Parliamentary Committees

Inquiry into the re-identification of Coal Workers' Pneumoconiosis in Queensland - Interim Report

Report No. 1, 55th Parliament
Coal Workers' Pneumoconiosis Select Committee
March 2017

Coal Workers' Pneumoconiosis Select Committee

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Abbreviations

BMA	BHP Billiton Mitsubishi Alliance
CFMEU	Construction, Forestry, Mining and Energy Union
CMDLDs	Coal Mine Dust Lung Diseases
CMHSA	*Coal Mining Safety and Health Act 1999* (CMSHA)
CMSHR	Coal Mining Safety and Health Regulation 2001
CMWHS	Coal Mine Workers' Health Scheme
COPD	Chronic Obstructive Pulmonary Disease
CWP	Coal Workers' Pneumoconiosis
DNRM	Queensland Department of Natural Resources and Mines
HSU	Health Surveillance Unit, DNRM
ILO	International Labour Organisation
MSHA	Mine Safety and Health Administration (US)
Monash Review	Monash Centre for Occupational and Environmental Health, *Review of Respiratory Component of the Coal Mine Workers' Health Scheme*, 2016
NIOSH	National Institute for Occupational Safety and Health (US)
NSW	New South Wales
OEL	Occupational Exposure Limit
SIMTARS	Safety in Mines Testing and Research Station, DNRM

Foreword

On behalf of the Coal Workers' Pneumoconiosis Select Committee, we present this interim report on the committee's inquiry into the re-identification of Coal Workers' Pneumoconiosis in Queensland.

We commend this report to the House.

Jo-Ann Miller MP

Chair

Hon Lawrence Springborg MP

Deputy Chair

1. Introduction

The Coal Workers' Pneumoconiosis (CWP) Select 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. The committee is to report to the Legislative Assembly by 12 April 2017.

Until recently, the entire coal industry laboured under the illusion that CWP had been eradicated in Queensland. In April 1984, the Queensland Coal Board published a report by Rathus and Abrahams highlighting 75 cases or suspected cases of CWP.[1] In the intervening years, there were no cases of CWP reported, with the incidence of the disease appearing to all but vanish. During this period, those tasked with monitoring the health of Queensland coal workers were not actively looking for the disease, and in many cases were insufficiently informed and ill-equipped to enable its diagnosis.

> *I had the naïve belief that there was in fact some form of long-term health maintenance and monitoring of the mine worker, but obviously … this was not the case.*[2]

Tragically, miners' concerns over their respiratory health were raised and met with denial, as worker Mr Stuart McConnell testified:

> *The attitude towards [CWP] was that it was eradicated to the point where you would go to the doctor and try to talk to the doctor about what you are coughing up and they would say, 'Don't worry about that.' In my opinion, if you are not looking for something there is no way you are going to find it. I could take you out into the scrub and say, 'Let's go looking for ants.' If you are looking up in the air, you are never going to find them. You have to get your head down in the grass and actually look for them, and that has not been happening. It had not happened for the 20 years plus that I was in the mines.*[3]

Clearly, CWP was never eradiated in Queensland. It did not "re-emerge" in 2015 but was merely re-identified, after more than 30 years of responsible Queensland authorities failing to look for it or properly identify it.

As at March 2017, 20 Queenslanders had been diagnosed with this insidious and entirely preventable disease, with more likely to follow.

Queensland coal miners diagnosed with CWP, giving evidence at the public hearing in Mackay on 25 November 2016.

1 E.M. Rathus & E.W. Abrahams, *Report on the Queensland Coal Board Coal Miners' Health Scheme: chest x-ray and emphysema check survey of colliery employees in Queensland*, The Queensland Coal Board, May 1984, p 6.

2 Dr Ewen McPhee, Nominated Medical Advisor and former President, Rural Doctors Association of Australia, public hearing transcript, Emerald, 15 November 2016, p 5.

3 Mr Stuart Connell, private capacity, public hearing transcript, Moranbah, 22 November 2016, p 2.

2. Inquiry Terms of Reference

In undertaking the inquiry, the committee was asked to consider the following terms of reference:

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, statutory requirements, and mine policies and practices, including practices in jurisdictions with similar coal mining industries; and

f. other matters the committee determines are relevant, including other respiratory diseases associated with underground mining.

3. Committee inquiry process

To date, the committee has received 44 submissions. However, as a result of recent hearings which canvassed the health risks of coal dust to workers in Queensland's ports and power stations, this number is set to increase, with a new round of submissions being received.

The committee has held 27 public and 15 private (in-camera) hearings and one departmental briefing. Over the course of these hearings, the committee has taken evidence from 190 witnesses.

