SUBMISSION

Consultation Regulation Impact Statement:

Managing the risks of respirable crystalline silica at work

Instructions

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- Use the saved version to enter your responses under each question below. These questions are from the Consultation Regulation Impact Statement on managing the risks of respirable crystalline silica at work.
- Once you have completed your submission, save it and upload it using the upload your submission link on the Engage submission form.

Submissions will be accepted until **11.59 pm on 15 August 2022.**

Additional documentation

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1. Name or organisation

Australian Manufacturing Workers' Union

2. Email used to log into Engage

[redacted]

Questionnaire

(Consultation RIS questions)

Statement of the problem (Chapter 2)

2.1 Do you agree with the identified problem? Has the entirety of the problem been identified? Please provide evidence to support your position.

We do not agree that the 'identified problem' is extensive enough. The purported preliminary consultation with stakeholders which highlighted "a lack of awareness of the risks associated with RCS and a lack of clarity on how to comply with the model WHS laws", is difficult to accept particularly when our own survey of members (workers) in key industries identified 73.63% are aware of the risks of occupational silica to their health. We can only conclude this ignorance has been presented so as to misdirect stakeholders from considering the core issues which present the problems.

Matters related to RCS have been at the forefront of health and safety in Australia prior to the turn of the last century. Silicosis is accepted as a deemed disease in all Australian workers compensation jurisdictions and forms part of the SafeWork Australia Deemed Diseases in Australia Report, meeting the rigid criteria of:

1. Strong causal link between the disease and occupational exposure; and

2. Clear diagnostic criteria; and

3. The disease comprising a considerable proportion of the cases of that disease in the overall population or in an identifiable subset of the population.

It is difficult to believe that some stakeholders in the leadup to this consultation could rely on lack of awareness as a justification given the relative high attention RCS has received by both governments and media in recent years.

What is missing when identifying the problem is the root cause. What drives/motivates or causes PCBUs (regardless of size) to knowingly put workers health in jeopardy; what are the factors that lead to those PCBUs to believe they can act with impunity? Let us no longer pretend that these matters are not at play. Only when these questions are answered will solutions to the problem materialise.

Within the areas of AMWU coverage there continues to be a lack of emphasis on atmospheric monitoring (only 31.50% reported their workplace maintains air monitoring to determine the airborne concentration of silica) and health monitoring (only 14.29% reported their workplace arranges for them to attend health monitoring related to silica exposure) for RCS as is required under the WHS legislation. This is resulting in workers becoming ill before there is an identification of failures with the health and safety management systems, including failure to apply any controls, or of the controls which are in place leading to noncompliance of the legislated exposure standard and an absence of any regulatory action.

This problem is exacerbated when considering the failure of SWA to adopt the recommended health exposure standard of 0.02 mg/m³ 8-hour TWA. Excuses of uncertainty in measuring levels of RCS below 0.05mg/m³ 8-hour TWA, falls on deaf ears when workers are dying. We are concerned that SWA have not set about testing these allegations *that this level is not measurable* or if finding them credible, leading the necessary research so testing at recommended health levels could be achieved.

Testing of these excuses regarding methodology would in our view be short lived as Hygienists in Europe already use high flow air samplers to measure RCS in compliance with lowered exposure limits. Questions which arise whether developments in instrumental and analytical techniques match up with these **lower concentrations** and will enable assessment of compliance with **new (lower) WES's** have been answered. Various respirable dust samplers have been used in compliance with lowers exposure standards including the low-flow Higgins-Dewell and Dorr-Oliver cyclones and high-flow CIP 10-R and FSP-10 samplers. (Source: Utrecht University, Netherlands)

2.2 Do you have further information, analysis or data that will help measure the impact of the problem identified?

To support its submission the AMWU has surveyed its members working in at risk work environments and occupations, for exposure to RCS including,

- mining, quarrying and mineral ore treating processes
- tunnelling
- construction
- abrasive blasting
- foundry casting

Following is the result of that survey

1) Have you ever been advised (as part of your job) that you're at risk of exposure to silica?
   Yes = 38.10%
   No = 50.92%
   Don't Know = 10.99%

2) Are you aware of the risks of silica to your health?
   Yes = 73.63%
   No = 20.15%
   Don't Know = 6.23%

3) Does your workplace maintain air monitoring to determine the airborne concentration of silica?
   Yes = 31.50%
   No = 31.50%
   Don't Know = 37.00%

4) Does your workplace arrange for you to attend health monitoring related to silica exposure?
   Yes = 14.29%
   No = 69.96%
   Don't Know = 15.75%

5) Does your employer provide all of your personal protective equipment?
   Yes = 89.01%
   No = 6.23%
   Don't Know = 4.76%

6) Does your employer pay for all of your personal protective equipment?
   Yes = 89.38%
   No = 7.69%
   Don't Know = 2.93%

The AMWU also notes the contemporary research from Renee Carey, Senior Research Fellow & Lin Fritschi, Professor of Epidemiology, Curtin University and is alarmed by the statement,

