



## National Dust Disease Taskforce

### Draft Vision, Strategies and Priority Areas for Action

### Australian Institute of Occupational Hygienists Submission

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## Introduction:

The Australian Institute of Occupational Hygienist (AIOH), <https://www.aioh.org.au/>, was established in 1980 and is the largest organisation representing professionals working in occupational hygiene in Australia. Membership of AIOH is open to both professional occupational hygienists and to those with an interest in worker health protection and a healthier work environment.

Our mission is to promote healthy workplaces and protect the health of Australian workers through application of the knowledge, practice and standing of occupational health and occupational hygiene.

In 2018 the AIOH launched the Breathe Freely Australia website, <https://www.breathefreelyaustralia.org.au/> to make information readily available for workers and supervisors about the hazards and prevention of lung diseases for construction, mining and the engineered stone industries.

The AIOH is committed to supporting the NDDT Registry and has provided a number of constructive comments in our Submission.

Most important is the focus on PREVENTION of harm. The need for engineering controls, safe and healthy work practices, training and medical surveillance will make the difference to protect our workers. The incorporation of good occupational hygiene and the engagement of competent occupational hygienists are fundamental to making the improvements.

### ACKNOWLEDGEMENTS

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## Executive Summary

The Australian Institute of Occupational Hygienists Inc (AIOH) welcomes the opportunity to contribute to the deliberations of the National Dust Diseases Taskforce. The AIOH commends the Taskforce for its efforts to date and looks forward to a successful outcome.

The AIOH believes that preventing exposure to respirable crystalline silica is the most important action that must be taken to ensure that there are no further cases of silicosis. We recommend that this intent should form part of the Vision statement.

However, the AIOH also recognizes that there will be significant problems of governance to manage, to successfully drive a collective focus on the critical changes required. For this reason, it is recommended that the Commonwealth Department of Health should be the lead agency and that a multi-disciplinary unit should be created within the Environmental Health and Health Protection Policy Branch. This would enhance the policy and regulatory expertise across and within departmental structures.

In addition, the AIOH believes that there is a need for an independent Institute of Occupational Health. A proposed model for such a body is the UK Institute of Occupational Medicine (IOM).

In responding to the questions, the AIOH has made a number of constructive suggestions:

- The AIOH can assist in the development of a sufficiently resourced inspectorate, with adequate occupational hygiene knowledge, through training in *Basic Principles of Occupational Hygiene*;
- The duties under the WHS Act on PCBU's should be enforced;
- The AIOH supports the creation of a national exposures database;
- The AIOH has developed Breathe Freely Australia as a web based information resource, available for use by employers, workers, trainers and others;
- The AIOH supports a nationally consistent licensing scheme;
- The duties under the WHS Act on manufacturers, importers and suppliers must be more rigorously enforced.

We look forward to further engagement with the NDDT and remain committed to supporting them in their work.

## Consolidated recommendations

### The AIOH recommends that:

Recommendation 1. The draft Vision, Strategies and Priority Areas for Action must place a much greater emphasis on the importance of preventing exposure to respirable crystalline silica dust and other toxic dusts, thereby eliminating occupational silicosis and other occupational respiratory diseases. (Refer page 6)

Recommendation 2: The Commonwealth Department of Health create a multi-disciplinary Occupational Health Unit within the Environmental Health and Health Protection Policy Branch. (Refer page 8)

Recommendation 3: Rather than using the WHS Regulations, WHS regulators prosecute PCBUs, using the provisions under the Act relating to the primary duty of care, for more serious offences. (Refer page 11)

Recommendation 4: Where the circumstances are appropriate, WHS Regulators prosecute PCBUs under s. 19(3)(g) of the WHS Act. (Refer page 12)

Recommendation 5: Safe Work Australia, State and Territory jurisdictions consider adopting “*AIOH Occupational Hygiene Monitoring & Compliance Strategies*” for guidance of regulators. (Refer page 12)

Recommendation 6: The training module *10830NAT – Course in Crystalline Silica Exposure Prevention* be adopted as a compulsory component of the General Construction Industry Training. (Refer page 13)

Recommendation 7: Consideration be given to all regulators adopting a tailored ‘*AIOH Basic Principles of Occupational Hygiene*’ course for training of compliance officers. (Refer page 14)

Recommendation 8: Workplace exposure assessments should be conducted by competent occupational hygienists. (Refer page 15)

Recommendation 9: A national exposure database (NEDB) be created to capture exposure surveillance. (Refer page 15)

Recommendation 10: It is recommended that companies need to be licensed to operate in this industry. Licensing should operate to a uniform national standard. (Refer page 17)

Recommendation 11: The authors of the report must draft an absolutely compelling case for the government, so there is no option other than to accept and act upon recommendations. (Refer page 18)

Recommendation 12: The final report must include lessons to be learned and where appropriate should be prepared to be critical of organisational failures. (Refer page 18)

Recommendation 13: The Taskforce develop meaningful and transparent mechanisms to monitor and report on system interface performance. (Refer page 20)

Recommendation 14: The Consulting Community of Practice of Governmental Occupational Hygienists is established as an Occupational Hygiene Technical Reference Group (OH TRG). This should include a more formal reporting relationship with HWSA. (Refer page 20)

Recommendation 15: In order to foster collaboration between stakeholders, the AIOH believes that the Commonwealth Government should identify suitable models for an Australian Institute of Occupational Health. (Refer page 21)

Recommendation 16: Workplace inspections, audits and reporting should be conducted by appropriately trained WHS Compliance Officers. Moreover, visits to premises should be unannounced. (Refer page 22)

Recommendation 17: Consideration be given to amending the Industrial Chemicals (General) Rules 2019, to extend to substances such as engineered stone. (Refer page 24)

Recommendation 18: WHS Regulators consider enforcement of WHS Act s. 17 duties on Manufacturers, importers and suppliers. (Refer page 25)

## A. VISION

### Q1: Does the Taskforce's Vision resonate with you and your agency? If not, what else should be captured in the Vision?

Rather than aspiring to a future where occupational dust diseases, including silicosis, are eliminated, the Taskforce's Vision sets out a series of steps and activities the Taskforce would like to see achieved within three years. The Vision, as it stands, describes the overall objectives of the Taskforce's 3-year work plan. As such, the Vision is short-term and could potentially limit the Taskforce's impact on preventing occupational dust diseases into the future.

The AIOH's view is that a vision should set out a desired future state. For example, the AIOH vision is for a healthy workplace<sup>1</sup>, where harm to workers is prevented. We understand the intent of the Taskforce's vision would be to achieve healthy workplaces, and in this regard, we strongly support the work of the Taskforce. However, we would encourage the Taskforce to look for a lasting impact further into the future than it is currently aiming for.

Recommendation 1. It is recommended that the draft Vision, Strategies and Priority Areas for Action place a much greater emphasis on the importance of preventing exposure to respirable crystalline silica dust and other toxic dusts, thereby eliminating occupational silicosis and other occupational respiratory diseases.

### Q2: Will the Vision drive a collective focus on the critical changes required? If not, what else needs to be included to inspire and drive collective effort?