The committee held 13 of these public hearings in Brisbane, during which it has taken evidence from government departments and agencies, medical specialists, occupational safety and health professionals, union representatives, academics, mining engineers, mine operators, retired and former coal miners, and coal mine workers presently employed in the industry. The committee also heard testimony from a number of the individuals who have been diagnosed with CWP, and their families.

Most of these witnesses came willingly to give evidence to the committee. However, the committee has been required to compel the attendance of some witnesses under summons, including officers of Queensland's largest coal mine operator, BHP Billiton Mitsubishi Alliance (BMA).

The committee's 14 regional public hearings were held in regional centres and mining towns including:

- Ipswich
- Mackay
- Rockhampton
- Collinsville
- Moranbah
- Dysart
- Middlemount
- Tieri
- Blackwater, and
- Emerald.

In order for the committee to hear from current miners, these hearings were timed to coincide with the conclusion of either a day shift or night shift. Consequently, the hearings took place from 6.00am in the morning or until 9.00pm at night. The committee was overwhelmed by the numbers of miners who attended and wanted to speak about their own experiences. Every miner had a story about the high levels of dust that they are exposed to as a result of their job. Most miners described health assessments and surveillance that were significantly lacking.

Public Hearing held at Middlemount on 24 November 2016

In November 2016, the committee visited Carborough Downs underground mine, located 20 kilometres east of Moranbah, and held talks with mine management on the operation of a longwall mine and the approach that Vale Australia had taken to dust management and worker health following the diagnosis of CWP in three of its workers.

In December 2016, the committee visited Grasstree Mine, located 25 kilometres south-west of Middlemount, and went underground to view a longwall in operation. During the site visit the committee held discussions with a large number of Anglo American senior executives and technical experts about the measures that Anglo has undertaken to mitigate and control dust at its Queensland mines.

In February 2017, the Chair and the Deputy Chair travelled to the United States to investigate how the United States (US) regulates its coal mining industry and identifies and manages Coal Workers' Pneumoconiosis (CWP) and other Coal Mine Dust Lung Diseases (CMDLDs). The US is now recognised internationally as the world's best practice jurisdiction in relation to dust regulation and health surveillance of coal workers. The delegation conducted site visits and held meetings at the following locations:

- National Institute for Occupational Safety and Health (NIOSH): Centre for Dust Control Research in Pittsburgh
- Mine Safety and Health Administration (MSHA): Dust Division in Pittsburgh
- NIOSH: Division of Respiratory Disease Studies in Morgantown
- Black Lung Clinic: Northwestern Medicine, Northwestern University in Chicago, and
- Black Lung Centre of Excellence: University of Illinois in Chicago.

Also in February 2017, the committee met with representatives from Coal Services Pty Ltd and the New South Wales (NSW) Resources Regulator to discuss the collaborative model approach taken in NSW in relation to the monitoring and management of coal dust exposure and worker health, and workers' compensation for coal industry workers.

In March 2017, the committee engaged in site visits at Wiggins Island Coal Export Terminal at the Port of Gladstone and Dalrymple Bay Coal Terminal at the Port of Hay Point, south of Mackay.

In March 2017, the committee also conducted a site visit to the Department of Natural Resources and Mines' (DNRM) Safety in Mines Testing and Research Station (SIMTARS) at Redbank.

During the course of the inquiry the committee has to date issued over 60 summonses to obtain information in regard to dust monitoring records and the health surveillance of coal workers in Queensland. This process has generated in excess of 10,000 documents.

4. Evidence to date

Since 2015, 20 current and former coal mine workers in Queensland have been diagnosed with CWP or "black lung" disease. In summary:

- 19 have been formally "confirmed" through the DNRM process, with the 20th case currently pending confirmation
- two cases are described as "complex", presenting with multiple conditions
- 17 involve miners who were actively working in the Queensland coal industry at the time of their diagnosis, and three were retired or former coal miners at the time of diagnosis
- current ages range from 38 to 73, with an average age of 56
- one involves an aboveground coal mine worker with no underground experience
- four have substantial overseas coal mine experience (UK and USA)
- two have worked in NSW coal mines, as well as in Queensland
- two have worked in the Ipswich coal fields, and
- all worked in Bowen Basin coal fields at some point in their careers.[4]

The committee considers that the overwhelming weight of evidence gathered to date suggests it is likely that many more Queensland miners and former miners will be diagnosed with CWP or related CMDLDs as a result of what has been a catastrophic failure of the regulatory and health surveillance systems intended to ensure the protection of coal industry workers.

