the moment about how we can make those into radio clips that people can actually hear on podcasts, et cetera, as we go forward.

The CHAIR: We have heard about some workers from a non-English speaking background, so that has been made very clear to the Committee, the importance of communication and education in that sector, particularly in dust diseases.

Mr DAVID SHOEBRIDGE: Is now a good time to address those concerns about customer liaison officers?

Mr NAGLE: Yes.

The Hon. TREVOR KHAN: Did you listen to Mr Fitzsimmons?

Mr KOTOULAS: Yes, I did.

The Hon. TREVOR KHAN: That is not a criticism. I assumed. In fact it is rather good that people actually know what is coming.

Mr KOUTOULAS: Yes. Customer liaison officers have an integral role to play from the commencement of the whole interaction with icare. So it is about helping navigate the system and the whole application process; the intensity of engagement during what we call an "on boarding process", for want of a better word. It is where they contact us feeling a symptom and then we take it from there. We continue that journey past the determination process and then into the access to the claims and supports. We have a whole existing constituent of workers. It is a lifetime scheme, so we have a whole cohort of workers and dependents pre the introduction of the customer liaison team.

The Hon. TREVOR KHAN: Is that 3,000.

The CHAIR: It is 3,970.

Mr KOUTOULAS: Three thousand in total. About 3,000 are roughly dependents, so they are accessing weekly benefits only; they do not access the care and support services that the workers do, the ones who have the actual dust disease. However, they still have access to a core team, which is our compensation and public services team, their needs on a daily basis around inquiries, around their payments and access to the services and so forth. They do have access directly to that competency and that expertise in the compensation, and health and care services teams.

The customer liaisons broker the interactions with new customers coming through with those teams over time to not create hand-offs. We are still looking at the caseloads for client liaisons. We still feel we are early in the journey. We are getting some great results. We are still looking at the caseloads for client liaisons. We still we are early in the journey. We are getting some great results. We are still learning from that implementation around what is the right caseload. There is a lot of intensity in the application process and there is some intensity once they become eligible into the scheme and we create the supports and the access to services. But once that occurs the intensity drops off. We want to understand the time frames as to when that occurs and then what is the right caseload for the customer liaison?

Mr DAVID SHOEBRIDGE: Is there a plan?

Mr KOUTOULAS: Yes, there is.

Mr DAVID SHOEBRIDGE: I understand having a totally different regime for dependents because they are not seeking medical treatment, they are not suffering the disease, but is there a plan for all the workers to eventually get a customer liaison officer and, if so, when?

Mr KOUTOULAS: Yes. We are looking to a single point of contact, but when, we do not know yet because we still want to understand the right caseload for some of the workers. But we were intending in 2019 at some point that there would be a transition.

Mr NAGLE: It is about the journey across one of our schemes that we are looking at. About 30 per cent of activity happens outside normal business hours when people are going to our we sites or contacting. We run our support centres seven o'clock to seven o'clock and yet we still have people who are trying to contact us in their time frame. We see further investments and artificial intelligence—WebChat and WebBox—and various other forms of robotics that will enable simple questions to be serviced at somebody's convenience.

Mr DAVID SHOEBRIDGE: Mr Koutoulas, your evidence was "we were" planning.

Mr KOUTOULAS: Sorry. We are.

Mr DAVID SHOEBRIDGE: One of the issues that was raised at the last hearing, which has not been addressed by legislative change, but you say can only be addressed by legislative change, is repeated eligibility disputes created by insurers into the Lifetime Care and Support Scheme. Is that still happening? What is the issue?

Ms LULHAM: Look, there are still occasions when it happens. It is not a common thing at all. We did take some of this feedback back to our participant reference group and to the CTP insurers and to our regular liaison with some of the legal reps. Apart from a few cases where it was quite significant there did not seem to be a big push to do anything in that area.

The Hon. DANIEL MOOKHEY: In the last review we took evidence about icare's line of sight.

The Hon. TREVOR KHAN: Sorry, before you go onto another line. When you say "occasionally", what does "occasionally" mean?

Ms LULHAM: Once a year. One dispute a year.

Mr DAVID SHOEBRIDGE: Or one dispute coming back repeatedly?

Ms LULHAM: Yes, one application for eligibility.

The Hon. TREVOR KHAN: I wanted to know whether it was one a month.

Ms LULHAM: No, the majority of our applications do not come that way.

The Hon. DANIEL MOOKHEY: During the last review the Committee explored the extent to which icare had or needs a line of sight over the first five years of treatment of people in the CTP before they arrived in lifetime care and whether appropriate care is being delivered during that time to avoid cost shifting into lifetime care in successive years. It think we said that SIRA had a role and responsibility to undertake that function. Have there been sufficient improvements so that we do not have to worry about that anymore?

Ms LULHAM: I do not think we have solved the problem yet, but we are certainly working on it with SIRA at the moment. We are calling this project "CTP Care". We are working with SIRA in looking at the framework we need to do that and what guidelines we need to put in place. We are very cognisant of that cost-shifting arrangement.

The Hon. DANIEL MOOKHEY: This is substantially the same position laid out at the last review; that is, there was a need for a process to develop guidelines. Two years later that has not been done. Is that what we should be inferring? It does not appear to be operational.

Ms LULHAM: No, there are some guidelines already. I cannot talk about the SIRA guidelines. We would expect more, and we anticipate that the very earliest we would get a person in there would be probably March next year.

Mr DAVID SHOEBRIDGE: And that would be by agreement prior to the five years.

Ms LULHAM: Yes. That would be one of our own interim participants in lifetime care whose brain injury has recovered. They will not stay in for their brain injury, but they have significant orthopaedic injuries so that otherwise they would come back to us.

Mr DAVID SHOEBRIDGE: There is no point in spitting them out and then bringing them back.

Ms LULHAM: No. That is the group we are aiming at.

The Hon. DANIEL MOOKHEY: I am confused. You said March 2020. What do you mean? The first person?

Ms LULHAM: Yes.

The Hon. DANIEL MOOKHEY: Not the first staff member?

Ms LULHAM: No. We have looked at our current participant group. Technically, this could happen from December this year. However, when we looked at them, we think that the more likely time is March next year. That is the deadline we are working towards.

Mr NAGLE: We have been doing a lot of work with SIRA on other data fields and the overall data we need jointly to be able to make good decisions. They are translating that into the insurance industry.

Mr DAVID SHOEBRIDGE: Ultimately, will the amount paid by the insurers as the liability shifts over be determined by clear guidelines? Will you plug into something and get a number, or will it be a mixture of that plus negotiation? How will it work, or do you not know yet?

Mr NAGLE: That is part of the discussions. This is very much based on our understanding of the injuries and the cost. We will have to get the data to be able to understand that. We are using that information to set the overall costs. Knowing the insurance industry, I am sure there will be an element of negotiation.

Mr DAVID SHOEBRIDGE: There are the insurers, CTP and icare. In the middle is SIRA, which will transfer that across and organise the payments. Is that right?

