



COAL WORKERS' PNEUMOCONIOSIS SELECT COMMITTEE

Members present:

Mrs JR Miller MP (Chair)
Mr JN Costigan MP
Mr CD Crawford MP
Mr JP Kelly MP
Mr S Knuth MP
Mr LJ Springborg MP

Member in attendance:

Mr J Pearce MP

Counsel assisting:

Mr B McMillan (Barrister at Law)

Staff present:

Dr J Dewar (Research Director)
Ms K Shalders (Principal Research Officer)

PUBLIC BRIEFING—INQUIRY INTO THE RE-EMERGENCE OF COAL WORKERS' PNEUMOCONIOSIS AMONGST COAL MINE WORKERS IN QUEENSLAND

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 14 OCTOBER 2016

Brisbane

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Committee met at 9.01 am

CHAIR: Good morning. I declare open the public briefing in the coal workers' pneumoconiosis inquiry. Thank you to everyone for your attendance here today. I am Jo-Ann Miller, the member for Bundamba and chair of the select committee of the parliament. The committee members with me today are: Mr Lawrence Springborg MP, the member for Southern Downs and deputy chair; Mr Craig Crawford MP, the member for Barron River; Mr Joe Kelly MP, the member for Greenslopes; Mr Jason Costigan MP, the member for Whitsunday; and Mr Shane Knuth MP, the member for Dalrymple. We also have as a guest today Mr Jim Pearce MP, the member for Mirani. He has leave of the committee to attend.

Those here today should note that the hearing is being transcribed by Hansard and that the media are present. Therefore, members may be filmed or photographed. Before we commence can I please ask that mobile phones be switched off or put to silent mode. For the benefit of Hansard, I ask that witnesses state their name and position when they first speak and that they speak very clearly into the microphone.

This hearing is a formal committee proceeding of the parliament. The guide for appearing as a witness before the committee has been provided to those appearing today. The committee will also observe schedules 3 and 8 of the standing orders.

ALBURY, Mr Russell, Acting Chief Inspector of Coal Mines, Department of Natural Resources and Mines

CRONIN, Ms Rachael, Deputy Director-General, Mineral and Energy Resources, Department of Natural Resources and Mines

PURTILL, Mr James, Director-General, Department of Natural Resources and Mines

STONE, Mr Mark, Acting Chief Mine Safety and Health Officer, Department of Natural Resources and Mines

CHAIR: I would like to begin the proceedings by welcoming senior officers from the Department of Natural Resources and Mines. Mr Purtill, would you like to make an opening statement?

Mr Purtill: Yes, thank very much. Thank you very much committee members for the opportunity to address you today. The chair's letter to me of 23 September requested that the department provide a briefing on the legislative and other regulatory arrangements related to this inquiry, and we are very happy to do so.

Before I commence, though, I wish to reinforce to the committee that addressing the re-emergence of coal workers' pneumoconiosis is the top priority for the department. To date there have been 16 cases of coal workers' pneumoconiosis reported by the Queensland coalmining industry. The most recent confirm case involves an above-ground miner. One case is too many.

Therefore in response, the department has, as a matter of urgency, undertaken a significant volume of work and has made substantial progress. The committee will be aware from the significant amount of work that has been undertaken since the first case in many years was confirmed last year—that work including the independent review by Monash University, new regulations gazetted, guidance material released, advertising to raise community awareness and our minister's direct engagement with various arms of the medical profession—that we are working very hard to address this issue. That material, of course—as I have just confirmed with the Dr Dewar—is available for the committee at any time and in very fashion. We are very happy to assist with that material and other materials as the inquiry proceeds.

The department has also been working in close collaboration with expert bodies within the medical profession and companies, coal operators and unions to find solutions. Following the release of the Monash review the department introduced immediate changes so that all new coalmine worker chest X-rays are assessed, both by an Australian radiologist and a US based National Institute for

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Occupational Safety and Health, NIOSH, accredited reader at the University of Illinois, Chicago. This interim measure will remain in place until local radiologists have undertaken further training to the required international standard and a new medical screening program is established.

With me today I have three senior departmental officers who have been introduced to the committee. The department is responsible for the regulation of coalmining safety and health, including the Coal Mine Workers' Health Scheme. We are happy to brief you on these matters today and provide factual and technical background to government, legislative and regulatory arrangements to the best of our ability.