By the end of 2016, experts advised:

> *…the CWP cases being identified now are a small indicator of what is to come. This will be an epidemic. The Australian coal mining industry as a whole, will see many more cases of this totally preventable disease in the very near future.*[5]

As at March 2017, the committee understands that 28 claims have been made with workers' compensation insurers in regard to CWP, with more claims lodged in relation to other respiratory conditions that may be related or co-occurring. As the world's leading expert on CWP, Dr Robert Cohen, told the committee:

> *When you identify something that is unusual, that could affect other people, it means that you do not just care for that one person; you immediately investigate the circumstances surrounding that case so that you can see if there are other cases or what was the causes of that. That should have triggered some major alarm bells at that time… What we all suspected was that it was just overlooked and now it has been rediscovered. Those are all examples of alarm bells that could have been rung and people could have answered that alarm and just started doing exactly what we are doing now, but we could have done it a decade ago.*[6]

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4 Department of Natural Resources and Mines, submission 35, p 7.

5 Dr Brian Plush, submission 15, p 1.

6 Dr Robert Cohen, Director of Occupational Lung Disease, Division of Pulmonary and Critical Care Medicine, Feinberg School of Medicine, Northwestern University, public hearing transcript, Brisbane, 15 March 2017, p 41.

CWP is a type of pneumoconiosis, or fibrotic lung disease, solely caused by the inhalation of coal mine dust.[7] There is a spectrum of lung diseases that are classified as pneumoconiosis:

- asbestosis, cause by the inhalation of asbestos dust particles
- silicosis, caused by the inhalation of silica dust particles, and
- CWP, caused by the inhalation of fine coal dust particles.[8]

In addition, there are a range of CMDLDs, related to CWP, that can be directly attributed to coal mine dust exposure but that are commonly not identified as arising from a coal mine worker's occupation. These include:

- emphysema
- chronic bronchitis, and
- Chronic Obstructive Pulmonary Disease (COPD).[9]

There are distinct features of early-stage CWP that contribute to what the committee discovered was a widespread and general belief that the disease had been eradicated in the Queensland coal mining industry:

- there is a long latency period before symptoms appear
- symptoms of the disease are highly variable and may be masked by features of other respiratory diseases, such as emphysema, chronic bronchitis and fibrosis (all of which are CMDLDs), and
- the disease requires experience and expertise among medical professionals to be accurately identified.

The evidence suggests that until the re-identification of CWP in 2015, the entire coal mining industry in Queensland (and NSW) seemed to believe that CWP had been eradicated in Australia, with the last cases in Queensland in the 1980s. This view was accepted by the DNRM, Queensland Health, the Department of Industrial Relations, coal mine operators, the Queensland Resources Council, trade unions, and coal workers. This is particularly concerning given the continuing high rates of CWP diagnoses in the United States over the same period.[10] However, it seems that all stakeholders accepted at face-value that the Coal Mine Workers' Health Scheme had not identified any cases of CWP in Queensland since 1984, and therefore, that it must have been eradicated here.

Clearly, CWP was never eradiated in Queensland. It did not "re-emerge" in 2015 but was merely re-identified, after more than 30 years of responsible Queensland's authorities failing to look for it or properly identify it.

The Monash *Review of Respiratory Component of the Coal Mine Workers' Health Scheme* (Monash Review) in 2016 found a general belief held by most stakeholders that, as there had been no new cases of CWP for many years, the disease had been eradicated in Queensland.[11]

The committee noted this general belief has influenced the development of government policy and regulatory frameworks, workplace health and safety policies and standards at mine sites, and the way medical professionals conducted their medical examinations and made diagnostic decisions. Evidence received at public hearings and in submissions from a range of stakeholders attested to this.[12]

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7 The Thoracic Society of Australia and New Zealand, submission 6, p 2.

8 Australian Institute of Occupational Hygienists Inc., submission 14, p 4; CFMEU Mining & Energy Division, submission 27, p 5.

9 Dr Robert Cohen, public hearing transcript, Brisbane, 15 March 2017, p 8.

10 Dr Robert Cohen, public hearing transcript, Brisbane, 15 March 2017, p 3.

11 Monash Centre for Occupational and Environmental Health, *Review of Respiratory Component of the Coal Mine Workers' Health Scheme*, 2016, p 19.

12 See for example: Public briefing transcript, Brisbane, 14 October 2016; Public hearing transcript, Mackay, 26 November 2016, p 23; Queensland Resources Council, submission 18.

