REPORT ON PROCEEDINGS BEFORE

STANDING COMMITTEE ON LAW AND JUSTICE

2019 REVIEW OF THE DUST DISEASES SCHEME

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At Macquarie Room, Parliament House, Sydney, on Monday 16 September 2019

The Committee met at 11:30

PRESENT

The Hon. Greg Donnelly (Acting Chair)

The Hon. Anthony D'Adam
The Hon. Wes Fang
The Hon. Trevor Khan
The Hon. Daniel Mookhey
The Hon. Rod Roberts
Mr David Shoebridge
The Hon. Natalie Ward

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The ACTING CHAIR: Welcome to the first hearing of the 2019 Review of the Dust Diseases Scheme. This review is focusing on the response to silicosis in the manufactured stone industry in New South Wales. Before I commence, I would like to acknowledge the Gadigal people, who are the traditional custodians of this land. I pay respect to elders past and present of the Eora nation and extend that respect to other Aboriginals who are present or watching this on the internet. Today is the first of two hearings we have planned for this inquiry. Today we will hear from a number of witnesses, including representatives from the Australian Institute of Occupational Hygienists; the Lung Foundation and the Thoracic Society of Australia and New Zealand; the Construction, Forestry, Maritime, Mining and Energy Union; the Royal Australasian College of Physicians; Maurice Blackburn lawyers; and the Australian Lawyers Alliance.

Before we commence I would like to make some brief comments about today's proceedings. The hearing is open to the public and is being broadcast 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 broadcasting guidelines, whilst 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 of the evidence at the hearing. I urge 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 an other person decided to take an action for defamation. The guidelines for the broadcast of proceedings are available from the secretariat.

There may be some questions that a witness could only answer if they had more time or with certain documents to hand. In these circumstances witnesses are advised that they can take a question on notice and provide an answer within 21 days. Witnesses are advised that any messages should be delivered to Committee members through the Committee staff. To aid the audibility of the hearing I remind both Committee members and witnesses to speak into the microphones. The room is fitted with induction loops compatible with hearing aid systems and has telecall receivers. In addition, several seats have been reserved near the loud speakers for people in the gallery who have hearing difficulties. Finally, could everyone please turn their mobile phones to silent for the duration of the hearing. I thank you for your patience in getting through those formalities.

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MARTIN JENNINGS, Fellow, Australian Institute of Occupational Hygienists, affirmed and examined

ANDREW ORFANOS, President Elect, Australian Institute of Occupational Hygienists, affirmed and examined

The ACTING CHAIR: I thank you both very much. The submission for the Australian Institute of Occupational Hygienists has been received. I thank you for that. It is listed as submission No. 4 to our inquiry. All members of the Committee have received that and have had an opportunity to review it. There is no need to go through that in your opening statement in a lot of detail. But emerging from your opening statement, leading into some of the points in your submission, there will be a range of questions. Would you like to make an opening statement?

Mr JENNINGS: We have got some thoughts. I would like to make three points that lie within our area of competence. One is that this was a foreseeable hazard. The question is: So why was it missed? Why did we get to this point? And I say that because it has got a very high crystalline silica content, in excess of 90 per cent. It was known that the job, polishing and cutting, would generate high levels of very fine dust, which is respirable, so that is the first point. The second one concerns the lack of information. One very common refrain when this was shown on *7.30* and other programs on the television in speaking to people who have been affected was, "Well, nobody ever told us about it". We have developed information addressing that lack of knowledge.

The third point is that very recently there has been a change to the exposure standard for silica in workplaces which has been promulgated by Safe Work Australia—we can talk a little to that—and the enforcement and regulation of workplaces by the regulators. Those are really the three points that we would like to talk around in particular. We are happy to take questions.

The ACTING CHAIR: Mr Orfanos, would you like to make any supplementary comments to those made by Mr Jennings?

Mr ORFANOS: No, not any more than what is already been put in our submissions. We are just open for questions.

The ACTING CHAIR: That is fine. Are you okay then if we open up to questions from Committee members? We have members here from the Government, Opposition and crossbench. If you are comfortable we normally share those questions around in a pretty fluid way?

Mr DAVID SHOEBRIDGE: Mr Jennings, I might just throw you what is called a Dorothy Dixer. You said there are a number of those issues you thought you would develop in this exchange?

Mr JENNINGS: Yes.

Mr DAVID SHOEBRIDGE: Can we go first to that issue of foreseeability and what was done?

Mr JENNINGS: Yes, and I should have made a point of saying we have provided some supplementary documentation to our submission.

Mr DAVID SHOEBRIDGE: One thing I was going to ask about was: There has been a lot of attention on this in the last few years and obviously if we look at current fact sheets for these various materials they probably talk about dust exposure, safe work method statements and the like. I was going to ask about what was happening with product safety sheets 10 years ago and you have given us one from DuPont?

Mr JENNINGS: Yes.

Mr DAVID SHOEBRIDGE: Do you want to tell us about that?

Mr JENNINGS: It is interesting. This was a revised version that was published in 2010.

The ACTING CHAIR: Just before you proceed. For the record, we have your submission?

Mr JENNINGS: Yes.

The ACTING CHAIR: Thank you very much. And we have a further document, which will be incorporated as what you are formally presenting to the Committee when we have our deliberative meeting later on. So talk to that, so we have on record formally that there are two documents from the organisation. Thank you.

Mr JENNINGS: Yes. I have tabled a material safety data sheet from DuPont for an engineered stone product called Zodiaq. What this shows is that this particular product, Zodiaq, has a 93 per cent crystalline silica content. If a hygienist had seen this 10 years ago, it would be a red flashing light. That would immediately highlight the fact that you have got a product with a very high crystalline silica content and it has been put out to

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these companies who are going to grind it, cut it and generate very, very high dust levels, so that would be the identification and the risk assessment that should have been done all those years ago.

If I can then refer you to the next sheet, which is published by the Centers for Disease Control and Prevention in the United States. They refer to this sheet—this was published in, I think, 2014. They have clearly identified this risk and at the bottom of that sheet they have asked for companies that are fabricating engineered stone if they can help by hosting the inspectors from National Institute for Occupational Safety and Health to come in, take dust measurements and build up some more information on what is a suitable level of control. They subsequently published this report in 2016, which I have not given you. What it did show, which was fascinating from hygiene point of view, was that even with dust suppression measures such as wetting, extract ventilation they were still above the exposure standard and they recommended that in addition to this, workers would need a very high level of respiratory protection, as in what we would call P2 or P3 level respirator. I think that would come as quite a surprise to a lot of people working in the field.

The Hon. TREVOR KHAN: Sorry, could you just tell me what a P2 or P3 respirator looks like?

Mr JENNINGS: Yes.

Mr DAVID SHOEBRIDGE: We assume it is not the paper mask.

Mr JENNINGS: Exactly. The sort you would get from Bunnings is really just for nuisance dusts like potting mix.

Mr ORFANOS: I will just say, you can get a P2 disposable respirator, a proper one that will comply with Australian standards. A P2 is a half face respirator—

The Hon. TREVOR KHAN: Right. That is one of those rubber ones that would cover the lower part of the mouth and nose and have the filters on the side, is that right?

Mr JENNINGS: That is correct. And a P3 is where you actually have a full face respirator where it actually goes all across and you are looking through a visor. That offers greater protection, a greater protection factor than the P2.

Mr DAVID SHOEBRIDGE: The Dupont material safety data sheet points out the risk of silicosis in bold terms and it says, it does not quite say it can kill you but it points out how it can be very debilitating and then talks about exposure controls, personal protection and talks about requiring a respirator which complies with—I assume it is a US standard—the Occupational Safety and Health Administration respiratory protection standard CFR 1910.134.

Mr JENNINGS: Yes.

Mr DAVID SHOEBRIDGE: I do not know what that is but is that a P2?

Mr JENNINGS: That is the regulation that is specific to respirators. OSHA is the Occupational Safety and Health Administration.

Mr DAVID SHOEBRIDGE: Alright. And would that be a P2 respirator?

Mr JENNINGS: It would be at that sort of standard. That is Australian terminology under the Australian standard which is AS 1716, for respiratory protective equipment, and if I could refer you to the next sheet this actually talks about respiratory protective equipment and illustrates the sort of respirators that would meet those requirements. I brought this along because in our submission we have a picture of a worker who has now had a lung transplant—he made the point, nobody told him, but what was interesting about that picture was you could still see dust in the side where he had had his respirator and one of the reasons for that was he had quite a growth of facial hair—

The Hon. TREVOR KHAN: Breaks the seal.

Mr JENNINGS: So that would really prevent any facial respiratory protection being effective.

The ACTING CHAIR: Mr Jennings, just with respect to the data sheet from Dupont, I note towards the top of the page that the title Zodiaq Quartz Surfaces that it says "revised 13 August, 2010." Obviously this is an iteration at that time but there is obviously previous iterations of this data sheet for this product known as Zodiaq. With respect to the earlier datasheets, do you have any insight into what they said or was there something specific about this particular one, the revised one that you wanted to draw to our attention?

Mr JENNINGS: It was really the date—2010. This was prior to any published information becoming available. I think the first report that was reported was in 2012.

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The ACTING CHAIR: Right.

Mr JENNINGS: Research about cases in Israel where their lung transplant register showed a significant number of people on that register from 1997 to 2010 were people from this industry.

The ACTING CHAIR: Right.

Mr JENNINGS: In 2012 this author called Kramer and his colleagues published a paper highlighting these risks so this actually predated any published available—

The Hon. NATALIE WARD: Can I just clarify, Mr Jennings, did you mean that is the first published data in the world?

Mr JENNINGS: That we are aware of on engineered stone. There have been previous data on things like granite but the difference between granite and engineered stone is the granite only has a silica content of a fraction.

The Hon. NATALIE WARD: Yes, it is very low.

Mr DAVID SHOEBRIDGE: What about Sydney sandstone, how does that compare? Because that has often been identified as a silicosis risk and we are seeing a lot of tunnelling and a concern about silicosis in tunnelling work in Sydney, what is the silica proportion in Sydney sandstone?

Mr ORFANOS: It is somewhere between about 20 per cent to 50 per cent, is it not?

Mr JENNINGS: I think so.

Mr ORFANOS: Whereas the manufactured stone is up at the 90 per cent so there is a significant amount more silica.

The Hon. NATALIE WARD: Sorry, if I may just complete that question before we go on to the types. I am interested in the published data. That was the first published data on that particular type of manufactured stone?

Mr JENNINGS: That is right, yes.

The Hon. NATALIE WARD: There had not been any other on that type. Is that what you are saying? I just want to be clear about when you said the first published ever.

Mr JENNINGS: Not that I am aware of prior to that particular paper by Kramer.

The Hon. NATALIE WARD: There have obviously been some since?

Mr JENNINGS: Yes. That was 2012. There was a paper from a Spanish author in 2014. These are mentioned in the section of the submission.

The Hon. NATALIE WARD: Thank you, I will find it.

The Hon. TREVOR KHAN: Is there any difference in the nature of the silicosis, say, in granite or sandstone as compared to this manufactured stone?

Mr JENNINGS: Difference between sandstone and manufactured stone?

Mr DAVID SHOEBRIDGE: A difference in the silicosis that develops—is it more aggressive? Are we seeing more aggressive silicosis happening now?

Mr ORFANOS: It is much more aggressive because they are being exposed to much higher proportions of silica.

The Hon. TREVOR KHAN: I accept the quantity. I suppose I am looking at, dare I say, the quality issue. Is the nature of the silicosis fibre or dust the same that you would get out of granite as you would out of this manufactured stone?

Mr ORFANOS: Yes.

The Hon. TREVOR KHAN: Or is there, in a sense, a subtle difference in the nature of it?

Mr ORFANOS: I suppose it would be the same. But in saying that, manufactured stone has some other—it is 90 per cent plus, but what is the rest that makes up to 100 per cent? That is the other thing: Is there something in that component that is contributing to the accelerated silicosis or not? The thing we have to also look at is not just the silica proportion—certainly that is playing a big part—but that other 10 per cent of the product. What is it, and is that actually having some impact on lung health?

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The Hon. ANTHONY D'ADAM: Is there a difference in terms of the size of particulates that are created when manufactured stone is sawed as opposed to granite or other forms, or Sydney sandstone?

Mr ORFANOS: There could well be, because—

Mr JENNINGS: Well, I think the critical point is this term "respirable", which is a particular size of particles which means it penetrates right into the gas exchange regions of the lungs, and thus why it is so damaging. The other aspect, which we have not mentioned, is freshly fractured—i.e. freshly cut or sundered—silica is particularly aggressive. It has surface radicals and these cause a lot of chemical-related damage. With ageing and wetting, this quenches the activity—this surface activity. That is why these types of processes on silica are particularly damaging as well.

Mr ORFANOS: Can I just add, with what you asked there, the other thing is that with the manufactured stone they are making it with already crushed silica, whereas a granite comes out of a volcano, it cools down and it crystallises so that the silica is almost like—a granite is a composition of sand that you see—

Mr DAVID SHOEBRIDGE: Large crystals.

Mr ORFANOS: Yes, large crystals, whereas the manufactured product is compressed from crushed, which means you have probably got a greater potential when you do cut it to generate finer stuff. So that would not surprise me at all.

Mr DAVID SHOEBRIDGE: Mr Jennings, you mentioned that the smaller fragments are more likely to embed themselves in the lungs at the gas exchange point.

Mr ORFANOS: Yes.

Mr DAVID SHOEBRIDGE: Are these issues related?

Mr ORFANOS: Yes.

Mr JENNINGS: Yes, because this is extremely fine dust now. It is too small to be seen by the naked eye. This is why it penetrates so deep into the lungs.

Mr DAVID SHOEBRIDGE: We had an informal briefing from icare at their facility in Pitt Street this morning, which was helpful. We had an informal exchange with a worker there. If I understood his position, he had been working in the industry for about three decades. When the manufactured stone first came in, there was concern about dust but then that concern was largely—there was a response from the industry which basically said, "Nothing to see here." The concern has then risen again in the last few years, so there is genuine concern in the industry. Are you aware of what, if anything, the industry said about its products, say, 10 years ago?

Mr JENNINGS: No, not really. They assure the buyers of the finished product that it is quite safe in that form and they have now started issuing fabrication guidelines to those people who cut, shape or polish the stone but 10 years ago I cannot find much information from them. It may be out there, it is just I have not found it.

Mr ORFANOS: Yes, I think the thing there is the manufacturers send the piece of the manufactured stone and that is not a risk and it is not until you start cutting it. But I think the manufacturer of that product knows what it is going to be used for and how it will be used. They say "That's not a hazardous chemical or substance" but really in the terms of how you are actually going to use it, it is hazardous. And the manufacturer knows what people are going to be doing with it. To say that it is not unsafe?

The Hon. WES FANG: Is the environment in which it is worked also part of the issue? If it is worked on in an industrial facility with proper extraction and water cutting it is a relatively safe workplace. But when it is on site without the proper tools and the proper extraction method is that where we are seeing a lot of the environmental issues as much as the issues of the product itself?

Mr JENNINGS: Yes. We have found one other document I have referred you here, that this is a guidance we have put out to the industry on working with engineered stone. This is just a couple of sheets of information that we have provided that addresses just that: how it should be worked—the most effective form of wetting. On the back we have someone wearing an air sampler and that is how we measure their exposure and check that they are within the exposure standard. Then the very final document is more a high level part of the Breathe Freely Australia information and this is for businesses on setting up safe systems of work where we talk about leadership, risk assessment, control, planning and prevention.

The Hon. DANIEL MOOKHEY: I am looking at the Breathe Freely Australia "Controlling exposures to prevent occupational lung diseases in the construction industry", which states that the control options are water

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suppression and respiratory protective equipment. To the extent of your knowledge, is the use of respiratory protective equipment enforced by the regulators?

Mr JENNINGS: No. Again that is a point we make in our written submission that while we have exposure standards the regulators have not been out there taking air samples to see whether these companies are above or below the exposure standard. It is interesting since we provided our submission on 20 August 2019 Victoria actually introduced a very prescriptive regulation as an amendment to the work health and safety clause.

The Hon. DANIEL MOOKHEY: I was going to get to that. To the extent to which the principal method that has been relied upon, the batches of wet cutting, and the extent to which there is a regulatory approach to ensure that wet cutting is taking place at the point of manufacture, what about at the point of installation that is when cutting takes place on sites ahead of time? To what extent are you able to give us any evidence about whether these control options and methods—and I assume the implication is that they are mandatory—is being followed throughout the supply chain?

Mr ORFANOS: When you get to the point when you are actually installing it in someone's house there would be concerns around if you use wetting you will make a mess of the place, will you not? There are probably factors there that stop people or make them hesitant to actually undertake those appropriate precautions.

Mr DAVID SHOEBRIDGE: What if you are installing 400 kitchens and bathrooms on a multi-level building site? That is, constantly exposed to it going from kitchen to kitchen, benchtop to benchtop.

Mr ORFANOS: That is right.

Mr JENNINGS: If I can just interject. Best practice is now if you do have a situation where the benchtop is not quite the right size you take it back to the workshop and do the cutting there rather than in someone's—

Mr DAVID SHOEBRIDGE: You take it from the kitchen on level 22, you put it on the hoist, you drop it down, you take it back, you bring it back to the workshop; or you just grind it off on level 22: What is realistically going to happen?

Mr ORFANOS: That is exactly right.

The Hon. DANIEL MOOKHEY: What is realistic.

Mr ORFANOS: We do not know—

The Hon. DANIEL MOOKHEY: Is it your view that it is not enough to rely on wet cutting it must be wet cutting and respiratory protection and both need to be enforced?

Mr ORFANOS: The evidence, the studies they have done is they have undertaken monitoring where they are doing the wet cutting and as you mentioned in that section, one of the other stakeholder submissions, was that evidence shows that even with those controls in place there were still airborne levels of dust above the current exposure standards, so you would need respiratory protection as well.

Mr JENNINGS: Yes, that is the Maurice Blackburn submission.

Mr DAVID SHOEBRIDGE: Is not the first control not having it in the first place?