For the Vision to drive a collective focus on the critical changes required, there must be agreement and collaborative actions by all levels of government, through inter agency agreements or other administrative mechanisms, and overseen by an Inter-jurisdictional Committee (IJC). This can include expert representatives. Such an IJC will require a strong lead by the Commonwealth to moderate differences across the jurisdictions and bring about change within the timeframe set by the Taskforce. An example, particularly relevant to silicosis, was the Asbestos IDC<sup>2</sup> (not however IJC). This IDC involved Commonwealth agencies meeting to enhance coordination on asbestos policy and regulatory issues. It was noted that asbestos policy issues were a shared responsibility across Commonwealth and state and territory agencies. However, recent experience from COVID-19 has shown that even a crisis such as this failed to achieve an optimal level of co-operation between State and Commonwealth governments.

<sup>1</sup> AIOH, About Us, <https://www.aioh.org.au/who-we-are/about-us.html> Accessed 18 April 2021.

<sup>2</sup> Asbestos Interdepartmental Committee (IDC) – 1<sup>st</sup> Meeting Minutes, 21 September 2016, <https://www.homeaffairs.gov.au/foi/files/2019/fa-181101241-document-released.PDF> Accessed 17 April 2021

Another consideration is that, while most occupational health is legislated by WHS regulators, differences in jurisdictional functions are likely to mitigate against achieving a collective focus on the critical changes required. As an example, in Queensland, the state's work health and safety regulator forms part of the Office of Industrial Relations<sup>3</sup>, while other workplaces may be subject to mining legislation. By contrast, health issues are for the most part regulated by States' Department of Health.

It appears that currently, the Commonwealth Department of Health does not have any occupational health capability; nor do State Health departments. This must change if the Vision is to be successfully realized.

The AIOH is firmly of the view that there is an overwhelming need for a multi-disciplinary Institute of Occupational Health. We would propose that it be similar to institutions like the UK Institute of Occupational Medicine, which include professionals such as Occupational Physicians, Occupational Hygienists, Epidemiologists, Toxicologists, Statisticians, among other specialisations.

This body would provide timely and relevant information for decision makers on policy, conduct horizon scanning and conduct and coordinate research as described in the Draft paper. It should be noted that a motion for establishing such an Institute was raised in the Senate by Senator Richard Di Natale in 2019, and that the motion was subsequently passed<sup>4</sup>. Realistically however, it is acknowledged that this may not happen within the time frame of the Vision statement.

Therefore, it is recommended that the Commonwealth Department of Health create a multi-disciplinary Occupational Health Unit within the Environmental Health and Health Protection Policy Branch. The new Branch would benefit from the experience and knowledge of Occupational Hygienists as people who have worked in Australian workplaces, understand work practices, industry standards, engineering controls and relationships with workplace exposure standards (WES). This expertise does not exist in other Commonwealth agencies, such as Safe Work Australia.

Among possible activities, this section would have carriage of the priority action areas identified in Strategy 5:

- Interfaces between the Occupational Respiratory Diseases Registry and the Exposure Surveillance Database;
- Development, coordination and funding of research to develop the evidence base into occupational respiratory diseases;
- Horizon scanning for new and emerging issues;

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<sup>3</sup> <https://www.worksafe.qld.gov.au/about/who-we-are/workplace-health-and-safety-queensland>

<sup>4</sup> Senate, Official Hansard, Tuesday, 2 April 2019, 45<sup>th</sup> Parliament First Session—8<sup>th</sup> Period  
[https://parlinfo.aph.gov.au/parlInfo/download/chamber/hansards/1c00fc1b-688f-430a-a9b3-920bb67a6cce/toc\\_pdf/Senate\\_2019\\_04\\_02\\_7034\\_Official.pdf;fileType=application%2Fpdf](https://parlinfo.aph.gov.au/parlInfo/download/chamber/hansards/1c00fc1b-688f-430a-a9b3-920bb67a6cce/toc_pdf/Senate_2019_04_02_7034_Official.pdf;fileType=application%2Fpdf) Accessed 21 April 2021

- Providing agreed science based occupational health policy advice;
- Consultation with key stakeholders, and,
- Development, funding and coordination of research, information and practical resources on occupational health matters at a national level.

Recommendation 2: It is recommended that the Commonwealth Department of Health create a multi-disciplinary Occupational Health Unit within the Environmental Health and Health Protection Policy Branch.

It is recognized that Safe Work Australia should retain their role as lead agency in developing workplace health and safety policy. However, as this is delivered within an industrial relations framework and by definition, represents compromise agreements by the social partners, it does not necessarily equate to being best practice. Moreover, some sections of the workforce – for example the self-employed, non-unionised workers – are underrepresented.

It is important that the Taskforce defines a range of existing governance mechanisms (including relevant minister’s forums) to manage, escalate and report on significant interoperability and interface issues in a timely and sustainable manner.

To help implement the outcomes from the Taskforce, it is considered that a number of Expert Reference Committees or Technical Advisory Groups should be established, covering areas such as the relevant strategies (shown by the number):

1. Nationally consistent regulation, compliance & enforcement;
2. National targeted prevention, awareness and education;
3. Nationally consistent health screening and surveillance;
4. Support for workers;
5. Research on prevention of dust diseases (Exposure reduction and control measures);
6. National governance of occupational respiratory diseases.

### **Q3: Is the suggested timeframe for change achievable? If not, what timeframe do you suggest and why?**

The three-year timeframe appears ambitious, although this depends upon the date of commencement and upon the attainability of the selected end state descriptors and ultimately the resources made available. Assuming the recommendations of the Taskforce are all adopted by the Morrison Government, it is recognized that the next election for the House of Representatives must be held, at the very latest, by 3 September 2022<sup>5</sup>. This suggests that any action on the implementation of Taskforce

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<sup>5</sup> ‘So, when is the next election?’: Australian elections timetable as at January 2020, <https://www.aph.gov.au/About-Parliament/Parliamentary-Departments/Parliamentary-Library/pubs/rp/rp1920/Next-Election>, accessed 11 April 2021

recommendations will more likely be taken by the next government. Moreover, as this government and especially the Minister for Health, are currently focused on managing the COVID-19 pandemic and vaccine roll-out, the work of the Taskforce is not a top priority. Hence, the three-year timeframe could be imposing on the Department/Taskforce an overly tight target. This could create undue stress and be enormously damaging.

Therefore, a five-year timeframe may be more realistic. This enables for appropriate planning and budgeting. It is a concern of the AIOH that without such a plan or inadequate resources for implementation, the good work of the Taskforce will not bear fruit. Previous high-level investigations, such as the Senate Inquiry into workplace exposure to toxic dust (2006)<sup>6</sup>, ultimately failed to deliver.

One commentator noted the reason for this was, 'that the crucial problem of workplace-related disease from toxic dusts, both world-wide and in Australia, has not been one of creation of standards, but of their implementation. Standards, for example, prohibiting abrasive sand blasting and providing recommended exposure limits for respirable crystalline silica, as well as respiratory protection, worker education and regular medical examinations have been in place in Australia since the late 1960's and early 1970's. Since that time, funding has been reduced for inspectors and insufficient attention paid to increasing their powers. It is imperative that the ASCC give priority to evaluating and recommending to State and Federal governments the required numbers of occupational health and safety inspectors capable of enforcing any new national standards'<sup>7</sup>.