There is no cure for CWP, and treatment consists of managing the symptoms.[13] However, a number of submissions to this inquiry noted that CWP is a completely preventable disease, which can be avoided by removing or limiting exposure to coal dust.[14] The risk of developing CWP is directly related to the magnitude and duration of exposure to coal mine dust.[15] When detected early, the progression of the disease can be halted by the removal of the worker from further exposure to coal mine dust.[16]

The evidence so far suggests that there has been a massive systemic failure across the entirety of the regulatory and health systems intended to protect coal industry workers. Prior to the re-identification of CWP in 2015, there was an absolute failure by the DNRM, its Mine Inspectorate, SIMTARS and its Health Surveillance Unit (HSU) to properly regulate air-borne dust and to look for or identify CWP or CMDLD. The evidence suggests that Queensland Health, WorkCover and self-insurers have played a role in this failure.

As identified in the Monash Review, 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 notes that following the diagnoses of coal miners with CWP in 2015, the CFMEU Mining and Energy Division commenced an industry-wide campaign to draw attention to black lung disease and the risk it poses to coal mine workers. Were it not for the efforts of the CFMEU in this regard, it is most unlikely all the current cases of CWP would have been discovered.

4.1 Department of Natural Resources and Mines

The evidence suggests that the DNRM did not administer the *Coal Mining Safety and Health Act 1999* (CMSHA) and the Coal Mining Safety and Health Regulation 2001 (CMSHR) to protect the safety and health of persons at mines with respect to respirable coal mine dust. DNRM did not have or adequately maintain dust records for coal mines. Coal mines were not, until recently, required to report dust monitoring results or exceedances to the inspectorate or the Commissioner for Mine Safety and Health. There was no central repository of data about dust exposures in Queensland coal mines.

No mine operator has ever been prosecuted for breaching the regulatory dust exposure limit or failing to ensure risk to workers arising from dust exposure was kept to an acceptable level. The use of other enforcement powers such as Directives issued by the mining inspectorate has been inconsistent and often takes many months to achieve compliance.

The Mines Inspectorate did not, in any systematic and co-ordinated manner, monitor the activities of mine operators in relation to respirable dust. Their focus was primarily on other mine hazards, with limited regard given to the dangers of respirable dust prior to the re-identification of CWP.

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13 CFMEU Mining & Energy Division, Submission 27, p 6.

14 See: CFMEU Mining & Energy Division, submission 27, p 6; AMA Queensland, submission 23, p 1; Australian Institute of Occupational Hygienists Inc., submission 14, p 2.

15 The Thoracic Society of Australia and New Zealand, submission no 6, p 2.

16 The Thoracic Society of Australia and New Zealand, submission no 6, p 3.

17 CFMEU Mining & Energy Division, submission no. 27, p 23; Public hearing transcript, Moranbah, 23 November 2016, p 15; Private hearing transcript, Moranbah, 22 November 2016.

SIMTARS, while a world leader in mine safety research, has not conducted any research on respirable dust or its mitigation. This is in stark contrast to the long-standing and extensive research in this area undertaken by the MSHA in the United States. Despite several senior officers of SIMTARS and DNRM visiting MSHA and NIOSH in the US over the past 10 years, it seems none of this research or knowledge was brought back to Queensland to be shared amongst regulators and mine operators.

SIMTARS dust monitoring is provided on a fee-for-service basis. The committee is concerned there may be inherent conflicts in the body charged with training and research functions providing commercial dust monitoring services to industry with no authority to report or act upon discovered breaches of regulatory standards.

The committee was deeply disturbed by the evidence uncovered in relation to the HSU. From its establishment, the HSU failed to undertake any actual health surveillance. It served as nothing more than a storage unit for miners' chest X-ray and health records.

> *Mr KELLY: … Was it your perception when you were sending things off to the department that there was going to be another level of vigilance in terms of reviewing the X-rays or other tests that may have been done?*
>
> *Dr McPhee: I think it was probably naïve of me to think that would be the case. When the title of the department was the Health Surveillance Unit, I thought that there would be some attempt to provide health surveillance because this is an insidious disease. The mechanisms that we have to diagnose it are not particularly reliable. Both spirometry and chest X-ray are really blunt instruments. This is a disease that evolves over time and, as I mentioned before, we often only may see this miner once in their career. I had the naïve belief that there was in fact some form of long-term health maintenance and monitoring of the mine worker, but obviously from my own reading this was not the case.*[18]

Even data entry and basic administration was hopelessly under-resourced to the point where at times, the HSU was staffed by only one part-time administration officer at the lowest classification level available.[19] As the Commissioner for Mine Safety and Health, Mrs Kate du Preez, attested:

> *… to my understanding, the HSU was only a storage facility in the past … at no time did they ever assess any of the documentation or the medicals that came to them. Their whole role was to ensure that it was stored and that the people's confidentiality was maintained.*[20]