The Hon. ANTHONY D'ADAM: I was just going to ask about the exposure standards. You mentioned there had been a change in the exposure standards but I wanted to draw your attention to this DuPont document where they say in their documentation they have an acceptable exposure limit of 0.02 milligrams per cubic metre over eight hours or 0.01 milligrams per cubic metre. It seems like they are much lower than the acceptable exposure standards that are currently in place, is that correct?

Mr ORFANOS: That is the American standard.

Mr JENNINGS: It is a United States standard and we have made the point that technically it is very difficult to measure down to those levels. You need to take a very large sample, as in, over an eight-hour day to get the volume of air to measure those sorts of dust levels.

The Hon. ANTHONY D'ADAM: There is a capacity to measure it at that level? There has been some evidence provided there is no capacity below 0.025?

Mr ORFANOS: Yes. It is important to understand that the levels of exposure where we are seeing these incidents of accelerated silicosis are 20, 30, 50 times greater than our current exposure standard. The issue here is if the current exposure standard was enforced and people were not exposed to levels above that level we would not be seeing what we are seeing today. A lot of people are submitting a recommendation to reduce the exposure

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standard. That is great, but a number on a piece of paper is not protecting the guy out there doing the work. What is critical is that awareness and understanding of the risks and that goes back to what Mr Fang was talking about.

Around the environment they are working my biggest concern is not the worker that is working for a big company—they have the resources, the money, the extraction systems—I am worried about the smaller micro businesses, the father and son businesses that are subcontracting to a principal and they have to get in. They want to do their work and they are not given that material safety data sheet. No-one is telling them that there is a risk to their health. I can assure you if they knew the real risks associated with this product they would be doing the right thing—if they knew and they were given the tools to appropriately control their exposure.

The Hon. NATALIE WARD: I may have missed it but what is the point of this DuPont mask? Is this a recommendation?

Mr JENNINGS: It is illustrating the point I made that this is a foreseeable risk.

The Hon. NATALIE WARD: I understood that. I am struggling to find the relevance of the actual DuPont manufacturing details? What am I supposed to take from this?

Mr ORFANOS: That it was a product that was used quite some time ago and they had identified the risks associated back then and they were warning people.

Mr JENNINGS: In that second section.

The Hon. NATALIE WARD: You also referred to inspectors that existed in the 60s through the Dust Diseases Board. There was awareness earlier than this.

Mr DAVID SHOEBRIDGE: Not in manufactured stone.

The Hon. NATALIE WARD: Okay. My second question is in relation to masks. Thank you for the pictures. They are very helpful. Going back to the bad old days of the asbestos difficulties and challenges, I am interested in these masks. My question is in relation to what happens when you take them off. I am sorry it is so basic. When the dust gets in the hair, other than the facial hair, even with the full-face mask, what happens? We know from history—this is very sexist—that blokes would go to work, come home and take their overalls off. The wife would wash the overalls and she would get asbestosis or mesothelioma as well, because she had exposures. I totally support the full masks. What are you proposing to do about the hair?

Mr ORFANOS: This is not just open to asbestos. I worked in a lead refinery for five years and managed people's exposure to lead. That was the same issue—getting it in your hair, your body, your clothes.

The Hon. NATALIE WARD: So what do you propose?

Mr ORFANOS: Back then, in a company that was big enough could provide resources and the money, you had a change house—a clean area, a dirty area and you would have a shower. Your clothes would be laundered on site.

The Hon. NATALIE WARD: I understand. So the small, dad-and-son business—

Mr ORFANOS: That is the challenge. It is certainly a challenge.

The Hon. NATALIE WARD: How do we manage that?

Mr ORFANOS: If you look at where you are going to get the biggest buck in reducing exposure—certainly in breathing it in—that is in the control measures. So if you work on them that is going to decrease significantly what is going to be on the person as well.

The Hon. NATALIE WARD: But is there a possibility that they will breathe it in taking all of this off and leaving it in the car—

Mr ORFANOS: You can understand that with asbestos they have given us the perception that you breathe one fibre and you are going to die. That is not the case. It is a dose dependent response. So if you are significantly reducing exposure you are going a long way in protecting that person from the disease. So the amount left would be much, much lower—below the exposure standard of what people are breathing in.

The Hon. NATALIE WARD: We are talking about what is foreseeable. You are saying that the potential risk posed by hair and clothes is negligible in your view?

Mr ORFANOS: It is much less. It is not negligible.

The Hon. NATALIE WARD: But we do not have any recommendations about what we should do about that.

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Mr JENNINGS: If I can just go back to your point about asbestos, the relevant codes of practice suggest you use disposable coveralls so you do not have the issue of contaminated clothing. That can be just left at the workplace.

Mr ORFANOS: Yes, that is something that can be done.

The Hon. NATALIE WARD: It does not deal with hair, but we will get to that.

Mr DAVID SHOEBRIDGE: The difference between asbestos and silica is the exposure levels that are likely required to give a realistic risk of having injury. Is there any evidence that a very small exposure to this kind of silicosis can cause incapacity or disease?

Mr JENNINGS: Usually, but that is the chronic condition—small exposure but over a long period of time. I think that that is what has really been so shocking about this. We are talking about accelerated silicosis—just a few short years of exposure—and this is why we are seeing young people being affected, as opposed to people of middle or older age.

Mr DAVID SHOEBRIDGE: When the Hon. Natalie Ward is talking about incidental exposure through clothes and the like—

Mr ORFANOS: Your body has mechanisms for getting stuff out of the lungs. So if you are exposed to a very low level of anything over a period of time, it comes out your lungs, comes into phlegm and you swallow it. If you are exposed to exceedingly high concentrations the system that your body has cannot take that much. That is when you get overload and irritation and the effects of it—whether it is asbestos or silica—in there. So at very low levels your body is quite resilient and it can deal with lots of exposures of lots of things to a certain extent, but if you keep on building it up or increasing it, greater and greater, you get to a point where the body cannot clear or cope with that hazard. So in that respect that is where the risk is occurring—because people are exposed to ridiculously high levels of the silica dust.

Mr DAVID SHOEBRIDGE: I am looking at your control options for stonemasons. My understanding of work health and safety is that there is a pyramid of control options—a hierarchy. The first is to remove the risk. Should we be considering that—saying, if you have a silica content above X of manufactured stone, you are not allowed to import it and you are not allowed to use it?

Mr JENNINGS: It is possible. It is interesting, in a previous year's review Unions NSW mentioned a product called GEOLUXE.

Mr DAVID SHOEBRIDGE: Yes, I recall that.

Mr JENNINGS: That is a Pyrolithic-type stone, which is made using a completely different process to engineered stone. It has a much lower silica content. Another product we mention is DuPont Corian, which is an alumina trihydrate product and has no silica at all. So there are alternatives.

The Hon. TREVOR KHAN: What were the old benchtops made of? Like my grandmother used to have, which was obviously a manufactured cement or the like. Do you know what I am talking about? It also used to be used in partitions in toilets and showers.

Mr JENNINGS: Yes.

The Hon. NATALIE WARD: Pebblecrete, wasn't it?

The Hon. TREVOR KHAN: No, it was not pebblecrete. I know what pebblecrete looks like.

Mr DAVID SHOEBRIDGE: It was a sort of dark grey concrete with rocks in it.

The Hon. TREVOR KHAN: Not always dark grey. Do you know what that was?

The Hon. ANTHONY D'ADAM: Terrazzo?

Mr JENNINGS: Those were maybe even moulded cement—liquid cement was poured into a mould.

Mr DAVID SHOEBRIDGE: Can I just go back to that point: Is there a silica content level above which we should be saying, "The risks are so large for this product, they are so uncontrollable. Because we know people will be installing it in unsafe situations, we should not allow this product into the market"? And if so, what would the threshold be?

Mr ORFANOS: That makes sense to me. In the hierarchy of controls, that is what you want to do—ban something so you do not have it entering the workplace. It would be about the science around what that level or concentration cut-off is that you would be looking at.

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Mr JENNINGS: In fact, beforehand we were asking whether a manufacturer wanting to introduce one of these products in 2019 would still get the go-ahead to do that.

Mr DAVID SHOEBRIDGE: We all like shiny benchtops but if that is inevitably going to cause people to die, then maybe we should rethink those particular shiny bench tops.

Mr ORFANOS: Absolutely.

The Hon. DANIEL MOOKHEY: Can I just ask, what is the market share of the products that are causing problems?

Mr JENNINGS: To be honest, I do not know. The only thing I have seen in the American literature is that this is a growing marketplace.

The ACTING CHAIR: Gentlemen, unfortunately we have to move on to the next witness. Your answers to the members' range of questions have been very illuminating, so thank you very much for coming along. There may well be some additional questions arising from members, after they have had a chance to read *Hansard* tomorrow. Would you be agreeable to receive some questions on notice?

Mr ORFANOS: Absolutely.

Mr JENNINGS: Yes.

(The witnesses withdrew.)

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SUSAN MILES, Lung Foundation Australia and Thoracic Society of Australia and New Zealand, sworn and examined

The ACTING CHAIR: Welcome, Dr Miles. Thank you very much. The submission from the Lung Foundation Australia and Thoracic Society of Australian and New Zealand has been received and all members have had an opportunity to read through that. I invite you to make an opening statement. You do not need to go through the submission per se, because I am sure that there will be some questions around that. You are more than welcome to make an opening statement of a few minutes and when it is completed we will share the questions around, if that is okay with you.

Dr MILES: Yes, thank you.

The ACTING CHAIR: Thank you, Doctor.

Dr MILES: I am a clinician primarily working at the coalface and I have a number of patients with silicosis obtained in the mining, tunnelling and now the manufactured stone industry, most of whom I have met in the last six months. There is a big problem in this country. It is of international proportions and I think we are seeing the tip of the iceberg in New South Wales. I am here today to represent the Lung Foundation Australia, which is the only national charity supporting anyone living with lung conditions, and the Thoracic Society of Australia and New Zealand, which is the only health professional peak body in respiratory health in Australia and New Zealand.

Our joint submission has been developed on the premise that everyone should be able to work in an environment free from harm. In order to assess the magnitude of this problem we need to know the size of the issue—what is happening including barriers to good practice—we need to plan evidence-based interventions to mitigate the issue and we need to act urgently to reduce the health, social and economic impacts for people in the industry. New South Wales has progressed well and we value the Government's interest and action in this area but we are lagging behind other States, with Queensland having particularly taken the lead. We need to learn from their example.

Our recommendation is that a similar program to that of Queensland be implemented in New South Wales where active case-finding is undertaken, targeting workplaces involved in the manufactured stone industry. We recommend an established system of mandatory notification of diagnosis which is shared with the regulator, requiring an audit of the workplace of the diagnosed worker in the same way that diseases like tuberculosis and measles are mandatorily reportable diseases. We recommend that those fabrication workshops where dust-related notices have been served be offered free screening of workers. That is not necessarily the case at the moment. And we recommend that New South Wales join the Australian Government and other States' jurisdictions on the task force to develop a national approach to addressing occupational lung disease including silicosis. This is a preventable disease. We should not be seeing it in Australia at this time.

The ACTING CHAIR: Thank you very much. That has been a very precise and clear opening statement.

The Hon. DANIEL MOOKHEY: Doctor, would you be able to set out how it would make the work of your profession much easier if there was a mandatory notification procedure such as you just mentioned?

Dr MILES: Yes, of course. We really do not have any idea the size of this problem, particularly in New South Wales, which is a very populous State. It would be very helpful to be able to identify workers early, before disease occurs, or identify them when they have disease when further exposure will reduce the progression of the disease and we can intervene medically to improve their outcomes. There are particularly vulnerable groups of patients who include migrant workers, people from non-English speaking backgrounds and, as my colleagues have already pointed out, people who are self-employed and are contractors and are not necessarily protected by the safety measures and the rights that people working as employees get, particularly in factories.

It is the people who work on site who are particularly at risk. It would help us identify these people. It would also help us know the severity of the disease and how we can better intervene to improve outcomes. It would allow us to share information with other States and to publish our data and compare data on an international scale and develop processes in place to reduce the burden of this illness. I see patients mainly at the secondary and tertiary prevention side. That is very important and that is primarily where my expertise is. We should be preventing this disease in the first place.

The Hon. DANIEL MOOKHEY: You made mention of the fact that these are in place for diseases like measles and tuberculosis. I can only presume that the existence of a notification register of the type you have

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just described is important in terms of suppressing the onset of the disease and also being able to pinpoint exposure. Is that part of the reasons why you support it?

Dr MILES: That is correct, definitely. If you notify a disease currently for measles and tuberculosis to Public Health it then allows a great team of people to go and identify those workers, send them out for proper screening and assessment, address the practices in their workplace and it is very important; it ensures the best quality of care.

The Hon. ANTHONY D'ADAM: What type of information sharing is available at the level of your profession in terms of identifying patterns?

Dr MILES: There is very active research and discussion internationally about this and we suspect we will have a very high prevalence of this in this country. It is a very active area of interest in this country and there is a number of dynamic people, including respiratory clinicians, that are involved in this space and involved in mutual research. I think we do communicate but we also have to respect patient privacy—it is very careful and you have to liaise with their workplaces and seek their permission. I get written consent from all my patients to deal with their workplace because it has implications for them with respect to their employment and also medico-legal implications should they wish to pursue a medico-legal case or seek compensation. In research studies patients are de-identified and give consent to take part in that.

The Hon. ANTHONY D'ADAM: The reason I ask is presumably if we have got mandatory notification those incidences are likely to result, if it is GPs identifying an occurrence of the disease, they would then be referring on to specialists presumably in your field and there would be some level of identification of where there may be hotspots or particular problems geographically.

Dr MILES: Whilst there are services in place to support that process I think there is a lot of confusion around what each body role is, whether it be icare, dust diseases care, SafeWork, the different colleges, and who is responsible for reporting what to who, and there has been a lot of work done at quite a high level by the colleges, Dust Diseases Care and SafeWork to smooth that process over and to speak it in a language that is easy to understand—it is every bit as confusing for patients. So that is extremely important.

The Hon. ANTHONY D'ADAM: How would a case-finding exercise contribute to providing further information of the nature that you are talking about?

Dr MILES: It will certainly detect a great many more cases. At the moment we cannot go out necessarily onto site as a doctor and meet these people, we cannot persuade them to come in to be screened by Dust Diseases Care. There are numerous cases of people being frightened of losing their working visas, not understanding what this represents, being related to someone who is an employer. It is very difficult for people to want to present in the first place, and case finding, especially if it is mandatory, would allow us to do that. This is a very toxic substance, manufactured stone, for the reasons my colleagues have alluded to, and I have other theories about that, and it seems to excite a very aggressive immune reaction and causes a range of diseases, not just lung disease but cancer of the respiratory tree, also chronic obstructive pulmonary disease [COPD], which is emphysema.

It causes kidney disease, rheumatological diseases such as rheumatoid arthritis and scleroderma; it also makes you more susceptible to acquire and reactivate tuberculosis. So it is very complex. We would have a better idea of the severity of the disease and the disease burden and what we can do about it. It would also find patients that may be able to be involved in studies to look at outcomes and to look at treatments, of which there is a very limited range of options.

Mr DAVID SHOEBRIDGE: Dr Miles, hearing that array of medical concerns, when I couple that with the fact that we had an informal briefing from icare this morning—and they said that in the last financial year there were 40 cases of silicosis reported through to them, which was a—

The Hon. TREVOR KHAN: I am just a bit concerned. I was obviously not there but relating something that is provided to us in an informal briefing—

Mr DAVID SHOEBRIDGE: But it was not confidential.

The Hon. DANIEL MOOKHEY: To be fair, that number was also provided to estimates.

The Hon. TREVOR KHAN: It might be but I am just a little bit concerned. If we get informal briefings I do not necessarily think we then appropriately repeat what is said.

The ACTING CHAIR: There was a document and that document is going to form part of the inquiry.

Mr DAVID SHOEBRIDGE: There was no suggestion it was confidential.

The ACTING CHAIR: A PowerPoint presentation.

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Mr DAVID SHOEBRIDGE: There is no point having a briefing if we do not use it in the hearing, Mr Khan. We can talk about it in confidence.

The Hon. TREVOR KHAN: Mr Shoebridge, we can talk about that later but we are told things that are not repeated to others.

The ACTING CHAIR: On this particular matter I think Mr Khan may have a point on certain situations and certain circumstances, but clearly in regard to this matter that was presented to those who attended, it was an open document for us to use to discuss there, there was no suggestion as far as I know that we were to keep such information out of the inquiry and was more formerly part of some private briefing. The intention I have at the deliberative meeting when we hold it is to have that formally incorporated as part of the evidence.

The Hon. TREVOR KHAN: I am comfortable. Let's just go on.

Mr DAVID SHOEBRIDGE: It was not, "Look, we will tell you quietly behind the scenes," it was for the purposes of this hearing.

The ACTING CHAIR: I understand where you are coming from, Mr Khan.

Mr DAVID SHOEBRIDGE: We heard there was that increase in the last financial year but then we also heard that in the period of this financial year to date there have been some 21 cases reported just in that period. Given those sorts of numbers, given the numbers we have seen in Queensland and given the health concerns that you are pointing, should we just be prohibiting this product, I mean, from a medical point of view?

Dr MILES: That is a very good question that a number of people have raised. It is a hazardous product, no question about it. I think that there needs to be a lot of discussion surrounding that. As you know it is popular. It occupies a large part of the marketplace. But asbestos has now been banned. This has some of the features of asbestos but in other ways it is very different, as are the diseases. It is foreseeable that that may be the case in the future, especially when there are other options that are safer.

Mr DAVID SHOEBRIDGE: The evidence we had earlier was that it may not just be a question of the quantum of silica in the product but also the nature of the crystals or the nature of the silica, which might be fine, more fractured, more broken or more aggressive. Do you have any knowledge about that, or is there any medical study on that?

Dr MILES: There is a lot of study and there are a lot of proposals for research seeking funding. One of the points I would like to make is that we need more funding towards research. There are some theories that the resins, glues and adhesives within it may protect the fragments of silica from being broken down by the immune system and may make them more likely to cause disease. In some patients it also seems to excite what is called a sarcoid-like response, which is an immune reaction to something in the environment and we do not know what that is. It has been noted that first responders at the World Trade Centre disaster have a higher rate of sarcoidosis, where there was an overwhelming exposure to dust, which would have been high in silica content. Even allowing for ethnic background—sarcoid is more common in African Americans—the rates are higher. It seems something about this is very dangerous to the health.