Given the latency period of coal workers' pneumoconiosis, some of the more critical decisions may have been made several years ago under a different management team. Every effort will be made to make available the supporting material the committee may be seeking to assist it in this process. Rachael, Mark and Russell will talk to you today about Queensland's coalmining safety and health legislative regime, the role of the department and the coalmining inspectorate in safety and health regulation and administration, a brief history of the regulatory regime and its development, regulatory and other arrangements for the monitoring, reporting and control of coal dust and the Coal Mine Workers' Health Scheme.

I anticipate the committee may have additional questions for the department that fall outside the scope of this initial briefing or questions that may arise for the committee out of this briefing itself today. The department will, of course, be very happy to take any questions on notice if we cannot provide a response to you today. The department will also provide you with detail about recent amendments to regulations which have been made to address this issue. We have a presentation pack prepared for the committee. I would like to hand over to Russell to begin the briefing.

CHAIR: Thank you very much. Director-General, will you be providing this committee with all documents that the committee seeks to have to assist us in our process going back decades?

Mr Purtill: To the best of our ability we will provide all of the records that are available, absolutely. Of course, we would have to find them.

CHAIR: You can take this on notice, but I would like to know whether there has been any destruction of documents within the department in accordance with the Archives Act?

Mr Purtill: Sure.

CHAIR: Who gave the approval for the retention or destruction of documents in accordance with the Archives Act?

Mr Purtill: I am happy to take that on notice.

Mr SPRINGBORG: Can I ask a couple of questions before we move to the next part of our briefing. Thank you very much, Mr Purtill. I was interested in a couple of things that you said. You are concerned, obviously as we are, about the current situation with regard to black lung disease. You used the term 're-emergence'. Does that presuppose that this is only just a modern issue and that it has only come up in the last year or so or that we have not been competently identifying and diagnosing this for years? It sounds to me that re-emergence means that it is just a modern problem rather than something that has been there under the radar for the last few years, possibly 20 or 30 years?

Mr Purtill: We have, if you like, a definition of a confirmed case from the coal workers health scheme. After a medical assessment is made and a diagnosis by the nominated medical adviser is made that diagnosis is then informed to our physician Dr David Smith who confirms that and it becomes a confirmed case. The first confirmed case in many years came to the attention of the department through the coal workers health scheme last year.

Mr SPRINGBORG: Using the terminology re-emergence only deals with the issue of confirmed diagnosis. It may not deal with the fact that it has been there significantly before the confirmed diagnosis?

Mr Purtill: That is right.

Mr SPRINGBORG: Mr Purtill, you said that decisions were made under a different management team. Can you explain what that means? Does that mean that there was a different approach under that management team towards dealing with this particular disease and things have changed? Can you expand on that, please?

Mr Purtill: Sure, I am very happy to clarify that. The disease itself has a very long latency period so its presentation in a diagnosis may take some years—in fact, some decades in certain cases. Therefore, some of the decision-making and policy setting around the coal workers scheme, since its

inception, has been made by people who are no longer with the department. I wanted to emphasise that because of that latency period we will use our best endeavours to find the material that we can, given that many of those, if not all of those individuals have now moved on from the department.

Mr SPRINGBORG: Are you suggesting or not suggesting an administrative failure there?

Mr Purtill: Neither at this stage. We are very happy to assist the committee with its inquiries.

CHAIR: In relation to your comments about changes in management, Mr Purtill, I have here the Report on the Queensland Coal Board Coal Miners' Health Scheme, commonly known as Rathus report, which was produced back in May 1984 when there were 75 coalminers diagnosed with pneumoconiosis. Can you tell us what happened in that case—what happened with the coalminers and whether they were advised that they had pneumoconiosis and what the department did after that, considering that you are saying that pneumoconiosis has just re-emerged?

Mr Purtill: That is definitely a question that I would have to take on notice to provide you with as much detail as we can of our understanding of what has happened since the production of that report until, what I am terming as, the re-emergence of coal workers' pneumoconiosis as defined by cases being diagnosed last year and this year.

CHAIR: Have you had anyone in your department at all who has been reviewing the Rathus report and has gone back to those coalminers who may or may not still be alive who have been diagnosed with pneumoconiosis? I am happy for any of your officers to answer that?

