

SA - NDDT table of comments phase 2 for consultation

Regulatory and Governance	
<p>1. From a regulatory perspective, what should be considered 'engineered stone'? Please provide the rationale for your recommendation.</p>	<ul style="list-style-type: none"> <li>• States define engineered stone in different ways (by product name, terminology, or by percentage).</li> <li>• Initially the target for silicosis prevention was engineered stone as it was causing the greatest respirable crystalline silica exposure risk due to its high crystalline silica (silicon dioxide) content.</li> <li>• It is not therefore the product <i>engineered stone</i> that should be regulated, but activities that generate high exposure potential for respirable crystalline silica (RCS) in close proximity to workers.</li> <li>• The SWA draft COP for managing the risks of RCS from engineered stone in the workplace contains a description that is under discussion, although it does not refer to AF (artificial stone).</li> </ul>
<p>2. Various jurisdictions have already banned uncontrolled dry processing of engineered stone. What other practical measures could be introduced to reduce worker exposure to silica dust?</p>	<ul style="list-style-type: none"> <li>• WHS legislation prohibits creating a hazard. Uncontrolled dry cutting of stone creates an unnecessary release of the hazardous chemical (RCS) which under safety legislation has many 'reasonably practicable' options to control i.e. extraction ventilation, wet process work, and on tool extraction at the point of cutting. All these practical control measures have been available for many years. The creating of dust clouds and exposing workers to a health risk has been 'banned' since the 1970's development of WHS /OHS laws.</li> <li>• Enforcement of the law has increase in recent years, and awareness of the risks have re-emerged, but more work could be done to raise awareness of the risks.</li> </ul>
<p>3. Relevant to dust-related diseases, what mechanisms exist or could be further developed to ensure effective enforcement of regulations and codes of practice?</p>	<ul style="list-style-type: none"> <li>• Under the WHS legislation, as part of operating a business, a <i>duty holder</i> is required to manage the health and safety risks of its workers. A PUBU (person conducting a business or undertaking) is the legal duty holder.</li> <li>• Introduce expiation fee for un-controlled dry cutting where reasonably practicable controls are available.</li> <li>• Amend legislation to require regular air monitoring and health screening where workers could be exposed to RCS.</li> <li>• Education in and enforcement of WHS laws is a government activity to try to ensure duty holders are aware of their obligations. All laws cannot be enforced with each PCBU everyday (like every speed limit cannot be enforced by the police for every driver) and the duty is not on the regulators to do this. However all states have run education campaigns for the relevant industries about the resurgence of silicosis, and most states have run compliance</li> </ul>