Dr ALLSOP: That applies only in the case where someone transfers prior to the five-year mark as well. If it is at the five-year point, that is already accounted for in the levy and the reduction in the CTP premium associated with it.

The Hon. TREVOR KHAN: But I would have thought there would be clearly a benefit in getting a person transferred sooner rather than later if it looks as though they are going to be in the scheme. That is, it would be better if the care package could be put in place appropriately for that person sooner rather than later.

Ms LULHAM: We would prefer that.

Mr DAVID SHOEBRIDGE: I was surprised at the small sum you have put on the Motor Accidents Injury, Treatment and Care Benefits Fund from 1 December 2017 to 30 November 2018 for persons injured in that period. You say that icare expects the fully funded present value of future treatment and care costs, claims management costs, case management costs and operating expenses to be $58 million.

Dr ALLSOP: That is correct. You must remember that we are making an estimate of those costs based on pretty much no data. We have had to use information from the ACT and New Zealand to estimate the number of people who will hit that five-year mark. There is a significant degree of uncertainty in there.

The Hon. DANIEL MOOKHEY: Why is there no data?

Dr ALLSOP: Under the old CTP system the claims were resolved prior to the five-year mark with lump-sum settlements. Therefore, no-one actually received treatment and care beyond the five-year point. We have no record of who would have reached the threshold and who would have participated beyond that.

Mr DAVID SHOEBRIDGE: If that $58 million is ultimately not sufficient to meet future costs—

Dr ALLSOP: That is $58 million that we will invest from the point of receipt and from which will receive an income.

Mr DAVID SHOEBRIDGE: That is already calculated on a present value concept. If that is not sufficient, can the fund be topped up? If so, how is it topped up?

Dr ALLSOP: If we think additional funding is necessary, we can adjust the levies in the future.

Mr DAVID SHOEBRIDGE: So future levies can be changed?

Dr ALLSOP: Yes.

The CHAIR: Mention was made earlier today of the foundation grants for research. It was pointed out that the majority of the grants seem to be going to research being undertaken in Western Australian rather than in New South Wales. Given that this is a New South Wales scheme, would you like to comment? You can take the question on notice.

Mr KOUTOULAS: The Dust Diseases Board considered that question when it was determining its strategy. We have a pool of research grant funds as well as fellowships, scholarships, and for the first time support organisations are receiving funds. Naturally, the inclination of board members was to support New South Wales capability building and so on. However, the crux was the objective of the research programs; that is, to generate outcomes for people. The grants program is competitive and merit-based. A lot of the decision-making relates to the merit of the programs, the capability, the likelihood of success and the flow-on benefit from the research.

Mr DAVID SHOEBRIDGE: To address those concerns it would be useful to get something on notice about why the Western Australian program was chosen for the $2.5 million.

The Hon. TREVOR KHAN: What is the Western Australian program?

Mr KOUTOULAS: They are different research projects.

Mr NAGLE: They are about treatment options. To clarify, the icare foundation is separate from the dust diseases grants program. The foundation certainly dwarfs anything that comes through the dust diseases grants program and 90-odd per cent of that is in New South Wales.

Mr DAVID SHOEBRIDGE: I refer to funeral expenses in the dust diseases spend. I go regularly to funerals, and particularly in Aboriginal communities. A basic funeral costs in the order of $20,000. The statutory scheme has a $9,000 payment for funeral costs. Does your organisation have a view about whether that is adequate? If it is not, how is it changed or reviewed? I do not think it has changed for about 15 years.

The CHAIR: An inquiry into the funeral industry might assist.

Mr DAVID SHOEBRIDGE: This has not come to me from the funeral industry. The cost of funerals is normally significantly more than $9,000. How is that reviewed, or can it be reviewed?

Mr KOUTOULAS: It must be reviewed through the statutory process, and we are bound by the statutory maximum.

Mr DAVID SHOEBRIDGE: How does that start?

Mr KOUTOULAS: With the regulator who determines the statutory maximums attached to the schedules.

Mr DAVID SHOEBRIDGE: That is SIRA.

Mr KOUTOULAS: I believe so.

Mr NAGLE: Workers compensation moved it to $15,000 as part of the 2015 reforms.

Mr DAVID SHOEBRIDGE: I would have thought that at a minimum we would meet the workers compensation change. That would make sense because it is no cheaper to be buried if you die from a dust disease rather than another occupational injury.

The CHAIR: Thank you for appearing before the Committee today and for your written submissions. The Committee has a tight timeframe and would be most grateful if answers to any questions on notice could be returned as soon as possible, but at the latest by 7 February.

(The witnesses withdrew)

CARMEL DONNELLY, Chief Executive, State Insurance Regulatory Authority [SIRA], affirmed and examined

DARREN PARKER, Acting Executive Director, Workers Compensation and Home Building Regulation, SIRA, sworn and examined

MARY MAINI, Executive Director, Motor Accidents Insurance Regulation, SIRA, sworn and examined

PETRINA CASEY, Director, Health Strategy, SIRA, affirmed and examined

The CHAIR: I welcome our witnesses and thank them for attending the hearing. Thank you for your written submissions and your answers to questions provided before the hearing. We appreciate your providing them to us ahead of time. You can assume that they have been read by the Committee members. Do you have an opening statement you would like to make before we commence questions?

Ms DONNELLY: I would like to make a few comments, if I may. Thank you for the opportunity to appear. We would also like to acknowledge the traditional custodians of the land. I know that the Committee will have seen submissions and the pre-hearing questions and will be aware that SIRA's role in this review is a little different to the others where the Committee has oversight in that we have a more focused role as a regulator. That said, one thing I have observed through the submissions and the evidence today are concerns around silicosis.

Prior to coming here today I sought agreement from SafeWork NSW, which is the lead agency, that if there are some questions that the Committee would like me to take on notice and seek some information from them, I am quite prepared to do that. I have noted the short time frame and hesitated a little, but I am certainly quite happy to make that offer. The other matter that the Committee may be aware of is that I am the New South Wales member on Safe Work Australia so there may be some updates I can give you either today or take away on that matter in that capacity.

The CHAIR: Good. Thank you. That is very helpful.

Ms DONNELLY: Other than that, we obviously will consider the evidence that others have given and the submissions. There are some things that we will follow up with those of the parties as well.

The Hon. TREVOR KHAN: You have obviously heard it, and can I say that, if I was a little concerned in 2017, I am more so now.

The CHAIR: Is at the conclusion of your opening statement?

Ms DONNELLY: Yes.

The CHAIR: Does any other witness have an opening statement? No. We will begin questions.

The Hon. LYNDA VOLTZ: Can I clarify this CTP thing before we go on?

The CHAIR: Yes. We have one specific question which technically is outside today's hearing but the Committee is interested in clarification on it.

The Hon. LYNDA VOLTZ: We received from you the "Review of the NSW CTP Green Slip Scheme under the Motor Accident Injuries Act 2017 (NSW)" from Ernst and Young, which I think we asked you to provide. On page iii, when Ernst and Young commenced its review, the market average filed premium's figure was redacted. Is there an explanation for why that figure was redacted?