The Hon. WES FANG: Just on a little bit of a different tack, as Mr David Shoebridge said, we have just been down to icare and part of what they were saying to us was that for respiratory physicians they struggle to get respiratory physicians to be engaged in this area of occupational-type medicine. As a practising physician and somebody who treats a lot of people with these symptoms, what are your thoughts on that? Seeing as we may need to have an increase in doctors into the future, what do you think we could do in that area?

Dr MILES: I have been very fortunate in my career to have found an area I am passionate about. I try very hard to attract my trainees into this field. It is absolutely true that occupational lung diseases are being recognised far more commonly than they were, even though they have always been prevalent. Silicosis is a national and international emergency, particularly accelerated silicosis, in the manufactured stone industry.

There are a number of colleges and peak bodies that are trying to raise awareness quickly about this. It is widely published in journals but the rate at which it is appearing is outstripping the ability to keep up to date, basically, and keep up with it because there is so much about the disease we do not understand. You will hear from my colleagues from the Royal Australasian College of Physicians in the college of occupational medicine shortly but we do need to train more graduates into this field. It is enormously attractive, very satisfying and very interesting to practise in Newcastle but I can scarcely meet the demand for my services.

We need to upskill everybody. The disease is still being missed by senior clinicians, radiologists and people who perform lung function tests. Patients are being told that they do not have silicosis, based on normal basic lung function tests and a chest X-ray, which is all the occupational screening some places provide. That is

not correct. No patient should be told that they do not have silicosis unless they have had a proper assessment with a high-resolution CAT scan, a detailed occupational medicine history, a good clinical examination and formal laboratory pulmonary function tests.

The ACTING CHAIR: I am not medically trained but, from your description, that is a very comprehensive basket of tests and work to be done to make that call about whether a person has it or may not have it. Is there anywhere in New South Wales where testing is done to that level of specificity, incorporating all those component parts?

Dr MILES: At the moment icare Dust Diseases Care does an initial screening—in some cases at the Pitt Street practice or with the bus coming throughout regional New South Wales—which involves a chest X-ray and lung function tests and does include what is called diffusing capacity which is a measure of oxygen into the bloodstream and lung size, which we would recommend. It does include a detailed occupational history and assessment by a clinician with expertise in the field. They are not respiratory physicians. That is what is initially provided for all patients with dust diseases that are compensable and covered by that program but then there is a second stage. If patients are identified by that as possibly having a disease or at high risk for a disease, they proceed on, either to be referred back to their GP for follow-up and referral to a respiratory physician or referred on for a CAT scan, paid for by the organisation, and full lung function tests. The patient will receive a letter saying that they do or do not possibly have disease and that they need further investigation, as will their local doctor.

There are some problems in that system. One is that even though they try to reach them before the letter arrives, it comes as a great shock when someone has told them they do not have disease and then they are told they do. Then there is a waiting list to get in to see someone like myself to confirm it. It is not a diagnosis I make likely. I always have each case reviewed by a multidisciplinary team of clinicians, pathologists and radiologists before I come to that conclusion. There are other forms of screening in other States but we are strongly advocating that we receive optimal screening and testing in this country to obtain a diagnosis as early as possible. There are concerns in CAT scanning, for instance, about the radiation dose initially, but radiation doses have been significantly reduced with increasing sophistication of CAT scanning machines, and protocols have been developed for low-dose CT scans down the track. There are concerns that there will be what are called incidentalomas—findings of spots or scars that may be misinterpreted as cancer and lead to—

The ACTING CHAIR: False positives?

Dr MILES: False positive—and lead to further investigations and anxieties, some of which may be hazardous. That is the nature of screening, unfortunately, but at the cost of missing a very serious disease or finding an alternative diagnosis that resembles silicosis but may in fact be treatable. Some patients do go on to have a lung or lymph node biopsy.

The Hon. TREVOR KHAN: I am not going to be long, and you may have provided it already. You spoke of the range of diseases that may flow. Are there any peer reviewed papers that further evidence the range of conditions related to exposure?

Dr MILES: There is a wealth of information about that, lots of evidence going back and I can most certainly provide that, yes.

The Hon. DANIEL MOOKHEY: Mine is a very basic question. A person with acute silicosis, what are their prospects of recovery and what is the mortality rate?

Dr MILES: Acute silicosis is a condition where you have a massive exposure, such as a huge dose of silica through sandblasting, and the lungs become filled with protein and literally drown in fluid. Then there is marked inflammation, irritation of the immune system and then rapidly progresses scarring, which makes you more likely to get accelerated silicosis. It can be fatal within days, weeks to months. Generally it has a poorer outlook than if you are not exposed in that way. People can end up with acute lung failure. There is some evidence for washing out the lungs. There is some evidence for immune modulating drugs, but mostly it is a disease that you have to support them on a ventilator or alternately lead on to lung transplantation, which is a limited resource, an expensive resource with lots of associated complications and not eligible for everyone.

The Hon. TREVOR KHAN: It is not really the answer, is it?

Dr MILES: Not, it is not, not at all. Prevention is the answer.

Mr DAVID SHOEBRIDGE: First of all, thank you for your evidence today. One of the concerns about the Dust Diseases Scheme in New South Wales in terms of providing support and counselling—and your recommendation 7 is about counselling and support post diagnosis—is that unless somebody is not only diagnosed with a dust disease but also found to be impaired, none of that can flow.

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Dr MILES: Yes.

Mr DAVID SHOEBRIDGE: Do you ever have that happen in your practice? Somebody has a diagnosis, they may have silicosis but in the very early stages and they cannot get support through Dust Diseases?

Dr MILES: Yes, that does occur, because many patients with early disease do not have any symptoms whatsoever, nor findings on chest X-ray or basic spirometry and they are enormously traumatised by this. They are usually young men who are facing a life-limiting severe disease that may be rapidly progressive, with young families who are earning and they may come from vulnerable groups. There is a high incidence of smoking and social disadvantage in that group. It is correct that currently, as I understand it, unless you are impaired you do not receive compensation. You receive care towards the cost of having your investigations and your medical follow up and compensation via other routes, but unlike, for instance, mesothelioma, because it is a fatal illness quickly, you do need to show a degree of impairment to be compensated, as I understand it.

Mr DAVID SHOEBRIDGE: In your practice have you seen, for example, a young worker with a family and financial commitments who gets that early diagnosis and because of the absence of financial or other support continues working in the industry, even though further exposure is going to be contrary to your medical advice?

Dr MILES: Yes. I have seen both situations. I have seen several people leave the industry completely, and it is difficult for them because they have no other prior skills and trades. I have seen some that both enjoy their work and rely on it financially and they do return. I do my very best, with the help of my occupational and safety and hygiene colleagues, to keep them as safe as possible. We have a negotiation, with their permission, with the workplace as to what they can and cannot do and what protection needs to be offered and what the duty of care is from their employer.

Mr DAVID SHOEBRIDGE: Do you think that is a gap the scheme should be looking to fix, that if someone has a diagnosis of silicosis there should be support to retrain them, take them to a different industry and provide support from the outset, rather than waiting for impairment to happen?

Dr MILES: Yes, I think that is extremely important. That is a duty of care we have to all of them. There is a real lack of support groups. We have identified in New South Wales we do not yet have one and that would also be something very worth investing funds in. There is a lot of goodwill to support these men but they are a unique group. At the moment, there are other organisations in other States but nothing to my knowledge here in New South Wales. There are support groups like the Lung Foundation Australia, which is superb, but nothing specific to the manufactured stone industry.

Mr DAVID SHOEBRIDGE: They would be a quite distinct group of workers to say those workers who have asbestos-related diseases—much younger, quite a distinct set of social needs, putting to one side economic needs.

Dr MILES: That is correct. Yes, they are.

The Hon. ANTHONY D'ADAM: Earlier in your evidence you spoke about onsite installation as a high-risk area, or being more at risk. Is that borne out in the cases that you have seen or is there some body of evidence that suggests that workers in that aspect of the industry are developing silicosis at a higher rate than those in a factory setting, for example?

Dr MILES: Yes, there is some evidence to suggest this, which is quite strong and growing evidence. As you know, manufactured stone is not actually manufactured in this country—it is imported from other countries such as Israel, Vietnam and China—but it is processed and fabricated in this country. There are dangers associated with many cases in places that manufacture it overseas but the danger in this country arises from cutting, polishing, grinding and producing dust. Could you repeat the end of the question?

The Hon. ANTHONY D'ADAM: My question is really about whether the cases are predominantly in installers as opposed to people working in a factory setting because the evidence that we have seen is that the installation is where there is less capacity to have controls and so the exposure is higher. I want to know whether there is a body of evidence that we can look to that says, "Yes, the installation side is the most dangerous part of the industry".

Dr MILES: I think it is the most difficult to regulate. I think the past couple of years, safety standards have improved a great deal through initiatives like SafeWork in the factories but it is the people that go on site. They need to get the job done quickly. It is hot to wear a mask.

The Hon. ANTHONY D'ADAM: Is that reflected in the cases? I suppose—

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Dr MILES: Yes, I believe so. Those are the most vulnerable groups. They will tell you, "Yes, the factory is dusty and things but now we wet everything down and we wear masks". There is an instant-dismissal-for-dry-cutting rule. It is not perfect but it is better than it was. Inspectors may turn up at a worksite and there is no longer a worker there to see things are being cleaned up. Workers have had to go home quickly and drag the dust into their cars, taking it home to their families. It is very difficult. There may be pressure from consumers of the product as well not to make a slurry and a mess in your house while you are cutting. That may be an incentive as well not to practice best practice and safest practice.

The ACTING CHAIR: I have one question myself. Obviously, I think most people are afraid merely with the tragedy around what happened with respect to asbestos, particularly in this country. A number of Australian people have seen it denied and then ultimately, gradually, forced and forced before it was fully reconciled. Now they are trying to deal with it in a way that we know. I want to careful that I do not exaggerate this but with respect to this matter that we are looking at, could it be on a scale of that particular situation that we are just very slow in waking up to what is before us or would that be an exaggerated position to put in—one would be seen as being scaremongering. I am trying to sort of—

Mr DAVID SHOEBRIDGE: Is it a sleeping giant?

The ACTING CHAIR: Yes, thank you, Mr Shoebridge. I speculate what your answer may be but I thought I will put it to you in those terms because we are going to produce a report with some recommendations. We would like someone with experience and expertise like you to call it frankly, as you see it. I guess I am inviting you to do that.

Dr MILES: There is no question it is a dangerous product. We are going to see a huge burden of disease as a result of it—some in the short term with the accelerated silicosis, some in the much longer term. It is a sleeping giant; we are trying to wake it up and detect it. The similarity it has with asbestos is that it is less expensive and it is non-porous. Asbestos was very non-friable, flexible, heat-resistant and cheap. Manufactured stone has some characteristics that make it attractive to be used as widely as it has. It has been used very widely since the 1980s when it was first developed, particularly in this country.

The diseases are somewhat different with asbestos. A heavy exposure will give you disease but often there is a longer latency with disease, with asbestosis taking 10 to 20 years to develop with heavy disease, plaques taking 10 years and mesothelioma taking 30 to 40 years with minimal exposure. By that time the patients are much older and many of them are not working and have other life-limiting illnesses. This is different. This is young people at the peak of their careers with dependants who thought they were going to live a long life but are not. I think what we are seeing is the tip of the iceberg.

The ACTING CHAIR: Thank you, doctor. That is in some sense quite frightening. But it was very frank and you have given us some very serious material to contemplate and think about. I thank you very much for coming along. We expect that some supplementary questions will arise from reading the transcript and going through what you have said. Would you be agreeable to receiving some supplementary questions from us? We will liaise through the secretariat so you can write back to us within 21 days.

Dr MILES: Yes, I am very happy to do that.

The ACTING CHAIR: Thank you, doctor. And thank you for the wonderful work you are doing for and on behalf of those individuals who are suffering with this terrible condition.

Dr MILES: Thank you for your interest.

(The witness withdrew.)

(Luncheon adjournment)

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RITA MALLIA, President, Construction and General Division, Construction, Forestry, Maritime, Mining and Energy Union, affirmed and examined

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

The ACTING CHAIR: Thank you both. We have received the union's submission. It is a very comprehensive document with much detail and a number of useful references. Take that as read by the Committee members. I will offer you now an opportunity to make an opening statement and once that is done we will move to questions. Are you okay with that?

Ms MALLIA: That is fine. I will make the opening statement and then we can go to questions.

The ACTING CHAIR: Thank you have very much. Please proceed.

Ms MALLIA: The CFMMEU's position remains concerned about the significant delays in dealing with the escalating crisis that is the silicosis crisis. This is really underscored by the tragic deaths of young workers exposed to these products. We have just brought the media story of Anthony White, who died in 2017. I just give you that. You are probably aware of that as a case study.

The ACTING CHAIR: Thank you.

Ms MALLIA: Our delegates and our members who are exposed to these products onsite are angered by the fact that there seems to be little or no action in New South Wales apart from some activity around getting people familiar with these products. We are concerned that SafeWork NSW argues that the dangers associated with manufactured stone can be simply resolved through control measures minimising exposure. We see in this the same sorts of arguments that were had around asbestos in the fifties and sixties and it took 20 or 30 years to ban asbestos. Quite frankly, our position is that this product should be banned. We are not going to shy away from our position on that. We cannot wait 20 or 30 years for that to occur.

SafeWork's own statistics show a frighteningly high level of non-compliance with workplace controls in the fabrication factories in western Sydney in particular but they have also admitted that they cannot measure the impact on installers because they do not know where they are and they cannot find them. They are such a mobile group of workers that these workers who are highly at risk, the effects of this product on them is almost immeasurable. It is one of the reasons why we are calling for a ban on the product. The exposure standards are out of date; in fact, it is impossible to measure a safe standard, which again supports our argument for a ban. We are also concerned that New South Wales lacks in terms of its health response. The Queensland Government, for example, initiated a case finding study which was responsible for uncovering the disease in Queensland.

My understanding is that in 2018 the Legislative Council inquiry recommended a similar case study in New South Wales and yet 12 months later we are still waiting for that case study process to occur and SafeWork's position was it was out of the scope of the manufactured stone taskforce terms of reference, which is a worrying thing because we need to be knowing what is out there in New South Wales to understand the impact and our response. We are also behind other States in New South Wales in terms of introducing mandatory reporting legislation and regulations prohibiting dry cutting, initiatives taken up in Queensland and Victoria. We just cannot continue to ignore the seriousness of the threat to workers and their health and safety. We note that recently icare numbers showed a leap from 7 to 8 per cent over the years to 40 of silicosis. We do not know the details of those silicosis cases and what the exposure to those workers was to cause the disease but it is alarming to think you go from less than 10 people to 40 people and not think that there is something going on. It really needs to be urgently addressed.

The ACTING CHAIR: Thank you very much for that very precise and clear opening statement. Mr Kruse, do you want to add to that or shall we open up to questions?

Mr KRUSE: We did bring a copy of the figures from the medical assessment panel from icare. These are very recently published—

The ACTING CHAIR: Yes, please, that would be helpful.

Mr KRUSE: —and show the figures from 2013-14 up to 2017-18. They range between 9, 9, 9, 6, 8 and then for 2018-19 there is a leap to 40 cases. Whereas the evidence in our submission points towards the high number of cases in Queensland, in some circles—and I know from my dealings with SafeWork it has been suggested that the silicosis crisis in Queensland somehow relates to the peculiarities of black lung issues in Queensland and does not translate to New South Wales but we now have direct evidence from recent experience in New South Wales that shows that the silicosis crisis is something which is affecting workers and the community

CORRECTED

here, and that is before we have conducted a case study finding in New South Wales. I just want to impress upon this standing Committee that that was a direct recommendation from the last round of hearings of this Committee and despite ourselves, the medical profession and others making it very clear to SafeWork during the manufactured stone taskforce proceedings, we have been repeatedly told by SafeWork that a case finding study is out of scope and not being considered.

The ACTING CHAIR: Thank you for that additional information for the for the opening statement. We will move now to questions.

The Hon. TREVOR KHAN: Can I just say, Mr Kruse gave evidence I think it was last year?

Mr KRUSE: Yes.

The Hon. TREVOR KHAN: His evidence was compelling last year. I do not have any questions because I thought his evidence was compelling last year and it will remain so. I do not have any questions but it is not a reflection of my view on this issue, quite to the contrary.

The ACTING CHAIR: Just to confirm because it is directly on point, we had a briefing this morning at icare at their office in Pitt Street and they provided a panel of information which is precisely what, in their PowerPoint presentation which contains the data, that you have referred to and they themselves drew that very point out, that that increase to 40 in the period is a noticeable increase on any calculation.

Mr KRUSE: Yes. It is a pity that we have had foresight of this. We knew this last time we all met here.

The Hon. TREVOR KHAN: In fact the time before that as well.

Mr KRUSE: And there has been time for us to take proactive measures to prevent this crisis from further developing. Quite frankly, we are not doing what needs to be done.

The Hon. DANIEL MOOKHEY: Mr Kruse and Ms Mallia, I found your evidence compelling last time as well but I do have questions still. Do not take it personally as a result.

The ACTING CHAIR: He is a very hard-working MLC, the Hon. Daniel Mookhey.

The Hon. DANIEL MOOKHEY: Mr Kruse and Ms Mallia, last time you made the point about the need for a supply chain approach towards how this is used from the point of implementation to the point of installation and every part along the chain. Since then we have had a few States become far more prescriptive in what they think each party should be doing. Firstly, I was going to ask whether or not you thought that particularly the Victorian approach, which is relatively new, ought to be endorsed as well as the other aspects of the Queensland approach? That is the first thing.

The second thing is that you made the point aggressively last time that the rising risk was the point of installation which is a point that we have since pursued with SafeWork who have just taken—and this was in estimates a week ago—who took a view at the time that we ought to be focusing at the point of fabrication and in the factory setting, to the extent to which they have a strategy to ensure that the practice of wet cutting is enforced as the principal control measure regardless of any other. We would like you to talk us through what you think about that enforcement approach and talk us through what we are up to with a subcontracting chain and whether or not the problem has grown better or worse since the last time we heard from you?