To ensure the successful implementation of the recommendations of the Taskforce, it is suggested that a steering committee should be established with the remit of oversight of the Vision. The Steering committee must be chaired at an appropriate level of responsibility, such as at the level of the Commonwealth Chief Medical Officer.

The report by Hall & Partners<sup>8</sup> (p. 17) includes a chart reflecting a collation of recommended actions from stakeholders specifically in relation to a phased approach over this period of time. The AIOH supports these actions and the phased approach. However, caution is urged before reducing the workplace exposure standard (WES) to 0.02 mg/m<sup>3</sup>. There is a view in the wider community that lower standards automatically equate to safer workplaces.

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<sup>6</sup> Senate Community Affairs References Committee, 2006, Inquiry into workplace exposure to toxic dust, [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Completed\\_inquiries/2004-07/toxic\\_dust/index](https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2004-07/toxic_dust/index) Accessed 11 April 2021.

<sup>7</sup> T. Faunce, H. Walters, T. Williams, D. Bryant, M. Jennings & W. Musk, (2006), Policy challenges from the "White" Senate inquiry into workplace-related health impacts of toxic dusts and nanoparticles, Australia and New Zealand Health Policy volume 3, Article number: 7 <https://link.springer.com/article/10.1186/1743-8462-3-7>

<sup>8</sup> Hall and Partners, National Dust Disease Taskforce Consultation Synthesis Report, February 2021, [https://www1.health.gov.au/internet/main/publishing.nsf/Content/562CF83B7AECFC8FCA2584420002B113/\\$File/Final-Report-Second-Phase-Consultation.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/562CF83B7AECFC8FCA2584420002B113/$File/Final-Report-Second-Phase-Consultation.pdf)

However, it is simply not possible to accurately measure dust levels at this low concentration using currently available technology<sup>9</sup>.

To enforce the law, regulators must be confident that the measurements are accurate and reliably consistent and robust enough to withstand challenge and scrutiny in court. At this proposed WES 0.02 mg/m<sup>3</sup> WES level, the analytical method approaches its limits of quantification (LoQ). In which case it is possible that some samples taken at the same site may not show evidence of exposure because of the relative variability of both the sampling and the analysis.

The real issue is still the lack of air monitoring and a failure by the WHS regulators to enforce their own legislation regarding compliance with existing exposure standards. The engineered stone industry has been operating “under the radar” and with little awareness or commitment to the basic engineering, administrative or PPE controls that would have prevented the serious health outcomes that have been identified over the last few years.

## B. STRATEGIES

### Q1: Are the identified strategies the right ones? If not, what alternate strategies do you suggest, and why?

There is a major weakness in the identified strategies. This is a lack of focus on the legislated duty of care of the manufacturers, importers and suppliers. The product stewardship aspects of the fabrication of engineered stone did not meet the standards which would be required of a chemical company introducing a toxic product.

These persons should have knowledge of the hazards and risks of their own products; they are intimately aware of the fabrication processes, appropriate engineering controls, equipment requirements, for example, dry cutting should NEVER have occurred. They are the best placed parties to advise downstream users on the means of processing engineered stone safely. There is significant evidence that manufacturers were well aware of the risks of processing engineered stone, yet they failed to adequately warn stone processors. Indeed, it is this behaviour that is now providing the basis for legal action by a number of law firms<sup>10 11</sup>. The manufacturers should also have notified the appropriate authorities, such as the Health Department and Safe Work Australia, of the hazards associated with processing their products.

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<sup>9</sup> A joint statement will shortly be issued on this subject drafted by AIOH and the National Association of Testing Authorities (NATA). This will be available on each organizations' websites.

<sup>10</sup> Shine Lawyers, Silicosis on the rise: The hidden dangers of engineered stone, <https://www.shine.com.au/blog/asbestos-and-dust-diseases/silicosis-dangers-reconstituted-stone> accessed 12 April 2021.

<sup>11</sup> Slater + Gordon Lawyers, Engineered stone silica class action, <https://www.slatergordon.com.au/class-actions/current-class-actions/silica-class-action> accessed 12 April 2021.

Strategy 1. Drive effective implementation of nationally consistent regulation, compliance and enforcement to appropriately manage the risk related to silicosis.

*Nationally consistent, easily understood and strengthened regulation, compliance and enforcement measures across all jurisdictions to ensure that workplaces minimise the risk of silicosis and improve worker knowledge and practice in relation to safe workplaces.*

PAA 1.3 This strategy is supported by the AIOH, although the lack of nationally consistent regulation is noted. A major problem with existing WHS legislation, across all the States and Territories is the failure by the regulatory agencies to enforce their own legislation. It is understood that only in the last 2-3 years has there been a blitz on stone processors. In New South Wales for example, during the period 1 July 2018 – 30 June 2019, all manufactured stone (fabrication) sites were visited - 246 sites, 523 visits (some received follow ups), with 578 improvement notices and 39 prohibition notices issued. Another 448 visits were conducted in other industries that work with silica<sup>12</sup>. Faunce et. al (2006) noted that, the infrastructure for successful implementation of national standards (including the number of occupational hygienists in government employment) has been eroded and few if any Australian companies have been prosecuted for exposing workers to the risk of dust-related disease<sup>13</sup>.

However, 15 years later, it will be interesting to see if there are any resultant prosecutions under the WHS Act (of any jurisdiction) for occupational diseases, even with fatal outcomes. Nevertheless, to more actively promote compliance activities, regulators should consider use of the duties under the Act to prosecute a person conducting a business or undertaking (PCBU) for occupational illnesses or disease. This may be difficult, but even if a prosecution fails, the validity of using the Act for prosecuting serious breaches of the duty of care for occupational health related illnesses has then been tested in court.

Recommendation 3: It is recommended that rather than using the WHS Regulations, WHS regulators prosecute PCBUs, using the provisions under the Act relating to the primary duty of care, for more egregious offences.

Under s. 19(3)(g) of the WHS Act (2011), the obligation is, “that the health of workers and the conditions at the workplace are monitored for the purpose of preventing illness or injury of workers arising from the conduct of the business or undertaking”. This is a rarely enforced duty; however, it should be relatively straightforward to obtain the evidence for a prosecution. WHS Regulators should be encouraged to enforce this duty.

<sup>12</sup> 2019 Review of the Dust Diseases Scheme Chair’s proposed pre-hearing questions SafeWork NSW, <https://www.parliament.nsw.gov.au/lcdocs/other/12505/SafeWork%20NSW-%20response%20to%20pre-hearing%20questions.pdf> Accessed 19 April 2021.

<sup>13</sup> T. Faunce et.al (2006), Op cit.

Recommendation 4: It is recommended that where the circumstances are appropriate, WHS Regulators prosecute PCBUs under s. 19(3)(g) of the WHS Act.

