

A Mine Safety and Health Authority for Queensland: A further response

Report No. 5, 55th Parliament

Coal Workers' Pneumoconiosis Select Committee

October 2017

Coal Workers' Pneumoconiosis Select Committee

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¹ The Member for Greenslopes, Mr Joe Kelly MP, was a member of the Committee up until 14 June 2017, at which time the Queensland Parliament agreed to a number of changes to committee membership. The Member for Mackay, Mrs Julieanne Gilbert MP, was appointed to the committee from 14 June 2017 onwards.

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Abbreviations

AFOEM	Australasian Faculty of Occupational and Environmental Medicine
AITHM	Australian Institute of Tropical Health and Medicine (James Cook University)
ARC	Australian Research Council
Authority	Mine Safety and Health Authority (proposed for Queensland)
<i>Black lung, white lies report</i>	Coal Workers' Pneumoconiosis Select Committee, <i>Report No. 2, 55th Parliament, Black lung, white lies – Inquiry into the re-identification of Coal Workers' Pneumoconiosis in Queensland</i> , Queensland Parliament, 29 May 2017
CFMEU	Construction, Forestry, Mining and Energy Union
CMDLD	Coal mine dust lung disease
Committee	Coal Workers' Pneumoconiosis Select Committee
COPD	Chronic obstructive pulmonary disease
CSIRO	Commonwealth Scientific and Industrial Research Organisation
CT	Computed tomography
CWP	Coal workers' pneumoconiosis
DSDG	Cromoglycate, a drug belonging to a class of medications known as 'mast cell stabilisers', which has typically been used to prevent symptoms associated with asthma
DNRM	Department of Natural Resources and Mines
Draft bill	Exposure draft Mine Safety and Health Authority Bill 2017
Draft bill report	Coal Workers' Pneumoconiosis Select Committee, <i>Report No. 3, 55th Parliament – A Mine Safety and Health Authority for Queensland, including the committee's exposure draft Mine Safety and Health Authority Bill 2017</i> , 24 August 2017
HRCT	High-resolution computed tomography
HSU	Health Surveillance Unit (Department of Natural Resources and Mines)
Interim report	Coal Workers' Pneumoconiosis Select Committee, <i>Report No. 1, 55th Parliament, Inquiry into the re-identification of coal workers' pneumoconiosis in Queensland – Interim Report</i> , 22 March 2017
IPNRC	Infrastructure, Planning and Natural Resources Committee

IPNRC report	Infrastructure, Planning and Natural Resources Committee, <i>Report No. 54, 55th Parliament – Exposure Draft Mine Safety and Health Authority Bill 2017</i> , 5 October 2017
JCU	James Cook University
LHRC	Lung Health Research Centre (University of Melbourne)
Monash Review	Monash Centre for Occupational and Environmental Health, Monash University, in collaboration with the School of Public Health, University of Illinois at Chicago, <i>Review of Respiratory Component of the Coal Mine Workers’ Health Scheme for the Queensland Department of Natural Resources and Mines</i> , 12 July 2016
MSHA	Mine Safety and Health Authority (USA)
NIOSH	National Institute of Occupational Safety and Health (USA)
NSW	New South Wales
OQPC	Office of the Queensland Parliamentary Counsel
QRC	Queensland Resources Council
Report on occupational respirable dust issues	Coal Workers’ Pneumoconiosis Select Committee, <i>Report No. 4, 55th Parliament – Inquiry into occupational respirable dust issues</i> , 29 September 2017
Senate committee	Federal Senate Select Committee on Health
SIMTARS	Safety in Mines Testing and Research Station (Department of Natural Resources and Mines)
TAAHC	Tropical Australian Academic Health Centre (Mackay)
US	United States
USA	United States of America
3D	Three-dimensional

Foreword

This report is the second report by the Coal Workers' Pneumoconiosis Select Committee in relation to its Parliament-assigned 'monitor and review' function, under which the committee is charged with monitoring and reviewing the implementation of its report recommendations, including developing a draft bill for the consideration of the Queensland Legislative Assembly.

The report outlines our response to the report of the Parliament's Infrastructure, Planning and Natural Resources Committee on this committee's exposure draft Mine Safety and Health Authority Bill 2017. The committee intends to present a refined, final version of this draft bill for the consideration of the Assembly in the near future.

The Mine Safety and Health Authority that the draft bill would establish would provide this state with an independent and dedicated regulatory body with a singular mission and purpose, unfettered by other industry aims. The health and safety of mine and quarry workers will be pre-eminent, and specific provision for expert input, research and innovation, and knowledge-sharing and education, all promise to support a proactive, comprehensive and best practice approach to safeguarding worker health and wellbeing.

The draft bill was informed by the committee's thorough and ongoing investigation into the re-identification of coal worker's pneumoconiosis and into other occupational respirable dust issues in this State. Especially critical to these inquiry processes were the committee's conversations with mine workers themselves, during various evidence-gathering and consultation sessions held across regional Queensland. These conversations provided the committee with honest and more nuanced insights into the nature of the industry and the actions and interactions of its key agents and players, free from the lens of corporate spin or other image management. This worker voice and perspective was noticeably absent during subsequent consideration of the committee's exposure draft bill.

On behalf of the committee, we wish to extend a sincere thank you to the many individuals and organisations who have provided input to the committee and informed the formulation and fine-tuning of its proposed reforms.

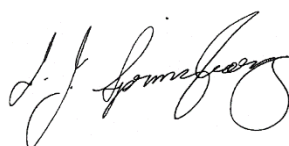
We also thank the committee's secretariat, counsel assisting, the Office of the Queensland Parliamentary Counsel, and the University of Melbourne's Lung Health Research Centre.

We commend this report to the House.



Jo-Ann Miller MP

Chair



Hon Lawrence Springborg MP

Deputy Chair

1 Introduction

1.1 The committee and its role

In September 2015, Queensland's Commissioner for Mine Safety and Health reported the diagnosis of 'the first case of coal workers' pneumoconiosis in a Queensland coal miner in 30 years'.² The re-identification of this entirely preventable disease – thought incorrectly to have effectively been eradicated in Australia – shocked and dismayed all involved in the coal industry. As at 11 September 2017, there were a total of 52 confirmed cases of mine dust lung diseases among current and former Queensland mine workers, at least 22 of which involve coal workers' pneumoconiosis (CWP).³ The remaining cases variously include diagnoses of asbestosis, chronic obstructive pulmonary disease (COPD), silicosis, or co-occurring (mixed) mine dust lung disease.⁴ Sadly, these numbers will no doubt increase.

The CWP Select Committee (committee) was established by the Queensland Parliament on 15 September 2016 to conduct an inquiry and report on the 're-emergence' of CWP amongst coal mine workers in Queensland.⁵ The scope of the committee's terms of reference was subsequently extended to include inquiry and report on other affected workforce cohorts and occupational dust issues.⁶ In addition, the extended terms of reference provided for the committee to monitor and review the implementation of recommendations made in its inquiry reports, including developing a draft bill for the consideration of the Legislative Assembly. The committee's full terms of reference are provided at **Appendix A**.

1.2 The committee's inquiries

The committee has provided detailed overviews of its inquiry activities in previous reports to the Parliament. A summary of these activities is provided at **Appendix B**.

