maurice blackburn lawyers

31 March 2023

Safe Work Australia

Consultation on the Prohibition on the Use of Engineered Stone

GPO Box 641

Canberra ACT 2601

By Online Upload

Dear Madam/Sir,

We welcome the opportunity to provide feedback in relation to Safe Work Australia's Consultation on the Prohibition on the Use of Engineered Stone.

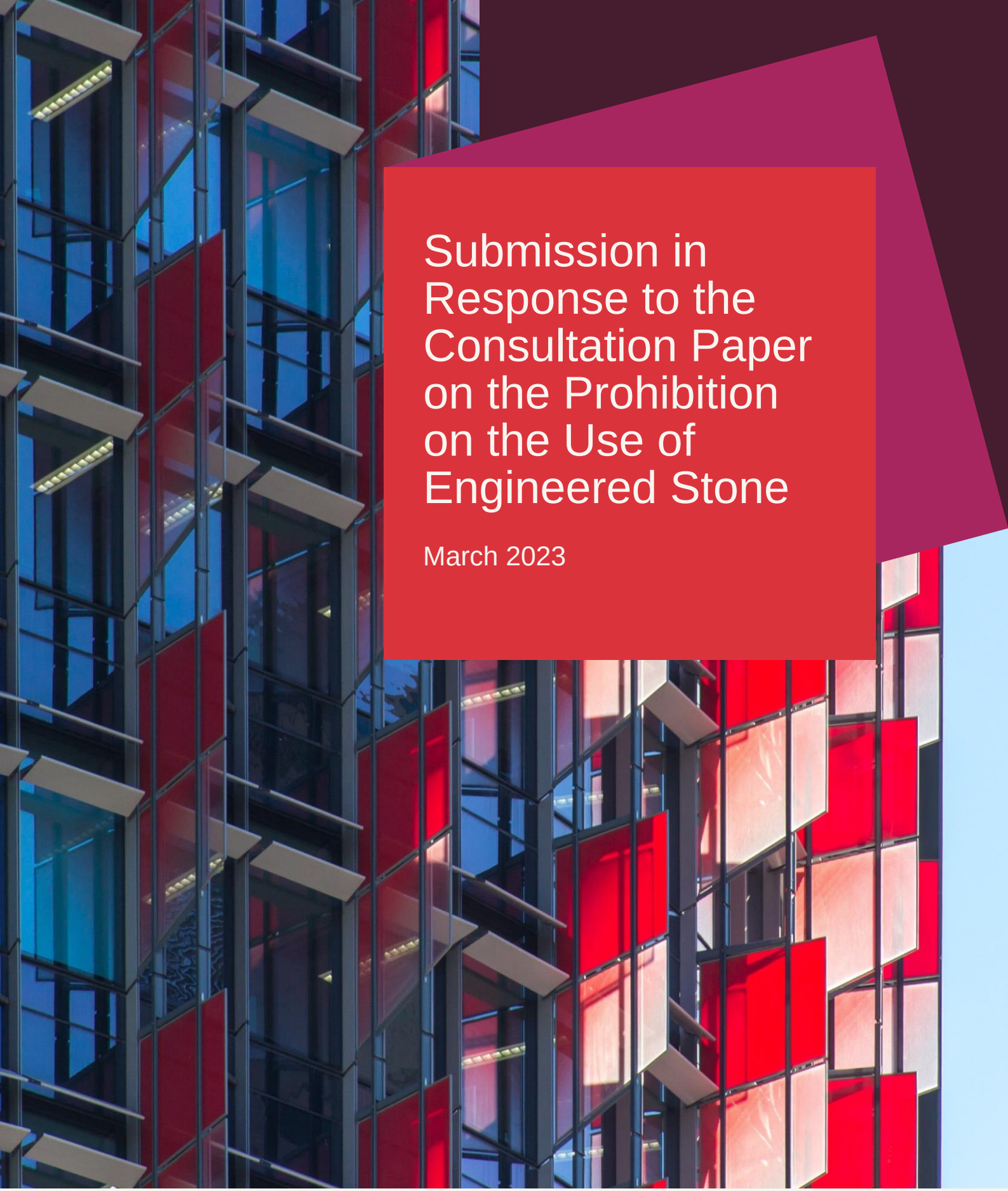
Please do not hesitate to contact me and my colleagues on [redacted] or at [redacted] if we can further assist with Safe Work Australia's important work.