Ms Cronin: I understand that at the time those individuals were referred to medical advisers. We have not followed up with them specifically in this recent period, to my knowledge. As the DG advised, we are happy to take that on notice and talk to our occupational physician.

CHAIR: Would you not consider that a failure of your work as director-general that this report has, in fact, been around since 1984 and, as you said, there is a so-called re-emergence of black lung, which may and may not be right, and yet no-one from your department has gone back to basically follow-up on those men and women who were diagnosed with pneumoconiosis from 1984? In other words, we do not know and you do not know who they are, where they may be located, whether they are alive and whether they are being treated or what is happening?

Mr Purtill: I am sure during the course of this committee that many lines of inquiry will be explored. Today we have come in accordance with the instruction we were provided with to talk about the legislative and regulatory environment. We are very happy to take any questions and requests on notice that are not part of that. It is difficult for me to be able to have that material available when we are simply following the instructions of the committee at this stage.

CHAIR: Mr Purtill, you are a director-general. You have come before this committee.

Mr Purtill: Yes.

CHAIR: Our committee is entitled to ask you whatever the committee sees fit; therefore, I would ask you to please come back before the committee with all the details in relation to every single miner that was diagnosed with pneumoconiosis from the Rathus report. I would like a detailed report as to whether or not those miners were followed up, how they were followed up and also the outcome of that. I would have thought, Mr Purtill, you would have been prepared for that, but never mind. We will get on with it. Ms Cronin, would you like to give your evidence, please.

Ms Cronin: We had arranged for Russell to address you next, if that is agreeable?

CHAIR: Yes.

Mr Albury: Thank you for the opportunity to attend today—

CHAIR: Just your name and title, please.

Mr Albury: My name is Russell Albury. I am the acting chief inspector for Coal. I started in the industry back in 1980, I have worked in underground coal for my whole career and I have experienced a lot of Queensland's recent coal history firsthand. Queensland's coalmining history has been shaped by several coalmining disasters resulting in far too many fatalities. As you can see on page 2 of the documentation pack that you have been given, the recommendations from the wardens' inquiries into these disasters have resulted in significant reforms, driving the evolution of a safety culture in Queensland and a development of our modern coalmining safety and health legislation. The major catalyst for the 1999 act, which was a major reform of Queensland's safety and health legislation, was the 1994 Moura No. 2 disaster. I will now hand over to Mark Stone to talk about the legislative framework.

CHAIR: Just before you do that, Mr Albury, I am the chair of the committee. You do not 'hand over' things. Can I just ask what your professional qualifications are?

Mr Albury: Certainly. I have a First Class Mine Manager's Certificate of Coal Competency.

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CHAIR: Where did you get that from?

Mr Albury: Queensland.

CHAIR: Good. Mr Stone?

Mr Stone: Thank you, Chair. My name is Mark Stone. I am the executive director for Mine Safety and Health. I have responsibility across the four inspectorates: coal, metalliferous mining and quarrying, explosives and petroleum and gas. The 1999 act recasts Queensland's approach to coalmining safety and health. The proposals which form the basis of the legislation were developed by a tripartite group with representatives from employee and employer organisations and from government. In developing the legislation it was recognised that modern safety management focuses on the creation of the concept of on-site ownership of safety and health issues. To provide some context to the policy setting I draw on the language used by the then minister in his second reading speech where he said—

The provisions of these Bills will clearly place responsibility and accountability for safety and health where it belongs: with the people in the best position to ensure that this is achieved—the mining industry itself.

The legislation may be described as risk based. It is underpinned by the requirement that the risk of injury and illness to any person resulting from coalmining operations be at an acceptable level. The legislation focuses on outcomes rather than prescription. It provides a framework under which individual mines must have systems for appropriately managing risks to an acceptable level. A mine safety and health management system will necessarily be tailored to the risks and conditions specific to the mine, however, the legislation is prescriptive about measures that must be taken in respect of some tasks, that is, where the risk can only be controlled in one way. An example of this would be the application of stone dusting as a mitigation for dust explosions.