The committee tabled an interim report on 12 April 2017⁷ and on 29 May 2017 tabled its final report on the re-identification of CWP among coal mine workers in Queensland, entitled *Black lung, white lies* (*Black lung, white lies* report).⁸ The detailed final report included 34 key findings and 68 recommendations for reform. In short, the committee found that there had been 'a catastrophic failure of the regulatory system that was intended to preserve and protect the health of coal miners'.⁹

² Queensland Government, Commissioner for Mine Safety and Health, *Queensland Mines Inspectorate Annual Performance Report, 2014-15*, 2015, p 3.

³ Department of Natural Resources and Mines (DNRM), *Mine Dust Lung Diseases*, webpage, last reviewed 26 September 2017, available at: <https://www.business.qld.gov.au/industries/mining-energy-water/resources/safety-health/mining/accidents-incidents/mine-dust-lung-diseases>. *All web references in this report are correct as at 24 October 2017.

⁴ DNRM, correspondence, 28 September 2017.

⁵ Hon S J Hinchliffe MP (Leader of the House, Member for Sandgate), 'Coal Workers' Pneumoconiosis Select Committee, Order of Appointment; Membership', *Hansard*, 15 September 2016, p 3619.

⁶ 'Coal Workers' Pneumoconiosis (CWP) Select Committee, Reporting Date, Terms of Reference', *Hansard*, 23 March 2017, pp 870-871.

⁷ CWP Select Committee, *Report No. 1, 55th Parliament, Inquiry into the re-identification of coal workers' pneumoconiosis in Queensland – Interim Report*, 22 March 2017 (Interim report). Available at: <http://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2017/5517T467.pdf>

⁸ CWP Select Committee, *Report No. 2, 55th Parliament, Black lung, white lies – Inquiry into the re-identification of coal workers' pneumoconiosis in Queensland*, 29 March 2017 (*Black lung, white lies* report). Available at: <http://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2017/5517T815.pdf>

The committee also tabled an executive summary version of this report, which can be accessed here: <http://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2017/5517T816.pdf>

⁹ *Black lung, white lies* report, p 3.

On 24 August 2017, in accordance with its Parliament-assigned ‘monitor and review’ role, the committee tabled a report (draft bill report) enclosing an exposure draft Mine Safety and Health Authority Bill 2017 (draft bill).¹⁰ The draft bill, which would establish an independent Mine Safety and Health Authority (authority) and substantially give effect to the legislative recommendations of the committee’s *Black lung, white lies* report, was referred to the Infrastructure, Planning and Natural Resources Committee (IPNRC) for consideration and report.

On 29 September 2017, the committee tabled its report on its inquiry into occupational respirable dust issues, which included a further five recommendations to enhance protections and engagement with workers and their communities around occupational dust hazards and disease prevention.¹¹

The IPNRC reported to the Parliament on the committee’s draft bill on 5 October 2017.¹²

1.3 Report structure

This report is the second of the committee’s reports in relation to its ‘monitor and review’ role.

The report outlines the committee’s response to the IPNRC report on its draft bill, as well as making some broader commentary in relation to the Queensland Government response to the recommendations of the *Black lung, white lies* report.

In addition, the report elaborates on its previous recommendation for the establishment of a properly resourced and dedicated health research function within its proposed Mine Safety and Health Authority, identifying promising options for future collaborative study to improve our understanding and treatment of CWP and other occupational lung diseases.

¹⁰ CWP Select Committee, *Report No. 3, 55th Parliament – A Mine Safety and Health Authority for Queensland, including the committee’s exposure draft Mine Safety and Health Authority Bill 2017*, 24 August 2017 (draft bill report). Available at: <http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2017/5517T1855.pdf>

¹¹ CWP Select Committee, *Report No. 4, 55th Parliament – Inquiry into occupational respirable dust issues*, 29 September 2017 (report on occupational respirable dust issues). Available at: <http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2017/5517T1855.pdf>

¹² Infrastructure, Planning and Natural Resources Committee (IPNRC), *Report No. 54, 55th Parliament, Exposure Draft Mine Safety and Health Authority Bill 2017*, 5 October 2017 (IPNRC report). Available at: <http://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2017/5517T1867.pdf>

2 A response to the Infrastructure, Planning and Natural Resources Committee's report on the draft bill

In its report on the draft bill tabled on 5 October 2017, the IPNRC made one recommendation:

*The committee recommends that the Legislative Assembly note the committee's consideration of the Mine Safety and Health Authority Bill 2017 as outlined in this report.*¹³

This committee was gravely disappointed in this recommendation and the broader IPNRC report.

The committee recognises that in considering the draft bill, the IPNRC did not have the advantage of close familiarity with the extensive evidence gathered by this committee, nor the cumulative insights into the relationships and established patterns of behaviour across industry that this evidence provides. However, the committee's detailed reports on these matters are in the public domain, as are the many hundreds of pages of evidence taken at public hearings throughout Queensland. It is clear to the committee that they were not considered by the IPNRC with the weight they duly deserve.

Further, the IPNRC did not request or seek access to transcripts of the many private hearings held by this committee, including hearings in which workers gave evidence of their personal experiences.

Rather, the IPNRC's report seems to be informed solely by the limited information submitted to it – that is, primarily by information from those industry players who would be challenged by the proposed reforms, and required to make some adjustments to their current practices and modes of business. A number of cited statements included mischaracterisations of the committee's findings, or statements of opinion shaped by certain vested interests. Remarkably, some of these statements appear to have been accepted at face value, overriding the significant body of evidence presented by the committee in support of its proposed reforms.

In the 'committee findings' which lead up to the IPNRC's sole recommendation, the IPNRC report states that the bill's establishment of an independent Mine Safety and Health Authority is:

*...based upon [the CWP Select Committee's] assertion the Department of Natural Resources and Mines (the department) was responsible for the failure of the mine safety and health system in Queensland. The committee found this assertion was not widely supported. Evidence given to the committee suggested the systemic failure of the mine safety and health system was a result of the collective failure of governments, industry, medical professionals, unions, departments and workers over a significant period of time, and that improvements are required across the entire system.*¹⁴

This statement is misleading on a number of levels. At no time has the committee asserted that the Department of Natural Resources and Mines (DNRM) was solely responsible for the failure of the mine safety and health system in Queensland. In fact, the committee has consistently argued, much as IPNRC also concluded, that this was a 'collective', catastrophic systemic failure 'across the entirety of the regulatory and health systems intended to protect coal industry workers'.¹⁵ In its very first report, tabled on 22 March 2017, the committee stated:

Prior to the re-identification of CWP in 2015, there was an absolute failure by the DNRM, its Mines Inspectorate, SIMTARS [Safety in Mines Testing and Research Station] and its Health Surveillance Unit (HSU) to properly regulate air-borne dust and to look for or identify CWP or CMDLD [coal mine dust lung disease]. The evidence suggests that Queensland Health, WorkCover and self-insurers

¹³ IPNRC report, p 2.

¹⁴ IPNRC report, p 2.