Yours faithfully,

[redacted]

Jonathan Walsh

Principal Lawyer
Maurice Blackburn Lawyers



Submission in Response to the Consultation Paper on the Prohibition on the Use of Engineered Stone

March 2023

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Introduction

Maurice Blackburn Pty Ltd is a plaintiff law firm with 34 permanent offices and 30 visiting offices throughout all mainland States and Territories. The firm specialises in personal injuries, abuse law, medical negligence, employment and industrial law, dust diseases, superannuation (particularly total and permanent disability claims), negligent financial and other advice, and consumer and commercial class actions.

Maurice Blackburn employs over 1000 staff, including approximately 330 lawyers who provide advice and assistance to thousands of clients each year. The advice services are often provided free of charge as it is firm policy in many areas to give the first consultation for free. The firm also has a substantial social justice practice.

Maurice Blackburn operates nationally across various practice areas including asbestos and dust diseases. As a firm we strive to support clients and their families to achieve access to justice, by ensuring they can access entitlements through compensation payments and medical and other compensable services.

Our Submission

Maurice Blackburn is grateful for the opportunity to contribute to this important public policy discussion.

Our main response to the options included in the consultation paper is that:

- Option one is our preferred option
- Option three should be adopted should option one not be implemented
- Option two is unacceptable

Maurice Blackburn has consistently argued that the major factor underlying the increasing rates of accelerated silicosis in Australia is not just the proliferation of engineered stone but more critically, the abominable work practices which have underpinned its use.

We are now at the point of saying that enough time has passed to assume that regulatory interventions have failed to stop or significantly reduce diagnoses – either because those interventions have not worked, or have not been implemented. We now believe that the imposition of a ban has now become the only meaningful way of preventing deaths and instances of severe chronic lung diseases.

We do not accept that a ban on engineered stone will lead to the decimation of the industry. It is not difficult to believe that, should a ban be imposed, market forces would drive innovation and alternative, safer products would be created to replace those silica-based products that are subject to the ban. This would be a very acceptable outcome.

All Maurice Blackburn contributions to public policy discussions are based on the lived experience of the clients we serve. To that end, we have restricted our commentary to those consultation questions which have direct relevance to our experience and expertise as legal professionals.

Responses to Consultation Questions

Q1. Do you support a prohibition on the use of engineered stone?

Yes.

Option one, as described in the Consultation Paper, is our preferred option.

For more than 5 years, Maurice Blackburn advocated for the banning of engineered stone products, if regulatory changes led to no discernible improvements in the rates of diagnosis.

Those regulatory changes might include:

- The immediate, nationally consistent adoption of mandatory forms of wet cutting;
- The immediate, nationally consistent adoption of an exposure standard for respirable crystalline silica of 0.025 milligrams per cubic metre (per 8 hour shift).
- The immediate adoption of mandatory minimum forms of PPE when dealing with engineered stone, including but not limited to oxygen fed, fully enclosed respirator masks;
- The immediate adoption of mandatory usage of approved vacuum fed cutting and grinding equipment;
- The immediate adoption of mandatory forms of dust extraction and ventilations systems in all workplaces where stone is cut;
- Better and more thorough health surveillance; and
- A tangible and visible increase in the activity of regulators in ensuring employers are providing the above.

We have consistently argued that the major factor underlying the increasing rates of accelerated silicosis in Australia is not just the proliferation of manufactured stone but more critically, the abominable work practices which have underpinned its use.

We are now at the point of saying that enough time has passed to assume that regulatory interventions have failed to stop or significantly reduce diagnoses – either because the above interventions have not worked, or have not been implemented. The imposition of a ban has become the only meaningful way of preventing deaths and instances of severe chronic lung diseases.

