CFMEU
CONSTRUCTION

Submission in Response to the Consultation Regulation Impact Statement on Managing the Risks of Respirable Crystalline Silica at Work

15th August 2022

Introduction

1. In June 2022 Safe Work Australia (**SWA**) released a Consultation Regulation Impact Statement (**CRIS)** on managing the risks of respirable crystalline silica (**RCS**) at work. The objective of the CRIS is to seek stakeholder feedback on the regulatory and non-regulatory options set out in the CRIS and the associated analysis.

2. The Construction, Forestry, Maritime, Mining and Energy Union (Construction and General Division) (the **CFMEU**) is the primary union covering and organising workers in the in the building and construction industry in Australia. Our members work in a diverse range of occupations in the different sectors of the industry including excavation, stonemasonry, demolition, tunnelling, quarrying, and the off-site manufacture of building products (including but not limited to precast concrete, brick, tile and ceramics, plaster products, shop fitting and joinery) where they come into contact with materials and products containing varying levels of crystalline silica.

3. Inhaling RCS can lead to a range of respiratory diseases which can be irreversible and fatal. Whilst the dangers of working with stone and breathing in dust have been known for centuries, it is over the past 30 years that we have witnessed an upsurge in workers affected by these respiratory diseases, especially silicosis. Part of this upsurge can be attributable to the introduction of engineered stone in the late 1980's, a cheaper and lighter product than natural stone that has become the product of choice for kitchen benchtops across the world. The boom in the use of engineered stone has increased the size of the workforce using the product but we have not witnessed a corresponding increase in worker awareness of the dangers of working with the product and the use of necessary safety measures.

4. Another factor in the increase of workers with respiratory diseases is the growth in the use of mechanical devices for cutting, grinding and polishing of products containing RCS. Workers in a range of different workplaces from quarries and underground tunnelling to the tiling of walls and floors are being exposed. More cases are being found as more people become aware of the dangers and detection methods are improved.

5. The rise in the number of cases of respiratory diseases demonstrates a failure of the regulatory regime to address this major problem. If action is not taken now to protect workers and members of the general public silica may become the modern day equivalent of asbestos.

6. Over the past four years we have seen governments take more notice of this significant problem and the ACT and Victorian governments introduce regulations to limit workers exposure. But more needs to be done. The release of the CRIS by SWA is a welcome step in this process but

it has to be said, and as this submission will show, the majority of the options set out in it are inadequate to address the problem.

Statement of the Problem

7. Section 2 of the CRIS sets out a problem statement which was developed following preliminary consultation with stakeholders. In section 2.5 of the CRIS it seeks feedback on the following consultation questions related to the problem statement:

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

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

8. Putting aside what we consider to be totally inadequate stakeholder engagement (the CFMEU was not consulted) the main point we would make is that it is not only workers directly working with materials containing crystalline silica that may be exposed to RCS. Workers in close proximity and members of the general public may also be exposed (as well as family members who may be exposed through the dust on work clothes that are bought home).

9. The CFMEU would agree with the statement in 2.2.3 that the estimate of the number of cases of silicosis in Australia "*is conservative and the true number of cases may be higher*". Reliance on accepted workers compensation claims always results in an underestimation of the problem. For example, Maurice Blackburn, one of many legal firms operating in the area of workers compensation, are currently representing approximately 130 clients nationally who are suffering from silica related disease. 15 of those clients are stonemasons who are members of our Victorian Branch.

10. The situation in New South Wales is particularly concerning where SafeWork NSW has failed to satisfactorily conduct a case finding study, mandated by section 276A of the *Work Health and Safety Amendment (Information Exchange) Act 2020,* to investigate respirable crystalline silica exposure in the manufactured Stone industry.[1] This study was meant to focus on residential installations understood to be the source of much death and disease. Instead SafeWork NSW employed consultants to undertake a desktop review and between 2020 and mid 2022 SafeWork NSW only conducted eight actual inspections of residential properties.[2]

[1] Section 276A *Work Health and Safety Amendment (Information Exchange) Act 2020* - the case finding study was required to be concluded by 30 June 2021
[2] NSW Legislative Council Standing Committee Report on the 2021 Review of the Dust Diseases Scheme, p29.

The CFMEU is concerned that the extent of the silica crisis in New South Wales may remain largely hidden.

11. Further research commissioned by the ACTU[3] estimates that occupational exposure to RCS will result in between 83,090 and 103,860 cases of silicosis in coming years.

12. The CFMEU is also concerned at signs of disintegration and possible market failure within the engineered stone industry. CaesarStone now report an inability to retain insurance for damages claims for exposure to their products post 2019 - in a context of estimating global claims of at least $42 million. [4]

13. To put the problem into greater perspective we would point out that millions of homes, offices and public buildings have been fitted out with a wide range of high-silica containing products that could result in life-threatening exposures for workers and the public for decades to come. It is a looming public health crisis on a scale that has the potential to be greater than the impact of asbestos disease in Australia.