¹⁵ Interim report, p 6.

have played a role in this failure. As identified in the Monash Review,¹⁶ there were serious shortcomings in the practices of health professionals charged with monitoring the health of coal workers in regard to the diagnosis, notification and treatment of respiratory disease. These professionals include Nominated Medical Advisors and examining medical officers (doctors engaged by mine operators to conduct health assessments under the Coal Mine Workers' Health Scheme), radiographers, radiologists, and thoracic specialists. Mine operators have also contributed to this failure through inadequate attention to dust mitigation and suppression, poor dust monitoring, and inadequate health surveillance. The increasing casualisation of the mining workforce has also intensified the vulnerability of coal mine workers. Workers report they are less likely to report or complain about excessive dust levels and are more likely to ignore respiratory symptoms for fear an adverse health assessment would put their employment at risk.¹⁷

The committee is extremely troubled by the IPNRC's suggestion that workers were, in any way, responsible for the failure of the system that was supposed to protect them. Quite to the contrary, the committee did not receive a single shred of evidence to support that conclusions.

The IPNRC's mischaracterisation of the rationale for the establishment of the authority and its objectives appears to have been promoted primarily by the Queensland Resources Council (QRC), which identified the apportionment of blame for the re-identification of CWP to DNRM as the 'underlying reason for having an authority' in testimony to the IPNRC.¹⁸

The proposed authority is not, as the IPNRC report might suggest, a narrow solution aimed solely at addressing the shortcomings of DNRM. Rather, it stands as the centrepiece of what is a wholesale approach to remedying the deficiencies of all parties to the regulatory system, and to providing a regulatory environment that is more supportive of continuous improvement and innovation to enhance safeguards on the safety and health of Queensland mine and quarry workers into the future.

As the committee's recommendations make clear, in addition to establishing a regulatory authority which is independent of DNRM – the government department also responsible for promoting and supporting the profitability of the industry – this central reform is to be supported by new regulatory requirements and approvals regimes for mine operators and medical professionals, together with a range of other recommended initiatives to be implemented through non-legislative reforms.

¹⁶ In December 2015, the Queensland Government commissioned an independent review of the respiratory component of the coal mine workers' health scheme by experts at the University of Monash, in conjunction with the University of Chicago at Illinois. The resulting review report (Monash review), finalised in July 2016, identified significant scheme shortcomings and provided 18 recommendations for improvement, including in relation to chest x-rays, lung function testing (spirometry), medical records management and health surveillance on data collected.

¹⁷ Interim report, p 6.

¹⁸ Hon Ian MacFarlane, Chief Executive, Queensland Resources Council (QRC), public hearing transcript, IPNRC, 8 September 2017, p 9. See also p 11, where the Hon Ian MacFarlane stated in relation to the proposed authority that 'the fundamental pretext that the re-emergence of black lung was the result of the department not doing its job is wrong'.

The model of the authority is a proven model, informed by the example of similar bodies in New South Wales¹⁹ and in the United States²⁰ – the jurisdictions recognised as representing best practice in dust management and risk monitoring in Australia and internationally.

Further, with regard to evidence cited by the IPNRC in its report findings, correspondence received by the committee from particulate matter scientist Dr Brian Plush highlights concerns also shared by this committee as to the balance of views canvassed in the IPNRC report:

Evidence presented for [the IPNRC's] recommendation included 6 submissions and a public hearing on Friday, 8 September 2017. Of the 6 submissions tendered, one was from the QRC, which represents mine owners, one is from the Queensland Government, which is responsible for the DNRM and the regulatory failure, one is from BHP, a mine owner with confirmed cases of CWP, all of whom have been identified as contributors to the systemic failure. Further submissions were from the Queensland Law Society which focusses on the legal aspects to the Bill and a submission by David Ralph providing editing suggestions for the Bill. The final submission is from the Australasian Faculty of Occupational and Environmental Medicine (AFOEM), who submitted that "due to the very short timeframe for this consultation, it was not feasible for AFOEM to produce a detailed submission in this instance".

In summary, of the 6 submissions, 3 have been named as complicit in the systemic failure, one did not provide a detailed submission and 2 were related to the legal aspects of the Bill.

I suggest that these submissions were insufficient upon which to provide an informed response from the Infrastructure, Planning and Natural Resources Committee in relation to the [Mine Safety and Health Authority] Bill 2017.²¹

The committee notes that evidence was provided to the IPNRC by representatives of the Construction, Forestry, Mining and Energy Union (CFMEU) at a public hearing on 8 September 2017. This amounted to approximately 23 minutes of testimony in a hearing of just under two hours in length. Despite this constituting the only testimony representative of the views of workers in the industry – the individuals who the system is designed to protect, and whose input should be highly valued – the IPNRC report cites the CFMEU testimony on just three occasions in its report. The CFMEU's general support for the establishment of the authority is overshadowed by the IPNRC's heavy reliance on mutually supportive and defensive statements from the QRC and DNRM, which essentially affirm their preference for moving to improve current arrangements without committing to any significant structural change.

The committee notes the more detailed testimony of the CFMEU (not included in the IPNRC report), that:

... Our view is that it [the authority] is something that we look forward to. It needs to take place. Having true independence is the only way the system is going to move forward. Obviously we have had failures over the last 30 years which have allowed miners to contract this terrible

¹⁹ New South Wales' (NSW) Coal Services, established as an independent organisation under the NSW *Coal Industry Act 2001*. Jointly owned by the NSW Minerals Council and the CFMEU, Coal Services provides a dedicated service for the prevention of illness and injury in the workplace, including holding specific statutory responsibilities in relation to the review of dust mitigation measures, dust monitoring, health surveillance, and workers' compensation.

²⁰ The US Mine Safety and Health Authority (MSHA) is responsible for the regulation of safety and health in all US coal and metalliferous mines and quarries. MSHA is supported in this role by the National Institute for Occupational Safety and Health (NIOSH), a dedicated federal agency responsible for conducting research on work-related diseases and injuries and recommending occupational safety and health standards. In Queensland, in contrast, government regulator DNRM is supported by the Safety in Mines Testing and Research Station (SIMTARS) which has had a relatively constrained budget and reliance on fee-for-service offerings, with a primary research focus on occupational safety and innovation in areas of explosive risk management, emergency response, and mine rescue – somewhat to the neglect of occupational health.

²¹ Dr Brian Plush, correspondence, 12 October 2017.

*disease. We need a change. If we do not change that means that we have not learnt from the mistakes of the past. In 10 years we will be back to where we came from. We are in an industry that has a reputation of not learning from the past. We need to go forward...*²²

*.... Both Mr Woods and I spent two weeks in the United States last year touring from Washington up through West Virginia to Pittsburgh and Chicago investigating their controls and issues with black lung. We looked at dust control and the black lung clinics in Chicago and the science behind it through NIOSH [National Institute for Occupational Safety and Health] in Pittsburgh. We believe if we have those organisations in place we can bring a proper debate to the table. We have the resources behind us to investigate this and have the science behind this...*²³

*... I think, like I said before, true independence is the only way to move forward. If you get persuaded by one side or the other, you are not going to get the best outcomes for the people at the end of the day. The people who we want to come home at the end of the day are the workers. If you are going to be swayed one way or the other—I suppose we all know how the government works. All organisations lean on them; it depends who is in at the time. Sometimes that is probably not the best outcome for the people at the coalface at the end of the day. We need true independence to get health and safety on the table to do our best to make sure that coalminers come home at the end of the shift free from injury.*²⁴