Ms DONNELLY: Yes. I am happy to explain. I will give Hansard a copy of this document.

The CHAIR: Can we clarify for Hansard specifically which document we are referring to?

The Hon. LYNDA VOLTZ: It is the "Review of the NSW CTP Green Slip Scheme under the Motor Accident Injuries Act 2017 (NSW)".

Mr DAVID SHOEBRIDGE: November 2018.

Ms DONNELLY: It was provided on 10 December as supplementary information that I just felt would be helpful to the Committee, so not so much part of evidence. In the document there are six redactions. They occur for two different types of reasons. The first type of reason is that we have redacted the filed market average, which comes from our review of the insurer premium filings. We redact that because insurers could actually use it to reverse engineer information about competition in the market that would enable them to then engage in anti-competitive behaviour, including perhaps profiteering. With the other type of information, there is a table on page 49.

The Hon. TREVOR KHAN: Can you explain why?

Ms DONNELLY: I am happy to, and Ms Maini may have something to add on this as well. They are aware of what the prices are of their competitors eventually, once they come out into the market, and we publish information about the average prices for the policies that are sold. But this is about their prices that are offered. It is just another level of detail that would enable—we have come to the conclusion—anti-competitive behaviour. I have a responsibility and we exercise this under the legislation under section 11.2 and section 9.15 of the 2017 Act.

Mr DAVID SHOEBRIDGE: They could potentially reverse engineer what their competitors where pricing it at.

Ms DONNELLY: And then potentially—

The Hon. LYNDA VOLTZ: I am sorry, before we go on to that, just explain to me why the market average filed premium is different to the average premium MAG Schedule 1 December 2017.

Ms DONNELLY: I can. Insurers have to file their intended premium with us and we undertake a compliance check. Then we let them know whether we have any objections or not. That will include a lot of detail for their price points for every kind of vehicle and person. It is quite a complex set of permutations. The other data you refer to, Ms Voltz, is, when they have successfully actually sold policies, what the average ends up being in the market. That has less risk of them being able to understand exactly what price point is being offered at every point in the market. I am happy to provide some more clarification on notice, knowing that this has arisen today, basically I am winging it in a sense.

Mr DAVID SHOEBRIDGE: I can understand why there might be sensitivities about this and any competitive issues. I can understand that.

Ms DONNELLY: It is a decision by SIRA as the regulator under the legislation to say that is not in the public interest mainly to have a higher premium without any good justification, and it is not good market practice.

The Hon. LYNDA VOLTZ: The average premium you have there is a market weighted premium, the 2017 figure—the MAG Schedule 1 of 1 December 2017. Is that right?

Ms DONNELLY: On page?

The Hon. LYNDA VOLTZ: Page iii.

Ms DONNELLY: I am not quite sure exactly what page you are looking at. I am happy to take that on notice.

The Hon. LYNDA VOLTZ: That is all right. Take it on notice and have a look. Sorry. I just needed to ask that question.

The Hon. TREVOR KHAN: No, it is important.

The CHAIR: No, it was absolutely important to clarify that.

Mr DAVID SHOEBRIDGE: Can I ask a question?

The CHAIR: Are we still on that?

Mr DAVID SHOEBRIDGE: Just on this, yes. I was grateful to receive this and also I think there was the Taylor Fry—

Ms DONNELLY: The peer review, the Taylor Fry report.

Mr DAVID SHOEBRIDGE: —sort of health check or peer review of it.

Ms DONNELLY: Yes.

Mr DAVID SHOEBRIDGE: It is a complicated document. I have read the Taylor Fry one because that was digestible. I got as far as I could before—

The Hon. LYNDA VOLTZ: Your eyes watered?

Mr DAVID SHOEBRIDGE: Yes, that is right. I got as far as I could on the Ernst and Young. There is probably a whole series of questions I would like to ask about the Ernst and Young, but this is not the hearing for that. Do I understand that there will be approximately a $17 premium reduction in the next year as a result of these actuarial reviews?

Ms DONNELLY: We have the opportunity, as I have discussed in previous hearings, not only for there to be a clawback provision, as it is commonly called, if there is excess profit but SIRA has stronger powers now to act, especially in the transitional period to direct premiums down. What it refers to is a reduction in the allowable range of premium that insurers can charge. It came into effect from 15 January so it is in effect now.

Mr DAVID SHOEBRIDGE: And that is $17? Was that it?

The Hon. LYNDA VOLTZ: Take it on notice, perhaps?

Ms MAINI: On average, $13.

Mr DAVID SHOEBRIDGE: On and from 15 January, you send a direction that had the effect of reducing premiums for this premium year.

Ms DONNELLY: It has reduced the allowable band. There are some insurers that have had to consider whether they are in the band or not, and it drives it down. Some of them may already have been there.

Mr DAVID SHOEBRIDGE: The only other thing I would ask about it is that a lot of what the reports say is that they have not got enough data and they are waiting for more data, particularly on the no-fault scheme.

Ms DONNELLY: Ernst and Young?

Mr DAVID SHOEBRIDGE: Yes, the Ernst and Young report, and it is matched by the Taylor Fry analysis. What is your proposed pathway to get that data and then put it either to Ernst and Young or Taylor Fry who are doing that?

Ms DONNELLY: My understanding of what they are meaning with that is that some of it is that not enough time has elapsed for enough development of those claims for the data to actually exist anywhere. Certainly the feedback that I have had from those independent actuaries is that the systems that we have now, which are a lot more comprehensive, are quite rich and should have the data. But we are constantly, given that it is a new scheme—both with the actuaries and with our CTP premium committee—seeking to understand what is emerging, what other data might be useful, how do we keep building our capability?

The CHAIR: Thank you. We will move on to the terms of this inquiry.

The Hon. TREVOR KHAN: But it has been very interesting.

Mr DAVID SHOEBRIDGE: Ms Maini wants to say something.

Ms MAINI: I just want to correct something. When I said $13, it is actually a $27 reduction. Fourteen dollars has come from claims and $13 from the levy.

The Hon. TREVOR KHAN: It is getting better every time.

Mr DAVID SHOEBRIDGE: So $13 from the lifetime care levy.

Ms DONNELLY: It is a combination of the two levies.

Mr DAVID SHOEBRIDGE: So it is $13 from the lifetime care levy and $14 from the CTP premiums?

Ms DONNELLY: I will need to correct you. It is $3 for the lifetime care levy, $10 from the Motor Accidents Fund and $14 is the shift in the premium parameters from the review that we have been talking about.

Mr DAVID SHOEBRIDGE: Could you just tell me what the $10 is?

Ms DONNELLY: The levy that funds the Motor Accidents Fund for SIRA's fund.

The CHAIR: We will now move to dust diseases. There has been some discussion about a national register. Can you address the feasibility of establishing a national register for reporting dust diseases?