The act establishes certain key offices as they are listed on slide 3 that you have. The primary function of the Commissioner for Mine Safety and Health is to advise the minister on safety and health matters. The current commissioner was appointed in June of this year and is independent from the Mines Inspectorate with no role in its day-to-day management. The Coalmining Safety and Health Advisory Committee is a tripartite committee representing industry, workers and government which is chaired by the Commissioner for Mine Safety and Health. Its primary function is to provide advice and make recommendations to the minister on safety and health in mines. The act establishes the Mines Inspectorate, which is responsible for enforcing the legislation and promoting the objectives of the act. Industry safety and health representatives are full-time coalmine workers elected by the union and have certain functions and powers concerned with representing the safety and health interests of coalmine workers. These include detecting unsafe practices and conditions at coalmines and taking action to ensure that risk to the safety and health of coalmine workers is at an acceptable level. Finally, site safety health representatives are elected by workers from the site and have similar functions to industry safety and health reps but their powers are more limited.

The act requires that management and operating systems must be put in place for each coalmine. The key instrument is a safety and health management system which underpins safety at the mine site. It incorporates risk management elements and practices to ensure the safety and health of persons at mine sites affected by coalmining operations. It must be auditable, documented and form part of an overall management structure with responsibilities, practices and procedures. The mines management structure includes various positions for which competencies are required under the act. These are assessed by an appropriately qualified and experienced board of examiners. The regulation prescribes ways to achieve an acceptable level of risk. An example of relevance to this committee is section 89 of the regulation, which prescribes measures for the management and reporting of coal dust. Mr Albury will speak to this later on in this briefing.

Recognised standards are made by the minister generally on the advice of the advisory committee and state ways of achieving an acceptable level of risk for particular hazards. If there is a recognised standard for a particular hazard, the mine must either follow that standard or adopt another way which achieves a level of risk which is equal to or better than the acceptable level.

CHAIR: Can I just stop you there, Mr Stone. What if they do not?

Mr Stone: If the mine does not comply? The regulation and the act provide a range of compliance measures which inspectors may take, and those range from—

CHAIR: Do they take it?

Mr Stone: They do.

CHAIR: What happens if the company continues to breach it?

Mr Stone: Chair, in a short while Mr Albury will cover a section specific to dust and he will talk about those compliance measures. I would ask if you would allow Mr Albury—

CHAIR: Yes.

Mr Stone: Thank you, Chair. There are currently 11 recognised standards for coalmining safety and health. Guidance notes, finally, are developed by the Mines Inspectorate to help operators meet their safety and health obligations, and there are currently nine guidance notes for coalmining safety and health.

CHAIR: Thank you very much. Ms Cronin?

Ms Cronin: I will provide an overview of the history of the Coal Mine Workers' Health Scheme. On page 4 of your presentation pack we have an overview. The health scheme was first established in 1983 and required all coalmine workers to undertake a chest X-ray. This scheme was administered by the Queensland Coal Board. Those X-rays were reviewed, as pointed out in the 1984 Rathus and Abrahams report, and it recommended the establishment of a permanent Coal Mine Workers' Health Scheme. The Coal Board introduced the new coal industry employees' health scheme in May of 1993 which resulted in the formation of the existing Coal Mine Workers' Health Scheme. We cannot provide any context as to what occurred between the period of 1984 and 1993 other than those significant events that Russell highlighted earlier. The Queensland Coal Board was abolished in 1998 and the administration of the scheme transitioned to the department. In 2001 the scheme was transitioned to its current legislative framework. We have been compiling a detailed history of the Coal Mine Workers' Health Scheme, and we can provide that to the committee once it is finalised if you would like to receive it.

On page 5 of the presentation we have given an overview of the current Coal Mine Workers' Health Scheme. The scheme is located inside the regulation. It requires a health assessment for every coalmine worker, and this health assessment is required to occur every five years or at a time more frequently as advised by the nominated medical adviser. It must be done in accordance with the approved form. It comprises both occupational health and a fitness-for-work element. Because of the personal nature of the information collected the records remain confidential. If the committee would also like a copy of the approved form over the fullness of time, we are also able to provide that to you if you would like to receive it.

Under the scheme the employer has the responsibility for administering the health scheme for its employees. The nominated medical adviser conducts the health assessment. This adviser is appointed by the employer and the employer plays the necessary costs. The nominated medical adviser must retain copies of the health assessment and those copies must also be provided to the department. Where the medical adviser has physically received the chest X-ray, that chest X-ray must also be provided to the department. The department makes records available at the worker's request. The Monash review has highlighted some limitations in the current health scheme, and steps have been undertaken to affect some immediate changes. There is a larger body of working undertaken to give effect to the recommendations in Monash.