Ms MALLIA: Our position is that the product should be banned so there is not a solution here that says that the manufacturer should take more responsibility for what happens on the job. Our position is this stuff is so dangerous that all of those things could be put in place and people are still going to be exposed to this product which can kill them, as we have seen. But of course, if that is not going to be the position then putting in place responsibilities by the manufacturers to the installers has to be part of the solution because otherwise nobody is going to take responsibility for what happens on site. We do not know what happens on site. We know anecdotally from our members and delegates who work on sites where big apartment blocks are being built and this stuff is being installed that it is dusty, there is no control over that dust being spread around the job.

It is not just the installers themselves exposed to that dust it is also the people working in and around. This stuff is very fine; it floats around. We do not even know the extent to the exposure. From our perspective banning is the critical thing but if you cannot get that then making sure that along the chain that the people responsible from the beginning to the end are held responsible. As we understand, the installers are largely owner trained, they are individual contractors—they are not people who have the resources to build elaborate tents and make sure that this stuff is not spread all around the job, let alone their own personal exposure. Nobody seems to be wanting to take responsibility for that, from either the manufacturers perspective or on-site, the persons conducting a business or undertaking [PCBU] who should be taking responsibility as well on the site.

CORRECTED

The Hon. DANIEL MOOKHEY: Do you know whether or not they are being screened, the point installers, particularly given the nature of the businesses that you have just described?

Ms MALLIA: Everything that we are aware of anecdotally is that they not being screened.

Mr KRUSE: We are not aware of any specific engagement with the installers. To be clear, the manufactured stone task force did oversee a process through which the SafeWork inspectors went out to the fabricators—to the factory sites, the fixed sites in Western Sydney where the materials are delivered and cut. They found an extraordinarily high level of non-compliance with basic engineering controls such as vacuum extraction, lack of wet cutting and the like. The inspectors went back to reinspect those premises; notices were issued, but extremely high non-compliance.

The Hon. TREVOR KHAN: On the second time round?

Mr KRUSE: Less so on the second time round. But what is really clear is the—we asked the inspectors how it is going with the actual installers. They said, "We've tried. We turn up but they've gone. They move on." The installers are small businesses. They are often not workers so they do not actually have access to this scheme. They do not have access to the medical care that is available through this scheme. At the moment in New South Wales there has been no real attempt to get to the heart of the problem: that is, follow this chain of supply to the installers. Our concern is that even if you do, how do you keep track of these people? How do you ensure that the controls—even if we pass every available regulation, how do you ensure that the controls are applied? It is the same problem which industry and society faced with asbestos in the fifties and sixties, and we took 20 years to ban it in the 1980s. This problem is unfolding now and it needs to be addressed through banning this product so that it is not used. There are safe alternatives.

The Hon. DANIEL MOOKHEY: I was going to follow up about the medical assessment panel data. I was going to follow it up with icare, which I think we still will. But the 40 that are listed here—that would not cover the installers or people who are not otherwise eligible to claim, would it?

Ms MALLIA: No, they would be just workers. They would be people deemed to be workers. You can probably multiply that by five times that; who knows?

The Hon. DANIEL MOOKHEY: To the extent to which we were to rely upon this as effectively a pseudo-register in the absence of a mandatory notification scheme like Queensland has, the big problem would be that this does not include people who are self-employed, which is chronic at that site.

Ms MALLIA: That is right.

Mr KRUSE: That is right.

The Hon. DANIEL MOOKHEY: Would you agree that perhaps one of the reasons why we do require a mandatory notification system in New South Wales is in order to capture people who are on the much smaller end of the scale and would not be showing up in icare's data?

Ms MALLIA: It is just like asbestos, where you have to report people who have the disease who have been exposed via the products that they have used, rather than as workers. You cannot just rely on the statistics provided by the dust board. I sat on the dust board, before it got abolished, for 17 years or something. Yes, it was a great tribunal and those workers got looked after. But if you are not deemed to be a worker or your disease was caused by a product outside of the employment relationship, then that was not open to you in terms of compensation and treatment et cetera. So, yes, it just shows we cannot just rely on this data.

Mr KRUSE: Just with reference to that, just take stock on this: The last time I was here and I gave evidence, I told the Committee that there were 22 identifiable cases in Queensland at that time. Since then in Queensland those figures leapt to 135 by March this year and 140 by June next year. That is with an active process of going out and conducting a case finding study and with actions underway to provide for mandatory reporting. New South Wales figures have gone from eight to nine to 40. That is without any attempt to implement mandatory reporting and without the case finding study. I have reported these figures to our health and safety representatives the week before last. It is 40 CFMMEU representatives who represent the thousands of workers in this industry. They said, "The figures are not 40. The figures here are much higher than that." It is just that we have not found them yet.

The Hon. DANIEL MOOKHEY: When you say, Ms Mallia, that you would like the product banned, what particular products would you like banned and what definition of product or concentration level do you think should attract a ban?

Ms MALLIA: It is the manufactured stone.

CORRECTED

Mr DAVID SHOEBRIDGE: All of them?

Ms MALLIA: From our understanding, anything—I do not always know how to tell the minimum exposure, but it is a very small level of exposure that leads to people potentially being injured or suffering a fatal disease. Caesarstone, I think it is anecdotally called, the manufactured stone product—that is what we want to see gone. That is the thing that is causing the disease.

Mr DAVID SHOEBRIDGE: Is it based—and I suppose this is where we would require expert assistance—upon the concentration of silica or the proportion of silica? We have seen some products with 93 per cent silica. Would it be based upon the proportion of silica in the stone?

Mr KRUSE: If I can answer that. It is a couple of things. It is the high density of silica. It is also the way in which this material disintegrates when it is cut. Our members say that when this material is dealt with it turns into an extremely fine—

The Hon. TREVOR KHAN: Powder—

Mr KRUSE: and highly respirable substance which nevertheless sticks to and attaches itself in the lungs. You would need to talk to the doctors about the mechanics of that but that is the narrative as it is outlined by our members.

Mr DAVID SHOEBRIDGE: Occupational hygienists have told the Committee that because of the way the stone is manufactured where they basically crush together all the aggregate, that, in fact, that then breaks up the crystals and it is a much finer, potentially more aggressive, form of dust that is produced in that way.

Mr KRUSE: What is incredibly frustrating is the report from SafeWork from the Manufactured Stone Task Force, which certainly does not represent a universal view of those people who participate on the task force, is that you should not distinguish between the controls and responses that it is relevant to apply to manufactured stone, and the controls and responses that you should apply to other silica-related substances like Sydney sandstone, and that flies in the face of the evidence that there is a very specific problem of manufactured stone that can actually be controlled by eliminating the substance. Sure, we cannot get rid of sandstone when we are tunnelling through Sydney but the choice to use manufactured stone in a kitchen setting is essentially a choice of aesthetics which is then backed up by a desire on the part of these importers to sell their products to our community. You cannot equate those two issues.

Mr DAVID SHOEBRIDGE: From a work, health safety perspective when you are talking about the hierarchy of addressing risk, the first response is to remove the risk?

Ms MALLIA: Is elimination.

Mr KRUSE: And that is completely ignored by the SafeWork report. It is as if it does not exist.

The Hon. DANIEL MOOKHEY: Why is that?

Mr KRUSE: My personal view—and we did not express this in our submission—is that SafeWork has become captured by an inertia and, perhaps in the worst cases, is influenced by the lobbying from the manufactured stone lobby. I think you noticed in our report that myself and Natasha Flores from Unions NSW were the subject of a lobby directed at us as individuals by the manufacturers in an effort to essentially silence us from criticising the product.

The Hon. ANTHONY D'ADAM: You have raised a number of concerns about the workplace exposure standard. Will you talk us through some of those in more detail?

Mr KRUSE: In America there are two standards: a general standard which is 0.05 micro grams per cubic metre. The standard for the construction industry is 0.25 micrograms per square metre. In Australia now it is 0.1 so it four times the American standard and four times the standard that is adopted in Mexico which has 0.02. A national review is underway to review the standard. The first draft of the national report recommended that our standard be dropped by half from 0.1 to 0.05—sorry, be dropped by five times from 0.1 to 0.02. However, the responses to that recommendation have indicated that the technology just is not there at the moment to actually measure the respirable substance in the air at that incredibly low health-related record.

We have an odd situation where a national review is recommending the adoption of a standard of 0.05 simply because the presence of the substance can be read in the air at that level even though it is acknowledged that a healthy exposure rate is less than half the 0.05 recommendation. We would say that tends to suggest that we should be looking to a ban. If this substance is so dangerous that it cannot be measured at a safe level why impose a workplace exposure standard which is adopted just because we can measure the presence of the substance at that level?

CORRECTED

The ACTING CHAIR: With that measurement issue, and the difficulty because the substance's has fine granules, almost dust granules, is it that in Australia we do not have access to and utilise equipment that can be used to make the measurement compared to other countries? Or is it absolutely a position whereby it is so fine that the machine we need to do that measuring would be so expensive that it is essential prohibitive?

Mr KRUSE: I think it is the latter. My understanding is that there are machines available.

The ACTING CHAIR: That could possibly do it.

Mr KRUSE: But they are not portable and they are too expensive to install in workplace settings.

The ACTING CHAIR: That is what I thought was the case.

The Hon. TREVOR KHAN: I suppose my concern would be this: I understand what you say with regards to banning. Let us suppose that a recommendation of banning was accepted but was unsuccessful, what is your fallback position?

Mr KRUSE: I do not know that there is a safe fallback position.

The Hon. TREVOR KHAN: I am not being critical.

Mr KRUSE: We cannot police those installers. Who is going out there to follow those installers day- by- day and protect them from putting themselves in an unsafe circumstance or protect them from being placed in a situation by builders or home renovators from getting into this sort of strife? I do not think there is a fallback position.

The Hon. TREVOR KHAN: My only concern with that, again I am not being critical, committees can make all sorts of recommendations which gather dust—no pun intended. Those recommendations that are often successful are, in a sense, the low hanging fruit that actually can practically make a difference in the short term before I suspect at a national level everyone decides that this issue really has to be addressed. Is it we move in the direction of what Victoria has done?

Mr DAVID SHOEBRIDGE: Or Queensland.

The Hon. TREVOR KHAN: Or Queensland?

Ms MALLIA: I think they are the alternative. At least they are steps that are trying to address the safety aspect, as imperfect as they are. It will probably need to put a lot more responsibility on the builders who have control of these projects at the end of the day.

The Hon. TREVOR KHAN: Indeed. Not just on this issue.

Ms MALLIA: Exactly right. This morning I was talking to the family of a guy who died two weeks ago. I absolutely get that. If banning is not going to be adopted then you are going to have to put a lot more obligation on not just the manufacturers but the builders and the subcontractor and the subcontractor of the subcontractor who engages these people at the end of the day to do the installation. If people are not prepared to do that really there is no solution. These workers are going to continue to be sick, they are going to drag the stuff home to their wives and their kids and we saw what that was like for asbestos victims. It is a tragedy in the making. We feel really strongly about this because there is really no safe exposure to this product.

The Hon. TREVOR KHAN: Again, I am not being critical.

Ms MALLIA: Asbestos was used to retard fire. It had a purpose. Eventually that purpose was overtaken by the fact that people were being killed. This is an aesthetic, this is something put in their kitchens. It is not saving them from being electrocuted. It is not protecting them from their houses burning down. These are purely aesthetic products and if it was not on the market there would be something else that would come to replace it.

The Hon. ANTHONY D'ADAM: There are alternatives, are there not?

Ms MALLIA: There is timber, there is laminates. A whole bunch of stuff people can do to their kitchens. I just googled "alternative to Caesarstone" and *Better Homes and Gardens* gave me 11 different types of things. Whether they are safe or not, I do not know. There are alternatives out there and this is not an essential industry. It is not creating many jobs in this State. It is not as if we are wiping out thousands of jobs in the process of banning this product. It is essentially an import that is not necessary.

Mr KRUSE: In terms of practical responses, one of the obvious ones is the case-finding study that should have been done 12 months ago and has been ignored—your own recommendation that has been ignored. Another one is the mandatory reporting legislation. In our submission we set out the relevant items of legislation that can be drawn from the Queensland experience. There is the wet cutting regulation which Victoria has recently

passed and that could be achieved extremely straightforwardly. We have not addressed this in our submission, but I will raise it; there needs to be more funding going into the training of doctors in the reading techniques that are necessary to identify this illness. It is a very specialised field of CT reading techniques. There needs to be money spent on that. In my role on the dust board I have been advised that the Lung Bus is currently booked up to the end of this year—

The ACTING CHAIR: And into next.

Mr KRUSE: —and into next. Even though workers can be referred down to Pitt Street for that fantastic facility there, we probably need another Lung Bus. I know that is a big cost item but we need to do everything we can to identify these cases so people can be referred for treatment.

The Hon. TREVOR KHAN: That is very helpful.

Mr DAVID SHOEBRIDGE: In terms of the response to that first recommendation of the 2018 review, icare have come back and said that case-finding is part of icare dust diseases care business as usual. Then they have referenced the Lung Bus and the screening programs and their partnership with SafeWork. They say that that is their response to the case-funding recommendation. How do you deal with that?

Mr KRUSE: That is not the case. The reason—I am just thinking this through—it has not happened is that it requires coordination between a few different Government authorities and, in particular, the medical profession. So for a case funding study to go ahead properly you need coordination from public health and you need the SafeWork inspectors to gain access to the premises which it is necessary to inspect. And then you need the medical professionals to also participate so that they can actually read the results. That is the difficulty. There needs to be coordination. I can tell you that SafeWork made it very clear. One of my colleagues on the task force, Dr Deborah Yates, put a motion up to say the case-finding study be implemented and we were told, "That is out of scope." That is not within SafeWork's purview. I do not think anyone is responsible for undertaking the case finding study within Government, now.

Mr DAVID SHOEBRIDGE: So if we were to refresh that recommendation that there be a case finding study, where do you think we should direct it to—to icare, to the State Insurance Regulatory Authority [SIRA], to NSW Health?

Ms MALLIA: Health. It seems SafeWork is not interested. Probably icare has its hands full looking after the injured workers. It needs to be led by the medical profession, I would say, through Health and with SafeWork, if you like, to provide the muscle, and the inspectors to make sure that the doors open in the relevant work sites. Of course, the CFMMEU will keep doing what we need to do but this needs to be a Government led initiative.

The ACTING CHAIR: Given that Health is such a behemoth as an organisation—you might care to take this on notice—what are your thoughts about how that might be domiciled specifically within health to produce this study that needs to be done?

The Hon. TREVOR KHAN: They have some statistics body within the—

Ms MALLIA: We can take it on notice. We can also consult with the colleagues in the medical profession who do doubt have much more experience than the CFMMEU officials about how that would work.

Mr DAVID SHOEBRIDGE: I just think we need to more carefully craft that recommendation going forward—

Ms MALLIA: I think that is exactly right.

Mr DAVID SHOEBRIDGE: —to task the right agency and be more specific.

The Hon. TREVOR KHAN: I have the feeling we are doing something, just about tomorrow, where the issue of data collection arises, quite frankly, and I think there is a capacity to do—

Mr KRUSE: The problem is not the data we have; it is the data we do not have. It is what we do not know about this issue that is the most dangerous feature of the crisis.

The Hon. ANTHONY D'ADAM: Do you have any suggestions about what kind of mechanisms might be available—flowing on from the issue around case finding—to identify the installers? How do we get that information to be able to identify where the installers are and who the installers are? Who has that information and how could it be—

Ms MALLIA: I would have thought that the builders who are building these apartments would be the starting point. Of course, if people are building single dwelling homes and things, who knows where they are?

CORRECTED

There is no register of those. Maybe there is a role for local councils to play, when people put in their development applications, about the types of contractors they are going to be engaging on their projects. I do not think the infrastructure is actually there to find all of these people, but to the extent that commercial—

Mr DAVID SHOEBRIDGE: Maybe we need a building commission.

Ms MALLIA: Maybe we need a building commission—exactly. That might have some jurisdiction in this space. There would be sources, as I said, in the more commercial apartment buildings. It is a disaster of an industry so—

The Hon. TREVOR KHAN: The domestic kitchen installers are everywhere.

Ms MALLIA: The domestic kitchen installers are everywhere. So unless you are going to ask people to register with the council or some other department it may be virtually impossible.

Mr KRUSE: There are licensing requirements. You might recall that last time we were here, there was actually a proposal on the books from the Minister to abolish licensing for manufactured stone installers. Luckily, common sense prevailed and that was withdrawn. But a good place to start would be those licensing records. Of course, many of these people will not be licensed.

The Hon. DANIEL MOOKHEY: In general the installation business segment is transient? Is that correct?

Mr KRUSE: Yes.

Ms MALLIA: Yes, it is the end of the process that would be transient and then when you get out of that type of brand-new build and it is just people doing renovations to their homes, et cetera—

The Hon. DANIEL MOOKHEY: It is lower margin?

Ms MALLIA: I would say they are very small businesses, low margin, probably—

The Hon. DANIEL MOOKHEY: Cash in hand type? Is this part of the—

Ms MALLIA: Possibly. You probably have a lot of people from non-English speaking backgrounds.

The Hon. TREVOR KHAN: If you get a kitchen installed it is not cash in hand. It is fairly big bucks to get your kitchen installed.

Mr KRUSE: We are talking about the construction industry, though.

Ms MALLIA: You could always have coordinated people but then those that they subcontract to are not quite coordinated, so that is we get to those issues.

The Hon. DANIEL MOOKHEY: The point being, a health-based approach targeted at installers is obviously valid, because they are the people who are experiencing health effects. But an enforcement-based approach, directed towards the bottom of the chain, is likely to fail because every time we have ever tried that in construction—as we have, incidentally, in transport—it always fails, which is why we tend to put it on people higher up in the supply chain. That is correct?

Ms MALLIA: In other issues, yes.

Mr KRUSE: Look at what has happened with the fabricators. There is a strong argument that the inspectors should be back doing another tour of those now—and at least they know where to go.