Ms DONNELLY: Certainly. The Committee obviously recommended that. Shortly after I convened a discussion with icare and, as part of the recommendation, a number of other bodies likes SafeWork NSW, the Resources Regulator, Coal Mines Insurance and others. We all agreed that it was important and SIRA has stepped forward to take the lead in that work. In a minute I will ask Dr Casey to talk a little bit about the work that we have done. In New South Wales we have also, in my capacity as a member of SafeWork Australia, promoted the importance of that feasibility assessment for a national occupational dust disease register. Related to that, one of the things needed to make that comprehensive so you can rely on the data is mandatory reporting. Dr Casey can you give an update on that?

Dr CASEY: Sure. As Ms Donnelly has said, we have taken the lead and really that is in the form of detailed consultation. I have got a list here for the Committee in relation to the people we have consulted at State and Federal level. We have also consulted—

The CHAIR: Would you be able to provide that list to the Committee?

Dr CASEY: Yes.

The CHAIR: You can do that through the staff or on notice. It would be helpful to see who you have spoken with.

Dr CASEY: Thank you. I guess a lot of what we found—and I will go through it in a moment—has reiterated some of the evidence that you have already heard today in relation to needing commitment at both a State and Federal level. That came through strongly with the consultations that we heard. Learning lessons from the past, so there has been a past attempt through a surveillance system and really that highlighted the need for it to be mandatory—if it was voluntary the notifications dropped off over time. The consultation highlighted that it really needs to be at the clinician level. So again not necessarily at a claim, compensation or regulator level. Again, I think we heard that evidence from the professor at TSANZ.

The CHAIR: I think the clinicians agree with you.

Dr CASEY: Yes, so that is really important. I guess we have come to a stage where we are at an intersection with what is happening at the national level. We have heard as well that the Council of Australian [COAG] are considering this. They have referred it to their clinical principal committee. We have also had consultations with them. We have given them I guess the benefit of the conversations and discussions that we have had because we were having them a little bit earlier. They are due to report in February and they will consider the input that we have given them. The only other point that I would like to make is, one of the things that came through in the consultation was really understanding the clinical pathways for exposure, which was another reason that it was really important that it was done at that sort of public health or health interface with the clinicians.

The CHAIR: The public pathway?

Dr CASEY: The clinical pathway.

The CHAIR: What does that mean?

Dr CASEY: Meaning that it is really important to understand where the exposure has occurred and that that is the best place to gather that information. If we use a parallel register, the cancer register, that is at a State level. It reports up to the Australian Institute of Health and Welfare, convened at a national level. They then conduct detailed telephone conversations with people who have been notified to that register to find that level of detail that we talked about or that the Committee heard evidence that was missing in terms of exposure. I guess the only other point I would make—I feel like I am rambling, sorry—is in relation to the fact that if it is not followed through then the utility of the register will be lost. It really is about education and prevention. So if it is going to be done it needs to be done in a holistic way so that you can use the information for prevention purposes, as opposed to just a data collection.

The Hon. DANIEL MOOKHEY: When do you consider the key decision points to be arriving for New South Wales and are you considering acting ahead of the COAG process?

Ms DONNELLY: The next advice that we expect to get from the clinical principal committee's deliberations is not too far away—it is February. I think it would be important to understand how quickly that feasibility assessment is going to be completed at the national level because it would be obviously good to have it aligned across the States. I know that there are other processes—the Committee will have heard about the Manufactured Stone Industry Taskforce, for instance, and other initiatives at State level. We will continue to work in parallel with stakeholders—Dr Casey is going to give you the list of people that we are in touch with and working with—but the first point is a read of whether the feasibility and action plan is going to happen at a national level.

Mr DAVID SHOEBRIDGE: But getting every single State and Territory to get on board and start doing it could take another two years.

Ms DONNELLY: Yes.

The Hon. TREVOR KHAN: Gosh, you are optimistic.

Mr DAVID SHOEBRIDGE: I think we are pushing against an open door; it may be more than two years. Meanwhile we are not starting on the collection in New South Wales. I think I asked icare whether or not

there might be some utility in simply getting a New South Wales register started, doing all the groundwork with the health sector, the lawyers, the courts and whoever now. What is SIRA's view about just getting started?

Ms DONNELLY: In fact, by convening those parties and then doing the consultation I think we are in a good place to be able to move forward. If all the right people are happy to start in New South Wales I do not see a barrier to that.

The Hon. DANIEL MOOKHEY: Is this a decision that SIRA can make itself?

Ms DONNELLY: No.

The Hon. DANIEL MOOKHEY: Who would be able to equip you with the authority to act unilaterally?

The Hon. TREVOR KHAN: You would need some legislative base, would you not, requiring mandatory reporting?

The Hon. DANIEL MOOKHEY: That is why I asked you.

Ms DONNELLY: That is right, but also I think—Dr Casey may wish to add to this—clearly for the individuals who have unfortunately acquired a lung disease there has got to be proper diagnosis, as we have heard, the clinicians providing information et cetera. So it really does need to be a partnership from a number different parts of the community and government working together.

Mr DAVID SHOEBRIDGE: You would pass a regulation to establish it under the Workers Compensation (Dust Diseases) Regulation or another dust diseases regulation. That does not seem to me to be too difficult.

Ms DONNELLY: I am not here to say that we cannot do it. I think it is a concerning area; I have pushed really hard for it nationally. I do not disagree that if the national agenda looks too slow and the will is there in New South Wales that we could not do it in New South Wales.

The Hon. TREVOR KHAN: Again, pushing against an open door.

The Hon. DANIEL MOOKHEY: How much process are you prepared to have for the COAG process before we have to confront this question?

The Hon. TREVOR KHAN: I am not being rude but is that a question for you?

Ms DONNELLY: I think it is really a question for the government of the day but I am prepared to say that certainly I have argued for the urgency in SafeWork Australia meetings.

Mr DAVID SHOEBRIDGE: As part of the offer you made earlier, perhaps you could ask SafeWork Australia what its view is about the capacity or utility of New South Wales in going ahead with its own register.

The Hon. TREVOR KHAN: By the look of her enthusiasm, this might be a question for Dr Casey. If there was some will on the part of the government to do something—it does not matter which colour it is—how complicated would the implementation phase of such a register be?

Dr CASEY: I do not think we can underestimate how complicated it is in terms of getting health departments, clinicians trained so there are some resources, but we can look to the existing mesothelioma register as an example of where it does work. We know there is an annual maintenance cost and we would have establishment fees. It is obviously doable but there would be some significant work in establishing it and training people in relation to what the reporting requirements would be. The other thing that I would add is that we have in consultation with TSANZ in particular, the thoracic society that we heard from earlier, supported the concept of a survey with clinicians. Again, SIRA is supportive of doing that concurrently with the national timetable that is occurring, which would be another area that would inform a register. That is really around the area of making sure that we know the scope or the reach that such a register would have. We have done that in consultation with TSANZ and we could pursue that.