CHAIR: Thank you very much. I would like to open it up for questions.

Mr SPRINGBORG: Thank you very much, Madam Chair. This seems to be the crux of the matter. We were speaking about the complexity of being able to diagnose these sorts of things, and I understand that diagnostics is not your area of expertise. The chair before referred to the Rathus report in 1984, which is some 32-odd years ago now back in the days when diagnostics were nowhere near as intricate or developed as we have today with regard to scanning technologies and techniques, yet in that year we were able to do comprehensive population health studies of coalminers—7,784 in Queensland—and detected 75 cases of suspected or actual black lung disease. Obviously there was an element of follow-up from there. After that we have no idea how many cases there actually were, so that is something we would appreciate knowing. How is it that we were able to competently do this in 1984, yet in the ensuing 32 years we seem to have dropped the ball somewhere along the line? We do not seem to be able to competently do this within our own state or indeed within our own nation, but in 1984 we could.

CHAIR: Director-general, would you like to answer that?

Mr Purtill: Firstly, there is a presumption that the report is comprehensive. Secondly, I think the fact that there was a point in time at which there was a dedicated focus on, if you like, setting the baseline for that scheme was very important and it has very strong similarities, I think, to the body of work that is being undertaken right now.

Mr SPRINGBORG: It is probably hard because you were not around and I was not around at that time, but we would like to know. Did anyone think it was somewhat passing strange that we seemed to have an epidemic and then all of a sudden basically it all went away?

CHAIR: Would you like to answer that?

Mr Purtill: As Rachel mentioned, we are struggling to find comprehensive intelligence on what occurred between the Rathus report and the implementation of the coal workers' scheme almost a decade later. That is a significant issue, of course.

CHAIR: That is why I asked about the archives act and in fact whether any of that documentation was destroyed, because it is a very important issue for this committee. Can I also ask about the program whereby miners are supposed to have X-rays every five years. We understand that approximately 100,000 or more of these X-rays were not read by your department or your agencies. The X-rays were done and completed, but they were not read. Can you comment on that?

Ms Cronin: I can provide some context. The health scheme actually requires a health assessment to be undertaken every five years, not necessarily an x-ray. Not every worker is X-rayed every five years. I think Russell will articulate some regulatory changes that have been recently—

CHAIR: I am not interested in what has recently happened, because we are aware of that. We are all members of parliament and we know what has recently occurred, which will come into effect on 1 January. What we are interested in is what has happened between 1984 and now?

Ms Cronin: Not every coalmine worker was X-rayed. It was only a health assessment. Only those workers deemed to be at risk from dust exposure were required, necessarily, to be X-rayed under the scheme. That is based on a risk assessment. That is the first clarification. The second is that you are right: there are or have been records kept in archive that have not necessarily been entered into our electronic management system. We have undertaken a process to do that with some focus in the last six to 12 months, since I have been in the chair. That information is being systematically entered. It is all filed and the records are being scanned, so they are accessible to workers upon their request. My understanding is that the X-rays and the medical assessments are provided by the nominated medical adviser. The department's role was to provide a record for all those coalmine workers, so that there was a library of those records available to them, not necessarily to undertake a second review of the initial medical assessments provided by the medical advisers.

CHAIR: What happened with the initial assessments? Did they just go in a box somewhere, from 1984? Where did they go?

Ms Cronin: The assessments are provided by the nominated medical advisers for the workers. Those GPs, occupational physicians—whatever their medical qualifications might be—work with the coalmine worker with regards to what might arise out of those medical assessments and then the assessments are sent to the department for storage.

CHAIR: Let me get this clear, please: Ms Cronin, the department did not look at the medical assessments when they were sent in from the GPs; they were simply sent to storage. Is that correct? You have just said that.

Mr Purtill: The Coal Mine Workers' Health Scheme is established so that the operator and the worker have the medical assessment undertaken by a nominated medical adviser. The medical work, the diagnostic work, the assessment of worker health is done by a nominated medical adviser. When those records have come into the department, they have simply been stored. That is the role of the government in the scheme.