Despite this expressed lack of trust in the current system and need for a more transparent and independent regulatory structure – a consistent theme of this committee’s inquiries – the testimony of the QRC and DNRM, which was more widely cited by IPNRC, appears at times to have downplayed the extent of the system breakdown, indicating an ongoing culture of denial and a failure to fully recognise the seriousness of dust issues. Notably, in a response to a question from the IPNRC regarding the loss of worker faith in the regulatory system, QRC Chief Executive the Hon Ian Macfarlane stated:

*I appreciate your comment and there is no doubt that public confidence has been shaken as a result of comments such as those, but the QRC stands by its view that those assertions are not correct. We also stand by the view that for 30 years the department has administered this area and it has done a job which gave confidence to the workers and the general community in relation to the monitoring and eradication of CWP.*²⁵

Further, the Hon Ian MacFarlane also notably articulated a view that the ‘status quo with more resources and a full understanding through this issues’ would be preferable, and:

*... it could well be that this problem is well and truly solved before that legislation makes it to the House. When I say ‘solved’ I mean in terms of ensuring we have the processes for cutting the risk of CWP as close as possible to zero.*²⁶

The committee was extremely concerned by this testimony, particularly in light of findings of its *Black lung, white lies* report, including that:

- there had been chronic understaffing and under-resourcing of the HSU within DNRM that was responsible for processing worker health assessment records, leading to a backlog of up to 10 years of records to be processed
- worker health assessment records had been ‘stored in a janitor’s cupboard next to the female toilets, and in shipping containers at the SIMTARS site at Redbank’

²² Mr Jason Hill, Industry Safety and Health Representative, Construction, Forestry, Mining and Energy Union (CFMEU), public hearing transcript, IPNRC, 8 September 2017, p 2.

²³ Mr Jason Hill, public hearing transcript, IPNRC, 8 September 2017, p 3.

²⁴ Mr Jason Hill, public hearing transcript, IPNRC, 8 September 2017, p 3.

²⁵ Mr Ian MacFarlane, public hearing transcript, IPNRC, 8 September 2017, p 12.

²⁶ Mr Ian MacFarlane, public hearing transcript, IPNRC, 8 September 2017, p 13.

- DNRM failed to implement all but one of 21 recommendations for reform of the HSU identified in a 2002 review, which had identified a vast number of shortcomings in the system. Many of these recommendations became the subject of similar recommendations in the 2016 report of the Monash Review commissioned in response to the re-identification of CWP, some 14 years later. Evidence from former departmental staff indicated concerns about health assessment processes raised on a number of occasions were dismissed or not pursued.
- reports from departmental representatives over an extended period demonstrate a strong focus on international cooperation and knowledge sharing around mine safety, strata risks and explosions, but limited consideration of respirable dust issues, and
- the use of compliance powers by the mines inspectorate to enforce respirable dust exposure standards has at times been inconsistent and often not met with appropriately forceful regulatory responses.

In light of these and other failings outlined in detail in the *Black lung, white lies* report, the persistence of such dismissive attitudes and accompanying resistance to reform are disappointing, particularly given the gravity of the current circumstances, and the high stakes for affected workers and their families. Many key players failed in their duties to workers, and to deny the lessons from any of these experiences is to miss an important opportunity to translate the lessons of this tragedy into reform.

In this respect, the committee notes that the CFMEU testified at the IPNRC hearing:

*In the last few weeks we have had four mines fail to comply with the dust monitoring requirements. Those failures related to the reporting of respirable dust levels which is a requirement under recognised standard 14. Four coalmines and their management failed to report. All that appears to have happened with that is that they received a slap over the knuckles and were allowed to continue to operate, potentially still exposing coalmine workers to unacceptable levels of risk. The industry needs to be truly independent, this includes medical practitioners and NMAs. We have had 43 chest X-rays recently come back. These are ones that on behalf of our members we sent to the United States to Dr Cohen. Sixteen of the X-rays that came back are 1/0 or higher. The X-rays of one retired member have come back. In 1995 his X-rays were read as 1/0. His CT scans from 2013 showed he had PMF. He subsequently died late last year without being diagnosed. He had a terrible retirement. One member received his X-rays back from Dr Cohen last week. He has had two health assessments between sending those X-rays to the United States. His X-rays came back as 0/1. The X-rays that he has had with his health assessments in Australia—he has two in the last 12 months or a bit longer—have failed to pick up anything. It looks like we are still having these failures...*²⁷

Dr Brian Plush similarly expressed his concerns to the committee in this regard:

Of major concern is the first submission to the Inquiry which was from the Queensland Resources Council (QRC) which is an independent body representing the commercial developers of Queensland's minerals & energy resources. The QRC is representing industry members that have been identified as part of the systemic failure as mentioned above.

The submitted report states that "No evidence has been put forward that the current compliance framework is fundamentally flawed, and without any contrary evidence the QRC is of the view that all of the problems identified that have resulted in the re-identification of CWP can be addressed through existing processes under the existing framework..."

The belief that no evidence has been put forward to support the systemic failure of an entire industry has been supported by the 2nd submission by BHP where, at point 1 they state that there is a "Lack of demonstrated need for amendments to the current regulatory scheme".

²⁷ Mr Jason Hill, public hearing transcript, IPNRC, 8 September 2017, pp 1-2.

Further, in the conclusion, BHP states “However, we are unable to support the Exposure Draft in its current form. Its central proposal, the creation of the MSHA, is not based on a demonstrable need...”.

The fact that there is now Black Lung in Australia is evidence enough that significant change is required. This change should be mandatory from the top level of the statutory regime to the coal face of the workers.

It must be noted that although the [CWP Select Committee] inquiry identified significant issues in the entire coal mining industry, nothing has currently changed to prevent workers contracting black lung since the first confirmed case over two years ago. The legislative framework remains the same, the regulator remains the same, respirable dust testing remains the same, the people taking the tests remains the same, the engineering controls remain the same, the tonnes cut remains the same and the risk potential for all workers in and around respirable dust production remains the same. New workers into the industry in the last 21/2 years have been exposed to the same risk of black lung as those workers already in the industry.

Who is responsible if a worker contracts black lung in the future and they commenced work during the period where it was known that black lung was evident and they were in the same working environment with the same known risk?

In closing, I would simply ask of the Infrastructure, Planning and Natural Resources Committee, what evidence, in addition to workers contracting black lung, would they accept to acknowledge that significant industry change is required to lower the risk potential of CWP in coal mine workers to as low as reasonably practicable?²⁸

This committee recognised that the proposed reforms challenge the status quo and accordingly that some aspects of the draft bill were likely to sit rather uncomfortably for parts of industry and particularly for officers of DNRM. The establishment of the authority stands to interrupt established patterns of behaviour and operation – and appropriately so, noting the tremendous loss of worker faith in the system, and real or perceived concerns about possible regulatory capture and an at times all-too-cosy relationship between the QRC and parts of the department.

To allow the resistance of the department and industry operators to prevail would be to do the mine workers of Queensland and their families and communities a great disservice. In this regard, the committee wishes to once more reaffirm the findings of its *Black lung, white lies* report:

Queensland’s coal mining industry needs a more effective system of oversight and compliance, including greater levels of transparency and accountability surrounding the roles and responsibility of all industry players...