As regards compliance, the Taskforce will be familiar with the Safe Work Australia (SWA) publications *Workplace Exposure Standards for Airborne Contaminants*<sup>14</sup> and *Guidance on the Interpretation of Workplace Exposure Standards for Airborne Contaminants*<sup>15</sup>. These documents are provided to help those required to undertake monitoring for airborne contaminants in the workplace and to make some sense of their monitoring results in a way that is consistent with the WHS laws. To complement the above two documents, the AIOH has published a guidebook for occupational hygienists on how to interpret exposure measurements in terms of exposure standards for atmospheric contaminants and noise in the Australian occupational environment, “*AIOH Occupational Hygiene Monitoring & Compliance Strategies*” (2014). This guidance on conducting a quantitative risk assessment of workers’ exposure is now referenced in some State’s legislation, e.g., Queensland<sup>16</sup>. This is available for downloading from the AIOH website<sup>17</sup>. Since publication of the 1<sup>st</sup> edition in 2001, it has been used as the key reference in this area by occupational hygienists nationally.

Recommendation 5: It is recommended that Safe Work Australia, State and Territory jurisdictions consider adopting “*AIOH Occupational Hygiene Monitoring & Compliance Strategies*” for guidance of regulators.

Strategy 2. Implement national and targeted prevention, awareness and education strategies relating to engineered stone/silica, silicosis and other occupational respiratory diseases for duty holders, workers, health professionals and consumers.

*The public sector and industry working together to implement and promote a nationally consistent approach to awareness and prevention under a national prevention strategy.*

The AIOH supports this strategy and is already working on initiatives to deliver on some of the Priority Action Areas (PAAs):

<sup>14</sup> Safework Australia, Workplace Exposure Standards for Airborne Contaminants December 2019 <https://www.safeworkaustralia.gov.au/system/files/documents/1912/workplace-exposure-standards-airborne-contaminants.pdf> Accessed 18 April 2021.

<sup>15</sup> Safework Australia, Guidance on the Interpretation of Workplace Exposure Standards for Airborne Contaminants, April 2013 <https://www.safeworkaustralia.gov.au/system/files/documents/1705/guidance-interpretation-workplace-exposure-standards-airborne-contaminants-v2.pdf> Accessed 18 April 2021.

<sup>16</sup> Queensland Government, QGL02 Guideline for management of respirable dust in Queensland mineral mines and quarries Mining and Quarrying Safety and Health Act 1999, Version 3 April 2020, p. 6. [https://www.resources.qld.gov.au/\\_data/assets/pdf\\_file/0006/1263669/qgl02-guideline-mines-quarries.pdf](https://www.resources.qld.gov.au/_data/assets/pdf_file/0006/1263669/qgl02-guideline-mines-quarries.pdf) Accessed 18 April 2021.

<sup>17</sup> David Grantham & Ian Firth (2014), Occupational Hygiene Monitoring and Compliance Strategies, AIOH, <https://www.aioh.org.au/static/uploads/files/ohmonitoring-final-wfovgmqvbpq.pdf> Accessed 18 April 2021

PAA2.3 The AIOH has developed a substantial body of useful information relevant to silica exposure from engineered stone, as *Breathe Freely Australia*, and has made this freely available online<sup>18</sup>. *Breathe Freely Australia* is aimed at reducing occupational lung disease and also provides information relevant to construction, mining and welding. It should be noted that Safe Work Australia has committed to developing a National Awareness campaign based on the *Breathe Freely Australia* program with the AIOH<sup>19</sup>.

The AIOH is also supportive of registered training organizations (RTOs) such as those that provide nationally accredited silica awareness courses e.g. *10830NAT – Course in Crystalline Silica Exposure Prevention*<sup>20</sup>. The AIOH considers that this represents an effective and efficient means of ensuring that nationally consistent information is accessible to all people who are potentially exposed to silica. As the people in question include building trades and apprentices, the AIOH recommends that this course should be mandatory for all construction trades. This should be delivered as part of the general construction industry training, as required in accordance with Part 6.5 of the model WHS Regulations (the so-called White Card).

Recommendation 6: It is recommended that the training module *10830NAT – Course in Crystalline Silica Exposure Prevention* be adopted as a compulsory component of the General Construction Industry Training.

PAA 2.4 The AIOH strongly agrees with this PAA, i.e. Air and environmental monitoring to be conducted using a standardised approach overseen by certified occupational hygienists (COHs), who then provide this information to regulators. It should be noted that such a standardized approach should be based upon the guidelines adopted by the Queensland government<sup>21</sup>. It is considered that the creation of a national exposure database (see below) would be a strong driver for achieving nationally consistent approaches.

PAA 2.5 The AIOH recommends that the AIOH Basic Principles of Occupational Hygiene<sup>22</sup> course be used as the basis for the "appropriate training of compliance officers"; this 1-week course has been delivered over many years to many hundreds of students, to provide them with a good working knowledge of occupational hygiene. The course would be specifically tailored for compliance officers, so there would be more information on rules of evidence; sample collecting methodology to withstand legal scrutiny; interpretation of exposure standards; etc. The AIOH believes this is consistent with the findings of the Chief medical Officer that without adequate

<sup>18</sup> <https://www.breathefreelyaustralia.org.au>

<sup>19</sup> Safework Australia Members meeting 43, 12 December 2018, Agenda item 3.

<sup>20</sup> Training.gov.au, National Register on Vocational Education and Training (VET), 10830NAT – Course in Crystalline Silica Exposure Prevention, <https://training.gov.au/Training/Details/10830NAT>, Accessed 18 April 2021.

<sup>21</sup> Queensland Government, QGL02 Guideline for management of respirable dust in Queensland mineral mines and quarries, Op cit.

<sup>22</sup> AIOH, Basic Principles of Occupational Hygiene, <https://www.aioh.org.au/education-cpd/basic-principles-of-occupational-hygiene> Accessed 18 April 2021.

understanding of risk at the workplace level, the system is then dependent on having a sufficiently resourced inspectorate, with adequate occupational hygiene knowledge, to identify risks and ensure their remediation. Consultations identified that many businesses were not sufficiently informed of the risks, and that the regulator's inspection programs were not effective in ensuring compliance with occupational health standards in engineered stone related industries<sup>23</sup>.

Recommendation 7: It is recommended that consideration be given to all regulators adopting a tailored 'AIOH Basic Principles of Occupational Hygiene' course for training of compliance officers.

Regarding the use of accredited occupational hygienists, it is assumed that accreditation refers to Full Membership of the AIOH. This enables occupational hygienists to use the post-nominals MAIOH. Full Members must have completed relevant tertiary studies and have been working in the field of occupational hygiene or one of its specialist branches for more than five years in a professional capacity. Full members must be able to demonstrate to the Council that a satisfactory level of professional competence has been achieved<sup>24</sup>.

The AIOH notes that many of Australia's allied health professionals are registered under the National Registration and Accreditation Scheme (NRAS) for health practitioners. It is considered that a similar model for accreditation could be adopted for the occupational health professions. In 2010, the NSW Ombudsman noted that in relation to asbestos<sup>25</sup>, "While WorkCover recommends the services of hygienists accredited by the Australian Institute of Occupational Hygienists (AIOH), there is no legislation making this mandatory. Given the importance of this work, it seems extraordinary that any person can claim to be an occupational hygienist and engage in assessment and testing at asbestos sites without having any formal qualifications or certification.