Mr SPRINGBORG: Regardless of what they may have said, they were simply stored?

CHAIR: Because no-one would have read it, Deputy Chair. No-one from the department obviously bothered to read them.

Mr Purtill: That is right: it is the doctor and the operator and the individual who receive the advice and then take action, depending on health or fitness for work.

Mr KELLY: In that entire period from 1984 through to 2015, presumably, a doctor, the individual and the company were going through an exercise of regularly and routinely assessing the health of worker. In that entire period, there was never a situation where a disease of any sort was identified and notified to the department and action taken? You are saying that, if a disease was notified during that period, it would have fallen to the individual and the doctor to resolve that issue; is that correct?

Mr Purtill: Mr Kelly, that is my understanding. There may have been occasions, but in terms of a systemic role for the department, in our records we have not been able to establish that as being part of the practice historically.

Mr KELLY: In 2015, when a diagnosis was made, was that notified to the department and was there a trigger for action, or did you simply take that document and store that one, too?

Mr Purtill: The original case happened with the former executive director of Mine Health and Safety, but once we became aware of it we have commenced action.

Mr SPRINGBORG: Is it possible that there is a significant number of confirmed cases that are basically tucked away in the archives somewhere, that no-one has been really notified about?

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Mr Purtill: We will be able, either now or in a subsequent session, to explain what we have been doing to assess whether that risk exists. We have not just ignored that. If we could explain it now, that would be helpful.

Mr Stone: That is correct. We did not come prepared for this briefing session to address that specific issue. The department has been doing work to look back at the historic records and review them. In fact, part of our preparatory work for the independent Monash review required us to review our database and understand our records more deeply, in order to prepare for that independent review. As the DG said, we would be very happy to come back with that level of detail at a subsequent briefing.

CHAIR: How far back did you go? To what year?

Mr Stone: I believe the review extended at least beyond a decade and possibly two decades from memory, but I will confirm that.

CHAIR: You did not go back to 1984, which was the Rathus report?

Mr Stone: I will confirm.

Mr SPRINGBORG: On the issue of the X-rays, Ms Cronin mentioned that the coal workers are required to have a health check and a particular number within that are required to have an X-ray. Is there a broad-brush percentage? Is that 10, 15 or 20 per cent of coal workers? How many coal workers have had such an X-ray over the last 12 months or last 10 years, whatever the case may be? Do we have those particular figures? Do we have an indication of what the results have been? I am asking for a broad brush, not dealing with individual circumstances, with regards to X-rays?

Ms Cronin: We will be able to provide those figures, if I could take that on notice. To the extent we can, we will.

CHAIR: Thank you. Are there any further questions?

Mr KELLY: I have a few. What happens if a worker leaves the industry in the period between their check-ups? Is there an ongoing requirement for check-ups? Is there education for the worker in terms of the need for ongoing assessments?

Ms Cronin: The ongoing care of retired workers was a limitation highlighted in the Monash report and it is something that we are currently considering.

Mr KELLY: No action has been taken to date, in relation to that matter?

Ms Cronin: My understanding is that the scheme did not cater for workers once they left the workforce because they are no longer employees, but that has been recognised as a limitation.

Mr KELLY: It seems amazing to me that in one year we have 75 cases and then we have zero, and we have zero every year through to 2015. It is like the disease just disappeared. As someone with a health background, I am trying to understand logically how that could occur. I could not think of any other situation where that has occurred. I am trying to analyse what has occurred there. Either the responses to the things that cause the disease have been so effective that no disease has been triggered or the assessment of the disease has failed to pick up the disease. Those seem to be two logical possible outcomes. I want to ask some specific questions to understand the role of the inspectors. When an inspector goes to a worksite, do they give notice or do they just show up?

Mr Albury: They can do either.

Mr KELLY: What is the more common approach?

Mr Albury: The more common approach is that they announce that they are coming.

Mr KELLY: When they arrive on a mine site, are they accompanied by representatives of the company or the union? How do they conduct themselves around the mine?

Mr Albury: Normally, they are accompanied by a representative of the company. The option is given to a representative of the union to also accompany the inspector.

Mr KELLY: Does the union exercise that option on a regular basis?

Mr Albury: Yes.