"*From a cohort of 18,770,982 adult Australians in 2016, it is estimated that 5.4% (n≈1,022,150) will develop lung cancer over their lifetime, of which 1.0% (n≈10,390) are attributable to occupational exposure to RCS.*
When extrapolated to silicosis, we estimated that between 83,090 and 103,860 cases of silicosis would result from current occupational exposure to RCS".
This research suggests that the banning artificial stone could prevent 100 lung cancers and1,000 cases of silicosis. No amount of commercial profit can justify this amount of suffering. (Source: Future burden from occupational silica exposure in Australia, 2022)

Why is Government action needed? (Chapter 3)

3.1 Do you agree with the case for government intervention? Please provide evidence to support your position.

Yes, we agree with the need for government intervention, The case provided in the paper is compelling, "*Silicosis and silica related diseases pose an unacceptable health risk to workers. There are significant financial and non-financial costs associated with diagnosis of silicosis and other silica related disease, including significant physical and emotional harm, reduced ability to work, reduced quality of life and premature death of workers. There are also significant costs to the public health system, including for health screening, diagnosis, treatment, and disease management, and to the workers' compensation system*". At the same time this statement is lacking in its ability to fully articulate the need for government intervention.

The re-emergence of a scourge from another century when there are known controls and methods of monitoring clearly identifies a failure of industry, legislation, and regulation to manage the issue. There are parallels to the rise in silicosis and that of Coal workers' pneumoconiosis (black lung) in coal industry only a few years ago. Yet again self-regulation has proven to be the equivalent to no regulation, alarmingly facilitated by Australia's so-call health and safety regulators. This leaves workers with the only plausible solution for the protection of their health arising from occupational exposure to RCS being government intervention.

3.2 Do you agree with the objectives of government intervention? Please provide evidence to support your position.

The paper states, *"The primary objective of government intervention is to reduce workplace exposure to RCS and reduce the number of cases of preventable silicosis and silica related diseases, and premature invalidity or death of workers*".

We do not agree that this is reflective of what the objectives of government intervention should look like. It is suggestive of governments having an objective of acceptable illness and death rate from RCS exposure in contrast with the objectives of the model Act, which states at section 3(1)(a), "*protecting workers and other persons against harm to their health, safety and welfare through the elimination or minimisation of risks arising from work or from specified types of substances or plant*" & at section 3(2), "*In furthering subsection (1) (a), regard must be had to the principle that workers and other persons should be given the highest level of protection against harm to their health, safety and welfare from hazards and risks arising from work or from specified types of substances or plant as is reasonably practicable*".

The primary objective of government intervention must be to eliminate workplace exposure to RCS above WES levels and eliminate the number of cases of preventable silicosis and silica related diseases, and premature invalidity or death of workers.

Health and safety legislation does not and should not allow for tolerance but require compliance, thus the reason section 12 of the model Act states, *Strict liability applies to each physical element of each offence under this Act unless otherwise stated in the section containing the offence*.

Government action is needed because the interests of some stakeholders - industry, regulators, and government policy agencies - have been allowed to prevail over the health of workers.

What policy options are being considered? (Chapter 4)

4.1 Do these options address the problem? Please provide evidence to support your position.

In considering the 5 options presented by the paper it has become evident that all are inadequate.

It becomes clearer that the National Dust Diseases Taskforce got it wrong in their final report of June 2021, when putting the interests of a few stakeholders ahead of workers health with regards to engineered stone. The taskforces own papers stated "*Reform is urgently required. There is evidence to suggest that nearly one in four engineered stone workers who have been in the industry since before 2018, are suffering from silicosis or other silica dust related diseases. Existing WHS regulatory frameworks have not effectively protected people working with engineered stone*" (p7). Yet when it came to making recommendations which would effect meaningful change to create the reform they had earlier spoken of, the taskforce members stumbled, likely deluded by the sense that there is some sort of (phantom) balancing act which must be accommodated when making decisions affecting workers health.

Chapter 4.8.1 Ban on engineered stone, as found in the consultation paper does not as it proposes provide a justification for not considering a ban on engineered stone, but rather is a constructed justification of what appears to be a predetermined outcome. Stakeholders should never be bound or limited by a consultation paper and options should not be removed if they hold merit. It is noted that none of the National Dust Diseases Taskforce members were workers or representatives of workers or at risk of losing their lives from silica in the workplace. Workers should not be asked to swallow the taskforce's manicured recommendations.

Most of the options as tabled have already been implemented in one fashion or another in every health and safety jurisdiction of Australia. All jurisdictions and SWA (The Clean Air. Clear Lungs. national education and awareness campaign) have rolled out awareness campaigns often accompanied with guidance material, the ACT has adopted regulation, other jurisdictions have adopted the inadequate National Code of Practice (which only deals with engineered stone) or developed their own and Victoria have adopted an engineered stone licence.

Mirroring failure as a means of delivering consistency should not be considered in the same light as delivering necessary work health and safety reform to protect workers.

4.2 Are there any other non-regulatory or regulatory options you think should be considered to address the problem?

No

What is the likely impact of each option? (Chapter 6)

6.1 Is the cost modelling methodology appropriate to estimate the costs to industry and governments (Appendix D)? Please provide evidence to support your position.