Importantly, it is clear that the responsibility for overseeing the health and safety of workers should not rest with the body also charged with promoting and supporting the industry; namely DNRM. While the objectives of a productive coal industry and a safe and healthy workforce are not altogether incongruous, this split focus is not in the best interest of either goal.

A dedicated and independent statutory mining safety and health body would be best positioned and most trusted by workers and the wider industry to address these aims without dilution. The committee notes the demonstrated benefits of such bodies in NSW and the USA.²⁹

The committee also considers that the establishment of the authority is consistent with the findings of the Federal Senate Select Committee on Health (Senate committee) in its *Fifth Interim Report: Black lung: ‘it buggered my life’* – a report the committee was required to consider under its initial terms

²⁸ Dr Brian Plush, correspondence, 12 October 2017.

²⁹ *Black lung white lies* report, pp 5-6, 71.

of reference. The Senate committee notably urged the Queensland Government to ‘do all it can to ensure the independence of its regulatory regime and officials’.³⁰

³⁰ Senate Select Committee on Health, *Fifth Interim Report, Black Lung: “it has buggered my life”*, Commonwealth of Australia, April 2016, p 74.

3 A response to the government response to *Black lung, white lies*

Within the scope of this response, it would be remiss of the committee not to also acknowledge the Queensland Government's response to the recommendations of the *Black lung, white lies* report, which was tabled during the course of the IPNRC inquiry, on 9 September 2017.³¹

Members of the committee, and indeed other members of the House,³² have previously expressed their disappointment at the government's lengthy delay in responding to this important report, particularly given the committee's conclusion that 'significant reform of the regulatory framework for coal mining in Queensland is urgently needed'.³³

This was a bipartisan report of the committee, adopted with the support of committee members from both sides of the House, and without reservation.

The committee notes that the government responded to the recent Forde report on the independent investigation into the tow truck industry within one day, accepting all 22 of its recommendations; and various child safety reports have similarly all been dealt with in an appropriately prompt fashion.

In contrast, the government was content to allow almost three months to pass before tabling only an interim response to the committee's report on 28 August 2017 – essentially, enough to comply with the minimum statutory requirement for responding to committee reports under the section 107 of the *Parliament of Queensland Act 2001* (Qld), without committing to any position or action on the recommended reforms.³⁴ The committee notes that it took a motion of an opposition member of Parliament on 5 September 2017 to eventually precipitate the government's tabling of its full response to the committee's report later that week.³⁵

The committee acknowledges the efforts of the Minister for Employment and Industrial Relations, Minister for Racing and Minister for Multicultural Affairs, the Hon Grace Grace MP, to enhance assistance and support for workers with mine dust lung diseases under the workers' compensation regime, and the efforts of the Minister for State Development and Minister for Natural Resources and Mines, the Hon Dr Anthony Lynham MP, to progress implementation of all 18 of the recommendations of the Monash Review³⁶ of the coal mine workers' health scheme.

However, the same cannot be said of broader moves to address shortcomings in the regulation of dust mitigation and management in Queensland. While on the surface, the government's response suggests its support or actioning of all 68 of the recommendations of the *Black lung, white lies* report, the government in fact provides unqualified support for only 14 of these recommendations. For a significant three-quarters of the committee's recommendations, or 52 recommendations in total, only

³¹ Hon Dr A Lynham MP (Minister for State Development, Minister for Natural Resources and Mines, Member for Stafford), *Coal Workers' Pneumoconiosis Select Committee: Report No. 2, 55th Parliament – Black lung, white lies: Inquiry into the re-identification of Coal Workers' Pneumoconiosis in Queensland – government response*, 28 August 2017. Available at:

<http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2017/5517T1647.pdf>

³² Mr A Cripps (Member for Hinchinbrook), 'Motion, Coal Workers' Pneumoconiosis Select Committee, Report', *Hansard*, 5 September 2017, pp 2657-2658.

³³ *Black lung, white lies* report, p 3.

³⁴ Hon Dr A Lynham MP (Minister for State Development, Minister for Natural Resources and Mines, Member for Stafford), *Coal Workers' Pneumoconiosis Select Committee: Report No. 2, 55th Parliament – Black lung, white lies: Inquiry into the re-identification of Coal Workers' Pneumoconiosis in Queensland – interim government response*, 28 August 2017. Available at:

<http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2017/5517T1477.pdf>

³⁵ 'Motion, Coal Workers' Pneumoconiosis Select Committee, Report', *Hansard*, 5 September 2017, pp 2657-2663.

³⁶ See footnote 16.

‘in principle support’ is offered, with various ad-hoc improvements or enhancements to the current system proposed as equivalent alternatives.³⁷

The committee considers that the proposals outlined in the government’s response to the committee’s report will be insufficient to adequately restore the trust of workers; to fully address the root causes of the system failings; or to support a more sustainably resourced, proactive and forward thinking regulatory system for protecting the health and wellbeing of workers in Queensland mines and quarries.

Similar concerns were raised by Dr Brian Plush in correspondence to the committee:

*In the Queensland Government response ... The Honourable Dr Anthony Lynham agreed with Committee findings that “I acknowledge the findings of the Coal Workers’ Pneumoconiosis Select Committee, and their agreement with me, that there has been a gross systemic failure in the detection of coal workers’ pneumoconiosis for more than 20 years”. However, he has only provided “In Principle Support – Further Consultation Required” for committee recommendations excluding recommendations 9, 23-29, 35 and 36, which are supported. Whilst his response is positive, it is silent on actual dates, other than within a 3-month period, that Government responses will be tabled and who will be involved in the further consultations. **My concern is that the lack of identified timeframes for support or non-support, will run in to the 2018 State elections with nothing being done about the report, in particular, the formation of [the authority].***

*Government and Regulatory Authorities have currently implemented recommendations based on the Monash Review. These recommendations are aimed at improving diagnostic skills only, which will do nothing to prevent workers from contracting the disease. **My concern is that nothing is being implemented to remove nor quantify the efficiency of installed controls for mitigating dust at the source. Malcolm Sims, Professor Robert Cohen and myself all agree that to stop this disease, the dust must be prevented from entering the atmosphere. Simply increasing monitoring and reporting failures does not provide a framework to quantify if the amount of respirable dust in the atmosphere is as low as reasonably practicable (ALARP). Also, there is nothing in place to measure the success or failure of the implemented recommendations from the Monash report. How will we know if these recommendations reduce the incidence of black lung in workers? The answer is that we won’t.***

As the committee enunciated clearly in its *Black lung, white lies* report:

Given the nature of the system breakdown in relation to CWP, it is clear that DNRM’s attempts to amend or improve the system within the limits of the current regulatory structure have been inadequate, resulting in a superficial treatment of some issues. This piecemeal approach will not be sufficient to restore workers’ trust in the system or in the adequacy of the protection it affords them.³⁸

The committee also notes that evidence received during its inquiry into occupational respirable dust issues suggested the persistence of a resource-constrained mindset within some parts of DNRM, and a lack of impetus or forward thinking to support necessary moves towards more informed, data-led oversight of industry compliance in the management of respirable crystalline silica and other dust hazards.³⁹

³⁷ The government response advised that two of the report’s recommendations have already been actioned.

³⁸ *Black lung white lies* report, pp 5-6, 71.