Mr DAVID SHOEBRIDGE: On 14 November Queensland, through Queensland Health, indicated it was going to amend its Health and Other Legislation Amendment Bill to make a notifiable dust lung disease register and to pick up, I think, silicosis in that. Queensland is doing it, and I assume they are doing it after and in parallel with all this consultation work. Have we got someone talking with the Queensland?

Dr CASEY: We certainly have. As part of our consultation we are aware of the bill. They have had to amend their Public Health Act to put the provisions in place to make it a notifiable disease as well as to establish the register. It is still a bill in Parliament so I think it is still under consideration.

The Hon. TREVOR KHAN: Dr Casey, Mr Shoebridge talked in terms of regulation, do you know in New South Wales whether it can be done by regulation or whether it requires legislation?

Dr CASEY: I would have to take that on notice. There are privacy considerations and there are other things that we need to consider.

The Hon. TREVOR KHAN: I have no doubt there are privacy considerations but the question is: Is there a legislative basis for it now or is there not?

Dr CASEY: I would have to take that on notice.

The Hon. TREVOR KHAN: Can you take that on notice?

Dr CASEY: Yes.

Mr DAVID SHOEBRIDGE: The only other thing I would say in this limited time is: We know all of this is going to have to happen at some point so you are going to have to get a scheme in place, you are going to have to talk with the doctors, you are going to have to work out the privacy concerns. Let us just start doing it now rather than wait for a decision to be made to have a national register and then do it. I would have thought the privacy concerns would have been sorted and all of that would have been done?

Ms DONNELLY: I quite agree with you and that is why we have taken the steps we have taken, because from my perspective, even if there is national agreement and great acceleration, New South Wales still has to have an informed position of what kind of national register would work.

Mr DAVID SHOEBRIDGE: You would like to have.

Ms DONNELLY: So we are doing that work.

The Hon. DANIEL MOOKHEY: Generally if you have plan beats no plan—

Ms DONNELLY: That is right, so we are investing our energy in coming up to speed and understanding what the views are, hence something like a survey, et cetera.

The Hon. TREVOR KHAN: More strength to your armaments.

Mr DAVID SHOEBRIDGE: Could you let us know on notice what the content of the Queensland example is and whether or not that is a good model to start with?

Ms DONNELLY: We can give you some views on that.

The Hon. DANIEL MOOKHEY: And if we were to provide a recommendation in our report to that effect, would that be something which SIRA would welcome?

Ms DONNELLY: We are supportive of there being a national register. We are concerned that the area needs to be given priority. We have certainly also from New South Wales argued for successfully lung disease becoming a priority condition under the Australian Work Health and Safety Strategy and had input into accelerating the forward work program for Safe Work Australia as well, so I think it is completely consistent.

The Hon. TREVOR KHAN: You understand that we are really skirting the edges of our terms of reference here but anyway I think we might get going.

The CHAIR: I think we have explored this issue and we might move on. I am going to move on unless someone else does.

The Hon. TREVOR KHAN: Can I just ask this: Are any of you on the task force?

Ms DONNELLY: No, SIRA is not represented on the task force but we are in communication with icare and Safe Work New South Wales, who are.

Mr DAVID SHOEBRIDGE: Do you think it would be useful for SIRA to be on the task force?

Ms DONNELLY: I am happy to stand ready to be on it. I think we certainly have an interest in it.

The Hon. DANIEL MOOKHEY: The Home Building Regulation aspect of SIRA's function, which I think is you, Mr Parker, does interact with one of the places of work in which caesarstone is being used on building. Do you have any relevance in that sense?

Ms DONNELLY: To some degree and Mr Parker may add. The scope of that does not really cover injury and illness acquired. It is more about protecting the home owner who has gone into hiring a builder to build their home and then the builder has disappeared, gone insolvent or passed away.

The Hon. TREVOR KHAN: I never have thought of that one.

Ms DONNELLY: No. It is those cases where the builder cannot be found anymore to cover their responsibilities.

The CHAIR: Having run some of those cases, it is always about waterproofing.

Ms DONNELLY: Waterproofing is actually—

The CHAIR: It is huge.

Ms DONNELLY: Yes.

Mr DAVID SHOEBRIDGE: Or the hidden structural defect.

Ms DONNELLY: Yes.

The Hon. TREVOR KHAN: No winners.

Mr DAVID SHOEBRIDGE: Apart from the lawyers.

The Hon. TREVOR KHAN: Apart from the lawyers.

The CHAIR: I didn't charge much.

Mr DAVID SHOEBRIDGE: The Thoracic Society has said there should be a review about the classes of lung disease that are covered by the Dust Diseases scheme.

The Hon. TREVOR KHAN: David, I tried to explore that.

Mr DAVID SHOEBRIDGE: It was in their submission.

The Hon. TREVOR KHAN: Yes, but I am not quite sure whether it actually got to that point.

Mr DAVID SHOEBRIDGE: I gave you one of my two copies.

The Hon. TREVOR KHAN: No, no. They clearly have a view as to what should be considered an occupational disease and that is why I was seeking to explore that. They did not address the question as to whether that should be under the Dust Diseases scheme.

The CHAIR: I think you did ask that question. You put it to that witness.

The Hon. TREVOR KHAN: Yes.

Mr DAVID SHOEBRIDGE: I will put what is in their submission.

The Hon. TREVOR KHAN: Yes, all right.

Mr DAVID SHOEBRIDGE: "The spectrum of diseases currently covered by Dust Diseases should be revised to ensure it conforms to international standards of attribution of causality in the field of occupational lung diseases." Does SIRA agree?

Ms DONNELLY: I would have to say I would like to consider it more. I have not got a fully formed view but I do know—

Mr DAVID SHOEBRIDGE: I am happy for you to take that on notice and then if so, how would that review be done because obviously you would want to include not just the surgeons, you would have to include employers and you would have to get a sense of what the cost was?

Ms DONNELLY: Yes, and because we have the more focused role in terms of the Dust Diseases scheme, we would certainly be interested and we would give advice to our Minister but I would have to just check whether that part of the legislation actually is something that we administer. I do not think so. I think it would be icare to lead but I am happy to take the question on notice and give you some information about that.

Mr PARKER: I can confirm that. Under schedule 1 of the legislation the responsible Minister is the Treasurer, so Ms Donnelly is correct that we would provide advice and that it would be the Treasurer who would be responsible.

Mr DAVID SHOEBRIDGE: And does that mean it is icare?

Ms DONNELLY: Yes.

Mr DAVID SHOEBRIDGE: So icare is the lead agency?

Ms DONNELLY: Unless the government of the day decided that they wanted to do it some other way. A government could decide that, for argument's sake, the Department of Premier and Cabinet [DPC] or Treasury or someone leads the development of a proposal.

Mr DAVID SHOEBRIDGE: What about funeral benefits because $15,000 if the scheduled fee under the general workers compensation scheme and $9,000 is the scheduled payment under the Dust Diseases scheme. Obviously it costs the same fee regardless of how you died, unless you are taken out by a Russian agent.

The Hon. TREVOR KHAN: It still costs the same.