Overwhelmed with health assessment records during the mining boom, the committee heard that many health records of the HSU were "…stored in a janitor's cupboard next to the female toilets",[21] and in shipping containers at the DNRM site at Redbank. Environmental conditions meant that when efforts were finally made to retrieve and review those records, many were destroyed or unreadable.[22]

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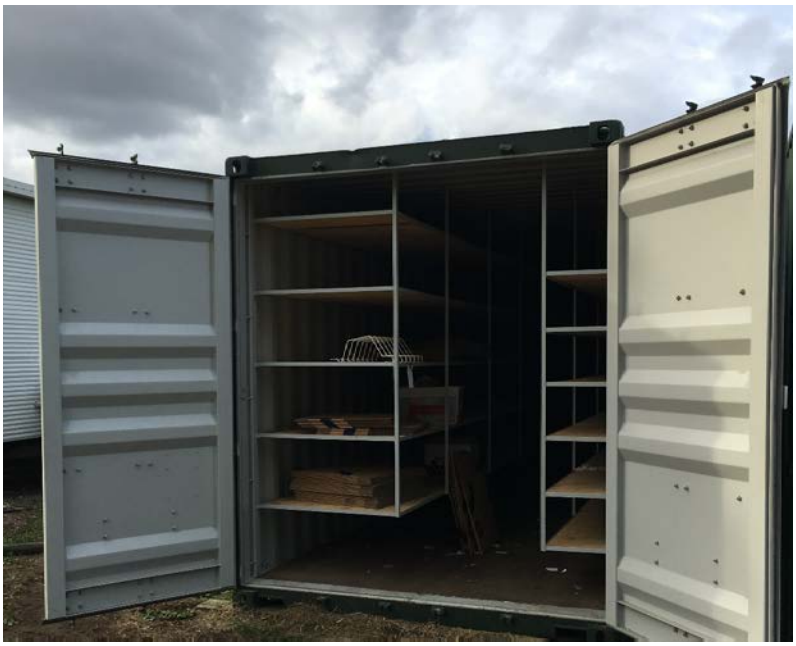
18 Dr Ewen McPhee, public hearing transcript, Emerald, 15 November 2016, p 5.

19 DNRM reported in response to a question taken on notice that the HSU operated with one full-time equivalent (FTE) employee in 2005 and less than three FTE staff up until 2010. See: DNRM, Response to Question taken on Notice No 8 asked on 30 November 2016, Brisbane, p 15.

20 Mrs Kate du Preez, Commissioner for Mine Safety and Health, Public hearing transcript, Brisbane, 2 November 2016, p 6.

21 Dr David Smith, Occupational Physician, DNRM, public hearing transcript, Brisbane, 30 November 2016, p 21.

22 Former HSU occupational physician Dr David Smith testified that "… the x-rays were subjected to high temperatures and terrible storage conditions". See: Public hearing transcript, Brisbane, 30 November 2016, p 15.



Shipping containers which housed the records of the HSU, SIMTARS Redbank site, 14 March 2017

Additionally, DNRM appointed an occupational physician to oversee the HSU on only a part-time basis. No senior executive of DNRM ever reviewed the performance of the occupational physician or discussed with him what work he was expected to do to ensure the HSU functioned as it should have.[23]

The committee discovered that efforts to improve the efficiency and purpose of the HSU, following a review in 2002 and again during development of a proposed regulatory impact statement on mine safety in 2013, became indefinitely delayed due to:

- the prioritisation of other perceived higher and more immediate risks, and
- lack of agreement among tripartite advisory committees.

Only one of 19 recommendations in the 2002 review of the HSU was ever implemented.

Many of these recommendations sought to address concerns with the HSU that were very similar to those dealt with in the Monash Review 13 years later.

The committee has been appalled by the level of disregard for its work demonstrated by some senior officers of DNRM. Despite repeated assurances from DNRM that it would work expeditiously to assist the committee in any way possible, the committee has been met with resistance and obstruction by some officers of DNRM. Documents requested have not been produced, requiring the issue of a summons. Key departmental witnesses, vital to understanding the system failure at HSU were not advised they would be required to give evidence; were then produced only under threat of summons; and were not properly prepared by DNRM prior to their appearances before the committee. Frequently senior officers have been unprepared and unable to answer important questions relevant to the committee's inquiry and where answers were given, often the officers were argumentative and resistant to acknowledging the wide-ranging failures of their department. This appears to be a reflection of a culture and attitude that has built up over 30 years.