The Ombudsman's report quoted AIOH concerns, regarding unqualified people acting as hygienists and the possible consequences:

*'A major concern of the AIOH is that there are many individuals claiming to be occupational hygienists, with no formal background in the area. It is not uncommon to see consulting companies offering services in occupational hygiene, despite having no known expertise as occupational hygienists. The consequence of unqualified, untrained and uninformed personnel advising employers on the management of*

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<sup>23</sup> National Dust Disease Taskforce Interim Advice to Minister for Health, December 2019

<sup>24</sup> AIOH, AIOH Membership, <https://www.aioh.org.au/membership/aioh-membership>

<sup>25</sup> NSW Ombudsman, Responding to the asbestos problem: The need for significant reform in NSW – November 2010, pp13-14, [https://www.ombo.nsw.gov.au/\\_data/assets/pdf\\_file/0015/3372/SR\\_AsbestosProblem\\_Nov10.pdf](https://www.ombo.nsw.gov.au/_data/assets/pdf_file/0015/3372/SR_AsbestosProblem_Nov10.pdf)

*health hazards in the workplace should be the cause of significant concern to all parties engaged in OH&S legislation’.*

AIOH recommended that consideration be given to the recognition of professionally qualified OH&S practitioners to ensure employers and employees are not subjected to unethical, inappropriate or incorrect advice”.

The AIOH believes the above statement by the Ombudsman is even more valid today, in relation to silica. To paraphrase the NSW Ombudsman (p. 14), ‘The current situation where any person can engage in work with [silica] as an occupational hygienist without qualifications or regulation is of serious concern, regardless of whether most other jurisdictions in Australia operate the same way’. The AIOH believes this can have significant repercussions on the quality of the monitoring data, advice on controls and waste of limited resources.

Recommendation 8: It is recommended that workplace exposure assessments should be conducted by competent occupational hygienists.

**Q2: Do the strategies identify the most critical areas where collective effort, resources and energy should be directed over the next few years to achieve the desired changes? If not, what other areas should be included?**

The strategies fail to address one of the more critical areas, which is that of a national exposure monitoring database. This was originally identified in the NDDT Interim report, which recommended that, “The registry should include disease notifications from all jurisdictions together with *available case finding data, exposure history and air sampling data* (author emphasis)”. It is understood that the Registry Steering Committee have determined that the Occupational Lung Diseases registry should not be linked to an air sampling database. However, the lack of a formal system to capture data about exposure and air monitoring was identified in the Interim report as an important contributor to the failure in workplaces to reduce exposure to silica dust<sup>26</sup>. Therefore, it is strongly recommended that such a database must be created to capture exposure surveillance. As part of the database involves collection of workplace exposures and work conditions, the AIOH welcomes the opportunity to assist the work on the Registry to provide input for the Worker History collection.

Recommendation 9: It is recommended that a national exposure database (NEDB) be created to capture exposure surveillance.

Why is exposure surveillance so important? Unlike disease surveillance of any condition, exposure surveillance fills an important niche in occupational

<sup>26</sup> National Dust Diseases Taskforce, Interim Advice to Minister for Health, December 2019, pp 14-15, [https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-nat-dust-disease-taskforce.htm/\\$File/nat-dusk-interim-advice-dec2019.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-nat-dust-disease-taskforce.htm/$File/nat-dusk-interim-advice-dec2019.pdf) Accessed 18 April 2021.

health because it identifies risks of ill-health, including long latency or chronic diseases, without waiting for the disease to be manifest. It allows for intervention and exposure reduction efforts to target interventions to locations already identified to be sources of exposures. In addition, it also removes any concerns of individual privacy in the reporting of health status. Exposure surveillance can also take into account the organizational context in which the exposure occurs — especially fixed industry versus mobile workforce such as construction, or on demand (gig) and freelance work, etc.<sup>27</sup>. This could also extend to cash-in-hand, casual employees and the less well organized workforce identified in the Interim Report of the NDDT<sup>28</sup>. There is anecdotal evidence that this may be a significantly sized group and that it may include school children working at weekend jobs. For this reason, it is essential that one outcome must be a leading performance indicator for exposure surveillance.

The AIOH is aware of the difficulties associated with creating such a database. We are aware that the National Mine Safety Framework Working Group spent considerable time working on such a database between 2009 and 2013. Many of the questions asked by the NDDT, were discussed at the time, and due to the differences in funding for regulators, historical capacity and the political leaning of the governments of the day there was no unified agreement.

Notwithstanding governance issues, there are significant benefits associated with an exposure surveillance database:

- It enables regulators to identify poor workplaces, for regulatory intervention;
- At risk workers are identified before developing silicosis,
- It enables referral of exposed workers to health surveillance providers;
- It enables exposed workers to be tracked over time;
- It provides high quality information for the National Occupational Respiratory Diseases Register;
- It drives standardization of sampling methodology, analytical techniques, data collection, reporting and interpretation.

## C. PRIORITY ACTIONS

**Q1: Will the key priority actions identified lead to the right recommendations, and deliver the desired outcomes?**

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<sup>27</sup> Noah S. Seixas and David Wegman, (2019) Looking Upstream, Editorial, *Annals of Work Exposures and Health*, 2019, Vol. 63, No. 5, 485–487, <https://academic.oup.com/annweh/article/63/5/485/5485363> Accessed 17 April 2021.

<sup>28</sup> National Dust Diseases Taskforce, Interim Advice to Minister for Health, December 2019, Initial finding #7, [https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-nat-dust-disease-taskforce.htm/\\$File/nat-dusk-interim-advice-dec2019.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-nat-dust-disease-taskforce.htm/$File/nat-dusk-interim-advice-dec2019.pdf) Accessed 18 April 2021.

A significant impediment to achieving the outcomes is the varied behavior of the engineered stone fabricators. Some companies, particularly smaller enterprises, consider the costs associated with workplace monitoring, health surveillance and use of effective controls to be unacceptable and therefore avoid making changes that would entail cost. This has led to ongoing problems in these workplaces. Companies that have tried to manage dust exposures through implementing controls, workplace monitoring and health surveillance, have to pass on the cost to the consumer, which in turn makes their product less competitive. One fabricator has likened this situation to a sports team competing against drug cheats. Therefore, there has to be an incentive to encourage fabricators to 'do the right thing'.

For this reason, the AIOH supports the proposed licensing scheme. For stone processors, the possibility of the business losing their license to operate is considered to be a strong motivator. This is a high-risk industry and companies need to be licensed to operate in this industry. Licensing will mean they meet high standards of exposure control and inspected on regular basis.

**RECOMMENDATION 10:** It is recommended that companies need to be licensed to operate in this industry. Licensing should operate to a uniform national standard.

**Q2: Are there any critical issues missing from the key priority actions? If so, please detail what else needs to be included.**

There is a high level of expectation in the community around the success of the Taskforce. Previous high-level inquiries, such as the Senate Inquiry into Toxic Dusts in the Workplace, ultimately failed to deliver on their promise. If the efforts of the Taskforce do not produce major changes, then it too will be judged a failure. To what extent the community will tolerate this is open to speculation, but it is certain that the level of disappointment will be high if yet another high-profile inquiry fails to deliver any lasting improvements.