Case Study 1 – Canberra Stonemason

A 52-year-old stonemason from Canberra who worked on Parliament House was diagnosed with silicosis in 2008. He began working in the industry in 1986. The material he worked on was natural stone – marble, granite and sandstone. The only PPE he was given were goggles, earmuffs and a paper mask. The dangers of working with silica containing materials were not explained to him. He first noticed health problems in 2008 and was diagnosed the same year. He was 38 years old at the time. It took 3 years for his workers compensation claim to be approved. He has not worked in over 10 years and the associated stress it caused led to the break-up of his marriage. He has been assessed as suitable for a double lung transplant and is on the waiting list. A decision will be made about the transplant on 24th August 2022.

[3] https://www.curtin.edu.au/about/wp-content/uploads/sites/5/2022/07/FEFreport_formatted.pdf
[4] Page 52 transcript pf proceedings 16/2/22 NSW Legislative Council Standing Committee Report on the 2021 Review of the Dust Diseases Scheme see https://www.parliament.nsw.gov.au/lcdocs/transcripts/2780/Transcript%20-%20CORRECTED%20-%20Dust%20Diseases%202021%20-%2016%20February%202022.pdf .

The Case for Government Intervention

14. In section 3 of the CRIS it sets out the case for government intervention and in section 3.3 it seeks feedback on the following questions:

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

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

15. In our view the case for government intervention is a "*no-brainer*". We totally agree with the argument that '*The recent and significant increase in the number of cases of these preventable diseases and the impacts on workers, their families and communities present an urgent case for government intervention to reduce exposure to RCS at work and subsequently reduce the number of cases of these diseases*."[5]

Case Study 2 – Sydney Stonemason

A 35-year-old CFMEU member has a defacto partner and two dependent children. He has worked for several years with a stonemasonry company working with a team of mostly young men. He has worked with CaesarStone and other imported manufactured stone products. The dry cutting of manufactured stone for fitting or variations/adjustments occurred on site. He described the work with manufactured stone as "putrid" - with dust everywhere. There was no warning of danger, no information given about lung disease, no advice about the use of respirators. Respirators were often damaged and rarely replaced.

He was diagnosed with silicosis in 2018 at 31 years of age.

16. Leaving industries to self-regulate and/or a light touch by regulators has clearly not worked in protecting workers and their families, and decisive government action and enforcement is urgently needed.

[5] CRIS, p.27

17. As for the objective of government intervention as stated in section 3.2 of the CRIS we believe it does not go far enough. The primary objective should be to eliminate workplace exposure to RCS where possible. If the types of government regulation suggested in the CRIS are not effective (within a very short period of time) and there are available substitute products that contain minimal or zero amounts of silica, then bans on the use of materials containing high levels of silica should be implemented.

Policy Options

18. Section 4 of the CRIS sets out five regulatory and non-regulatory options to reduce workplace exposure to RCS and the number of cases of silicosis and silica related diseases. In section 4.9 it seeks feedback on the following questions related to the regulatory and non-regulatory options:

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

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

19. Three of the options are either non-regulatory or have no additional regulatory burden. Why they are even being considered given the depth of the crisis is unfathomable. It is very disappointing that the Regulatory Impact Analysis Guide for Ministers and National Standard Setting Bodies advises that "*the base case and at least one non-regulatory option should be included*".[6] We suggest that this is perhaps a result of the laissez-faire approach to regulation of the previous regime and is a clear indicator that the Guide needs immediate attention by the new Federal Government.

20. The remaining two options (there are really 3 as the options are numbered 4, 5a and 5b) are based on greater regulation and appear to be reflective of measures introduced by the Victorian government. Option 4 seeks to implement a national licensing framework for PCBU's working with engineered stone and is based on the *Victorian Occupational Health and Safety Amendment (crystalline Silica) Regulations 2021*.[7] The problem with this option is that it is limited to engineered stone and does not address workers using other materials and products where there is a high possibility of exposure to RCS. There is also no requirement for mandatory silica awareness training which has recently been introduced in the ACT.[8]

[6] CRIS, p.28
[7] CRIS, p.31
[8] See https://legislation.act.gov.au/View/sl/2022-12/current/html/2022-12.html and https://www.legislation.act.gov.au/DownloadFile/ni/2022-354/current/PDF/2022-354.PDF

Mandatory Silica Awareness Training in the ACT

Schedule 1 of the *Work Health and Safety Amendment Regulation 2022 (No 1)* (ACT) (made on 1st July 2022) contained a new *s.418D - Duty to train workers about crystalline silica awareness*. The new regulation, which comes into force from 1st July 2023, requires that a PCBU must ensure that the following people are trained in a course in crystalline silica awareness declared under subsection 418(D)(2)(a):

(a) a worker engaged by the person who the person reasonably believes will carry out high risk crystalline silica work in the business or undertaking;

(b) a worker engaged by the person in an occupation declared under subsection (2)(b).

The *Work Health and Safety (Crystalline Silica Awareness Training Course and Occupations) Declaration 2022* declares the 10830NAT – Course in Crystalline Silica Exposure Prevention as the prescribed course for the purposes of s.418D(2)(a). The Declaration further declares the occupations required to be trained in a course in crystalline silica awareness declared under section 418D(2)(a).