It is worth noting that asbestos was banned in Australia a little over 80 years after it was first produced here.[1] It has caused the deaths of tens of thousands of Australian workers.[2] Even after the ban, it is still claiming hundreds of lives each year due to exposure decades earlier.

It is also worth noting that, in the lead up to the ban on asbestos, the asbestos industry argued passionately that a ban was unnecessary, too expensive to implement, and a disproportionate response to the issues at hand.

Public attitudes toward a ban vary greatly. While some laud engineered stone as an affordable alternative to real stone or marble, we believe that large numbers of consumers would be horrified with the thought that an essentially decorative product in their kitchen could have led to serious illness and death in its production and installation in their homes.

[1] https://www1.health.gov.au/internet/publications/publishing.nsf/Content/asbestos-toc~asbestos-when-and-where

[2] The Asbestos Council of Victoria estimates that asbestos related disease costs over 4,000 Australian lives every year. https://gards.org/asbestos-related-disease-facts-and-figures-australia-2018/#

The hierarchy of controls regime which dominates OHS policy cites 'elimination of the risk' as being the highest priority. Surely a ban on harmful products would tick that box just as it did with asbestos in 2003 (but altogether far too late for literally thousands of Australians). As a nation, we cannot consign whole new generations of silica exposed workers to the same indolent and frankly, reckless policy inaction as we did when it came to the asbestos manufacturing industry and asbestos based products.

Maurice Blackburn is yet to see a properly argued downside of imposing a ban.

We understand that such a ban would force change to the work practices of a relatively small number of employers, who are currently engaging in business activity which continues to prove dangerous to their workers.

We do not accept that a ban on engineered stone will lead to the decimation of the industry. It is not difficult to believe that, should a ban be imposed, market forces would drive innovation and alternative products would be created to replace those silica-based products that are subject to the ban. This would be a very acceptable outcome.

The economic impact of the change, within the industry, is minuscule – particularly compared to the economic impacts associated with workers becoming ill and losing their capacity to work and the consequent multiplicative cost and strain on our already stretched State and Territory health systems.

It is worth remembering that it is estimated that 4,400 stonemasons are currently employed in Australia[3], but it is also estimated that 600,000 workers are potentially exposed to silica dust each year[4]. The industry is much bigger than just kitchen renovations.

It should be noted that a ban will not provide a panacea for ending workplace silicosis. Even the cutting of a lower silica content product (or a natural stone), in a workplace with poor controls has and will lead to poor health outcomes for its workers. But, in the absence of adequate regulation and compliance, it will go a long way toward reducing them.

Q2. If yes, do you support a prohibition on the use of all engineered stone irrespective of its crystalline silica content?

Yes.

As noted above, option one, as described in the Consultation Paper, is our preferred option.

Our perspective on this issue is derived from our caseload, which includes hundreds of clients whose lives have been impacted by their contact with engineered stone.

Please see our response to question 6 for more on 'irrespective of its crystalline silica content'.

Q3. If no, do you support a prohibition of engineered stone that contains more than certain percentage of crystalline silica?

N/A

[3] Ref: https://labourmarketinsights.gov.au/occupation-profile/stonemasons?occupationCode=331112

[4] Ref: https://lungfoundation.com.au/news/national-silicosis-prevention-strategy-consultation-period-closing-soon-amidst-call-for-ban-of-engineered-stone/

Q4. How many businesses work with engineered stone only?

No response to this question.

Q5. How many businesses work with both engineered stone and non-engineered stone products?

No response to this question.

Q6. Do you have any data or information on the risks to workers from the other non-crystalline silica elements of engineered stone? Are these risks increased in engineered stone of less than 40% crystalline silica content?

The Consultation Paper tells us that:

> *Safe Work Australia is not aware of evidence that 40% crystalline silica content represents the threshold between lower risk and higher risk engineered stone products.* (p.4)

We share SWA's lack of confidence in this number.

The 40% figure seems to represent industry attempts to ringfence some materials from a ban and/or to salvage a market for their products, seemingly with disregard to any established medical or scientific evidence and the impacts on worker and consumer health.

We reiterate that even the cutting of a lower silica content product (or a natural stone), in a workplace with poor controls has and will lead to poor health outcomes for workers.