4.2 Workers' Compensation

Despite the widespread belief that Queensland had not had a case of CWP for 30 years until 2015, the committee discovered that WorkCover approved a claim for CWP in 2006. That worker was diagnosed

[23] Dr David Smith, public hearing transcript, Brisbane, 30 November 2016, pp 18-19.

with CWP in a Queensland public hospital in 2004. The Medical Assessment Tribunal confirmed the diagnosis in 2007.

Neither WorkCover nor Q-Comp (as it then was) alerted DRNM to the diagnosis. Queensland Health did not treat the diagnosis as a sentinel event or undertake any investigation as to how a disease previously thought to have been eradicated had re-emerged.

It is evident that no information sharing occurred between the Queensland Health, DNRM and WorkCover. As Dr Cohen told the committee:

> *This is another example of why these data systems need to talk to each other. Hospital discharge data systems, death certificate data systems, compensation data systems and surveillance data systems need to be coordinated.*[24]

The committee has also heard from current CWP sufferers, including Mr Steve Mellor, that the diagnosis comes with massive financial and emotional impacts that are only exacerbated by the impersonal and bureaucratic approach of workers' compensation insurers.

> *CHAIR: How are you living in terms of money?*
>
> *Mr Mellor: My father recently passed away so I have had a small inheritance that I have been living off…To then be advised by WorkCover that you have been assessed as having a zero per cent permanent impairment and offered a lump sum of zero dollars is offensive and humiliating. I cannot help wondering, if the system is not changed, how many other employees of contractors will be tossed to the scrapheap with me.*[25]

It is apparent that the current workers' compensation scheme needs modification to ensure current and former coal workers effected by respiratory symptoms are supported and encouraged to seek appropriate diagnosis and treatment, and that those diagnosed with CWP or CMDLD have easy access to comprehensive support, assistance, and treatment.

4.3 Queensland Health

The committee heard evidence from Queensland Health that CWP was not a primary concern of that department.

> *Queensland Health has not had responsibility for occupational health and safety since 1988 when it was transferred to the then Division of Workplace Health and Safety within the department of industrial relations. As such, we do not hold any records in relation to this. Legislative and other regulatory arrangements for occupational health and safety are now the responsibility of other agencies.*
>
> *When we are looking specifically at Queensland Health's role in the management of coalmine workers with pneumoconiosis, miners may be reviewed in a specialist outpatient setting or require hospitalisation for the treatment of symptomatic coalmine workers' lung disease. Miners with simple coal workers' pneumoconiosis would not be expected to have any symptoms that would require hospitalisation, and it would be expected that only those with more advanced disease would require inpatient treatment.*[26]

This simplistic understanding of CWP and its effects on the health and well-being of coal workers (and complete absence of recognition of other CMDLD) is typical of the level of knowledge demonstrated across the health system until very recently. While Queensland Health was working within the bounds of its regulatory framework at the time, if the 2004 case of CWP that was diagnosed in the public health system had been treated as a notifiable disease, it could have been recognised as a sentinel event and

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24 Dr Robert Cohen, public hearing transcript, Brisbane, 15 March 2017, p 42.

25 Mr Steve Mellor, private capacity, public hearing transcript, Brisbane, 15 March 2017, p 44.

26 Ms Sophie Dwyer, Executive Director, Health Protection Branch, Prevention Division, Queensland Health, Public briefing transcript, Brisbane, 14 October 2016, p 33.

referred to the Chief Health Officer, and action taken 11 years before its positive re-identification in 2015.

The committee considers that CWP and CMDLDs should be classified as notifiable diseases, ensuring they are brought to the attention of the Chief Health Officer. Further, there is currently no clinical pathway for CWP or CMDLD that ensures sufferers get access to proper treatment and referral, including pulmonary rehabilitation. It is critical that Queensland Health develop this in the future.[27]

4.4 Medical Professionals

The committee strongly supports the findings of the Monash Review. It is likely that all the recommendations of that report will be adopted or encompassed within the recommendations of the committee.

The committee heard evidence from a very large number of miners who had lost faith in the medical professionals who were tasked to monitor and protect their health. In evidence, the committee has heard that:

- some medical professionals undertaking CMWHS medicals did not live in or near a mining town and had no clear understanding of the occupational groups employed in a mine or the work done by mine workers
- most medical professionals undertaking CMWHS medicals did not take complete occupational histories
- the scheme is predominantly focussed upon fitness for work assessments rather than true health screening and surveillance
- despite the recommendations of the Monash Review regarding the need for x-rays to be performed by appropriately trained staff to a suitable standard of quality,[28] approximately 20 per cent of chest x-rays taken for the CMWHS medicals are still of poor quality and cannot be read or interpreted[29]
- chest x-rays that indicated signs of CWP were not correctly read
- coal mine workers were confirmed fit for work and continued to work underground for years after chest x-rays showed CWP[30]
- coal mine workers were not informed of the outcomes of their medicals
- specialist medical professionals gave conflicting and confusing diagnoses and information, and
- mine operators were not informed of workers' adverse health assessments due to privacy concerns.