21. Options 5a and 5b are stated to include requirements in addition to option 3 by way of requiring PCBUs to conduct a risk assessment and to develop and implement a silica risk control plan if they or their workers undertake a high crystalline silica process, and to provide all results of health monitoring and workplace air monitoring to the WHS regulator within 30 days of receiving reports.

22. Option 5b is said to be different to 5a because it excludes engineered stone. According to the CRIS this would allow the regulation of high risk crystalline silica process for CSC materials except engineered stone to be implemented in combination with a national licensing framework for PCBUs working with engineered stone (option 4).[9] The wording of the CRIS

[9] CRIS, p.34

is not entirely clear on this point, if option 5b is a combination of a national licensing scheme for engineered stone (option 4) and option 5a then it should clearly say so. Both of the options 5a and 5b fail to include a requirement for mandatory silica awareness training.

23. Section 4 of the CRIS also contains a section on options that were considered, but assessed as infeasible. These options were:

    4.8.1 Ban on engineered stone

    4.8.2 Replacement of chest X-Ray with low dose High Resolution Computerised Tomography in the minimum regulatory requirements for health monitoring

    4.8.3 Cost recovery of activities related to licensing of PCBUs working with engineered stone

24. It would appear that these options were not included in the CRIS because either the National Dust Disease Taskforce's Final Report did not recommend them (in the case of a ban on engineered stone), or if it did recommend them it found other reasons not to include the option (in the case of low dose [HRT] scans and cost recovery activities).

25. None of the grounds for not including them are particularly convincing. The CFMEU remains concerned that the failure to consider a ban on engineered stone may be largely associated with the extraordinary influence of the engineered stone lobby. Whilst this option remains out of scope the proposed regulatory responses will pay lip service to the workplace, work health and safety issues arising from silica exposure.

26. A ban on engineered stone would be consistent and compliant with the Hierarchy of Control – which is what all the OHS/WHS legislative frameworks are based and founded upon. Next down the hierarchy is Substitution – which is again consistent with banning engineered stone.

27. Both options would need to be deemed "*impracticable*" if we are not going to follow the Hierarchy. This is arguably impossible to justify because the definitions of what is "*reasonably practicable*" under all of the State and model legislative frameworks (i.e. Model Act Section 18, Vic Act Section 20(2)) will always make eliminating and/or substituting a "*hazardous and dangerous*" product a viable and safer alternative.

28. Further, we see no reason why the use of low dose HRT scans has been excluded as being out of scope. The West Australian government has successfully introduced a requirement that respirable crystalline silica health monitoring be carried out using a low dose high resolution computed tomography scan supervised by an appointed medical practitioner.[10] This is

[10] *Amended Schedule 5.3 of the Occupational Safety and Regulation 1996*

particularly important in the context of what is understood to be a poor response by state safety regulators and subsequent low reporting rate of injury.

Likely Impact of Each Option

29. Section 6 of the CRIS sets out how the impact of each option was measured. Following consultation with the OBPR a combination of multi-criteria analysis (MBA) and breakeven analysis (BEA) was used.

30. In section 6.8 of the CRIS it seeks feedback on the following consultation questions related to the impact analysis:

    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.

    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.

    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.

    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.

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

31. As with all economic modelling if the assumptions or inputs are wrong then so are the results. There are so many issues with the modelling used that it would be an exercise in futility to explain them all. One simple example is the underestimation of data concerning illness and injury which, combined with the risks of market failure at the industry level (see paragraphs 8 to 13 above), bring into question the statistical basis upon which the breakeven analysis presented in the CRIS represents a genuine statement of the extent of the economic and social costs associated with crystalline silica exposure.

32. Further the failure to consider the substitution of hazardous engineered stone products for non-hazardous low silica or non-silica options, which is the lowest cost option in the medium to long-term, is a glaring omission. By failing to consider the practical implications of a ban on engineered stone the breakeven analysis does not represent a true consideration of the actual range of options available.

33. The final point we would make on this section is that we consider it immoral to even contemplate using the breakeven analysis when considering the health and safety of workers. Workers are real people and so are their families. If a risk to their health and safety can be avoided by putting in place more controls on the use of hazardous materials and/or substitution of some or all of the hazardous materials, then the controls and substitution must be enacted.

Discussion of Options

34. Section 7 of the CRIS provides a discussion of the options, and in section 7.7 it seeks feedback on the following consultation questions related to the regulatory and non-regulatory options presented:

    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.

    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?

35. The CFMEU response is that the options provided are inadequate. What is needed now is one option that combines the following:

    (a) option 4;
    (b) option 5b;
    (c) mandatory silica awareness training (as has been introduced in the ACT);
    (d) a ban by the Commonwealth on the importation of engineered stone;
    (e) the introduction of regulatory controls to implement a future ban on the use of engineered stone;
    (f) a regulatory requirement to use low dose High Resolution Computerised Tomography for health monitoring unless a worker is advised by their medical practitioner to use another method; and
    (g) the introduction of cost recovery for the licensing of PCBU's working with engineered stone.

36. There are no significant barriers to introducing this combined option. The costs to industry and governments are not substantial and pale into insignificance compared to the costs to workers and their families of not taking action now.