³⁹ See: CWP Select Committee, *Report No. 4, 55th Parliament – Inquiry into occupational respirable dust issues*, 29 September 2017 (report on occupational respirable dust issues), pp 92-94.

4 Emerging opportunities for collaboration to improve understanding and treatment of occupational lung disease

In its *Black lung, white lies* report, the committee recommended the establishment, within its proposed authority, of a ‘properly resourced and dedicated health research function, including epidemiological research into health conditions experienced by mine workers’ (recommendation 14). Recommendation 14 also stated ‘these research functions should be undertaken in a collaborative way, drawing upon and sharing research with leading international research bodies such as NIOSH’.⁴⁰

In its report on occupational respirable dust issues, the committee further recommended that the Queensland Government ‘consider commissioning research into the impacts of environmental dust exposure on occupational dust exposure tolerance thresholds’ (recommendation 5).⁴¹

In addition, the committee has made comment on the need to enhance understanding of the development of occupational lung disease, including investing in research to:

- quantify the dose-response relationship between levels of exposure to respirable coal mine dust and the associated onset of disease⁴²
- characterise dust components and their effects on toxicity,⁴³ and
- identify clinical advancements to improve the diagnostic and treatment pathways for persons affected by occupational lung diseases.⁴⁴

In both its *Black lung, white lies* report and its subsequent report on occupational respirable dust issues, the committee made clear that it considers that ‘all of these valid and important areas of research’⁴⁵ are lines of enquiry that could be appropriately be pursued ‘by the dedicated health research division of its proposed Mine Safety and Health Authority’.⁴⁶

Within the scope of its role of monitoring and reviewing the implementation of these and other committee recommendations, a committee delegation travelled to Melbourne to meet with experts and collaborators from the University of Melbourne’s Lung Health Research Centre (LHRC) on 16 October 2017.

The LHRC is an integrated, multi-disciplinary centre with expert capacity in the epidemiology, pathogenesis, diagnosis, and treatment of fibrotic lung diseases, drawing on a partnership between lung researchers in the university’s Department of Pharmacology and leading clinical research groups at the Department of Respiratory Medicine and Department of Clinical Immunology at Royal Melbourne Hospital.

During the visit, the committee was provided with an overview of the LHRC’s approach to integrating preclinical and clinical disciplines to advance translational research, with a focus on delivering

⁴⁰ *Black lung, white lies* report, p 74.

⁴¹ report on occupational respirable dust issues, p 106.

⁴² *Black lung, white lies* report, p 94; report on occupational respirable dust issues, p 98.

⁴³ Report on occupational respirable dust issues, p 99.

⁴⁴ Recommendation 62 of the *Black lung, white lies* report also called for legislative amendment to support the provision of ‘enhanced rehabilitation (including, where appropriate, pulmonary rehabilitation) and return to work programs for those diagnosed with CWP or other CMDLD [coal mine dust lung diseases]’, including workers who have retired and left the industry prior to the implementation of any reforms. The committee acknowledges the reforms subsequently implemented by the government to address this recommendation.

⁴⁵ CWP Select Committee, *Report No. 4, 55th Parliament – Inquiry into occupational respirable dust issues*, 29 September 2017, p 99.

⁴⁶ *Black lung, white lies* report, p 94; CWP Select Committee, *Report No. 4, 55th Parliament – Inquiry into occupational respirable dust issues*, 29 September 2017, p 99.

immediate gains in improved treatment and prevention. This includes developing approaches that bring rapid symptomatic benefits to patients in the short term, integrated with research methods to develop disease-modifying approaches in the longer term, with an underlying continuous emphasis on possible cures for lung diseases. In support of these endeavours, the LHRC brings together experts in clinical care, physiotherapy and rehabilitation, and population health/epidemiology, to inform comprehensive health policy and treatment approaches.

The committee was impressed by a number of promising areas of LHRC research, and by the enthusiasm and willingness of the LHRC to offer its expertise and solutions to help those affected or at risk of occupational lung disease, and their families.

Researchers briefed the committee on recent developments with cromoglycate (DSDG), a long-established and safe anti-asthma drug recently shown to reduce coughing in patients with lung fibrosis.⁴⁷ Professor Alastair Stewart⁴⁸ proposed a clinical study to examine DSDG in miners with CWP and in those with cough, noting that DSDG is 'already registered and inexpensive and is extremely well tolerated, having only minor adverse effects and showing an excellent safety record'.⁴⁹ Professor David Story⁵⁰ further supported the statistical aspects of the proposed trial, advising that it would provide initial answers on the drug's effect on chronic cough and quality of life within only a few months of data collection, as part of an extended trial to gauge the impacts of the drug on progressive massive fibrosis.

Professor Alastair Stewart further advised in correspondence to the committee:

*The cromoglycate trial could be done in as few as 25-30 patients with Coal Mine Dust Lung Disease. The well-validated trial design would be scalable to larger at-risk groups including miners with cough, providing a well-structured system for clinical future trials of newly registered anti-fibrotic agents, including pirfenidone and nintedanib, with which the LHRC has a depth of expertise... The LHRC is offering the prospect of therapeutic interventions that alleviate the symptoms and potentially delay the progress of Coal Mine Dust Lung Disease.*⁵¹

The committee considers that the proposed clinical trial of DSDG should be supported and progressed by relevant Queensland authorities as a matter of priority, with a view to offering all affected mine workers the opportunity to participate. Accordingly, the committee has written to the Minister for Employment and Industrial Relations, Minister for Racing, and Minister for Multicultural Affairs, the Hon Grace Grace MP, and to the Minister for Health and Ambulance Services, Hon Cameron Dick MP, to seek their immediate support and assistance in advancing the proposal. These items of correspondence are included at **Appendix C**.

The committee notes that clinical experts and researchers at Mackay's recently-established Tropical Australian Academic Health Centre (TAAHC) have adopted a similar cross-disciplinary structure to the LHRC which likewise integrates research and clinical services, and have identified occupational health and safety as one of the centre's main priority areas.⁵² The committee notes that the TAAHC's

⁴⁷ S Birring et al, 'A novel formulation of inhaled sodium cromoglycate (PA101) in idiopathic pulmonary fibrosis and chronic cough: a randomised, double-blind, proof-of-concept, phase 2 trial', *The Lancet Respiratory Medicine*, vol 5, no. 10, October 2017, pp 806-815.

⁴⁸ Professor Alastair Stewart is the Co-Director of the Lung Health Research Centre and Director of the ARC (Australian Research Council) Industry Transformation Training Centre for Personalised Therapeutic Technologies.

⁴⁹ Professor Alastair Stewart, correspondence, 18 October 2017.

⁵⁰ Professor David Story is the Director of the Melbourne Clinical and Translational Sciences Platform and Chair of Anaesthesia at the University of Melbourne.

⁵¹ Professor Alastair Stewart, correspondence, 18 October 2017.