In the absence of an appropriate evidence base, it is essential that the determination of what threshold determines what is and what is not a dangerous product must rest with medical science. We understand there is a growing body of medical opinion that using any product with more than 10% silica content is likely to lead to poor health outcomes. If medical science is recommending that as a more appropriate threshold, we urge SWA to adopt it in its recommendations.

Our position that all engineered stone, regardless of silica content, should be banned is based upon our clients' experience that any silica-bearing product has the potential to poison. Silicosis aside, these materials also cause cancers and multiple myeloma.

Q7. In relation to Option 3

a) Do you have any information on the additional benefits of a licensing scheme over the enhanced regulation agreed by WHS ministers (Option 5a) that would already apply to engineered stone products containing less than 40% crystalline silica content?

b) feedback on the implementation of concurrent licensing schemes for both prohibited engineered stone and non-prohibited engineered stone?

As noted earlier, Maurice Blackburn's response to the options included in the consultation paper is that:

- Option one is our preferred option
- Option three should be adopted should option one not be implemented
- Option two is unacceptable

A prohibition, but with limited exceptions for products containing lower percentages of silica content would have some benefit to workers and their families, as long at the percentages are informed by medical evidence (see our response to question 6).

As outlined in option three, those working with products exempted from the prohibition would be bound by licensing requirements.

As SWA will be aware, the Victorian licensing scheme set a deadline for licences to be in place by November 2022. As such, it is too early to be able to confidently estimate the effectiveness of this system in instituting meaningful change, or to derive data about, for example, the rates of compliance with the exposure standard.

We suggest that SWA seek information from the Victorian regulator about the implementation of their licensing scheme, and request any early reports of challenges and benefits which could inform SWA's considerations in this space.

While Maurice Blackburn supports the idea of a licensing scheme, scheme design and implementation are pivotal to ensuring it achieves its stated aims.

Q8. Are the assumptions and scenarios described for Option 6 in the Decision RIS accurate and appropriate?

Maurice Blackburn understands that an essential function of any Regulation Impact Statement is to describe the potential costs and benefits of the various policy options, in order to inform an assessment of a preferred model.

We believe, however, that the lenses adopted for the assessment of Option 6 in the Decision RIS, like the assessment of the other options, are far too narrow.

Discussion of the impact on individuals and the community is severely lacking, with the impact analysis skewed in favour of an economic analysis of impacts on business.

The lived experience of sufferers of work-related lung diseases, including severe forms of silicosis and silica induced auto-immune diseases, is that their families and communities are comparatively devalued. Indeed, within the parameters of the DRIS, it is treated as being unimportant.

We believe that the DRIS would benefit from a greater analysis of the physical, social and psychological impacts (and benefits) for individuals and their families, as a result of each option. Indeed, to ignore these very significant impacts of favour of what is virtually a strict economic analysis of new regulation means that the DRIS will grossly undervalue the true costs of the impact of the RCS disease in Australia and therefore any potential new regulation will be necessarily sub-optimal.

We make the following specific points in relation to the content of section 6 of the DRIS:

In relation to section 6.3:

For many small and medium sized traders, the cost of switching to safer products would be more viable than the costs associated with ensuring their plant and equipment are compliant

with new safety requirements, should they continue to focus their business around dangerous products.

The construction/home improvement boom is showing no signs of abating. If anything, a prohibition on working with engineered stone will level the playing field – those who use cheap and unsafe products would no longer be able to under-price those who choose to offer safe products.

In relation to section 6.4:

Section 6.4 assumes that switching to a non-stone, or a safer stone product, would require new equipment. We believe that existing equipment would be able to be adapted in a lot of cases.

It should also be noted that the cost of adapting equipment to be able to continue to use engineered stone *safely* would be high too.

In relation to section 6.5:

Section 6.5 should note that workers are leaving the industry now:[5]

- because it's unsafe,
- because there are safer industries to work in, and
- because they're unable to continue to work in that industry due to acquired illness.

A prohibition on the use of engineered stone would make for safer, cleaner working environments, and thereby would actually attract workers to the industry.