	<p>campaigns. It is possible that some duty holders were more serious about their obligations to the health of their workers than others. The PCBUs who have not met their duty may be prosecuted by the regulator if there is <i>proof beyond reasonable doubt</i> that they disregarded the law and are liable for criminal prosecution.</p>
<p>4. Hazard elimination sits at the top of the hierarchy of control measures (see <a href="https://www.safeworkaustralia.gov.au/risk">https://www.safeworkaustralia.gov.au/risk</a> for an example of a hierarchy of control measures). Do you consider a ban (either total or partial) of high silica content engineered stone material, a proportionate and practical response to the emergence of silicosis in the engineered stone benchtop industry in Australia?</p>	<ul style="list-style-type: none"> <li>• A ban on engineered stone could achieve a similar outcome to that of the ban on asbestos. Alternative materials would be sought by consumers and would replace engineered stone in the market over time. However the disease data for engineered stone may not mirror that of asbestos and therefore a ban may not be justifiable as the evidence would suggest the product can be used safely with the appropriate controls for exposure in place.</li> </ul>
<p>5. The Taskforce is aware some jurisdictions are considering a licensing scheme for engineered stone. Do you consider this a proportionate and practical response in relation to the following: a. restricted (under licence) or otherwise prohibited manufacture in Australia? b. restricted (under licence) or otherwise prohibited importation and distribution? c. fabrication and installation performed only under licence? d. licence required after installation modifications or repurposing of installed engineered stone?</p>	<ul style="list-style-type: none"> <li>• Licensing may generate revenue states if there are multiple businesses using engineered stone.</li> <li>• The development of a licensing system would not be cost effective in most small jurisdictions e.g. the cost of legislating such a system and implementing would be prohibitive in SA as the industry is relatively small. Licensing is a state issue and would be considered as such.</li> <li>• It is understood that Victoria is the only jurisdiction considering a licensing scheme – it is not a WHS state and therefore does not have harmonised WHS laws in place.</li> <li>• An import prohibition is a federal matter and could be considered if the risk can be justified.</li> </ul>
<p>6. What learnings from the re-emergence of accelerated silicosis as an occupational health and safety risk can be applied to enhance workplace health and safety systems more generally?</p>	<ul style="list-style-type: none"> <li>• Not all states have accelerated silicosis cases.</li> <li>• Exposure to substances has been raised as an unexplored cost in many countries and in the last 10 years as the global burden of disease.</li> <li>• The medical recognition of work-related disease over the long term is generally poor in Australia.</li> </ul>
<p>Workforce Organisational Culture</p>	
<p>7. Given the nature of the building and construction industry, and the increase in the number of smaller, often independent businesses and suppliers, what</p>	<ul style="list-style-type: none"> <li>• The building and construction industry will implement the controls they are required to by the Code of Practice (when this is released and explained to them by state regulators).</li> </ul>

<p>particular strategies and supports are needed to ensure that these businesses are able to provide adequate protection for workers?</p>	<ul style="list-style-type: none"> <li>• The cost of disease in workers however is not directly felt by this industry as many workers will not be diagnosed for many years, or until during retirement.</li> <li>• Small businesses will need additional support to provide protection for their workers.</li> <li>• It is not thought that diseases in the 5-10 year or more chronic category, or that can be contracted from exposures in multiple workplaces over years as workers move between jobs, are not likely to be considered by PCBUs.</li> </ul>
<p>8. What health and safety strategies can be improved?</p>	<ul style="list-style-type: none"> <li>• The medical recognition of lung disease needs work in Australia.</li> <li>• Work health needs to be more strongly linked to safety regulation.</li> <li>• More GPs need to recognise that there are workplace obligations in this area and be educated in this.</li> </ul>
<p>9. What return to work support is available or should be considered to assist workers following a diagnosis of silica-associated disease, including for those who are unable to return to the engineered stone industry?</p>	<ul style="list-style-type: none"> <li>• Return to work programs are in place in most jurisdictions.</li> <li>• The object of Part 3 of the <i>Return to Work Act 2014 (SA)</i> is to establish a system that seeks to ensure that a worker who sustains a work injury is supported in achieving practicable levels of physical and mental recovery, and returns to their pre-injury work, or where that is not reasonably practicable is in any event restored to the workforce and the community in a timely, safe and durable way.</li> <li>• What does this mean for workers who have a claim in relation to a diagnosis of silica-associated disease? For many workers with silica related disease the option to return to pre-injury employment is not available and so the focus is on identifying suitable, alternative employment early in the life of the claim to ensure they are supported in achieving a sustainable return to work prior to the end of their entitlement period.</li> <li>• For the silicosis claims that are currently being managed by ReturnToWorkSA, ReturnToWorkSA has engaged with providers that offer vocational counselling services, to work with the worker and help identify suitable employment options. Where appropriate re-training has been provided.</li> </ul>
<p>10. What are examples of good dust exposure workplace monitoring processes? (Where possible please provide evidence to support the effectiveness of these processes).</p>	<ul style="list-style-type: none"> <li>• Good workplace safety occurs when dust exposure is controlled through wet processes as described in the Code of Practice. Monitoring that the controls are working via dust monitoring at regular intervals just provides evidence of this.</li> <li>• The Code of Practice specifies when monitoring should be carried out i.e. at least annually, when the processes change, and when there are changes to plant and personnel. This can be an expensive process for small business.</li> </ul>
<p>Resourcing and Capability</p>	