Mr KELLY: Are you concerned or have you had any concerns in your experience, given your long history here, that if you give advance warning that you are coming you may be shown the things that you are not looking to see?

Mr Albury: That is always a possibility. However, I am confident in the ability and experience of mine inspectors to be aware of that when they go to a mine. It is pretty hard to hide some things in an underground coalmine. It may be that the representative of the company tries to force the agenda on where they go to, but normally an inspector will go where he wants to go.

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Mr KELLY: I would assume that, at times, you get notifications from representatives of unions or workers or even, say, a manager in a mine, that there is an area of concern. Is that something that has occurred in your time working for the department, Mr Albury?

Mr Albury: It happens fairly regularly.

Mr KELLY: What is the time frame in responding to that?

Mr Albury: That varies on what the issue is, to be honest. If it is a concerning issue, it is straightaway.

Mr KELLY: Do you notify the company that you are coming, in an issue like that where there has been a concern raised?

Mr Albury: Again, it depends on what the issue is. If we determine that it is best to go underground unannounced on a night shift, for example, to actually see what is going on, we will do that.

Mr KELLY: Director-general, is there training specifically for inspectors but more broadly across your department for people who are dealing with mining companies around the issues of regulatory capture and influence by mining companies?

Mr Purtill: I am happy to answer that. I think specifically to the inspectorate, because of the nature and the type of work that they do, there is a suite of training involved in everything as broad as the public sector code of behaviour through to specific technical aspects of the role. Of course, many of the inspectors come from the industry, which makes sense because we want people who know what they are doing and how to conduct themselves on the site, particularly to maintain their own personal safety and wellbeing and that of those around them, with their decisions on how they move. We have been aware, if you like, of a concern about regulatory capture. I think that we have a very robust model to ensure that we have our compliance plans freely available and we have our performance standards freely available.

CHAIR: Mr Knuth?

Mr KNUTH: Director-general, who determines the level of risk for a coal worker to receive an X-ray?

Mr Purtill: The nominated medical adviser, in consultation with the coal worker themselves.

Mr KNUTH: With regard to the Mines Inspectorate since 1984, do you believe that there has been sufficient staffing for the Mines Inspectorate to cover the job and what they are supposed to do?

Mr Purtill: Mr Knuth, I am sorry, but I really cannot answer for the years before I have been here or in more recent history. I believe that the inspectorate is well resourced and that the level of compliance activity, the ability for us to visit mines and our ability to conduct our business would lead me to believe that we are well resourced and that we have a very competent workforce in the inspectorate, as well—very experienced individuals. Back in time, I am sorry, but I really do not know.

Mr KNUTH: There has been no issue in regards to Mines Inspectorate resources?

Mr Purtill: No.

CHAIR: Can I just follow up on that? You are giving evidence to this committee that you believe that there have been no issues with Mines Inspectorate resources, yet I am personally aware of issues that have been raised in relation to Mines Inspectorate resources for many, many years. Can you please go back and have a look at the records of the department and advise the committee whether there have been any issues raised in relation to the resourcing of the Mines Inspectorate and produce it to the committee?

Mr Purtill: I am very happy to do so.

CHAIR: Thank you.

Mr COSTIGAN: All of these missing years, as I see them—lost in time: where are these documents stored and has the DG or any of your staff seen these records sitting there perhaps wondering what they are? Do you know what they are? Do you know where they are? Have you seen them? Have any of your staff seen them boxed up or in whatever way they are stored?

Mr Purtill: I think Rachael has some information first, Mr Costigan, and then I am happy to clarify.

Ms Cronin: Just as a point of clarification, there was a Coal Board established prior to the department taking on responsibility for the medical assessment records. My understanding would be that much of those records would be in the archives of the Coal Board. At this point in time, I could not say exactly where those occurred, but I am happy to take that on notice and see what information is available.

CHAIR: Mr Costigan's question, I think, was do you know where they are stored now?

Mr COSTIGAN: Could you take the committee and say, 'Here are the records from those missing years?' Could the committee walk out of parliament here today and say, 'Look, there's the records that were discussed here at this historic public briefing this morning?'

Ms Cronin: Sorry, for the 1984 Rathus report? I am sorry, I just need the question clarified. I apologise. I do not think that I have understood.