The Hon. DANIEL MOOKHEY: To the extent to which we allocate legal responsibility for the safe performance of work, we really ought to be directing it to the people who actually have power and influence, should we not?

Mr KRUSE: Yes.

The Hon. DANIEL MOOKHEY: That tends to be higher up in the supply chain than just the installers, would you agree with that? The builders, really.

Ms MALLIA: Yes. To the extent that there are builders and others like that who you can identify.

The Hon. DANIEL MOOKHEY: Sure.

Ms MALLIA: But I think with this particular product—

The Hon. DANIEL MOOKHEY: With home renovation, you are in a very different—

CORRECTED

Ms MALLIA: —that is not necessarily the case and it is a much bigger problem. Some of those mechanisms are not going to address the danger.

Mr KRUSE: Don't forget, the builders as the PCBU or one of the affected parties under the Work, Health and Safety Act, they already have duties in relation to the installation of that work. It is just that the practicality of applying those duties when you are—

Mr DAVID SHOEBRIDGE: When you area a $2 company, as well.

Mr KRUSE: Yes, that is what becomes difficult.

Mr DAVID SHOEBRIDGE: I know you touched upon this earlier—about the data and the numbers that are coming through. The medical assessment panel data confirms what we heard from icare this morning about the numbers of silicosis going from eight in 2017-18 to 40 in 2018-19. Given the nature of the construction industry and the nature of employment or engagement of people doing installations, they would very often be subcontractors who are sole traders or independent contractors and they would know that they would not have a claim under the dust diseases claim, being self-employed. How much do you think that masks the numbers in New South Wales that we are getting through icare?

Ms MALLIA: I think it marks it incredibly. It is hard to know the extent of it but the dust diseases legislation is limited because it is about people who have an employment relationship and installers are largely going to be owner-operators—people not in traditional employment relationships—so they are not going to be caught by those statistics.

Mr DAVID SHOEBRIDGE: When icare says that going out and doing case findings is part of its business as usual, in fact, that aspect of the industry is not a part of icare's legislative remit at all, is it?

Mr KRUSE: Yes.

Ms MALLIA: That is right.

Mr DAVID SHOEBRIDGE: If it is not looking there, you could hardly criticise it.

Ms MALLIA: It is not a proper answer to the problem.

Mr KRUSE: It is frustrating that the Manufactured Stone Industry Taskforce was established and it had representatives from Health, the unions, the medical professionals and SafeWork NSW all there. That body could have developed quite a compelling prescription for the case finding study, but it was ruled as out of scope. A body such as that needs to be established and funded to perform its activity.

Mr DAVID SHOEBRIDGE: Did the taskforce keep minutes?

Mr KRUSE: No. There were minutes but apart from the first few meetings, the work of the taskforce largely consisted of reports from the Chair on activities that were being performed by SafeWork NSW. Essentially the work of the taskforce was shut down through SafeWork NSW as the taskforce progressed.

Mr DAVID SHOEBRIDGE: I am just wondering if it would be useful to enquire of SafeWork NSW to provide the minutes and the agendas for those meetings, which might give us a further insight into what happened.

Mr KRUSE: It may be but certainly in my view the minutes did not properly reflect the conduct.

Mr DAVID SHOEBRIDGE: They were more sanitised than the workplaces.

Mr KRUSE: They were sanitised, yes.

The ACTING CHAIR: Thank you both very much. It has been great to have you come along to provide the opportunity for us to interrogate you and get some more information to supplement your submission. Thank you both very much.

Mr KRUSE: Thank you, Chair.

Ms MALLIA: Thank you.

(The witnesses withdrew.)

CORRECTED

GRAEME EDWARDS, Occupational and Environmental Physician, Royal Australasian College of Physicians, sworn and examined

DEBORAH YATES, Consultant Thoracic Physician and Conjoint Associate Professor, University of New South Wales, sworn and examined

The ACTING CHAIR: Good afternoon. Please state the capacity in which you are appearing this afternoon.

Dr EDWARDS: I am an occupational and environmental physician. It was my clinic that first identified the emergence of the epidemic on the Gold Coast. I have since been appointed as the national spokesperson for the Royal Australasian College of Physicians and its faculty of occupational and environmental medicine. I have also been appointed by the college to the working party of the Office of Industrial Relations in Queensland on developing a code of practice for the engineered stone workers in the kitchen benchtop industry. I have been appointed by the faculty and college to a clinical reference group for the Office of Industrial Relations in Queensland and most recently I was appointed to the National Dust Diseases Taskforce by the Hon. Greg Hunt.

Dr YATES: I am a thoracic and respiratory physician but I also have qualifications in occupational medicine having done that many years ago. My particular area of interest is occupational respiratory disease. I am a member of the board of the Thoracic Society and have been very highly involved in the special interest group which is the occupational and environmental group. We were instrumental in producing the position paper on coal worker's pneumoconiosis and I became involved in the issue of the resurgence of pneumoconiosis throughout Australia a few years ago. We described the first case of artificial stone silicosis in New South Wales. I have a number of patients who have this particular disease and I have sat on the New South Wales silicosis task force with Susan Miles and other physicians. I am also part of the Royal Australasian College of Physicians and have contributed towards their position with regard to artificial stone silicosis as well as with the Thoracic Society of Australia and New Zealand.

The Hon. TREVOR KHAN: And you have given evidence before.

Dr YATES: And given evidence before—hello again.

The ACTING CHAIR: Thank you both very much for coming along. You are both eminently qualified and experienced to provide some valuable evidence to the inquiry. Thank you very much. With respect to the formal submission from the Royal Australasian College of Physicians, it has been received and is marked as submission No. 6 to the inquiry. Members are familiar with that. I invite both of you or, if you wish to do so, one of you to make an opening statement or statements. Once that is done, if it is okay with you we will open it up for questioning from the members. Are you happy with that format?

Dr EDWARDS: Certainly.

The ACTING CHAIR: We will start with Dr Yates.

Dr YATES: Thank you for allowing us to discuss this issue again. I think I would echo a lot of what has already been said. I think that the issue with regard to artificial stone silicosis has been unresolved and I, like other members, would echo the sentiments which say that the case-finding study has not occurred and that in practice there has been really no action. We in the Australasian College of Physicians have a number of different suggestions that we would like to make with regard to a solution of this problem and I think I would support the view for a coordinated approach which involves the involvement of many different bodies because this is not just one particular department that can change this.

I think that Graeme Edwards is going to give us a bit more detailed information about this later on, but I would like to emphasise the fact that we as physicians can provide expert advice but we as physicians cannot make the bureaucracy make things work and that is what is needed. I would urge the Committee to enable the bureaucracy to have effective action for our patients because we are seeing people die of this totally preventable and unnecessary disease. With regard to banning of artificial stone benchtops, this is an issue which we have thought about a lot. On a personal basis I have come towards that position, but I do not think that is the stance of the Australasian College of Physicians as yet; it is still under consideration. So perhaps you would like to talk to Graeme now.

The ACTING CHAIR: Thank you for that, that is very helpful. The key words were "preventable" and "unnecessary". They are very definitive words you have used there to describe this particular—

Dr YATES: We should have no cases of silicosis full stop.

CORRECTED

The ACTING CHAIR: Dr Edwards, would you like to augment what has been put by Dr Yates?

Dr EDWARDS: I am on the public record of stating that in my opinion, and it is the opinion of my colleagues, that this is worse than asbestos because of the age at which these people are suffering. With asbestos and asbestos-related diseases it is affecting people at the end of their working life and into their retirement; they have had an opportunity to contribute. My youngest patient is 23 years of age. I have patients who have to contemplate what are they going to say to their eight-year-old daughter at Christmas time because they are dying. This is a tragedy that should never have occurred and every case—over 166 now in Queensland; you heard this morning over 40 that you know about in New South Wales—is evidence of system failure in the work health and safety spectrum—failure.

The ACTING CHAIR: That is as clear as you could possibly make it.

Dr EDWARDS: In the 12 months since we brought this epidemic to the attention of government a lot has happened—a lot was happening in New South Wales before that and there is a lot more to be done and, unfortunately, in New South Wales there is such fragmentation of resources that you have, in effect, a defunct, ineffective system and it is killing workers today and tomorrow and next week and next year and in the years to come unless your Government facilitates behaviour change within the bureaucracy of this State. I cannot put it any blunter than that.

Mr DAVID SHOEBRIDGE: We are the Parliament, not the Government, and there is a very real distinction there. But your point is well made, Dr Edwards.

The ACTING CHAIR: Just before you commence, Dr Edwards, that has been very definitive and clear, were there any further points you wanted to make before we open up for the questioning?

Dr EDWARDS: I am open to questions. Obviously, from my experience in the last 12 months, you can take it in whichever direction the Committee needs to.

The ACTING CHAIR: We will commence with Mr David Shoebridge.

Mr DAVID SHOEBRIDGE: Again, thank you both for your evidence and thank you particularly, Dr Yates, for having the emotional gumption to come back and do this twice. Since we saw you what has happened?

Dr YATES: I suppose a lot of disappointment. The silicosis task force I was hoping would actually implement change but it has resulted in fragmentation and has not resulted in an implementation of a case-finding study, which was the key recommendation. With regard to patients, I take care of patients on a day-to-day basis in the hospital. We are getting more and more. They actually express real anxiety and also real day-to-day difficulty with their work and with their health care, which I think is remediable. In terms of the science, with regard to artificial stone, I am part of the International Consortium for Silicosis, which involves people from all around the world. We have an internet-based communication system. There are a large number of cases that have been described in Australia, probably the largest number throughout the world, which I think is a really embarrassing thing to happen with a very well-resourced society. If you look at the cases from Israel, a large number of them have died, a large number have been transplanted.

If you look at the ones from Spain, which were the original ones actually described, probably the number of people with severe disease has gone up even higher than we would have expected. There is definitely something that is present in artificial stone—not necessarily just Caesarstone, because there are many different varieties—which is more toxic. It is probably a combination of different things but there is definitely something with this particular stone that we need to be particularly wary about. In addition to that, I think in the healthcare sector we need to be aware of the fact that this is not just one particular disease. I mentioned this last time I came. Silica exposure gives you silicosis, which we are all obsessed with, but in addition to that it gives you lung cancer, it gives you COPD and it gives you emphysema.

The ACTING CHAIR: Just for the purpose of Hansard, COPD?

Dr YATES: Chronic obstructive pulmonary disease; the sort of thing that has usually occurred with cigarette smoking. If you look at the comparison between one pack of cigarettes a year and dust exposure, it is probably equivalent.

The Hon. TREVOR KHAN: Sorry, one pack of cigarettes a year?

Dr YATES: Yes. One pack of cigarettes. So 20 cigarettes a day for a year is probably equivalent to the current recommended dust exposure levels, not the actual ideal levels.

Mr DAVID SHOEBRIDGE: This is the 0.1 micrograms per cubic metre?

CORRECTED

Dr YATES: Well, we think. Of course, one of the difficulties with medicine is that we look at historical exposures, because with these long-latency diseases we are looking at people who have been exposed 10 to 15 years ago with the historical exposures. It is not an exact science. But if you look at the studies that have actually measured the effects of both silica and coaldust in terms of the information we can get, then the equivalent effect on emphysema and chronic bronchitis is identical to that of cigarettes.

Mr DAVID SHOEBRIDGE: If we are going to direct recommendations to manufactured stone, and the range of potential recommendations go from banning the product through to further controls and regulations, how do we define the manufactured stone product that we want to target? Is it on the percentage of silicosis, is it on the nature of the production—how do we define manufactured stone for that purpose?

Dr YATES: Manufactured stone is artificial stone and I do not think we know enough about the silica alone to define it on that basis. I think we have to say artificial stone, manufactured stone is everything that is made during this particular process. It also involves resins and various other metals.

The ACTING CHAIR: Sorry, what particular process?

Dr YATES: What they do is—

The ACTING CHAIR: Sorry, can I just ask: Is there a specific process that can be used to define manufactured stone?

Dr YATES: Yes, definitely.

Mr DAVID SHOEBRIDGE: Tell us, Dr Yates.

Dr YATES: The different types of silica are crushed and then put into a presser with resins, often with different colourants and different metals to produce a different effect. It is then baked in a heated process and then it is ground and cut. Those things are then actually exported. We get the majority of ours from Israel. Caesarstone is probably about 40 per cent of the market, and then the rest of it we get from China, from Vietnam and also sometimes other places I think. So it is something which is identifiable. The silica content is measuredly very, very much higher but will vary a lot because there are more than 400 different types of stone that you can get. It would be identifiable at the point of import.

Mr DAVID SHOEBRIDGE: So recommendations should be directed to manufactured stone as a class of product, not related to silica content?

Dr YATES: Definitely. If you just go for silica content you will get even more confusion.

Mr DAVID SHOEBRIDGE: Can I ask you just to clarify your evidence. Did I understand you to say that—

The Hon. TREVOR KHAN: Sorry, can I just ask: Is it manufactured stone on a resin base?

Dr YATES: Yes, resin is added.

Mr DAVID SHOEBRIDGE: Is the resin a key part of it?

Dr EDWARDS: As distinct from the ceramics, which are baked in a different way. Usually the ceramics are of the order of five per cent or 10 per cent quartz content; quartz being the origin of where the silica obviously comes from.

Mr DAVID SHOEBRIDGE: It is resin-based manufactured stone?

The Hon. TREVOR KHAN: Yes, it is the suspension of the silica in a resin base. That is what is giving the problem and the fine dust.

Dr YATES: We are not sure. We do not actually really know.

Dr EDWARDS: We do not, no.

Dr YATES: The other thing to bear in mind is the fact that it is produced in places where we do not know how it is really done. For example, China makes quite a lot of it and my workers say that they can tell the different places from the smell when they cut it. So we are in a position where we know this is dangerous, we do not know what is in individual types but we do know that we can actually identify it.

Mr DAVID SHOEBRIDGE: But we are not talking about that kiln-based ceramic product. It is that resin-based manufactured stone, however it is manufactured.

Dr YATES: We do not know.

CORRECTED

Dr EDWARDS: Most likely that is the case.

Dr YATES: Most likely but we are not sure.

Dr EDWARDS: But can we categorically say that one is safer than the other? The answer is no. Can we infer that the ceramic-type products are potentially safer? Yes, we can.

Dr YATES: But ceramic products have caused silicosis over the past 150 years.

Mr DAVID SHOEBRIDGE: Dr Yates, did you say that working in this industry and being exposed to the recommended maximum standard for a year is the equivalent of smoking 20 cigarettes a day for a year in terms of lung health?

Dr YATES: We think it probably is, yes.

Mr DAVID SHOEBRIDGE: That is the regulated levels?

Dr YATES: That is the regulated levels, yes.

The Hon. DANIEL MOOKHEY: Dr Yates, you have made repeated references to your participation in the task force. I think that perhaps you have reached the conclusion that the task force is not succeeding in its purpose. Is that a fair characterisation of your evidence?

Dr YATES: Yes.

The Hon. DANIEL MOOKHEY: Do you want to give us your theory as to why that is? Whilst you make the point about the fragmentation of the New South Wales Government's efforts over a variety of different agencies, can you focus on what SafeWork NSW should be doing and what it is not doing?

Dr YATES: Yes. I think SafeWork—I think the level of support was not at a high enough seniority. I think there was an under-appreciation of the seriousness of this disease.

The Hon. DANIEL MOOKHEY: You are speaking in the past tense. Are you implying that you think that has changed or is it still the case with the task force?

Dr YATES: The task force is finished and there is nothing else that one can do about it. We understood that the task force was meant to implement a case-finding study because this is the area where the majority of cases were anticipated to occur and this has not happened. The dust diseases system does not capture the sort of people who would be at risk. We felt that the liaison between the different groups—Dust Diseases was there, icare was there and the manufacturers, the unions and everybody was there—but the open, free and constructive conversations did not eventuate. There was a good emphasis on education but the committee felt that education was a very important part but not the only thing that should have been followed. In fact, the specific recommendations from the committee were not followed at all.

So we felt that, really, the optimal way to proceed would be—and this may be something you would anticipate—to have something led by the experts rather than led by the bureaucrats because we felt that the level of understanding was possibly limited and also the importance of this. We felt that the Health department should be highly involved, particularly the public health aspect from the Health department. We felt also that various different committees should actually talk to themselves on a very, very close basis in order to try to urgently address this problem and maybe take advice from the expert committee that would consist of, basically, medical practitioners who are particularly concerned. I should add that we already have a committee. We doctors have got together. We have a voluntary committee that consists of respiratory physicians, occupational physicians, radiologists and occupational hygienists. We are very concerned to ensure that the state-of-the-art recommendations—which are gathered from the world data, not just from Australia—are actually implemented as rapidly as we can for the sake of our patients.

The Hon. DANIEL MOOKHEY: To the best of your knowledge has any equivalent body taken over the work of the task force, and if not should we have complete confidence in their ability to regulate and handle this by themselves?

Dr YATES: No. I do not think any other body in New South Wales has taken over this particular role. I think that the national task force will be a valuable contribution towards it, but obviously it works at a different level. We think it is urgent that this should be addressed.

The Hon. DANIEL MOOKHEY: And the regulators? They are on top of their game and we should not worry?

Dr YATES: The regulators are well motivated, but on a practical basis they did not address the particular place of exposure, which was small workers, the buildings and—

CORRECTED

The ACTING CHAIR: Installation.

Dr YATES: —installation places.

Mr DAVID SHOEBRIDGE: I cannot work out how the task force ceased to be. Nothing has been fixed. We have not resolved the problem.

The Hon. WES FANG: The Minister made reference to it two weeks ago.

Mr DAVID SHOEBRIDGE: What was the last work of the task force? Did they hand out some chocolates and say: Problem solved. Thank you very much? How did it end?

Dr YATES: It ended because they said they had come to the end of their term and they need to present a report and that they had done what was necessary.

The Hon. DANIEL MOOKHEY: When was that?

Dr YATES: It was just a couple of months ago. It was not very long ago.

Mr DAVID SHOEBRIDGE: Have you seen the report?

Dr EDWARDS: I can say that the national task force was advised that the New South Wales task force finalised its activities on 30 June 2017. That is all I know.

Mr DAVID SHOEBRIDGE: Have you seen the report?

Dr YATES: Yes, I have.