11. What specific resources (e.g. information, education, other supports etc.) are required, that are not currently available, for small to medium sized businesses, to ensure that owners and staff are fully informed of the availability and correct use of control methods, including by workers from non-English speaking backgrounds?	<ul style="list-style-type: none"> <li>• An explanation of the medical risks could be useful for workers from non-English speaking backgrounds, however this should occur in tandem with the medical professional undertaking the workplace health monitoring.</li> <li>• Providing translated versions of general working with silica guidance into a variety of the languages that are common to non-English speaking workers in the industry would also be useful.</li> </ul>
12. With a specific focus on dust related diseases, what mechanisms exist that could be used as a basis for providing a coordinated national system with representation across stakeholder disciplines for identifying and communicating emerging issues?	<ul style="list-style-type: none"> <li>• There has been discussion about disease and exposure registries. An exposure registry would provide a national coordinated basis for monitoring rates of exposure and disease.</li> <li>• Because early intervention is important, it is proposed that silicosis is made a notifiable disease.</li> </ul>
Research and Development	
13. What industry mechanisms could be introduced to ensure workers have appropriate competencies for handling engineered stone or performing processes that generate silica dust?	<ul style="list-style-type: none"> <li>• Stone masonry is a trade that requires education and certification.</li> <li>• Working with engineered stone does not require the same training and therefore does not require trade trained and certified workers.</li> <li>• A requirement that only those qualified in a trade through TAFE training courses may help with education.</li> <li>• Additional modules could be added to existing TAFE courses (e.g. carpentry).</li> <li>• A new trade TAFE course could be developed, e.g. cutting engineered stone safely, or working with engineered stone safely.</li> </ul>
14. What are the specific challenges related to linking workplace exposure with disease development (at a later date) and how should these be addressed?	<ul style="list-style-type: none"> <li>• Disease in an individual cannot currently be linked to a specific product for compensation or prosecution by regulators. Workers' compensation schemes in many states allow for compensation without a definite cause of disease i.e. on the <i>balance of probabilities</i> this workplace caused this disease. However, for prosecution, the dust in the lung may need to be specifically matched to a product (and workplace) and current research this may soon make this possible.</li> <li>• In the future we may be able to determine that exposure to <i>this stone</i> type was not controlled and therefore <i>this</i> workplace may be prosecuted i.e. by matching lung biopsy to product fingerprint.</li> </ul>

<p>15. What are three key pieces of information about dust disease that you would like to see collected at a national level? What are the three key uses of the information collected at a national level?</p>	<ul style="list-style-type: none"> <li>• A disease/exposure registry has been discussed at a number of forums.</li> <li>• Most concerning is the low number of years' dry dust exposure that has resulted in disease in some workplaces, however the level of the exposure has not been provided as workplace monitoring is not able to be done retrospectively.</li> <li>• Proper history collection for those with accelerated disease is needed with a better estimation of exposure based on modelling.</li> </ul>
<p>16. What alternative products are currently available which could replace high silica-content engineered stone? How could we drive innovation in relation to products?</p>	<ul style="list-style-type: none"> <li>• There are many products that can be used for benchtops – laminate, stainless steel, natural stone, wood, or glass. The composite products release dust much more readily than solid products.</li> </ul>
<p>17. The interim advice identified immediate research priorities which has led to a research funding grant opportunity announced by the Medical Research Future Fund and National Health and Medical Research Council. Are there other research priority areas that have not been identified in the interim advice that should be considered, and why? What research areas should be a priority following this first round of research funding?</p>	<ul style="list-style-type: none"> <li>• Research funding is mostly based on diagnosis and treatment options.</li> <li>• Existing research could be brought together, peer reviewed, and analysed. After that, an analysis of gaps in research could be identified.</li> <li>• Very little funding has been put into prevention of disease.</li> </ul>