Therefore, the Taskforce needs to present an absolutely compelling case for why reform is needed. It also needs to outline the cost of failure, i.e., if nothing is done. The Taskforce must clearly demonstrate that the 'do nothing' option is not open to consideration.

First, the cost of doing nothing, can be estimated in dollar terms and the cost to the tax payer. In 2008-09, the cost of work-related injury and illness in Australia was estimated at A\$60.6 billion. This was determined to be the equivalent of 4.8% of Gross Domestic Product (GDP). This figure includes direct costs, such as payments for health care and income replacement, and indirect costs, such as lost productivity and reduced quality of life. Just over

half of the total cost (51%) was due to injury, with the remainder due to work-related disease<sup>29</sup>.

In 2012–13, work-related injury and disease cost the Australian economy \$61.8 billion, representing 4.1% of GDP<sup>30</sup>. This data is the most recent available for Australia, but the figure of 4 - 5% is consistent with other Organization for Economic Cooperation and Development (OECD) member countries.

In 2019, prior to the COVID-19 pandemic, Australian GDP was estimated at \$1.95 trillion<sup>31</sup>. Projecting the estimated burden value of 4%, this gives an updated total cost estimate of \$77,912 billion, of which 49% or \$38 billion is attributable to occupational illness or disease. As occupational illness and disease is almost entirely preventable, this represents a largely avoidable cost to the Australian taxpayer and to Australian businesses.

A second significant consideration to reinforce the importance of necessary action. Unlike asbestos, which can have a latency period of many decades, accelerated silicosis is affecting young stonemasons. The first known fatality in Australia was just 35 years old<sup>32</sup>. Other young workers may be in their late twenties or early thirties and need a lung transplant to stay alive<sup>33</sup>. This means they are often parents of young families and are unable to provide the support they require. Australia is lagging behind other countries without a national resource to provide leadership and co-ordination.

**Recommendation 11: The authors of the report must draft an absolutely compelling case for the government, so there is no option other than to accept and act upon recommendations.**

A third critical consideration to be included is the question as to how this epidemic arose to such a catastrophic level in Australia. There is ample evidence of cases occurring in countries such as Spain and Israel several years before the first case was diagnosed in Australia. This case was detected in 2016 in a Vietnamese-born Australian man, after an alert clinician trained in South Africa recognised a disease that was thought to have been obsolete<sup>34</sup>. There are questions that must be asked about the behavior of the manufacturers and suppliers. However, questions must also be asked about the adequacy of the extant systems in Australia and the performance of the

<sup>29</sup> <https://theconversation.com/dying-for-work-the-changing-face-of-work-related-injuries-40328>

<sup>30</sup> SafeWork Australia, (2015), Cost of injury and illness statistics, <https://www.safeworkaustralia.gov.au/statistics-and-research/statistics/cost-injury-and-illness/cost-injury-and-illness-statistics>

<sup>31</sup> Australian Bureau of Statistics, Key Economic Indicators, <https://www.abs.gov.au/statistics/economy/key-indicators>

<sup>32</sup> Annie Guest, Her son was the first known victim in a new wave of a deadly workplace disease, now Di White is speaking out, ABC RN Breakfast, 16 August 2019, <https://www.abc.net.au/news/2019-08-16/mother-of-first-silicosis-victim-speaks/11416934> Accessed 20 April 2021

<sup>33</sup> Lisa Martin, Stonemason with lung disease says new silica dust exposure limit will 'cost lives', The Guardian 31 July 2019, <https://www.theguardian.com/australia-news/2019/jul/31/stonemason-with-lung-disease-joins-push-to-reduce-silica-dust-in-workplaces>

<sup>34</sup> D. Yates, et. al, Time for a national response to the epidemic of silicosis from manufactured stone benchtop use in Australia, Croakey, 02 October 2018, <https://www.croakey.org/time-for-a-national-response-to-the-epidemic-of-silicosis-from-manufactured-stone-benchtop-use-in-australia/> Accessed 20 April 2021.

authorities. Therefore, a critical element that must be included in the final report is “lessons learned”.

Recommendation 12: The final report must include lessons to be learned and where appropriate should be prepared to be critical of organisational failures.

### Q3: What key issues regarding the implementation of the key priority actions need to be considered?

PAA 6 indicates the requirement to establish key performance indicators and establish baseline measures in year 1. The AIOH supports this, on the basis that what doesn't get measured, doesn't get done. In this regard, it is essential to understand the difference between an Outcome metric and a Performance metric in the context of this project.

A performance metric tells how well the preventive health activities are performing that have been determined as the most likely to positively impact the outcome. These are “lead measures,” because they are proactive and drive the outcome in advance of the measurement of that outcome.

An outcome metric indicates the result of something, i.e., it is reactive. It's a “lag measure,” because once you have the measure it's done. Over. Too late to do anything with<sup>35</sup>. In this context, it appears that the proposed occupational lung disease registry will generate lag indicators. Other lagging performance measures may be generated from compensated cases, or even from the proposed notification system that is under consideration. While these are valuable, the AIOH emphasises that caution must be applied. The UK Health & Safety Executive (HSE) has recognised that recorded occurrences have an important role to play in monitoring and reducing occupational illness in the future, they also recognise the limitations of using such methods as they are dependent on the outcome measures of illnesses, which have already occurred, and as such are no longer preventable.

In a review of occupational health lead performance indicators, the HSE<sup>36</sup> suggested a range of possible types of indicators, including:

- Ratings of occupational health management systems, such as access to occupational hygiene expertise;
- Key Performance Indicators, such as percentage of workforce covered by exposure monitoring;
- Implementation of workplace risk controls, such as provision of training and PPE, hours working in exposed areas;

<sup>35</sup> Ruth Henderson, What Gets Measured Gets Done. Or Does It? Forbes June 8, 2015, <https://www.forbes.com/sites/ellevate/2015/06/08/what-gets-measured-gets-done-or-does-it/?sh=5e60606d13c8> Accessed 18 April 2021.

<sup>36</sup> Health and Safety Executive, (2009), Leading indicators for assessing reduction in risk of long latency diseases, Research Report RR734 <https://www.hse.gov.uk/research/rrpdf/rr734.pdf> Accessed 18 April 2021

- Worker surveys of awareness, attitudes and behaviours, such as awareness of health risks and attitude towards use of controls.

The AIOH agrees that the agencies identified in Strategy 6 will need to improve and formalize coordinated action. Given the interfaces between work health and safety, worker's compensation, public health systems (and possibly the Department of Education, Skills and Employment, for training), the Taskforce will also need to develop meaningful and transparent mechanisms to monitor and report on system interface performance. This will gauge the effectiveness and efficiency of the coordinated framework as described in the Vision statement.

Recommendation 13: It is recommended that the Taskforce develop meaningful and transparent mechanisms to monitor and report on system interface performance.

**Q4: To ensure the effectiveness of the proposed regulatory changes, it is important that various stakeholders work together to promote change. Do you have any suggestions to foster collaboration amongst the stakeholders, in particular (a) industry and regulators; (b) occupational hygienists and WHS regulators; (c) public health, WHS system and medical experts, and (d) overall collaboration to ensure worker safety?**

Regarding (a) it could be argued that industry and regulators are already adequately represented through their membership of Safe Work Australia. Moreover, this relationship is continued at State and Territory level, through their respective work health and safety commissions.