⁵² Professor Louis Schofield, Director, Australian Institute of Tropical Health and Medicine, public hearing transcript, Mackay, 25 November 2017, pp 46-52.

collaborative partnerships have been identified as promising to ‘help medical companies fast track clinical trials in public hospitals, providing patients with greater access to the latest and greatest medical innovations’.⁵³

In a submission to the committee’s inquiry into occupational respirable dust issues, Dr Gunther Paul⁵⁴ proposed the establishment of a ‘one stop shop’ for miner health and safety in Mackay, to be delivered by a consortium comprising TAAHC,⁵⁵ the Mackay Institute of Research and Innovation, the Mackay Health and Hospital Service, the Australian eHealth Research Centre,⁵⁶ and Ernst and Young.⁵⁷ Dr Paul noted that the proposed, independent one-stop shop could offer a ‘cohesive Miner Work Health and Safety Scheme in Queensland, similar to CS [Coal Services] Health and CS Technical Services in NSW, and in line with the NIOSH gold standard for a Miner Health scheme in the US’.⁵⁸

In addition, the committee notes that the multi-disciplinary team at the University of Queensland’s Thoracic Research Centre at the Prince Charles Hospital also has a demonstrated record and expertise in undertaking clinical, translational and scientific research to improve lung health – particularly in relation to lung cancer, mesothelioma and chronic airway diseases such as COPD.⁵⁹

The committee considers that both of these expert groups may have a role in facilitating the proposed clinical trial in Queensland, and supporting further collaborative efforts to improve preclinical, diagnostic and treatment options to prevent and reduce the incidence of occupational lung disease. Accordingly, the committee wishes to encourage their engagement and knowledge-sharing with the LHRC, the Monash Centre for Occupational and Environmental Health at Monash University, and other national and international experts and expert groups.

During the committee’s visit to the LHRC, the committee delegation also visited laboratories where researchers are investigating the molecular mechanisms of fibrosis, using lung organoids – 3D, tissue-engineered miniature lungs – combined with innovative approaches derived from microfluidics (a mix of approaches from physics, engineering and chemistry) to study cell and tissue stiffness. These advanced technologies were discussed in the context of moves towards developing ‘personalised precision medicines’, where the individual patient’s own genetic make-up and disease pattern may be used to design their therapy.⁶⁰

Such developments stand to enhance the current mix of treatment options for occupational lung disease, in which pulmonary rehabilitation currently plays a central role.⁶¹ In this respect, the LHRC also discussed with the committee the important ancillary effects of pulmonary rehabilitation on quality of life, including through helping to reduce the balance impairment during exacerbations of

⁵³ D Bateman, ‘JCU plans FNQ style Mayo Clinic’, *The Cairns Post* (online), 7 April 2015, available at: <http://www.cairnspost.com.au/news/jcu-plans-fnq-style-mayo-clinic/news-story/4dcc67f1d366e626cf41d6c88e132d4b>

⁵⁴ Dr Paul is a James Cook University (JCU) Principal Research Fellow in Occupational Health and Safety, and affiliated with the University’s Australian Institute of Tropical Health and Medicine (AITHM), one of the collaborative partners in the Tropical Australian Academic Health Centre (TAAHC).

⁵⁵ Dr Paul’s submission notes that ‘In the near future, TAAHC will be the Northern Australia Centre for Research Development and Translational Science. Until the TAAHC will be fully established and operational, this proposal builds on JCU and AITHM capability’.

⁵⁶ The Australian eHealth Research Centre is a joint venture between the CSIRO (Commonwealth Scientific and Industrial Research Organisation) and the Queensland Government.

⁵⁷ Dr Gunther Paul, inquiry into occupational respirable dust issues, submission 11, pp 8-12.

⁵⁸ Dr Gunther Paul, inquiry into occupational respirable dust issues, submission 11, pp 9.

⁵⁹ The University of Queensland, *Thoracic Research Centre*, webpage, 9 February 2017, available at: <https://medicine-program.uq.edu.au/school-of-clinical-medicine/research/thoracic-research-centre>

⁶⁰ Professor Alastair Stewart, correspondence, 18 October 2017.

⁶¹ Professor Alastair Stewart, correspondence, 18 October 2017.

COPD and other occupational lung conditions, and thereby decreasing the incidence of falls and associated hospitalisation and morbidity.

From a diagnostic perspective, the committee delegation also discussed with LHRC experts the demonstrated higher and more informative diagnostic yield of low-dose, high-resolution computed tomography (CT) scans from patients with occupational lung disease.

Within the context of recommendation 47 of the committee's *Black lung, white lies* report, which recommended the utilisation of a mobile unit or units 'capable of delivering chest x-ray, spirometry and general health assessments for coal workers and former coal workers in regional Queensland', the committee wishes to affirm that it considers that high-resolution CT scanning equipment should be included in the mix of equipment engaged in these units.

In this respect, Professor Alastair Stewart advised:

*Portable approaches could be brought directly to mines, including high resolution CT (HRCT) scanning which is more sensitive and precise than chest x-ray and more advanced lung function performed by certified trained Respiratory Scientist (skilled lung function technicians). Digital data could easily be transferred to specialist multiple disciplinary teams.*⁶²

⁶² Professor Alastair Stewart, correspondence, 18 October 2017.

Appendix A – Terms of reference

Initial terms of reference

On its establishment on 15 September 2017, the committee was asked to consider:

- (a) the legislative and other regulatory arrangements of government and industry which have existed in Queensland to eliminate and prevent CWP
- (b) whether these arrangements were adequate, and have been adequately and effectively maintained over time
- (c) the roles of government departments and agencies, mine operators, nominated medical advisers, radiologists, industry safety and health representatives and unions representing coal mine workers in these arrangements
- (d) the study into CWP undertaken by Monash University and the findings of the Senate Select Committee on Health (Fifth Interim Report) and other relevant reports and studies
- (e) the efficacy and efficiency of adopting methodologies and processes for coal mine dust measurement and mitigation, including monitoring regimes, engineering measures, personal protective equipment (PPE), statutory requirements, and mine policies and practices, including practices in jurisdictions with similar coal mining industries
- (f) other matters the committee determines are relevant, including other respiratory diseases associated with underground mining.

In considering these matters, the committee was granted the power to call for persons, documents and other items. Subsequent to an extension to the reporting date granted on 23 March 2017, the committee was required to report to the Parliament by 29 May 2017.

Extended terms of reference

Additional terms of reference established on 23 March 2017 also extended the committee's remit to include inquiry into and reporting on:

- (a) occupational respirable dust exposure for:
 - (i) coal port workers
 - (ii) coal rail workers
 - (iii) coal-fired power station workers
 - (iv) other workers
- (b) the legislative and other regulatory arrangements of government and industry which have existed in Queensland to prevent or reduce the harm caused by occupational respirable dust exposure to port, rail, power station, and other workers
- (c) whether these arrangements were adequate, and have been adequately and effectively maintained over time the roles of government departments and agencies, industry, health professionals and unions in these arrangements
- (d) the efficacy and efficiency of adopting methodologies and processes for respirable dust measurement and mitigation, including monitoring regimes, engineering measures, PPE, statutory requirements, and industry policies and practices, including practices in jurisdictions with similar industries
- (e) other matters the committee determines are relevant to occupational respirable coal or silica dust exposure.

The committee was also granted the power to call for persons, documents and other items in relation to its consideration of these matters. The committee was required to report on its extended terms of reference by 29 September 2017.

Monitor and review role

The committee was also asked to monitor and review the implementation of recommendations made by the committee in its reports on:

- (a) the terms of reference approved by the House on 15 September 2016
- (b) the first extended terms of reference, including the development of a draft bill for the consideration of the Assembly.