4.5 Mine Operators

Evidence provided to this committee suggests a large difference in management and approaches between mine operators in relation to their commitment to dust mitigation and to the health of their workforce. The re-identification of CWP triggered responses ranging from quick acknowledgement and action to blame-shifting and avoidance.

While many aspects of the current risk-based regulatory framework are effective, self-regulation as a model is not without problems. The committee has heard in regard to dust monitoring:

> *Dust sampling is undertaken by the companies. It is not an independent process. When you put the fox in charge of the hen house, eventually it fails.*[31]

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27 Dr Robert Cohen, public hearing transcript, Brisbane, 15 March 2017, p 20.

28 Monash Centre for Occupational and Environmental Health, *Review of Respiratory Component of the Coal Mine Workers' Health Scheme*, 2016, p 12.

29 Public hearing transcript, Brisbane, 15 March 2017.

30 Public hearing transcript, Mackay, 25 November 2016.

31 Mr Jason Hill, Industry Safety and Health Representative, CFMEU Mining & Energy Division, public hearing transcript, Ipswich, 4 November 2016, p 31.

The evidence suggests a number of mine operators have not complied with their statutory responsibilities to protect the safety and health of workers from the hazard of respirable coal mine dust. Examples include:

- regular and gross exceedances of the regulated dust limits
- limited provision of PPE in high dust environments
- limited base-line dust monitoring
- limited use or availability of dust suppression mechanisms
- poor systems for responding to dust exceedances, and a
- lack of diligence by mine operators in meeting their obligations under the CMWHS.

5. Emerging issues

It is the committee's intention to report as soon as possible to the Queensland Parliament. However, by December 2016, 17 cases of CWP had been confirmed in Queensland and the issue of CWP was much larger and more complex than was understood when the Parliament established the committee's Terms of Reference. There are currently 19 confirmed cases of CWP in Queensland but the committee is aware of more miners who may soon have their diagnoses finalised. The evidence suggests many more cases are out there but are yet to be identified.

During the course of this inquiry it has become apparent that CWP is not a disease that effects only underground coal mine workers. One case of CWP in an above-ground coal worker has been confirmed in Queensland, and the evidence suggests that more cases of CWP will be found in this occupational cohort.

The committee has heard evidence which raises concerns about all workers who are exposed to coal dust, including port terminal workers, rail workers, and coal-fired power station workers. These occupational cohorts were not initially considered as part of this inquiry – however, where there is coal there is coal dust; and where there is coal dust, there is the potential for CMDLD.

Throughout the inquiry, mine workers also raised their concerns about silica. The committee heard testimony about the debilitating effects of silicosis on mining workers and the lack of support and medical help these sufferers receive. Dr Cohen gave evidence that:

> *Silica is probably more dangerous than coalmine dust. We talked about the toxicities earlier. Quarriers, tunnelers, metal miners—anyone who is disturbing the earth's crust and drilling through rock is at risk for quartz and silica exposure.*
>
> *There should be industrial hygiene monitoring of the exposure levels. We just lowered our exposure level to silica from 0.1 milligram per metre cubed to 50 micrograms or 0.05 milligrams per metre cubed because of the horrendous diseases that occur from silica. Aside from the diseases we have already talked about for coalmine dust, silica is actually a lung carcinogen. It is an International Agency for Research on Cancer, IRAC, class 1 human carcinogen. It causes renal disease and causes other autoimmune diseases like rheumatoid arthritis and other things.* [32]

6. Recommendations

The committee expects to make significant and wide-ranging recommendations in relation to the public administrative framework for protecting the health and welfare of coal workers in Queensland.

[32] Mr Greg Dalliston, Industry Safety and Health Representative, CFMEU Mining & Energy Division, public hearing transcript, Brisbane, 15 March 2017, p 31.

The committee may recommend changes, including in the following areas:

- the Occupational Exposure Limit (OEL) for respirable coal mine dust
- the regulation of atmospheric dust monitoring
- the frequency and extent of atmospheric dust monitoring inspections
- the workplaces at which atmospheric dust monitoring must be undertaken
- the use of real time personal dust monitors
- the current Coal Mine Workers' Health Scheme
- the providers of radiographic imaging and spirometry under the Health Scheme
- the arrangements for ensuring coal workers' chest x-rays are properly read and classified according to the International Labour Organisation (ILO) system for Classification of Radiographs by properly qualified and approved B-Readers
- the cost and scope of health assessments for retired or former coal workers
- the workers' compensation scheme as it applies to long latency respiratory diseases
- the regulatory environment, and
- the implementation of a new regulatory environment.