Regarding (b), there is an extant networking community of practice arrangement for occupational hygienists employed by Government Occupational Health & Safety regulators: the Government Occupational Hygienists Regulators (GOHR) Community of Practice. The purpose of the group is to:

1. Share Information on emerging issues and jurisdictional key focus areas and initiatives
2. Provide forums to discuss national compliance campaigns and their technical issues and solutions
3. Operate as a national knowledge resource for HWSA members and HWSA Project Working Groups in relation to worker exposure to noise, respirable particles and chemical toxicity<sup>37</sup>.

Matters are referred by the GOHR up to the Heads of Workplace Safety Authorities (HWSA). It is proposed that this group could develop a more formal reporting relationship with HWSA, say as an Occupational Hygiene Technical Reference Group (OH TRG).

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<sup>37</sup> Government Occupational Hygienists Regulators Community of Practice – Terms of Reference

Recommendation 14: It is recommended that the Consulting Community of Practice of governmental occupational hygienists is established as an Occupational Hygiene Technical Reference Group (OH TRG). This should include a more formal reporting relationship with HWSA.

Regarding (d), it is considered that worker safety should be addressed by collaboration between experts from a range of relevant disciplines, as well as from relevant Commonwealth, State and Territory agencies. This is a potentially a difficult exercise to manage various interfaces. As a point of comparison however, the AIOH has noted that in response to the COVID-19 crisis, the Australian Healthcare and Hospitals Association (AHHA)<sup>38</sup> called for an Australian Centre for Disease Control (AusCDC). The AIOH believes that the Commonwealth Government should consider the recommendations in their position paper as a suitable model for an Australian Institute of Occupational Health.

Recommendation 15: In order to foster collaboration between stakeholders, the AIOH believes that the Commonwealth Government should identify suitable models for an Australian Institute of Occupational Health.

**Q5: What mechanisms and arrangements need to be put in place to ensure the momentum generated by the Taskforce continues, and that responsible parties are held to account for the implementation of the recommendations?**

The AIOH is most anxious that the good work of the Taskforce to date should be followed up with an appropriate secondary phase of work to consolidate the findings and recommendations. Otherwise, there is a serious risk that no significant benefit will accrue to workers exposed to occupational respiratory hazards in their place of work. It would be highly unusual for the government of the day rarely to adopt all recommendations unreservedly.

In order to better facilitate the transition to the secondary phase, the final report must include a roadmap of the recommended way forward, with timelines. The potential roadmap included in the Hall & Partners' report is noted, but it is acknowledged that this is rudimentary.

One of the very first mechanisms will be to conduct a Regulation Impact Statement (RIS)<sup>39</sup>. This being so, it is anticipated that there would be appropriate consultation with stakeholders, and the AIOH looks forward to being engaged in this process.

<sup>38</sup> AHHA, An Australian Centre for Disease Control, October 2020, <https://ahha.asn.au/australian-centre-disease-control> Accessed 23 April 2021.

<sup>39</sup> Commonwealth of Australia, Department of the Prime Minister and Cabinet, 2014, *The Australian Government Guide to Regulation* [https://www.pmc.gov.au/sites/default/files/publications/Australian\\_Government\\_Guide\\_to\\_Regulation.pdf](https://www.pmc.gov.au/sites/default/files/publications/Australian_Government_Guide_to_Regulation.pdf) Accessed 15 April 2021

**Q6: Does the proposed timeframe of three years from the implementation of a nationally consistent licensing scheme by a jurisdiction allow sufficient time to collect the necessary data to support the consideration of further regulatory improvements?**

Appendix B states that adhering to appropriate laws and regulations the risk of engineered stone may be managed appropriately. It should be noted that unlike asbestos or lead, there are currently no regulations specific to silica. At the time of writing, only Victoria and NSW have OH&S Regulations specific to manufactured stone - cutting, with Victoria proposing further silica specific regulations for finalization later in 2021<sup>40</sup>.

On 28 February 2020, the Victorian Government Minister for Workplace Safety Jill Hennessy announced that Victoria would introduce Australia's first licensing scheme for engineered stone<sup>41</sup>. It was also announced that consultation was underway to design the scheme, which will ensure licensees have appropriate safety measures in place to protect workers from exposure to silica dust. However, it appears that at this time this is yet to happen – possibly due to the COVID-19 crisis.

There is also anecdotal evidence to suggest that some of the smaller states are concerned that for the relatively small number of businesses in their jurisdiction, the cost of implementing a licensing scheme is unacceptable. Therefore, the prospect of achieving a nationally consistent licensing scheme within three years appears highly unlikely.

**Q7: Licensing schemes are usually accompanied by a suite of non-regulatory measures for improved effectiveness, for example, education, auditing and reporting. How can consistency be improved in relation to the development and delivery of education and awareness sessions to PCBU's?**

Licensing of businesses has the potential to be a very effective mechanism. Consistency can be improved by limiting the ability of PCBU's to interfere with the scheme. Therefore, measures such as approved independent monitoring of workplaces are supported by the AIOH. Workplace inspections, audits and reporting should be conducted by appropriately trained WHS Compliance Officers. Moreover, visits to premises should be unannounced.

**Recommendation 16: It is recommended that workplace inspections, audits and reporting should be conducted by appropriately trained WHS Compliance Officers. Moreover, visits to premises should be unannounced.**

<sup>40</sup> SafeWork Victoria, Proposed OHS Amendment (Crystalline Silica) Regulations 2021, <https://engage.vic.gov.au/proposed-silica-regulations-2021> Accessed 19 April 2021.

<sup>41</sup> Premier of Victoria The Hon Daniel Andrews, Licensing Scheme To Boost Engineered Stone Safety, 28 February 2020. <https://www.premier.vic.gov.au> Accessed 23 April 2021.

## Other issues

This consultation paper is strangely silent on the duties on manufacturers, importers and suppliers. This is particularly relevant to recommendation #5, in the Interim report of the NDDT,

*“Develop a strategic national approach to improve Australia’s ability to detect and rapidly respond to any future emerging occupational diseases of significance<sup>42</sup>”.*

There is significant evidence to indicate that manufacturers were well aware that their products were causing accelerated silicosis in stonemasons, several years before this became known in Australia. This evidence included:

1. Reports in the Spanish media [in 2010-2011], which included reports of Caesarstone and Cosentino being prosecuted for failing to provide adequate information to fabricators;<sup>43 44 45 46</sup>;
2. After publication of the article by Kramer in *Chest Journal* [in March 2012], Caesarstone threatened legal action against the publication, which had documented the outbreak of silicosis in Israel. Originally, the article used the term “Caesarstone silicosis” in its title<sup>47</sup>, in reference to the company’s major position in the Israeli market for engineered stone. But soon after the study appeared, Caesarstone threatened to bring a lawsuit against the American College of Chest Physicians, the organization that publishes the journal, unless the term was removed<sup>48</sup>;
3. Caesarstone annual report for the period ending 12/31/2014, stated, “We are party to 60 pending bodily injury lawsuits that have been filed against us directly since 2008 in Israel or that have named us as third-party defendants by fabricators or their employees in Israel, by the injured successors, by the State of Israel or by others. ... The plaintiffs claim that they contracted illnesses, including silicosis, through exposure to silica particles during cutting, polishing, sawing, grinding, breaking, crushing, drilling, sanding or sculpting our products. ... Such claims could be asserted by claimants in different jurisdictions, including ... Australia and other markets where our products are distributed and sold and could result in significant legal expenses and damages<sup>49</sup>”.