Mr DAVID SHOEBRIDGE: Yes, well it may be cost more, but surely we should be getting parity in that workers compensation is $15,000. Does SIRA have a view about whether or not there should be parity and the Dust Diseases benefit should be $15,000 at least? Do you want to take that on notice?

Ms DONNELLY: I am happy to take that on notice, yes.

Mr PARKER: Can I add to that?

Mr DAVID SHOEBRIDGE: Yes.

Mr PARKER: There are two steps for us to do that. One is in the guidelines for the benefits.

Mr DAVID SHOEBRIDGE: Correct.

Mr PARKER: And the reference in the guidelines is to the dust diseases Act so that if we wanted to change it, once again the responsible Minister would be the Treasurer and the guideline would be something that just refers to those changes.

Ms DONNELLY: We will give you an answer on notice.

The Hon. DANIEL MOOKHEY: I turn now to Lifetime Care and Support. Ms Maini, is that you generally?

Ms MAINI: Generally.

The Hon. DANIEL MOOKHEY: I think you were here for the question to icare about transfer?

Ms MAINI: Yes.

The CHAIR: It was my question.

The Hon. DANIEL MOOKHEY: Yes, and you heard the discussion we had arising from our 2017 recommendation for the need for SIRA to coordinate a lot more on the way insurers behave prior to the five-year transfer or prior to transfer. Are you able to update us as to the progress SIRA has made in that respect?

Ms MAINI: Yes, absolutely. I will just start with the comprehensive third party [CTP] care program that we have put in place. I will take Dr Casey's lead and hand out the program of work we have in place with icare and SIRA. As Ms Lulham gave evidence about earlier, we do not expect the first participant to enter the program until March 2020 but we are actually gearing up and setting up a program of work now so the program of work that we have actually established is the objectives that we want to achieve, that we have quick and easy transition from the insurers into the care program, easy access and information for all parties, maximising social and health outcomes and also ensuring sustainability in terms of payments.

The Hon. TREVOR KHAN: Just before you go on, as to this March 2020 date, did I get the flavour that you have actually identified the potential person or persons?

Ms MAINI: We have identified potential cohorts.

The Hon. DANIEL MOOKHEY: Yes, and I was about to ask that.

The Hon. TREVOR KHAN: Sorry.

The Hon. DANIEL MOOKHEY: I was about to ask that and equally what is the size?

Ms MAINI: That is okay. If I could take it a step at a time?

The Hon. DANIEL MOOKHEY: Please?

Ms MAINI: One of the streams that we have in the program is the customer experience stream and the other one is data and reporting, future operating model and implementation. In terms of customer experience, that is a lot of identification as well of the experience that someone has navigating between the two schemes. With the identification we believe that those people who are interim participants in the Lifetime Care and Support Scheme

who will not become permanent participants, we believe they will be part of the care program, and the reason for that is their injuries may be amputation or brain injury that has gone from severe to a recovery rate that does not qualify them to be permanent. We know that those people will require care and treatment beyond five years. So there is an easily identifiable cohort and we believe they are the interim participants. The next cohort that we are looking at—

The Hon. DANIEL MOOKHEY: As you are going through these cohorts can you give us projections as to size?

Ms MAINI: I can provide a lot more detail for you. We looked at the transport accident data when they first did the analysis and we also shared that with icare and the assumptions were that it would be 1,000 people. If I can give you the breakdown and also give you the breakdown of the overlay of the injury profile for that cohort? We do know that we have got the interim participants. To answer your question in terms of size, we know that there are 103 participants from the 2017 scheme in lifetime care and support now; not all will be permanent. So that is 100—

Ms DONNELLY: Less than that number.

Ms MAINI: Less than that—some move out. The next stream, if we look at the TAC data—and they have said that they are happy for us to provide this to the Committee—we have a combination of people who have had whiplash and fractures and another injury group. So pulling all those together and trying to identify which one from that group will have care and treatment beyond five years is what we are working on with icare at the moment.

Mr DAVID SHOEBRIDGE: I imagine it would be unusual for whiplash to lead to SIRA in five years. But you are getting the data.

Ms MAINI: We have got the data, yes.

Mr DAVID SHOEBRIDGE: What does it show? Does it show whiplash—

Ms MAINI: Yes, as an injury group, whiplash. I do not want to make assumptions—I was going to make some but it is probably best not to.

Mr DAVID SHOEBRIDGE: You might give us some detail on that on notice.

The Hon. DANIEL MOOKHEY: Is that the answer?

Ms DONNELLY: It is a process of having started—as the previous witnesses said, the old scheme prior to the 2017 reports did not really have a cohort in New South Wales that we could use as a basis for analysis. As we look at the TAC data we are then growing in our ability to say, "Does that align with what we are seeing in New South Wales?" I think you would look at people with whiplash and think that it would be much more beneficial if they were recovered before then. So I think there is also a conversation about what can we do to ensure that they are not having preventable ongoing disability effectively.

Mr DAVID SHOEBRIDGE: How far along the road are you to working out the guidelines or the process under which that liability will be transferred from insurers to icare?

Ms MAINI: We have got that on the delivery roadmap. We have very clear milestones of when we will be developing all the guidelines. The question that you had asked was how many were in that cohort. We are trying to identify that cohort now. I am happy to provide all the data that we have, especially all the TAC data that shows you what we are looking at. We are looking at how we identify those participants and we are also, with icare, doing some customer mapping and we are identifying people who were in the Motor Accident Compensation Scheme that have had payments greater than five years, and those that we think may be participants in this current scheme and we will be asking them what are their expectations, especially from the past participants.

The Hon. DANIEL MOOKHEY: In the document it says that in March 2020 to June 2020 you are expecting transfers to icare as early by agreement. Do you have a projection as to how many people you think there will be by agreement? It is actually pleasing that if we are short-circuiting the process they are going to end up there and we just get them there earlier—that is what we want to do—but do you have an estimate as to the size?

Ms MAINI: We do not at the moment because we are doing the exploratory data, but one of the things that SIRA is keen to do is ensure that insurers meet their obligations to drive really early recoveries.

The Hon. DANIEL MOOKHEY: Which is the very next question I was going to ask you. The substance of the sentiment that was driving this in the last inquiry was perhaps that there were perverse incentives

for insurers in the first five years of care to otherwise delay, defer or cancel treatment that would make rapid recovery early.

The Hon. TREVOR KHAN: That was the assertion or allegation.

The Hon. DANIEL MOOKHEY: That was a contention that we were exploring. I wonder whether you are able to update us as to whether or not that is still a concern and whether or not that has been accommodated in the framework that you have just laid out?

Ms MAINI: I cannot say it is not a concern, but what we are doing is putting reporting frameworks in place to make sure that that does not happen. I can take you through the reporting frameworks. We also have in the guidelines a provision that allows for if a claim transfers over and there has been—I would not describe it as mismanagement—a delay in actively managing that claim, Lifetime Care can recover as well. We are working with Lifetime Care to put in the reporting requirements on those claims as well.