The committee is to continue in existence in this capacity until the Legislative Assembly is dissolved or the Legislative Assembly otherwise orders, despite reports by the committee.

Appendix B – CWP Select Committee inquiry activities

Over the course of its inquiries into the re-identification of coal workers' pneumoconiosis amongst coal miners in Queensland and into occupational respirable dust issues, the committee has cumulatively:

- received and accepted 74 written submissions
- conducted three departmental briefings, 30 public hearings and 15 private hearings, amounting to hundreds of hours of verbal testimony from more than 190 different witnesses.⁶³ Close to half of these proceedings – 14 public hearings and nine private hearings in total – were held in key regional centres and mining towns, including:
 - Ipswich
 - Mackay
 - Rockhampton
 - Collinsville
 - Moranbah
 - Dysart
 - Middlemount
 - Tieri
 - Blackwater, and
 - Emerald
- conducted a series of site visits and meetings at:
 - Carborough Downs underground mine, 20 kilometres east of Moranbah
 - Grasstree underground mine, 25 kilometres south-west of Middlemount
 - Wiggins Island Coal Export Terminal at the Port of Gladstone
 - Dalrymple Bay Coal Terminal at the Port of Hay Point
 - SIMTARS at Redbank, and
 - the University of Melbourne's LHRC
- travelled to NSW to meet with representatives from Coal Services, and travelled to the USA to meet with representatives from MSHA and NIOSH
- issued over 60 summons requiring the production of documents including from DNRM, the CFMEU and all operators of coal mines. The summonses required the production of safety and health management system documents, dust monitoring results, directives and compliance notices, mine record entries, minutes of meetings, correspondence, policies and procedures and resulted in the provision to the committee of many thousands of documents
- conducted nine public forums to report back on the committee's findings and recommendations and consult with workers and community members on the reform measures proposed, in:
 - Collinsville
 - Moranbah
 - Dysart

⁶³ A number of witnesses appeared before the committee on multiple occasions.

- Middlemount
- Tieri
- Emerald
- Blackwater
- Moura, and
- Rockhampton, and
- consulted privately with representatives of the QRC and major mining companies and with the CFMEU Mining and Energy Division on the committee's proposed reforms.

More detailed accounts of these activities are provided in the committee's *Black lung, white lies* report, in its draft bill report, and in its report on occupational respirable dust issues.

Appendix C – Requests for ministerial support for a proposed clinical trial



Coal Workers' Pneumoconiosis Select Committee

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26 October 2017

Hon Grace Grace MP
Minister for Employment and Industrial Relations,
Minister for Racing, and Minister for Multicultural Affairs
GPO Box 611
BRISBANE QLD 4001

By email: employmentIR@ministerial.qld.gov.au

Dear Minister

Request for your support of a proposed clinical trial in patients with mine dust lung diseases

We write on behalf of the Coal Workers' Pneumoconiosis (CWP) Select Committee (committee) to seek your support and assistance in facilitating a proposed clinical trial of cromoglycate for current and former mine workers with CWP and other mine dust lung diseases.

The proposal for this clinical trial was presented to the committee during a recent meeting and site visit with experts at the University of Melbourne's Lung Health Research Centre (LHRC) on 16 October 2017. Experts at the LHRC have advised that cromoglycate is a long-established and safe anti-asthma drug that has been shown to reduce coughing in patients with lung fibrosis. The drug is registered, inexpensive, and generally well tolerated, with a strong safety record characterised by only minor adverse effects.

The committee understands that the proposed trial would provide initial answers on the drug's effect on chronic cough and quality of life in affected individuals within only a few months of data collection, and could serve as the basis for a more extended trial to gauge the impacts of the drug on progressive massive fibrosis. Further, the trial design may be scalable to larger at-risk groups including miners with cough, as well as providing a structured system for future clinical trials of newly registered anti-fibrotic agents, including pirfenidone and nintedanib.

Recognising the severely limited range of treatment and rehabilitation options available to individuals affected by CWP and other mine dust lung diseases, the committee considers that the proposed clinical trial should be progressed as a matter of priority, with a view to offering all affected mine workers the opportunity to participate.

Accordingly, we request your immediate assistance in advancing this proposal with workers' compensation insurers and other members of the Workers' Compensation Stakeholder Reference Group.

To discuss this request, please contact the committee's Acting Committee Secretary, Lucy Manderson, on 07 3553 6603 or via email to CWPSC@parliament.qld.gov.au.

Yours sincerely

Handwritten signature of Mrs Jo-Ann Miller in black ink.

Mrs Jo-Ann Miller MP
Chair

Handwritten signature of Hon Lawrence Springborg in black ink.

Hon Lawrence Springborg MP
Deputy Chair

cc: Mr Bruce Watson, CEO, WorkCover Queensland: Bruce.Watson@workcoverqld.com.au



Coal Workers' Pneumoconiosis Select Committee

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26 October 2017

Hon Cameron Dick MP
Minister for Health and Ambulance Services
PO Box 48
BRISBANE QLD 4001

By email: health@ministerial.qld.gov.au

Dear Minister

Request for your support of a proposed clinical trial in patients with mine dust lung diseases

We write on behalf of the Coal Workers' Pneumoconiosis (CWP) Select Committee (committee) to seek your support and assistance in facilitating a proposed clinical trial of cromoglycate for current and former mine workers with CWP and other mine dust lung diseases.

The proposal for this clinical trial was presented to the committee during a recent meeting and site visit with experts at the University of Melbourne's Lung Health Research Centre (LHRC) on 16 October 2017. Experts at the LHRC have advised that cromoglycate is a long-established and safe anti-asthma drug that has been shown to reduce coughing in patients with lung fibrosis. The drug is registered, inexpensive, and generally well tolerated, with a strong safety record characterised by only minor adverse effects.

The committee understands that the proposed trial would provide initial answers on the drug's effect on chronic cough and quality of life in affected individuals within only a few months of data collection, and could serve as the basis for a more extended trial to gauge the impacts of the drug on progressive massive fibrosis. Further, the trial design may be scalable to larger at-risk groups including miners with cough, as well as providing a structured system for future clinical trials of newly registered anti-fibrotic agents, including pirfenidone and nintedanib.

Recognising the severely limited range of treatment and rehabilitation options available to individuals affected by CWP and other mine dust lung diseases, the committee considers that the proposed clinical trial should be progressed as a matter of priority, with a view to offering all affected mine workers the opportunity to participate.

Accordingly, we request the immediate assistance of your department in advancing this proposal with the Coal Mine Dust Lung Disease Collaborative Group and other relevant audiences.

To discuss this request, please contact the committee's Acting Committee Secretary, Lucy Manderson, on 07 3553 6603 or via email to CWPSC@parliament.qld.gov.au.

Yours sincerely

Handwritten signature of Mrs Jo-Ann Miller in black ink.

Mrs Jo-Ann Miller MP
Chair

Handwritten signature of Hon Lawrence Springborg in black ink.

Hon Lawrence Springborg MP
Deputy Chair

cc: Dr Jeanette Young, Chief Health Officer and Deputy Director General, Prevention Division Queensland:
Jeanette.Young@health.qld.gov.au, CHO_CHO@health.qld.gov.au;
Ms Sophie Dwyer, Executive Director, Health Protection Branch: Sophie.Dwyer@health.qld.gov.au