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<sup>42</sup> NDDT, Interim report, Op cit.

<sup>43</sup> Revisión general de todas las marmolerías, (General review of all marble shops), El Pais; Madrid, 02 Apr 2010

<sup>44</sup> Catorce años sin información, (Fourteen years without information), El Pais; Madrid, 06 Apr 2010

<sup>45</sup> La fiscalía investiga los seis casos de silicosis en una empresa de Vizcaya, (The prosecution investigates the six cases of silicosis in a company from Biscay), Gorospe, Pedro, El Pais; Madrid, 06 Apr 2010

<sup>46</sup> La silicosis se enreda en Gernika (Silicosis becomes entangled in Guernica), Gorospe, Pedro . El Pais; Madrid, 29 May 2011

<sup>47</sup> Kramer, M., Blanc, P., Fireman, E., & Amital, A., Guber, A., Abdel rahman, N., & Shitrit. (2012). *CaesarStone Silicosis, Disease Resurgence Among Artificial Stone Workers*. *Chest*. 142. 419-24. 10.1378/chest.11-1321. – republished in August 2012 as: *Artificial Stone Silicosis, Disease Resurgence Among Artificial Stone Workers*, CHEST;142(2):419-424. [https://journal.chestnet.org/article/S0012-3692\(12\)60455-3/fulltext](https://journal.chestnet.org/article/S0012-3692(12)60455-3/fulltext) ;

<sup>48</sup> Popular Quartz Countertops Pose a Risk to Workers, Barry Meier, The New York Times, April 1, 2016

<sup>49</sup> Annual Report Pursuant to Section 13 or 15(D) of the Securities Exchange Act of 1934, For the fiscal year ended December 31, 2014, FORM 20-F, (Annual and Transition Report (foreign private issuer)), Filed 03/12/15 for the Period Ending 12/31/14, United States Securities and Exchange Commission, Washington, D.C. 20549, pages 9-11, [https://www.annualreports.com/HostedData/AnnualReportArchive/c/NASDAQ\\_CSTE\\_2014.PDF](https://www.annualreports.com/HostedData/AnnualReportArchive/c/NASDAQ_CSTE_2014.PDF)

It appears that when the engineered stone industry became aware of silicosis associated with engineered stone, there were limited attempts to notify processors. It is suggested that a more responsible action by the manufacturers, importers and suppliers would have been to impose a complete moratorium on supply to processors until they could ensure, through direct customer engagement, that the product was being handled safely.

It is noted that under Australian Consumer Law, suppliers are required to report any product-related death, serious injury or serious illness associated with a consumer product<sup>50</sup>. As it was, the authorities only became aware of the gravity and magnitude of the situation as cases of accelerated silicosis were reported in the media. Despite this, there appears to be no corresponding requirement for non-consumer products to be notified to authorities. Had engineered stone manufacturers notified Health authorities when they first became aware of the earliest cases of silicosis, it would have enabled governments to act more proactively. It is proposed that, if the *Industrial Chemicals (General) Rules 2019*<sup>51</sup>, were amended to include substances such as engineered stone, under the Australian Industrial Chemicals Introduction Scheme (AICIS), this may offer a relatively straightforward means of closing this loophole. This legislation is administered by the Office of Chemical Safety, within the Commonwealth Department of Health.

Recommendation 17: It is recommended that consideration be given to amending the Industrial Chemicals (General) Rules 2019, to extend to substances such as engineered stone.

The information provided by manufacturers and suppliers in the stone industry has only improved in quality in the latter part of the last decade. Nevertheless, it is still far from being of an acceptable standard. Major faults include:

- a failure to provide information on the serious nature of accelerated silicosis;
- not providing information on Australia legislation or standards;
- not providing adequate information or detail on the engineering controls to ensure the levels of dust are kept below the exposure standard;
- recommending respiratory protection that was inadequate for the purpose; and,
- not advising processors of the absolute necessity of exposed workers having regular health surveillance.

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<sup>50</sup> Australian Competition and Consumer Commission, A guide to the mandatory reporting law in relation to consumer goods, 2016  
<https://www.productsafety.gov.au/system/files/cps%20ham%20rm%20publications%20mandatory%20reporting%20guidelines%20final%20feb%202016%20%28D...pdf>

<sup>51</sup> Industrial Chemicals (General) Rules 2019, <https://www.legislation.gov.au/Details/F2019L01543> Accessed 19 April 2021.

As fabricators typically buy product from several suppliers, they would be reading different suppliers' information that was often inconsistent, conflicting and would ultimately have been confusing. Some early information, particularly from overseas suppliers did not reference Australian legislative requirements<sup>52</sup>, standards or guidance; or they referenced irrelevant and inappropriate US or EU legislation<sup>53</sup>. Other MSDSs from overseas suppliers could be so poorly translated with the resultant information being difficult to implement.

Given this lack of clear and specific direction, it would not be surprising if fabricators chose to select recommended measures that were most readily within their means. Typically, this could result in use of P1 or P2 respirators, the lowest and least effective of measures in the hierarchy of control, instead of installing more expensive engineering controls. If the manufacturers, importers and suppliers followed the example of other industries, e.g., the product stewardship code by PACIA (Plastics and Chemicals Industry Association), the engineered stone industry association could have developed information products appropriate to the nature and magnitude of the hazard. By acting in concert, this would have ensured fabricators received clear and consistent information.

The Draft report has proposed licensing fabricators (not suppliers), but it is noted that a product ban is under consideration. This should provide an incentive for the manufacturers, importers and suppliers to lift their game. However, it is also incumbent upon the WHS Regulators to ensure that these persons discharge their Risk management duties under s. 17 of the WHS Act<sup>54</sup> to the fullest extent.

**Recommendation 18:** It is recommended that WHS Regulators consider enforcement of WHS Act s. 17 duties on Manufacturers, importers and suppliers.

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## END OF SUBMISSION

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<sup>52</sup> Cosentino, Silestone, MSDS, 8<sup>th</sup>. Version, date of revision: July 2010, replaces: April 2009 version.

<https://content.cosentino.com/docs/silestone/MSDS-Silestone-EN.pdf>

<sup>53</sup> Caesarstone SDS, SDS Revision Date: December 2016, <https://mos.caesarstone.com.au/home-page/article-collection/safety-data-sheet-caesarstone-english/>

<sup>54</sup> **17 Management of risks**

A duty imposed on a person to ensure health and safety requires the person:

(a) to eliminate risks to health and safety, so far as is reasonably practicable; and

(b) if it is not reasonably practicable to eliminate risks to health and safety, to minimise those risks so far as is reasonably practicable. <https://www.legislation.gov.au/Details/C2018C00293> Accessed 22 April 2021.