The Hon. TREVOR KHAN: And you are not allowed to say? Or you do not wish to say?

Mr DAVID SHOEBRIDGE: I think Mr Kruse is waving a document at the back.

Dr YATES: There is a report, but—

The ACTING CHAIR: So it is clear, the matter of a final report was in fact referred to by a previous witness.

Dr YATES: Yes, it has been produced. But I would agree with Ben Kruse in saying that this was not a final report of all the different contributors towards the Committee.

Mr DAVID SHOEBRIDGE: It was not adopted by the task force. He did not have a meeting and go through it and say: This is a great report.

Dr YATES: We were circulated with it and certain comments were made, which were not taken on board.

The Hon. DANIEL MOOKHEY: Is it junk?

Dr YATES: I do not think it is junk. I think that a lot of the things that they have done have been very valuable, but I think it just represents part of the whole issue, an important part but not anything which will actually immediately address the current problem.

The Hon. ANTHONY D'ADAM: Has the report been published?

Dr YATES: No. I do not think it has been yet.

The Hon. ANTHONY D'ADAM: What is its status then?

Dr YATES: I understood that it was actually with the Minister and was waiting for approval. I may be wrong.

The ACTING CHAIR: In your opening statement you described a number of roles you have, and work particularly with respect to Queensland, but more recently now with some Federal responsibilities. Can I ask you to bring your set of eyes to the New South Wales situation, perhaps in light of reference back to what is happening in Queensland. We had some evidence earlier today about some regulatory developments in Victoria, but perhaps also to the point of your work federally. Could you perhaps take this opportunity? Both of you could add to that I think.

Dr YATES: Yes. I think that Queensland has been ahead of the game because of the fact that it had the experience with the coal workers pneumoconiosis, and that a lot of what they have implemented has been extremely helpful. For example, there are a couple of things that could be done immediately. I think dry cutting should be banned in New South Wales. The data is very clear. And I think that mandatory reporting is absolutely key, and both of those have been implemented rapidly in Queensland. There are a couple of other things that have

been implemented in Queensland in particular and which I know are coming up in Victoria, which will be very useful. The first one is a clinical pathway, which we actually developed for coalmine workers. The silicosis task force in Queensland has actually also produced a document on regulation of dust levels, which has also been very helpful.

From the point of view of implementation a little bit, in other areas I think that one of the really key things that has come out of Queensland has been the fact that the regulators came and really discussed the issues with a large number of different experts and took on board the information that was freely offered. That includes international experts as well. From that arose a number of different training modules. On Saturday, for example, I took part in an international training session with the University of Illinois for the medical assessors in Queensland. We had 67 participants and it worked very effectively.

One of the things that has been key about the Queensland Worksafe has been the fact that it has really promoted the education and also the collaboration between the different groups. That is what is really, I think, essential. What needs to happen as this problem needs to be addressed is using the information that has been gained from Queensland because it has been ahead of the game and it has learnt from that particular group. Also, we need to make sure that we do not underestimate the importance of allowing dissemination of appropriate information at a very basic health level because we are the people whom these patients will come and see and we are the people whom they trust. They will come and talk to us about things whereas they are scared—they are dead scared—of the regulators—they are dead scared of Worksafe.

Mr DAVID SHOEBRIDGE: Sometimes they are scared of their employer.

Dr YATES: They are very definitely scared of their employers. They are scared even of their own employers because of the implications for their families.

The ACTING CHAIR: Sorry to interrupt, doctor, but is the pathway to seeing someone like yourself not a difficult pathway for someone to get onto in the first place?

Dr YATES: Yes.

The ACTING CHAIR: In other words, that is a threshold question about how does a person who is out there undiagnosed alternate contact with someone like yourself or Dr Edwards.

Dr YATES: That is exactly right.

Dr EDWARDS: That is the clinical pathway that the clinical reference group has actually developed and it is in the consultation phase at the moment. In terms of the pragmatic translation of what we have seen in Queensland and elsewhere to the New South Wales setting, number one is that you do not have a code of practice for this industry sector. When the inspectors go out to those sites, they actually make it up on the go because they have no reference document to reference against. So then you get variation in the level and consistency of applying the rules and the advice that is given to those employers.

One easy translation is that the tripartite work that has gone into developing the draft code of practice can be looked at by the New South Wales authorities to its applicability here which will then give two things. One, it informs the industry what is expected of them. It has been developed in concert with the current model laws. Even though the current model laws, from our perspective, need to be refined and critically changed but at least there is the existing statutory authority in New South Wales that can be enacted if you have adequate guidance material to provide all the way down to the level of the inspector going into that worksite.

There is, as I said, the clinical pathway. From the very point of anxiety and concern of an individual—where do they go, how do they go, what is said, what is communicated to that practitioner, how does the practitioner and GP at the coalface, who is naive to the issues of silicosis or any understanding of the workplace behaviours and tasks that these people are exposed to, go and trigger that conversation and facilitate the individual through a process. There are multiple layers—at each different layer what needs to happen, who needs do it, who is qualified to do it, what screening instruments are used to distinguish those people who were at high risk as opposed to low risk or medium risk or, in effect, no risk because they just have not been in the industry long enough. There is a whole array of critical questions that need to be condensed into a clinical pathway. Not only do we have to develop it and when it is well developed in its formulation it then has to be disseminated across the medical community in such a way that it can be implemented. All this takes time.

Dr YATES: Could I respond to how the patient gets to someone like me?

The ACTING CHAIR: Thank you. I will be most interested.

Dr YATES: That is really the key for people because I think the awareness has increased and people now are worried about it. They will go to their general practitioner and the general practitioner generally will not

CORRECTED

know what to do. In New South Wales there is a Royal Australasian College of Physicians website where we talk about silicosis but there is no central, proper website that would really help. That needs to be done to the through the College of General Practitioners because they are the people that they talk to. Then what happens is that the GP does not know what to do. We need to provide them with information and a clinical pathway so they know what investigations are needed. We also need to provide them with an easy pathway for referral. At the moment we do not really have that and there are problems with access to respiratory physicians.

The main thing that worries all these patients is the money. It is the money. They cannot afford it. It is becoming increasingly difficult for people to first, actually get in to see a respiratory physician and, second, to pay for it. What they did in Queensland was pay. They said that they would cover all the costs. That is a huge thing that makes a difference. Then once you have a possible case of someone who has a silica-related disease—the broad spectrum of them—they need to be sent to a hospital where there are people who know about these diseases. This is another whole area of expertise. But we do have a system that exists at the moment where other types of lung diseases are discussed in what we call a multidisciplinary meeting. That involves radiologists, physicians, physiologists and various different people who come to a consensus diagnosis and then have some sort of management plan. That is what is needed.

We need to have specialised, occupational multidisciplinary teams in the major teaching hospitals that can vet all of the cases and get good information, which can then be passed on to a central register. You can then also provide advice. One of the problems is that the general practitioners are the point of care for the majority of these people, and these people have a lot of other issues. They have anxiety; they have depression. Some of them, for example some in Queensland, have turned to drugs and things like that because they cannot deal with it. These are young men at the peak of their working careers. They need access to help. They need psychiatrists and psychologists and practical ways of getting through this particular crisis. We need to have a health focus and regulatory focus. We cannot just stress one. We need to involve all the different aspects for these patients. Essentially what we need to do is deal with the people that have been exposed already and then stop anybody else from being exposed at all.

The ACTING CHAIR: Thank you very much.

The Hon. WES FANG: How important is early intervention in this process?

Dr YATES: Very, very important. If you look at silica exposure generally, although traditionally we would stop people from being exposed when they had the disease, it continues. The reason we have people who do not get bad is because we remove them really, really early on. We have been incredible with that. It has really revolutionised the issue. Silicosis used to be terribly common and then it almost disappeared. That is the situation we want to gain. We have to pick them up really early. The catch is that they do not have symptoms. They will have terrible radiological diseases—One of my patients has the worse type of disease and he is hardly breathless from doing his job. He has been assessed as 1 per cent disabled by the Dust Diseases Board.

Mr DAVID SHOEBRIDGE: We have heard that in those cases there is no support for the worker, because until they show impairment the rights to medical expenses, the rights to income support and the rights to the kind of assistance they need to get out of the industry do not kick in. But in those cases—I would have thought—it is urgent for them to get out of the industry and get that assistance.

Dr YATES: Absolutely. That is the key. One of the problems is that these people are stuck in this situation because they have wives and children to support and there are no other jobs that they can go to. What they need is a financial bridge to a different job. That is something that could be relatively easy to implement. What it does require is money. But this is absolutely key.

Dr EDWARDS: One of the problems we have at the moment is that the definition within the statutory entitlement parts of the game relies on them having either an impairment or advanced radiological changes on their chest X-rays. We know that in this particular cohort of individuals, the chest X-ray is falsely reported as negative in over 40 per cent of cases. The chest X-ray that is prescribed by the model laws as being the test is wrong in four out of 10 cases.

Mr DAVID SHOEBRIDGE: Is the X-ray wrong or is the reading of the X-ray wrong?

Dr EDWARDS: Even in the competent hands of good B readers, you will see a false negative test result in four out of 10 workers.

Mr DAVID SHOEBRIDGE: There is no B reader system formally in place in icare, is there?

Dr EDWARDS: The B reader system is valuable for what it is.

The ACTING CHAIR: Doctor, could you explain what that means for the purposes of Hansard?

CORRECTED

Dr EDWARDS: Basically there is a credentialing process of the radiologist who interpret the film. So not only do we actually have the film taken in a set way so that we get consistency and reliability of the image but we also want consistency and reliability of the reporting—the interpretation of the image. The first read is done by the assessing radiologist. Then there is a B read, a second read that is done independent of the initial read and then, depending upon the concurrence between those two reads as to whether it goes on to a third, fourth or even a fifth read as necessary to get a considered opinion as to what is the actual characterisation of the radiology.

So the B reading process was developed to improve reliability and consistency of the radiology reports. It is an internationally accepted credential process. It is not inexpensive and the radiologist spends a fortune to actually just get the ticket but it does rely on exposure to case material to maintain competency and reliability. Now that is on the chest X-ray. What we know is that even when you have highly qualified and experienced radiologists reading those chest X-rays, four out of 10 are wrong when you compare it with the findings on high-resolution CT scan. Six out of 10 are wrong when you compare it with the autopsy studies.

Mr DAVID SHOEBRIDGE: There are a couple of things. First of all, we have got a Lung Bus going around in New South Wales at the moment doing thousands of X-rays.

Dr EDWARDS: Missing the diagnosis.

Mr DAVID SHOEBRIDGE: In 40 per cent of cases?

Dr EDWARDS: In this high-risk group.

Mr DAVID SHOEBRIDGE: You can say that unambiguously, that the Lung Bus is missing 40 per cent of cases?

Dr EDWARDS: I have no reason to say that the radiologists and the people interpreting the films of the Lung Bus are any different or any better or any worse than any other B readers anywhere in the world.

Dr YATES: And this is for all types of lung disease as well. This is, for example, the lung cancers or anything else. The high-resolution CT scanner is far superior and is the modern technology now.

Mr DAVID SHOEBRIDGE: What is the barrier to putting high-resolution CT scanners in?

Dr EDWARDS: One is that chest X-rays are embedded in the current regulatory framework of the model laws so it is in the legislation that that is what you have to do. That is one barrier. The other is the evolving knowledge and understanding of how do you actually rate a high-resolution CT scan? They are all not the same. We might use the phrase in a glib way but there is low dose, ultra low dose, standard dose high-resolution CT scans.

Mr DAVID SHOEBRIDGE: You were giving some data about the improved diagnosis rates?

Dr EDWARDS: Yes.

Mr DAVID SHOEBRIDGE: That must relate to a particular type of CT?

Dr EDWARDS: That is the standard high-resolution CT scan taken at one millimetre slices.

Mr DAVID SHOEBRIDGE: Does that have a high X-ray or radiological burden which would be an issue, which is why you have lower rates?

Dr EDWARDS: Which is why we are exploring ways to better screen for the pathology without exposing the individual to the same degree of radiation.

Dr YATES: There are now ultra low dose high-resolution CT scans which have been used for screening in the general population which have a much, much lower dose and it is practical to actually recommend and use those in Australia at the moment.

Mr DAVID SHOEBRIDGE: So it does not sound to me as though it is even possible—

Dr EDWARDS: And the penetration of those particular machines in the marketplace in New South Wales for instance—if a high-resolution CT scanner has the capacity to do what is called coronary angiography, so a rapid sequence process, then it can be programmed to provide an ultra low dose or low dose sequence.

Dr YATES: The Australasian College of Radiologists has recently produced specific guidelines with regard to the recommended protocol in artificial stone silicosis.

Mr DAVID SHOEBRIDGE: Could you provide us with that on notice?

Dr YATES: I will ask them to provide it.

CORRECTED

Dr EDWARDS: At the moment the college of radiologists are seeking a consultation before they finalise their position paper, so I would defer to the college of radiologists for the release of their document.

Dr YATES: I am sure they would be happy to help.

Mr DAVID SHOEBRIDGE: The last thing I was hoping to get from you was: Does the Lung Bus currently have the B reading process, it does not?

Dr YATES: No.

Mr DAVID SHOEBRIDGE: Even with the reader you have a 40 per cent error rate?

Dr YATES: Yes.

Mr DAVID SHOEBRIDGE: Without a B reader I assume the error rate is even higher?

Dr EDWARDS: Potentially.

Dr YATES: Potentially, yes.

The ACTING CHAIR: So the idea of getting a second bus on the road as a way of moving things along may not be particularly wise?

Dr EDWARDS: Getting a second bus on the road is highly valuable if they are asking the right questions of the right people in a location that they can access.

The ACTING CHAIR: That is what I am trying to draw out.

Dr EDWARDS: Asking the Lung Bus to do the radiology as well is questionable at best.

Dr YATES: You could put a CT scanner in a bus; it has been done. In America, for example, they do this all the time.

Mr DAVID SHOEBRIDGE: I am certain you can and I am certain you could also change the regulation to say "either a lung X-ray or a CT scan." I am sure that none of that is beyond the capacity of government.

Dr YATES: Yes, absolutely.

The ACTING CHAIR: Before we leave that point, because I think it is an important one, with the Lung Bus, on notice perhaps, you do not need to answer it straight up, but in addition to the answer to Mr Shoebridge, some further reflection about what would be your first preference in what a state-of-the-art Lung Bus would be in terms of its equipment and help us scope that out vis-a-vis what we understand to be provided for in the current Lung Bus. That might be a useful point of reference for us.

Dr EDWARDS: The simple answer is: Equivalent to a lung laboratory in terms of reliable and consistent in obtaining the respiratory function testing as well as the appropriate radiological investigation. But the other part, the pillar of diagnosis is competent people taking a competent history and documenting that in a way that we can access rather than to rely on a narrative that is collated at that point of interaction. At the moment, when we attempt to understand the exposure history of an individual we are relying on the narrative between an individual and a clinician. If the clinician does not have the tools to enable them to take a structured and informative history then all you get is a vague collection of labels relevant to the employment history of the individual—not even the roles that they were providing—and do not go back far enough in their employment history, then you are going to get nonsense in terms of understanding the exposure patterns of these individuals.

Mr DAVID SHOEBRIDGE: One of the issues in terms of diagnosis is, say, spirometry results. It is potentially subtle changes over time in spirometry that can be enormously important for a clinical diagnosis but there is no central repository of prior results. You have a worker come in, you interrogate a whole new history, the results are done but if there is no comparison to prior results you may be missing some of the key information.

Dr EDWARDS: Absolutely.

Dr YATES: You are absolutely correct.

Mr DAVID SHOEBRIDGE: How do we fix that?

Dr YATES: We fix it by getting rid of spirometry alone to begin with because spirometry alone is insensitive in the same way that chest X-rays are. You will miss majority of the pathology by just using spirometry. Secondly, you need a central database and a register so that you would feed back standardised data into a central register—

Dr EDWARDS: That is accessible by the clinician interfacing.

CORRECTED

Dr YATES: —at the time. And you need a standardised occupational repository where you put all the exposure information, again, in a centralised, presumably cloud-based system.

Mr DAVID SHOEBRIDGE: Is anyone doing that? The Queensland register? Is that registering just cases of silicosis? Is it registering the results because registering the result seems to be almost as important.

Dr EDWARDS: There is no entity currently doing it. It is in development in Victoria with the research registry associated with the case-finding activity that they have implemented down there. One of the lessons of our Queensland experience is that we did not have that registry of data. So, as an aftermath effect, we have now got a disease registry which is all about the confirmed cases. The registry in Queensland is not one that enables retrospective assessment of the exposures of that individual; it is only after they have reached the diagnosis stage. In Victoria there are two effective registries, one is the disease registry that is coming on line and the other one is an exposure registry associated with the research projects of Monash University.

Mr DAVID SHOEBRIDGE: And those are both essential, is that your evidence ?

Dr EDWARDS: It is central to Victoria.

Mr DAVID SHOEBRIDGE: No, those having a record of prior tests and prior lung test results—

Dr EDWARDS: Essential?

Mr DAVID SHOEBRIDGE: —is as essential as having a registry of actual disease.

Dr YATES: It is essential.

Dr EDWARDS: Absolutely, no question about that at all.

Mr DAVID SHOEBRIDGE: What about the concept of something like a lung passport, where a worker has just a simple document that records the results over time? Would that be a sort of interim stage, maybe?

Dr YATES: It would. I think that one has to ensure that the data that is collected is of the appropriate standard, because otherwise you may get abnormalities.

Dr EDWARDS: The problem with lung passports of that type is that they get lost and they are not available at the time that they need to be accessed.

Mr DAVID SHOEBRIDGE: If you are going to do something, do not do that; do the register?

Dr YATES: Yes, do the register.

Dr EDWARDS: Do the register. It is simple; there are plenty of models out there where it has been effective, whether you are talking about the Q fever register of people who have been vaccinated for Q fever, whether you are talking about—we have had experience of setting up these sorts of registries in the past, but they then require the ongoing administration and funding to keep them going. So they are not an insignificant expense.

Mr DAVID SHOEBRIDGE: But led by Health, you think, in that regard?