Ms DONNELLY: The Committee recommended that we would report on that in our annual reports each year. We have had very little to report so far but we will do so; so that will be transparent.

Mr DAVID SHOEBRIDGE: Where there is an intractable dispute in the lifetime care and support system, say about a medical treatment or another sort of reasonable expense, as I understand it once there is an internal review the venue for external review is the District Court. Is that right?

Ms DONNELLY: Is this for the 2006 scheme?

Ms MAINI: For the current lifetime care participants.

Mr DAVID SHOEBRIDGE: For the current lifetime care and also for dust diseases. Perhaps we will deal with dust diseases first. Dust diseases, if there is a dispute it is the District Court. Is that right? Probably lifetime care is the Supreme Court, now I think about it. So dust diseases it is the District Court? Once there is an internal review on medical treatment or the like it goes to the District Court?

Ms DONNELLY: Yes, the District Court.

Mr DAVID SHOEBRIDGE: One of the suggestions from the lawyers was that instead of going to the District Court's general jurisdiction that it go off to the Dust Diseases Tribunal where you have judges with specific expertise on dust diseases. That seems to make an awful lot of sense. They also asked about the costs regime, that there should not be a penalising costs regime.

The Hon. TREVOR KHAN: I think that followed from the transfer, if it were done through the tribunal.

Mr DAVID SHOEBRIDGE: It may or may not. What is SIRA's view about that?

Ms DONNELLY: To be honest, not having that responsibility for administering this part of the legislation, we have not formed a definitive view, but I would say that given the terms of reference of the Committee's other review into the feasibility of a personal injury tribunal, one of the things that I would be thinking about if I was giving evidence is if CTP and workers comp. are grouped together there is a number of other related injury and illness decisions.

Mr DAVID SHOEBRIDGE: I think if anybody touched the Dust Diseases Tribunal there would be enormous anger about that and I do not think anyone is proposing changing the Dust Diseases Tribunal, which kind of works. The question is about if you have got a dispute about medical issues in the Dust Diseases Tribunal, having that reviewed by the court that has expertise in dust diseases makes sense to me.

Ms DONNELLY: It is not something that we have analysed and it probably would be something that icare would want to give you their view of.

The Hon. TREVOR KHAN: It is probably a policy position.

The Hon. DANIEL MOOKHEY: Did you hear the evidence we received this morning from Ms Franco, and as well icare, about accreditation audit standards for lifetime care service providers?

Ms DONNELLY: I did not hear that evidence.

The Hon. DANIEL MOOKHEY: Do you have a role in any of that or not?

Ms MAINI: No.

Ms DONNELLY: No.

Mr DAVID SHOEBRIDGE: One of the good things about these two schemes is that largely they seem to be operating with strong support from the stakeholders and seem to both be very well supported schemes.

Sometimes the issues, though, that are brought in the course of these inquiries may not be the sort of hard issues that you, as the regulator, see the schemes face. Are there any issues that you see that the Dust Diseases Scheme or the Lifetime Care and Support Scheme are facing that you would want to draw to our attention that have not been brought to our attention by the submissions from stakeholders?

Ms DONNELLY: I did give that some thought because obviously I thought you may ask. Our role, as I said, as prescribed in the legislation is quite narrow, but we do have a view that we work closely with both these schemes and have a role in giving leadership. My view is if SIRA was aware of problems and issues we would give advice to government about them. I am not in a situation at the moment where I think there are. I do agree with you that from time to time there will be matters that are raised by stakeholders in the reviews that the Committee does. They do seem to get followed up and actioned. We have quite a small number of complaints even around the actions of CTP insurers who we are holding accountable in the interface with Lifetime Care. So I do not have anything that is current at this point.

The Hon. DANIEL MOOKHEY: When you say you have issues and you are holding to account, can you elaborate?

Ms DONNELLY: We have had recently, I think, something like four complaints about individual matters. They might be matters around people who either—and Ms Maini may want to add—have both a CTP claim with a CTP insurer and they are a lifetime care participant. We have strengthened the guidelines recently to ensure that there is a number of points in the process where the CTP insurer must engage with lifetime care, advise them that they are thinking of making a decision, seek information and make sure that lifetime care is aware of that. Probably each one of those four is somewhat different. What I am saying is they are individual matters, but we are not seeing a systemic issue.

Mr DAVID SHOEBRIDGE: The issue about multiple applications by insurers to put people into lifetime care—we have not seen a change in legislation so they still have the statutory right to keep making applications, but we heard from icare that it was not a systemic problem—one or two issues, at most, a year.

The Hon. TREVOR KHAN: I think one.

The CHAIR: One, she said.

The Hon. TREVOR KHAN: Yes, one, not two.

Mr DAVID SHOEBRIDGE: She said one in the last year, I think. But that was multiple applications.

Ms DONNELLY: That is consistent with what we are aware of.

Ms MAINI: The other thing we are also doing, part of the program is working through how we get more information if icare suspects, or has reason to believe that there are issues with insurers, to refer them to us as well.

Mr DAVID SHOEBRIDGE: How often do you an icare meet?

Ms MAINI: Monthly.

The Hon. DANIEL MOOKHEY: For the purposes of these schemes?

Ms DONNELLY: Absolutely, because we have responsibility to oversight other lines of icare's activities. I would be surprised if there are not multiple points of contact every day from my officers with other people in icare. It is pretty intensive.

The Hon. TREVOR KHAN: But there is a formalised meeting once a month?

Ms DONNELLY: Ms Maini is talking about formalised meeting around lifetime care, CTP. There are formalised meetings around workers' compensation at a number of different levels, and also about home building compensation which we regulate. So it is quite a lot of contact.

Mr DAVID SHOEBRIDGE: You have a monthly meeting on lifetime care?

Ms MAINI: Yes.

Mr DAVID SHOEBRIDGE: And then you will have another monthly meeting on dust diseases or are they brought together? I am assuming you just do not have just one monthly meeting?

Ms DONNELLY: No, we do not. There are different experts required at some of the different meetings, or different accountable officers that we will be dealing with. Dust diseases, for instance, our role there is pretty well limited to the allocation of levies—distribution of how levies are paid—so it is on annual cycle for review. It is less concerned with individual injured people and what is happening with them, and design of a system.

Mr DAVID SHOEBRIDGE: There was a suggestion at some point, going to the levy, that the Dust Disease Scheme might be self-sustaining on the basis of investment funds because it had a big war chest of investment funds at some point. As I understand it, this year about 50 per cent of the scheme is being paid from investment returns and 50 per cent from levies, but I could be wrong.

Ms DONNELLY: A little under 50 from investment.

Mr DAVID SHOEBRIDGE: Do you sit down with icare and discuss the principles under which that mix is done?

Ms DONNELLY: I am happy to talk you through the process. Icare is accountable for ensuring it has adequate funds, so it will look at what its requirement is in total to fund next year's service delivery and it is on a pay-as-you-go basis, which is important to understand. It is a little bit different to other types of insurance. They are also looking at what their claim costs are and they have their actuaries undertaking liability evaluation. They will provide us with a certificate that is signed off to say "these are our requirements". They have considered in that what they are going to earn in investment revenue and offset that, and then we are informed of their view of how much of the levy is required.