The pretext to this question is appalling and considered a slight to all Australian workers who have been treated as a disposable commodity in the consultation paper. Cost to industry and government in this matter has inappropriately been given primacy when workers are dying, having their lives shortened and been disabled with appalling quality of life prospects. The consultation paper has got this wrong.

The false assumptions made with regards to costs to governments is absurd when noting work health and safety regulatory costs in Australia are mainly recovered from industry, not from government treasuries. Some of the assumed additional government costs are already in place and would not be created as a result of the recommendations.

A significant weakness which has been identified in the consultation paper and the cost modelling methodology is in what is missing. What does not seem to have been fully considered is the cost of doing nothing.

The complexity which has been devised in Appendix D only serves those who have designed it and as such must be approached with scepticism. We do not consider the cost modelling methodology appropriate or rational.

6.2 Are the estimates of the number of businesses covered by each of the regulatory and non-regulatory options accurate? Please provide evidence to support your position.

Click or tap here to enter text.

6.3 Are there other factors that should be considered in the assessment of the effectiveness of each option (Section 6.5)? Please provide evidence to support your position.

Click or tap here to enter text.

6.4 Are the cost and other estimates (including worker wage assumptions) listed in Appendix D accurate and appropriate? If not, please provide additional data to support a more accurate estimate of costs.

Click or tap here to enter text.

6.5 Do you have further information regarding the costs to the public health system for silicosis and silica related diseases?

Click or tap here to enter text.

Discussion of options (Chapter 7)

7.1 Which option or combination of the options presented is most likely to address the identified problem? Please provide evidence to support your position.

We do not support any of the options or combination of the options as being sufficient.

The AMWU has concluded the only way to effectively manage the health risk factors which arise from RCS is a combination of,

1. A ban on engineered stone products including a ban on the importation of such products (mirroring the bans on asbestos as adopted in 2003), and
2. Option 5b: Additional regulation of defined high risk crystalline silica processes, excluding engineered stone
   Such regulation must,
   - Require compliance with Part 3.1 Managing risks to health and safety of the model WHS Regulation
   - Require PCBUs to inform workers of the dangers of high-risk silica work – in line with the requirements in Part 7.2 of the Model WHS Regulation Lead
   - Define work/industries where mandatory silica training of workers is required
   - Define high risk silica processes
   - Require the development of a risk control plan for high-risk silica processes
   - Require the application of higher order controls and a combination of controls to all high-risk silica processes e.g. wet methods, ventilation etc.
   - Rule out the use of PPE as the sole control measure used
   - Require documentation of risk assessment which supports the control plan
   - Require the active participation of HSRs and workers deciding upon the of risk controls methods to be used
   - Require regular reporting of air and health monitoring results to the relevant H&S regulator.

We also support the position presented by the ACTU's submission, "*The CRIS presents a list of Options that have been assessed as being mutually exclusive. All regulatory frameworks must be accompanied by education and awareness programs.*
Information and education are essential to highlight the necessity to control exposures to RCS and all the health outcomes of failure to do so".

7.2 Are there any significant barriers to implementation of the options presented? What are those barriers? Is there a cost associated with them? How could they be overcome?

We recognise that the self-interest of those who profit from engineered stone products will want to present a barrier of cost. Given that their products are little more than fashion products and not a 'necessary' part of a benchtop and that other safer products are available to be used as a substitute for engineered stone products, this barrier must be set aside.

We are not of a view that additional regulation of defined high risk crystalline silica processes will present substantive barriers. The argument has failed to be made that current health and safety management systems don't exist which will reduce the risk of hazardous exposure to RCS, noting that most enlightened PCBUs already have these systems in place.

Other comment

Do you have anything further you would like to add as part of this process?

The use of the breakeven analysis (BEA) to measure the impact of each option is disturbing and offensive towards Australian workers (Breakeven analysis measures how effective an option needs to be so that the benefits outweigh the costs p51). The economy is there to serve the people of Australia, workers are not products to serve the economy. The removal of the human and emotional toll and the costs associated with grief, suffering and premature death is a poor reflection on the framing of what should have been approached as a sensitive matter with empathy.

The thinking behind applying what appears to be a linkage to what is 'reasonably practicable' in this context is improper when considering possible health and safety legislation, as opposed to managing risks and considering appropriate controls. It raises serious questions as to the suitability of the consultation paper to achieve its intended objective and raises concerns as to what can be expected in the future.

We do not consider it appropriate for a consultation paper to remove options which are viable. The option to ban engineered stone should have been presented with the barriers listed below as was done for every other option. The presentation within the paper is indicative of the agency (or their contractor) having applied a decision to which we would ask, **with what right**? There are enough barriers to protecting workers at work without them being built into consultation papers.

The whole notion that a cost-benefit analysis can be applied to workers' health and their lives is distasteful. We have been on record as opposing the use of OBPR in a work health and safety context and if nothing else this "consultation" paper about non-preferred options shows the bankruptcy of such an approach.