Dr YATES: Led by Health. I think it is really important to remember that the dust diseases bus will get very, very few of the people. It is a small fraction of those who are actually out there and the only way to really access those people is through the healthcare system, because the point was made much earlier that these small businesses are not covered at all. So it needs to be through Health and in conjunction with everybody else. Ideally you would have a central cloud-based repository of all information, and that is eminently practical. We do it already in the international clinical trials, so it is not something that is impossible in any way. There are lots of problems along the way but it is practical.

The ACTING CHAIR: Dr Edwards, can you provide any insights into Federal responsibilities about what the Commonwealth is likely to—if you are able to reveal such information, what the Commonwealth is looking at in terms of taking a direction on dealing with this matter, which obviously is an issue in an emerging number of States and Territories?

Dr EDWARDS: Obviously border control is a federal jurisdictional issue and so banning the product which has been talked about earlier within your Committee is a subject of further inquiry. We have had—it is not outside my authority to indicate that we have had a presentation from border protection in terms of the processes and the ability to detect the product coming into Australia. Part of the remit of the national task force is to look at the regulatory framework and to identify what changes need to be made at the model law level. There is also activity occurring in terms of the construct and the functionality of a national registry, both for an exposure registry as well as a disease registry.

CORRECTED

Obviously, while it is recognised that it is a State-based jurisdictional issue to be responsible for the work health and safety of the people of New South Wales, we also recognise that it is really important at the national level for there to be consistency and uniformity across the federation. So it is how do we actually achieve that in a way that recognises the authority and responsibility of the State-based jurisdictions as well as the need for a unified, nationally coordinated response to this epidemic. Using the silicosis phenomena as a lead into the occupational lung diseases—so the issues around how do you actually set up an appropriate register and where do you put the boundaries to that register—they are all issues that are under active consideration.

The ACTING CHAIR: Would you agree with Dr Yates that having Health, within Health—public health being at the core of this—is very important?

Dr EDWARDS: Absolutely. You asked me the comment on New South Wales. My understanding is that there are four different Ministers responsible for the different issues that are directly applicable. So we need a unified coordinated response with a lead Minister. Treasury seems the appropriate—I would point the finger in that direction. So it has to be a ministerial authorised response with each of the different stakeholders, all of which are important and none of which has a lesser role than the others, working in a coordinated and accountable way.

Mr DAVID SHOEBRIDGE: I counted three ministers, because I have icare, the SIRA, SafeWork and Health—four agencies.

Dr EDWARDS: I was given four different names.

Mr DAVID SHOEBRIDGE: If there is another one, tell me, that is what I am trying to say. I have icare SIRA, SafeWork and Health. If you have another one please tell the Committee on notice.

Dr EDWARDS: Yes, icare, SafeWork NSW, SIRA and Health are the four. My understanding is that icare ultimately reports to the Treasurer. SafeWork NSW, has a Minister or a junior Minister—exactly where it fits I am not sure; SIRA has a different ministerial—

Mr DAVID SHOEBRIDGE: Dominello—

Dr EDWARDS: And then you have got a fourth one being Health.

Mr DAVID SHOEBRIDGE: You would not start there, would you, to fix the problem? I mean you would not start with four Ministers.

Dr EDWARDS: We would like one Minister to stand up and take leadership.

The ACTING CHAIR: Indeed, that is what the question mark is.

The Hon. ANTHONY D'ADAM: Given there are some indications about the establishment of a national register should New South Wales wait or proceed immediately? Do you have a view on that?

Dr YATES: I do not see any reason to wait. We in the occupational medicine and respiratory health areas work together so we are very aware of trying to actually make the registries work in this space in a very similar way. A wait merely involves an extra, however many months at the other end.

Dr EDWARDS: There is no need for New South Wales to wait because the ultimate architecture of any register or composite registry will be that State-based jurisdictions will have a responsibility for State-based activity and then that will then pool into a national. Where the line in the sand is, however, that ends up working, that is a work in progress but there is absolutely no reason for New South Wales to sit on their hands at this point in time.

Mr DAVID SHOEBRIDGE: The Master Builders Association has an interesting proposal to address this. It recommends that in order to reduce red tape that we apply the existing asbestos safety controls to the generation, management, and disposal of silica dust. That is seen as an off-the-shelf system, apply the asbestos controls, given how dangerous this product is.

Dr EDWARDS: It is a proposal that is not without merit.

Mr DAVID SHOEBRIDGE: Do you want to take that question on notice and respond?

Dr EDWARDS: I am happy to do so.

(The witnesses withdrew.)

(Short adjournment)

CORRECTED

JONATHAN WALSH, Principal, Maurice Blackburn Lawyers, sworn and examined

TIMOTHY McGINLEY, Associate, Maurice Blackburn Lawyers, sworn and examined

JOANNE WADE, NSW Committee, Australian Lawyer Alliance, sworn and examined

The ACTING CHAIR: With respect to the submissions, just to confirm that first of all the Australian Lawyers Alliance submission is marked number 10 to the inquiry. Members have been circulated a copy of that. It can be taken as read. With respect to Maurice Blackburn Lawyers, your submission is number eight and can be taken as read. What we would like to proceed with is to invite you both as separate organisations to make an opening statement of a few minutes and once that is done open it up to questions from the members of the Committee.

Ms WADE: Today I am here representing the Australian Lawyers Alliance [ALA] being a national association of lawyers, academics and other professionals 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. The ALA promotes access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious beliefs. The ALA has made written submissions to this review and we thank you for the opportunity to give evidence to the Standing Committee. In relation to manufactured stone and engineered stone there are a few examples that the ALA would like to give if it is suitable to do that now.

The ACTING CHAIR: You may, yes.

Ms WADE: Silicosis is a disease that is preventable. It is caused by the inhalation of crystalline silica and I am sure you have already heard earlier today that engineered stone has a content of up to 90 per cent silica. We in the ALA and members of the ALA have been seeing workers coming forward with silicosis who are young, they are in their thirties and forties; even in their twenties.

A recent example is a worker aged 47 who has come forward with complicated silicosis. He has worked as a stonemason all his life since the late 1990s. He started work as a stonemason in 1998. He tells a story about the factories he worked in where dry cutting of engineered stone was a daily occurrence and was continuing right up until his diagnosis in July this year. He was diagnosed in July this year with complicated silicosis and progressive massive fibrosis. He was told on 30 July that he had those diseases and he was immediately told that he had to cease work and he cannot continue working in that industry. He is only 47 and he has no other formal training in anything else. He is now proceeding through a number of medical tests trying to understand where this disease is going to end up for him and he is not able to work.

I have a further example of another worker who is sadly now deceased. He was only 46 years old. He was diagnosed in 2017 with progressive massive fibrosis. He started in the industry in the year 2000. He, again, told a story of dry cutting. The first slab, he told us, was cut with a bridge saw—which does have a water attachment—but after the first cut is done every other cut of the stone is done by dry cutting with hand-held grinders. He talked about the factories being full of dust. It was like a snow storm; you could see dust everywhere. The dust also gathered all over the factory and was never cleaned out. His progressive massive fibrosis and complicated silicosis also led to scleroderma, and sadly it took his life at the age of 46. He left behind two young children.

Again, as I said, his story was one of dry cutting, using hand-held grinders for the cutting of the slabs. So the ALA does support and recommend that a case study for silicosis in the manufactured stone industry be undertaken, and that there be mandatory free screening for all stonemasons and workers in the industry. The ALA supports a recommendation for a New South Wales register to be established immediately. The ALA supports the New South Wales Government continuing its targeted awareness and education into the dangers associated with the manufactured stone industry.

The ACTING CHAIR: Mr McGinley and Mr Walsh, do you want to make it joint one, or do you have separate opening statements?

Mr WALSH: I will give one on behalf of both of us. Dear members of the Committee, on behalf of Maurice Blackburn Lawyers, we welcome the opportunity to contribute to this important and timely review of the New South Wales Dust Diseases Scheme. By way of introduction, my name is Jonathan Walsh. I am the principal lawyer and practice group leader for asbestos and dust diseases at my firm. Although I am now based in Brisbane I have practised in New South Wales for over 12 years and continue to do so. I am an accredited specialist in personal injuries, with a sub-specialty in dust diseases in New South Wales. I continue to represent many clients in New South Wales and Queensland—latterly, in respect to the black lung and silicosis epidemics in those states.

CORRECTED

My colleague to my right is Tim McGinley. He is an associate based here in Sydney, and he, too, specialises in asbestos and dust diseases. He, too, is an accredited specialist in personal injuries with a sub-specialty in dust diseases. Together we will be able to respond to questions related to the day-to-day interaction between our clients and the New South Wales Dust Diseases Scheme, but also provide the bigger picture perspective of how New South Wales compares with other jurisdictions with respect to how well these laws cater for the needs of people working in dusty, at-risk industries. Of course, the Committee has our copy of our submission.

The ACTING CHAIR: Yes.

Mr WALSH: More broadly, I will draw your attention to a few matters. We thought it would be worthy for us to review silicosis in context within the history of New South Wales. It has been around since the twenties and thirties in this State, and a lot of learnings can be drawn from that, but also a lot of comparisons and differences between what we are now seeing in the silicosis epidemic and what we have seen with the asbestos epidemic which commenced in the late seventies and through until today. With that context, we draw the Committee's attention to the likely increase in costs associated with silicosis. We know that there is likely to be an increase in claims related to silicosis and the consequential importance of ensuring that the Dust Diseases Authority is adequately resourced to cope with this influx.

Third, we provide our perspective on the safe handling and exposure limits. We believe that Australia is ranking behind other developed nations in the limits we set on exposure to crystalline silica. We also note that New South Wales is lagging behind other States in Australia in their requirements in relation to risk mitigation. We believe that national leadership in a coordinated response is most definitely required.

Finally, our submission discusses the need for effective screening and early diagnosis, to explore the importance of learning from international and interstate models relating to screening, and the difference that consistent data collection can make in the lives of workers. Importantly, all of our comments and recommendations are drawn directly from our experiences and those of our clients. It is their stories and their experiences within the system that drive our push for a vastly more effective and more compassionate approach to improving the lives of these workers. Maurice Blackburn is pleased to offer our experience and expertise for the Committee, and we commit ourselves to supporting the work of the Committee into the future.

The ACTING CHAIR: Thank you, Mr Walsh and Mr McGinley. That is very helpful.

The Hon. ANTHONY D'ADAM: In your submission you make a recommendation about immediately lowering the legal limit of exposure for respirable crystalline silica to 0.05 milligrams per cubic metre. We have had other evidence of the safe level actually being far below that. Is there a reason why you are recommending that particular level, as opposed to a safer threshold?

Mr WALSH: As an initial step the reduction must be by at least half and that is why we recommend 0.05 milligrams. Of course, we adopt and endorse the approach that any reduction to the exposure of crystalline silica in the workplace must occur, and must occur immediately. We know of examples in the US in particular, where the adopted standard is 0.025 milligrams per cubic metre averaged out over an eight hour shift. That is certainly something we shall be progressing towards. We heard the evidence of the occupational physicians association. With respect to some difficulty around the actual capability to measure at those levels, we nonetheless broadly adopt the position that reduction at all costs of exposure in the workplace must occur immediately.

Mr DAVID SHOEBRIDGE: A number of submissions have recommended—and, indeed, some of the witnesses we have had today have basically said—that there is really no safe way of dealing with manufactured stone, particularly when you think about the dry cutting that happens on site. That perhaps the only solution is a prohibition on this as a product. What do you say to that?

Mr McGINLEY: We would support looking into a total ban on certain high-risk products, if it can be shown that those occupational standards cannot be properly enforced. What we would say is that legislators would be have to be very careful about defining and coming up with this ban because there is no set definition of engineered stone—it is a type of composite material, which can vary between the types of manufacturers that produce it. It is not simply the silica content which makes it so dangerous, it is how the silica is held within the material. That is, it is crushed up to a very fine powder and located in the resin.

If you were to simply say, "Let's ban all products that have 50 per cent silica content in them", the effect would be that you would ban some natural granite products as well. As well as, what would stop a company from producing something that is 49 per cent silica, which would still be quite dangerous? So yes, in principle we would support a ban on high-risk products. You just have to think very hard about how you would achieve that to stop manufacturers from working around it.

CORRECTED

Mr DAVID SHOEBRIDGE: One of the suggestions was to simply ban manufactured stone as a category of building product. There was some discussion as to whether it would be resin based or ceramic based—do you distinguish between the two? A precautionary principle of banning manufactured stone for building work might be the only safe route.

Mr McGINLEY: Absolutely, that might be the only safe route but that should be properly investigated. In the interim, there are people who are still being exposed at the moment and so the most immediate thing that must be done is to increase the standards of occupational health and safety, such as reducing the respirable silica amounts standards—until legislators come up with a more comprehensive ban.

Mr DAVID SHOEBRIDGE: We can ban dry cutting today

Mr McGINLEY: Absolutely.

Mr DAVID SHOEBRIDGE: But I could walk onto a multilevel building site tomorrow and see a bunch of subcontractors with their angle grinders out, resizing manufactured stone using dry cutting. Because how do you police such a fractured industry? I do not know what your experience is of the reality out there.

Mr WALSH: There is great difficulty and complexity to the enforcement of any exposure standard or any ban on any product in Australia or any developed nation. Of course, we saw the ban of asbestos occur in 2003 in this nation, yet we see many examples of Chinese manufactured products still getting into the country—

Mr DAVID SHOEBRIDGE: But overwhelmingly that ban has been successful in reducing exposure to asbestos.

Mr WALSH: Very true.

Mr DAVID SHOEBRIDGE: That would be a case in point where you would say that bans have been effective.

Mr WALSH: Mostly effective, I would agree. It goes back to the point of having enough resources to enforce the ban in the workplaces. As you very correctly point out it is a fractured industry. Many of the workshops are small workshops of three to five employees with owner-operators running the show so it is very difficult on the enforcement front to ensure that that occurs. But I think in some ways too the banning of manufactured engineered stone is complex and problematic. An easy answer may well be to ban it outright but one would think that there is a great vacuum in knowledge as to the way in which engineering controls can be put into the workplace currently, because nothing is in fact being adhered to in most places around the nation.

So going from zero to 1,000, banning a product without actual enforcement of proper engineering controls, both around monitoring levels—so a safe exposure limit—is one of a number of control measures. Banning of dry cutting is another. The institution of wet cutting only is another. And the most effective way in which to reduce exposure to a worker is proper and adequate PPE—personal protective equipment. That is simply not being done. That is why we are seeing such an epidemic in silicosis around the nation.

Mr DAVID SHOEBRIDGE: But I think it is your Maurice Blackburn submission which says that even with wet cutting the exposure is at 4.9 milligrams per cubic metre—that is the exposure rate when you are doing wet cutting.

Mr WALSH: Yes, that is right.

Mr DAVID SHOEBRIDGE: That is, what, 196 times above what a safe standard is.

Mr WALSH: Absolutely. And significantly less than dry cutting, but as I said before—

Mr DAVID SHOEBRIDGE: Dry cutting is off the charts.

Mr WALSH: But that is one of a number of measures which needs to be cumulatively put together and implemented at the same time, not just having no dry cutting, wet cutting only, without PPE, because that simply does not make sense. So that is banning of dry cutting, it is the introduction and the mandatory use of wet cutting in conjunction with PPE, in conjunction with adequate dust extraction equipment within the workplace to ensure that respirable crystalline silica is reduced to the lowest extent possible.

Mr DAVID SHOEBRIDGE: That all sounds great but how is that going to be implemented on level 7 of a multi-storey building site that is going up five kilometres from the station at Liverpool? How is that going to implemented in the small cottage industry when you have a large subdivision in north-west Sydney? That sounds great. We could feel good passing these regulations but is that the way, ultimately, of making us safe—or making workers safe, more importantly?

CORRECTED

Mr WALSH: As indicated before, the great complexity to it is the enforcement and making sure that that occurs. Of course there are a number of practical reasons as to why it may not work as effectively as we want it to be but it will go a long way in ensuring that workers get reduced dust exposure if we implement measures now to ensure that they do occur. Then further thought can be given to dry cutting or cutting on site, which is just the preferred method of installing stone benchtops because it is more practically and commercially efficient to do so, as to whether that ought to be looked at in terms of a ban, whether all cutting needs to be done within a controlled environment in a workshop before those cut pieces of stone are taken to the worksite. Again that raises its own practical implications.

Mr DAVID SHOEBRIDGE: And just the practical reality of it. If a benchtop is provided to a building site and it is half a millimetre or three millimetres too long, are they really going to send it back to the factory to be resized or are they just going to grind it down on site? That is the practicality issue. The Master Builders Association has suggested just treat dust from manufactured stone in the same way as you would treat asbestos, with all of the existing set of controls. You just roll out the asbestos controls to dust from manufactured stone—would that be one way?

Mr WALSH: It is something that we first heard of just sitting in the audience as you raised it previous to our session here and it is something we will take on notice. There are some complexities to that but it is something that we will certainly take on notice.

The Hon. WES FANG: Ms Wade, I was just having a look through your submission and of note is the recommendation in paragraph six. You talked about the focus on non-English speaking workers. Do you have much experience with the difficulties in communicating the dangers in this product to workers who do not have an English-speaking background?

Ms WADE: There are a large proportion of workers in this industry who are non-English speaking. I have acted for a number of those workers who were of the Vietnamese background and they did not speak a word of English. In trying to educate them or enforce standards or teach them about, for example, PPE, it would need to be all in a number of different languages, not just English, so that they are understanding what needs to be done.

The Hon. WES FANG: In your experience, having dealt with a number of these cases, have you seen any common themes that are emerging?

Ms WADE: The common themes that I have seen is that nearly every worker who I have acted for and taken a history for have all been dry cutting and have not had proper PPE equipment, sometimes they are only wearing a paper mask; dust is accumulating everywhere and it is not being cleaned up at the end of the workday, so even just walking through the factory itself is dusty. For people going out installing onsite they are dry cutting and, again, with no proper PPE equipment and not cleaning up at the end of the day. All of them tell a very, very, very similar story and they all talk about the first cut is always with a bridge saw with water attached and after that everything is dry.

The Hon. WES FANG: Do you find that a lot of the people who you are representing work for companies or are they self-employed?