7. Conclusion

7.1 Extension to reporting date

Over a six month period the committee's inquiry has generated a significant amount of public interest and has produced a significant amount of evidence. The committee has heard evidence from 190 witnesses and has held 42 public and in-camera hearings. It has received 44 submissions and obtained over 10,000 documents under summons.

In light of the evidence received, the committee intends to make significant and wide-ranging recommendations in relation to the public administrative framework for protecting the health and welfare of coal workers in Queensland. This will include the administration of the CMSHA and the CMSHR; the *Mining and Quarrying Safety and Health Act 1999* and Regulation; the *Workers' Compensation and Rehabilitation Act 2003* and Regulation; the *Public Health Act 2005* and Regulation; and consequential amendments to a range of other legislation.

To provide the committee with the time needed to undertake the task at hand the committee has resolved to seek an extension to its reporting date until 29 May 2017 for the committee's first report.

7.2 Extension to the terms of reference

A number of issues have emerged during the course of this inquiry that had not been envisaged at the establishment of this select committee. These include:

- respirable dust exposure for coal port workers
- respirable dust exposure for coal rail workers
- respirable dust exposure for coal-fired power station workers, and
- respirable dust exposure for other workers.

The committee requests that:

- the parliament amends the terms of reference of the Select Committee to allow inquiry into these important issues and that the committee report the findings of this inquiry to the Legislative Assembly by 29 September 2017
- the Coal Workers' Pneumoconiosis Select Committee be extended to monitor and review the implementation of recommendations made by the CWP in its reports, including the development of a draft Bill for the consideration of the Assembly, and
- the committee continues in existence until the Assembly dissolves or otherwise orders, despite reports by the committee.

Statement of Reservation

Statement of Reservation

Inquiry into the re-identification of Coal Worker's Pneumoconiosis in Queensland – Interim Report

There has been broad support across party lines during the conduct of this inquiry. All committee members have shown a willingness to conduct the inquiry according to the current terms of reference with the objective of establishing processes that prevent pneumoconiosis, provide ongoing health screening for those engaged in coal mining, detect the disease in people currently in or retired from coal mining, provide ongoing high standards of health care for those affected and provide appropriate compensation.

This problem spans three decades and all parties involved share some responsibility for the current situation including employers, government departments, health care professionals and unions.

The work of the committee has built on and added substantially to work done by a Federal Senate inquiry and the Monash Review.

The interim report is fair, balanced and no doubt discomforting for some people. That discomfort does not compare to the suffering of people affected by CWP or their families.

We support the committee expanding its terms of reference to inquire into coal port worker, coal rail workers and coal fired power plant workers and dust issues for workers in all industries. We also support the role of the committee being maintained to monitor and review the implementation of recommendations made by the committee.

The Minister, Dr Anthony Lynham has shown leadership on this very difficult issue. As a medical doctor, he understands what this condition means for people and their families. The Minister has already taken action to deal with this terrible disease, action that has received support of employers, unions, academics and medical professionals. No doubt the Minister, like many others are awaiting the outcome of the report to determine what further action can be taken to deal with this disease including administrative, regulatory and legislative changes.

We do not support the committee taking on the role of drafting legislation. we believe, if the opportunity is granted by the house, the committee should focus

on investigating the matters referred to in the extended terms of reference as well as monitoring and reviewing any other recommendations. The Minister is fully capable of drafting any required legislation and may have already taken steps in the right direction based on recommendations gathered from other inquiries.

We fully support the right of any member of this house to bring a Private Member's Bill and no doubt all involved as committee members would be fully capable of this task, however, we believe the Minister is most appropriately placed to enact all administrative, regulatory and legislative actions to deal with this terrible disease.

While we have made a statement of reservation about one aspect of the interim report, we wish to make it clear to all people who work in the mining industry and their families, particularly those diagnosed with this disease, that all members of the committee and secretariat are committed to getting this situation resolved. The majority of employer representatives, union officials and members, public servants, academics and health professionals have showed a similar commitment, although as noted in the report some people have for a range of reasons been less than cooperative. We trust this interim report will play an important part in preventing this disease and supporting the people affected.

Joe Kelly

Member for Greenslopes

Craig Crawford

Member for Barron River

Date: 21 March 2017