Q9. Are there any other options or issues you think should be considered for a prohibition on the use of engineered stone?

No response to this Consultation Question.

Q10. Should there be a transitional period for a prohibition on engineered stone?

Maurice Blackburn recognises the need for traders to have time to transition to new business models following the introduction of a prohibition on engineered stone. In setting that transition period, we make the following observations:

- Recommendations should prioritise adopting the shortest possible period. While-ever businesses are able to continue to promote and provide unsafe products, their workers will continue to suffer the health consequences.

- Businesses have been on notice for at least the past five years that the use of engineered stone heightens the risks of silica related disease. The more astute (and caring) providers will have already commenced the transition. It is probably those with the worst systems and processes that will benefit most from a lengthy transition period.

- There are alternate products readily available now.

[5] See for example: https://www.abc.net.au/news/2019-04-30/stonemasons-get-out-of-industry-as-silicosis-epidemic-strikes/11057592

- In terms of retraining, our experience with injured workers from this industry reveals that most already work across a range of products. It is not the case that retraining involves 'starting from scratch'.

- Any transitional period merely indulges manufacturers. We urge SWA to base any discussion on transition on the immediate needs of workers, then the needs of traders, before considering the needs of those who generate and promote dangerous products.

Q11. Do you have any data on the number of cases of the other silica-related diseases attributed to exposure to crystalline silica from engineered stone?

No response to this question.

Q12. Do you have any additional evidence or information on the impacts of silicosis or silica related diseases?

Though not reflected in the DRIS, it is worth restating that biggest impact of the issues associated with failing to act on initiatives such as a prohibition are borne by employees.

SWA would be aware of numerous tragic stories of the devastating impacts of silicosis and related illnesses on individuals and their families. It is a horrible, frightening illness. The America Lung Association[6] provides this description:

> *People with acute silicosis experience cough, weight loss, tiredness, and may have fever or a sharp chest pain. You may also have shortness of breath over time, especially with chronic silicosis. Your healthcare provider might hear crackles or wheezing when they listen to your lungs. Having silicosis increases the risk of other problems, such as tuberculosis, lung cancer, and chronic bronchitis.*
>
> *Each type of silicosis affects the body somewhat differently:*
>
> - *In acute silicosis, the lungs become very inflamed and can fill with fluid, which causes severe shortness of breath and low blood oxygen levels.*
> - *In chronic silicosis, the silica dust causes areas of swelling in the lungs and chest lymph nodes, which makes breathing more difficult.*
> - *In accelerated silicosis, swelling in the lungs and symptoms occur faster than in chronic silicosis.*
> - *Over time, lung capacity decreases, and people with silicosis may need support with oxygen and other devices to help them breathe.*

The physical trauma is accompanied by the psychological impacts. The worker is suffocated of not only their ability breathe, to function and to exist as they once did but also to suffer concurrently from a loss of self-worth and dignity as their health slowly and increasingly fails them, and they become more and more dependent on others.

At the same time, silicosis has a huge impact on families. Silicosis prevents a worker from earning an income, not just as stonemason, but in any physical role in which dust exposure

[6] https://www.lung.org/lung-health-and-diseases/lung-disease-lookup/silicosis/learn-about-silicosis.html

occurs. This places a huge financial strain on every family, where mortgages, rent, car repayments, electricity bills and weekly groceries costs continue to mount week in week out.

It is worth restating that many of the jobs that involve exposure to silica are low-skilled roles, often filled by some of the more marginalised workers. These might include:

- Workers from immigrant backgrounds
- Workers with language barriers
- Early school leavers
- Workers who would struggle to find work in other industries

This vulnerability often places them at a distinct status disadvantage in negotiating appropriate employment conditions. This is typified by:

- Employee non-engagement with unions or forms of workforce organisation,
- Employees not questioning inappropriate behaviours of employers through fear of retribution, or not being able to find alternative work, and
- Employees not seeking external information on entitlements.

Once again, Maurice Blackburn calls for solutions to this crisis to be worker-focused. Concerns expressed about the profitability and basic viability of importers and manufacturers of engineered stone pale in significance compared to the impacts on workers and their families.