Ms WADE: It is a mixture. A lot of workers some are self-employed.

The ACTING CHAIR: Just the learnings we can take thus far from what is happening in Queensland and more recently we have heard about some regulatory developments in the study in Victoria, would you like to comment, particularly, Mr Walsh, in terms of your experience from Queensland?

Mr WALSH: Yes, certainly. Queensland was quite quick to ban dry cutting almost immediately. I think that was in recognition of the science and medicine around how much that would immediately reduce the workplace exposure in terms of cutting stone.

The ACTING CHAIR: Sorry to interrupt. When you say "immediately", was that done rapidly? Was a decision taken, and perhaps if you could just explain if it was a decision by an Act of Parliament or a regulation? Could you flesh it out a little bit?

Mr WALSH: There was an Act of Parliament. They only have a single system there, there is no two-tiered system like we have in New South Wales and other States. So that is possibly why the ban was introduced rapidly, as you describe it. What I think has assisted in bringing this issue to the fore and identifying those workers who are at risk is the mandatory screening of all those workers in that particular industry and that is why we have numbers in excess of 100 workers diagnosed with silicosis in Queensland, and counting, of which 15 have progressive massive fibrosis, because the mandatory screening was done.

CORRECTED

I have seen and spoken with a number of clients who but for that mandatory screening process would not have known they had silicosis and they, because they were quite young, they had their own financial commitments and mortgages and young families, were not necessarily minded to want to find out whether they had a silicosis condition because they knew what that would mean to their ability to earn an income going forward. So the mandatory screening process was able to identify those particular workers because they are at extreme risk and at least prevent them, sadly for them, from continuing to work in those dusty environments.

The ACTING CHAIR: The mandatory screening, how does that work? Are people contacted from a central point and invited or requested to participate or does it come from the other way, the individuals become aware somehow and then sort of volunteer to come forward and present themselves?

Mr WALSH: The exact mechanisms of how the mandatory screening process was implemented I am not completely across.

The ACTING CHAIR: That is fine.

Mr WALSH: However, what I do know is that it was a combination of both and that workers could seek the screening process via their GP and have that cost covered. Also, the other way in which WorkSafe Queensland was going into workshops, the larger workshops, and identifying those workers through a screening process too. So it was basically in parallel from both ways.

Mr DAVID SHOEBRIDGE: Who are your cases against? Obviously, you have got employers, but then you have also got manufacturers and you have got importers. Who has been held legally liable?

Mr WALSH: It depends on the situation. But you are right, for employers, their liability is resting with the relevant workers compensation insurer for the period of employment within which the exposure occurred is certainly one defendant. Others being product manufacturers as well. We are particularly seeing that arise in situations where workers are exposed as subcontractors, so they do not have an employer sitting above them who has the duty to design a safe system of work. They are purchasing the product wholesale from their various suppliers and they are facing a situation of having to pursue the manufacturers in those circumstances.

Mr DAVID SHOEBRIDGE: What is the capacity to hold particularly an overseas manufacturer to account?

Mr WALSH: Those issues are currently being explored through various cases before the courts. There has been no decision by any court in Australia to our knowledge of a case against an artificial stone manufacturer, but they are some complex questions that are currently being explored.

Mr DAVID SHOEBRIDGE: It seems like there are some large overseas corporate interests that are obviously making very handsome profits but it is difficult to see how they can be held to account for the damage. It seems to be very predictable damage they are causing to the workforce in Australia. How does that work?

Mr WALSH: We would draw parallels to the asbestos industry and the asbestos products that were manufactured, distributed supplied and here in this country, and the duty of care that those manufacturers had to end users, consumers of their product, where they know a dangerous substance is going into it

Mr DAVID SHOEBRIDGE: But there we had assets here that we could hold onto. At one point from memory James Hardie tried to offshore all of his assets to try and defeat those claims. How does that work with overseas manufacturers?

Mr WALSH: Overseas manufacturers have local suppliers—quite large companies in the case of some of those manufacturers. Other insurance is in place as well, which workers ultimately would need to try and access.

Mr McGINLEY: Just from a practical note as well, when you are trying to prove one of these cases, if you were to bring a claim against the manufacturer you have to prove it was their product that you were exposed to. Often an employee, if they are in a company, might not know if they were exposed to one company's product or multiple companies' products, but they definitely know who they worked for.

Mr DAVID SHOEBRIDGE: Is there a need for some kind of facilitating legislation like we have with asbestos to assist in those kinds of cases, to assist in apportioning liability or using prior cases so as you can establish liability from prior rulings to bring it into the Dust Diseases Tribunal?

Mr WALSH: Those particular procedural rules are applicable to all dust diseases and cases which are brought before that particular court, whether it is an asbestos-related disease or not, whether it is a silicosis-related disease, those procedural advantages to workers are still available to them.

Mr DAVID SHOEBRIDGE: Is that where the cases are being prosecuted?

CORRECTED

Ms WADE: In New South Wales the cases will be prosecuted and are being prosecuted in the Dust Diseases Tribunal, yes. But they do not go under the Claims Resolution Process, which is the asbestos process that deals with apportionment, contribution and compulsory mediation. But they are in the Dust Diseases Tribunal and they do have the benefit of the rules in relation to previous decisions, schedule 25 (3) material.

Mr DAVID SHOEBRIDGE: But those case management procedures, which are designed to bring cases on rapidly, to get an early resolution, they do not apply to silicosis.

Ms WADE: They do not apply to silicosis cases.

The ACTING CHAIR: With respect to the medical experts we have had before us, and we had some earlier today, I do not want to quote them specifically, but in terms of the import of what they were saying, they were suggesting to us that this is a very significant issue, there can be no question about this. Whether one would make the direct comparison to asbestos I guess is a matter of judgement. But there can be no doubt this is a very significant matter for us. In New South Wales we are certainly lagging. Would you agree with both those propositions, that this is an issue before us which we are only really starting to come to terms with and it is likely to be a significant matter? And with respect to the State of New South Wales we are lagging somewhat? Would you care to comment on both of those ones?

Mr McGINLEY: I will comment on the first part there. Yes, it is a significant issue, and with the comparison to the asbestos, silicosis presents potentially more serious, more unique problems than the previous asbestos-related illnesses that we have and the way it has happened there specifically because what you have seen with asbestos-related diseases—the cancer, mesothelioma, is the most common one that would come out that—is that, although the medical evidence says that you need about 10 years before it develops, on average it would not develop for 40 or 50 years after exposure. Often by that time people are in retirement. On top of that, the mesothelioma disease does not have a cure and has quite a short life expectancy—usually between eight and 14 months.

As a result of this, someone who gets mesothelioma in their 70s has less medical expenses because there is no treatment and because it is such a short period—as perverse as that may seem—there is less compensation for medical expenses to be sought. Because they are often retired, there is usually no loss of earnings claim. The opposite of that is true in silicosis claims. They are in their 20s, 30s and 40s, so if they are taken away from work they have a huge economic loss claim for future earnings. On top of that, while you do get some silicosis claims that have very short life expectancies, there are many claims, especially if they are found early and moved away but not early enough that they can continue working, they may be disabled and have a life expectancy for decades, in which case they will be disabled and require care and medical expenses throughout that period.

Some of those medical expenses can be quite significant. For example, a lung transplant is sometimes considered for some people when their life expectancy gets below five years. It is a very expensive procedure and the price tag that is put on the New South Wales health department says that it costs, on average, for a public hospital somewhere between $120,000 and $150,000 just for the surgery. That does not include the recovery period and the ongoing pharmaceutical needs and rehabilitation needs with that. So, yes, it is a significant issue. You might find that even if not as many cases of silicosis occur in this wave than in the previous asbestos wave, it may come at a much greater cost.

The ACTING CHAIR: That is very helpful

The Hon. ANTHONY D'ADAM: Have you read the CFMMEU's submission? It raised some concerns particularly about the notification requirements under the Work Health and Safety Act for dust exposure and also questions about mandatory monitoring under the WHS monitoring. Do you have any observations or comments about those prescriptions?

Mr WALSH: Yes, I think that is drawn from the Queensland experience in that silicosis, any pneumoconiosis—whether it is asbestosis, silicosis or coal workers' pneumoconiosis—needs to be notified via Queensland Health so that the workplace is identified as to where that occurred to draw attention, to gather the data on where these incidents and diagnoses are occurring. But it goes back to our point around enforcement. Mandatory monitoring of workplaces and of workers in those workplaces is essential to ensure that the exposure standards—whatever is adopted—are actually adhered to and that further data can be collected as to how much these workers are getting exposed to even with new or introduced engineering control measures in the workplace. We would certainly adopt and support those positions.

Mr DAVID SHOEBRIDGE: Is Queensland the best practice in Australia at the moment?

CORRECTED

Mr WALSH: In terms of covering the field, both in terms of worker monitoring, banning of dry cutting and having pneumoconiosis as an identified and notifiable disease, I believe that is correct. It is certainly leading the way in that regard.

Mr DAVID SHOEBRIDGE: Some of the evidence we had earlier was about ensuring that we have a register not only of proven incidents of lung disease but also that we have a register of all the prior tests that have been done so that a clinician who undertakes a fresh test can assess the difference between the outcomes in that test and a prior test. There was a suggestion that Victoria is moving down that path. Do any of you have any observations about that?

Mr WALSH: I think that is an eminently sensible position to take. In a practical sense we see cases day-to-day where one of the essential bits of advice we need to give our clients is around what is the rate of progression of their disease, because that factors in to not only their incapacity to earn an income but also their potential medical costs down the track and other related matters to do with care and domestic homecare and assistance and things of that nature. A lot of the times we are obtaining expert evidence for these cases and the history of that worker in their situation, how they got to this point of a diagnosis is very potted and they are often asking: Where is the latest CT scan? Where is the CT scan from years ago? Have they ever had a proper, full lung function test done?

We need to get that done now and then wait six months to see what the rate of progression is so that we can form a reasonable view as to whether they have got progressive disease. We see that practically as a problem, inhibiting our clients pursuing compensation but from a broader perspective of basic data collection, ensuring that workers attract from the very first time they exhibit symptoms to the point where they get diagnosed and some point down the track where a disease might progress and deteriorate, that type of information is absolutely critical to retain.

Ms WADE: I would support that as well.

Mr DAVID SHOEBRIDGE: Even for getting a diagnosis. There was evidence earlier today that the X-ray screening, even with a B reader—and the Lung Bus in New South Wales does not seem to have a B reader process—is missing at least 40 per cent of silicosis cases. Is that your understanding in terms of that mode?

Mr WALSH: Yes. We often liken, at least from the legal perspective, a chest X-ray as a prehistoric way in which to basically identify general disease. We often advise our clients to obtain a high-resolution CT scan as almost a first point in the evidence gathering process from the medical side of things because that is the best method to detect the nature and extent of disease at that point.

Ms WADE: All people I have seen who have been diagnosed have all had high-resolution CT scans to enable the diagnosis.

Mr DAVID SHOEBRIDGE: If you are putting thousands of building workers through the process of screening, and you are doing it with a diagnostic tool that is missing 40 per cent of instances of silicosis, how would you describe that as a system?

Ms WADE: You would have to question whether it is the right system. It might be a complete waste of money because you are not picking up the burden of the disease.

Mr DAVID SHOEBRIDGE: The evidence seems to be that is the system in New South Wales, with the Lung Bus in particular.

Mr WALSH: That is very concerning.

The ACTING CHAIR: Ms Wade, but gentlemen, you may be able to contribute as well, in terms of enabling people from the industry who receive a diagnosis to move out of that industry to further employment somewhere else, I would imagine it may provide some challenges, given the people who are drawn to work in this area. I do not know what their salary or wage is, but they may be doing reasonably well in terms of how they are doing it, and the possibility of transitioning to something else may not be to an income of equivalence, so there are challenges associated with that. Your thoughts, if you have any insights about how one can usefully go about transitioning people out of this work?

Ms WADE: It is a very challenging issue because a lot of these people who go into this industry leave school when they are 15 or 16, they do not have any other formal qualifications or education. A lot of them do not even go to TAFE. They have worked in that industry, that is all they know. Then to be told: You cannot do this work any more, you have to do something else. To go back and retrain them is very difficult for them. Also, if English is not their first language, you are adding an extra layer on top of that.

CORRECTED

Mr DAVID SHOEBRIDGE: And they can be very good at it and take pride in it and enjoy being competent at it and go to work at something that they are talented at.

Ms WADE: Yes.

The ACTING CHAIR: They are probably craftsmen in their own right in terms of the skill that they can lay a piece of this and get it perfectly synced up against the edges and symmetry inside the room.

Mr DAVID SHOEBRIDGE: When you tell them to get a new job, what do they say?

Ms WADE: I have got one particular example. I have got a young man, he was 39 when he was diagnosed. He has progressive, massive silicosis. He has left the industry. He has attempted to retrain. He has done a course at TAFE in building estimations, but he cannot get a job, because he has no experience and he is competing against people who are in their twenties, who might have a university degree, and he just keeps applying for jobs and cannot get anything.

The ACTING CHAIR: This is a particular challenge because these individuals may have decades of working life in front of them.

Ms WADE: Decades—that is right.

Mr McGINLEY: Another problem that can be faced as well is once you have got a diagnosis for one of these conditions it can actually close the door on a number of other jobs as well, particularly in the construction industry where they are likely to move in.

Mr DAVID SHOEBRIDGE: Any exposure.

Mr WALSH: An added issue is the regional nature of some of these workshops, too. These clients have grown up in regional parts of various States around the country and it is not always going to be—if they get retrained, where are the jobs for them in these regional areas? Will they will need to move with their entire family in order for them to find permanent employment again? Particularly for the decentralised State like Queensland, much it is like with New South Wales, there are various regional pockets that have supported these industries but where are these workers going to go?

Ms WADE: For workers who have worked for 10, 15 or 20 years in a factory, to tell them to go work in an office is like, "I can't do that".

Mr DAVID SHOEBRIDGE: What is your experience in terms of there being a barrier to getting diagnosed based upon the cost of screening? Is that a barrier that is in place?

Mr WALSH: From my personal experience, yes. I draw that experience from clients based in Queensland. A lot of them in the metro areas do not have too many issues because GPs are up to date on the latest screening processes and get the process going very quickly. But for those in the regional areas—

The ACTING CHAIR: Is that about Queensland because of where Queensland is on the trajectory of dealing with this or is it a statement specifically with the GPs?

Mr WALSH: I think it is both because in a perverse way Queensland had the benefit of the black lung issue and now the silicosis issue. It is a bit more up to date with the latest screening processes but I think there would be an equivalent experience for our New South Wales-based clients because a lot of the clients tell me, "I gotta go and I gotta take a flight into Townsville or some other regional centre to get the high-resolution CT scan. I cannot afford that. My employer is certainly not going to pay for that. I cannot take the time off work so I simply won't get it done." These workers feel as though they are on a time bomb but they do not want to quite find out what precisely it is at the same time, which makes it very problematic.

Mr McGINLEY: Even those who do want to get a diagnosis or are willing to see those specialists, especially in regional areas there can be quite a delay on that. I fielded a call from a gentleman a week ago who is in south-western New South Wales. His GP suspects that he has early silicosis and has given him a referral to a respiratory physician but the first time he can get on with the closest respiratory physician in his area is March next year.

Mr DAVID SHOEBRIDGE: Meanwhile, he may continue to be working.

Mr McGINLEY: He is still working.

The ACTING CHAIR: It is more than likely that he will need to work in that role.

Mr DAVID SHOEBRIDGE: icare gave us some information in advance of the hearing. Its position is that if an employer is hit with an improvement notice from SafeWork about how they deal with silicosis and if it

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is a small employer, there is no cost for the screening. If it is an employer with greater than 30 employees, then there is a 50 per cent cost for the screening but if an employer is just doing the right thing and voluntarily having their staff screened, they have to pay 100 per cent of the screening.

The Hon. TREVOR KHAN: Sorry, say that again.

Mr DAVID SHOEBRIDGE: If the employer is doing the screening because of an improvement notice from SafeWork—it has said you must get it screened because of issues in the workplace—if it is small employer it is free for the screening and if it is an employer greater than 30 employees, then they pay 50 per cent of the cost but if an employer is just trying to do the right thing and proactively having their staff screened on a voluntary basis, they have to pay full freight. For me that seems almost back to front.

Mr WALSH: It is a disincentive.

Mr DAVID SHOEBRIDGE: In fact, if you have been forced to do it because of that improvement notice, they are the people who should be paying full freight but if good employers are coming forward and saying, "We want to get people screened", that is where it should be free, surely.

Mr WALSH: Absolutely.

Mr DAVID SHOEBRIDGE: How does it work in Queensland?

Mr WALSH: With the mandatory screening process, the full cost of the screening process is now covered for the workers in those particular industries whether it is coal or in the stonemasonry industry.

Mr DAVID SHOEBRIDGE: By who?

Mr WALSH: By WorkCover Queensland.

Mr DAVID SHOEBRIDGE: I assume that you would recommend that for New South Wales it is a basic first step.

Mr McGINLEY: Yes.

Mr WALSH: There should be no disincentive to a screening of a worker who is at risk.

Mr DAVID SHOEBRIDGE: Would that include travel from a regional area for the purpose of getting the screening done?

Mr WALSH: Most certainly.

Mr McGINLEY: Absolutely.

Mr DAVID SHOEBRIDGE: Does it happen in Queensland?

Mr WALSH: It does, yes.

The ACTING CHAIR: It is very good evidence. Thank you all very much for coming along. It has been a very good to hear from you. There has been a lot of useful information. I suspect emerging from reading the *Hansard* tomorrow members may have some additional questions. Would it be okay to provide some supplementary questions if they come from the members?

Mr WALSH: Absolutely.

Mr McGINLEY: Yes.

Ms WADE: Yes.

The ACTING CHAIR: Normally the secretariat will liaise with you and there is a 21-day turnaround time.

Mr DAVID SHOEBRIDGE: You will not have to deal with us directly.

Mr WALSH: That is a shame.

The ACTING CHAIR: Once again, thank you for the good submissions, the quality evidence this afternoon and the great work you are doing representing the workers, particularly in these circumstances. Thank you all very much.

(The witnesses withdrew.)

The Committee adjourned at 15:48.