I think there has been one occasion where we have had quite an active conversation about that to ensure that we were sure that that was the appropriate figure. We will have a look at their valuation and we will have a look at their method and we take their input and recommendations quite actively about distribution across the different types of industries if there have been shifts. We have moved to looking at that quite thoroughly every year. My understanding is that previously it did not change from year to year. Quite often there was no change for a period of years. We are now looking every year because we know what we do have, a changing risk.

We will engage with them, get their opinion and have our two sets of actuaries talk to each other and consider a number of issues about whether or not those levies—the way that they are distributed—are fair and reflective of risk. Some of the issues in this space—I think it is quite an interesting area that there are cross subsidies. Some of those occur and have always occurred in the scheme because even though some industries might generate the hazard and even if you think about the early days of silicosis with sandstone tunnelling to set up the sewers, every other industry benefited from their being sewers and the hazard that those workers were in.

The Hon. DANIEL MOOKHEY: Yes. The principle of insurance generally is risk-pooling?

Ms DONNELLY: It is risk-pooling as well. There is also long latency, as you would understand—a very long period of time for some of these diseases—so there are intergenerational issues. Even in the same industry that someone's lung disease has arisen from there may have been preventive measures that have come in place—

Mr DAVID SHOEBRIDGE: Getting employers to pay now for past problems.

Ms DONNELLY: Employers now are not the same ones. We consider all of those and we do that interactively with icare.

Mr DAVID SHOEBRIDGE: Thank you for that; that is good detail. Is there a view about whether or not at some point the Dust Diseases Scheme will get to a point where it is fully funded by investments because it was looking like it might get to that at one point.

Ms DONNELLY: I might defer to Mr Parker. I know there is a trajectory that icare is working on in terms of its capital adequacy.

Mr PARKER: Mr Shoebridge, you are right that there is $1.1444 billion sitting in reserve at the moment. The funding ratio for 2017-18 was distributed by use of about 50 per cent, as you talked about, with premiums and the other half was due to that investment of the $1.1 billion. The funding ratio is at 71 per cent as of June last year. The projections based on investment return would bring that to 100 per cent in between 2025 and 2026.

Mr DAVID SHOEBRIDGE: And that includes the downturn. Is that current, including the downturn in investments we have seen in the past few months?

The Hon. DANIEL MOOKHEY: What is the rate of investment return that you are projecting?

Ms DONNELLY: We might need to take that on notice.

Mr DAVID SHOEBRIDGE: Is SIRA supportive of that regime where you get to a point whereby at 2024-25 there is no longer a levy, but it is funded from investments?

Ms DONNELLY: I should probably be clear that that is actually a decision for icare to take. They make the decision about what their funding requirements are and then advise us about what they believe needs to be collected in levy.

Mr DAVID SHOEBRIDGE: Yes, but their funding requirements will be very different if you said to them, "Do you know what? We want to reduce the levy. Therefore, you have to eat into your capital." I do not know if that is a decision that is made by you or a decision that is made by them. given it is meant to be a pay-as-you-go scheme.

Ms DONNELLY: We can take that question on notice. However, the use of the investment earnings to offset the levy has commenced since SIRA and icare were established and started to have that conversation.

The Hon. DANIEL MOOKHEY: Are you saying that icare has effectively unilaterally set its own capital adequacy ratios?

Ms DONNELLY: It is their accountability under the legislation.

The Hon. DANIEL MOOKHEY: Do you have any role or responsibility?

Ms DONNELLY: We do not have the same sort of oversight. We work together and we exchange information. If we felt there was a concern, I would be absolutely confident in raising it with icare. They share with us the detail of the valuations so that we are all able to do our part of the levy setting in a way that we are confident will get the best results.

Mr DAVID SHOEBRIDGE: If you reject their levy and say that more or less must be accumulated then that would surely have an impact on their capital adequacy.

Ms DONNELLY: Surely.

Mr DAVID SHOEBRIDGE: I can see real benefits in getting to a point where you have a self-sustaining scheme based on its investments and with a capacity to issue a levy if there is a problem. That seems to be a good goal and it sounds as though that is where it is going. Is that correct?

Ms DONNELLY: I think that is a question for icare.

The CHAIR: Would you like to add anything?

Ms DONNELLY: I would like to address one of the matters raised in evidence by the Motorcycle Council about the levy. I have some information that might assist the Committee with regard to local roads. I have three things to say.

The Hon. DANIEL MOOKHEY: Just three?

Ms DONNELLY: Yes.

The Hon. TREVOR KHAN: The Nationals will never agree with his proposition.

Ms DONNELLY: I looked at the council's submission, which refers to 21 per cent of motorcycle accidents being attributed to road surface. That data comes from a report I know well because it was developed by the Motorcycle Council and supported by the Motor Accidents Authority when I was the head of the authority. It is based on data well over 10 years old, and it would be interesting to know whether it still holds up. If this Committee were to engage with the Staysafe Committee, it could access a recent report about future road safety issues that it might examine. A submission has been made by the Institute of Public Works Engineering Australasia raising local government. Members asked whether if the money were available would it be used to maintain roads. The data provided is quite old and it is time to look at it again. Is it about road safety or having a lot of court cases?

Mr DAVID SHOEBRIDGE: The issue they pointed out in particular was large-capacity motorcycles. The levy is about $136 in the regions and about $89 in the city, and they want an explanation for that.

Ms DONNELLY: We meet regularly with the Motorcycle Council and we would be happy to take up that and the other issues they raised with them.

The Hon. TREVOR KHAN: I do not think he queried that. I thought he said towards the end of his evidence that that was based on the data.

Mr DAVID SHOEBRIDGE: There was definitely an improvement. The Motorcycle Council this time did not complain about not having meetings or not getting information from SIRA. That is a good thing.

The Hon. TREVOR KHAN: There was a different tone.

Mr DAVID SHOEBRIDGE: There was. It sounds to me that your relationship is on the mend. You have mended that pothole.

Ms DONNELLY: Yes, I hope so. We will follow up all the issues raised and ensure we have an exchange of information and discussions.

The Hon. DANIEL MOOKHEY: You said you had three things to say. You have covered one of them. What are the other two?

Ms DONNELLY: I think I covered them all. I said that the data was quite old.

Mr DAVID SHOEBRIDGE: Ms Donnelly also spoke about the Staysafe Committee and the engineers' report.

Ms DONNELLY: Yes.

The CHAIR: Thank you for your evidence and for appearing before the Committee. You have taken some questions on notice. The Committee is working to a tight timeframe and would appreciate the answers being returned as soon as possible, and at the latest by 7 February. We appreciate your cooperation with that to assist committee staff, who will be in touch with you about the questions.

(The witnesses withdrew)

(The Committee adjourned at 16:15)