Mr COSTIGAN: All of this data that seemingly has been dormant for all of these years, could anyone from the department say, 'There it is?'

Ms Cronin: We have archive facilities with a number of records in storage. I would have to clarify whether those archive facilities are containing the records that you are necessarily asking of me today. If I can get that articulated I am more than happy to take that on notice and have a look, but we have a number of archive facilities where records are retained.

Mr COSTIGAN: How many people work in data entry for the department, director-general?

Mr Purtill: Specifically for the coal workers health scheme?

Mr COSTIGAN: Specifically, yes.

Mr Purtill: It is difficult to answer the question. I do not think that we have a specific data entry role for individuals. We are working our way through the records for digitisation and I think we will be able to talk about that. That is the specific medical records and we mentioned the shortcomings that were highlighted in the Monash report. That is part of the body of work now so that we are able to identify those records, sort them, glean information about systemic issues that may be emerging that we have not been able to do historically.

Mr COSTIGAN: Just summing up my line of questioning, is it fair to say that the electronic management system of the department in this regard is shambolic?

Mr Purtill: I think the recommendations in the Monash review articulate the areas that we need to work on.

Mr CRAWFORD: I am interested in the inspectorate with the dust testing. Does it undertake any of its own dust testing or does it just rely purely on what comes from the operators?

Mr Albury: We rely on the results that come from the operators.

Mr CRAWFORD: The department does not do any of its own testing?

Mr Albury: No independent third-party testing, no.

CHAIR: I would like to ask Mr Pearce, the member for Mirani, if he has any questions.

Mr PEARCE: Thank you. Can I get an explanation for the process from when a worker goes for a medical check? What happens from there on?

Mr Albury: You mean from when the person gets tagged to go for an assessment? From that point?

Mr PEARCE: Yes.

Mr Albury: There is a health assessment form, which has four sections to it. The employer has to fill out a section and the employee has to fill out a section. The appointment is made with the NMA. The individual goes to the NMA and has his assessment and that will possibly involve chest X-ray, spirometry et cetera. That examination can either be done directly by an NMA or supervised by an NMA—in other words, another GP—but the NMA has to review the report that comes from that GP. Once the NMA is satisfied with the medical and the report, he will send the form forward to the employer and have a discussion with the employee if there are any concerns. That is basically it.

Mr PEARCE: A nominated medical adviser? Can you tell me how he or she gets that position?

Mr Albury: A nominated medical adviser is a doctor who has a contract with the company to conduct health assessments.

Mr PEARCE: There is a pretty good link between the employer and the doctor, or the medical adviser. Do we have any concerns about that relationship? I am going to go back to this period of time when there has been no reporting of the disease itself. I have concerns about the relationship there.

Ms Cronin: If I may answer? Mr Pearce, the Monash review has highlighted a number of shortcomings in the current scheme, one of which was the number of nominated medical advisers currently registered. While I cannot really recall the number specifically—they are in the report—there were several hundred. As such, the report is recommending that a smaller number of nominated medical advisers undertake the health assessments, that those advisers be registered, endorsed by

the department and that we undertake a process where they meet certain competency criteria. The department is working through that work to come up with a preferred outcome that we will consult with the relevant parties about how that will work going forward. It has been identified as a shortcoming.

Mr PEARCE: If there were an issue with the patient, or the mineworker, would you aware if there has been any discussion between the nominated medical officer and the employer with regard to the condition of the worker? Are there any notes on the documentation to say, 'This was brought to the attention of the employer and the mineworker is aware of it?'

Ms Cronin: Under the proof form, which is completed as part of the health assessment, there is a section that is simply referred to as section 4—mostly because that is how it is numbered. That section 4, or form 4—that might be another vernacular—is the documentation that the nominated medical adviser provides to the employee and the employer and that is the level of information that is disclosed. That is my understanding.

Mr PEARCE: That is what is happening now?

Ms Cronin: That is inherent in the scheme from the beginning.

Mr PEARCE: It has always been there?

Ms Cronin: It has always been there. It would be open to the employee to discuss more information with the employer, but the information on the form is what is required to be given to the employer.

Ms PEASE: I am just a bit concerned about this gap that everybody keeps referring to. There would be evidence in those reports that there had been consultation with the patient and consultation with the employer?

Ms Cronin: Yes, that is correct. I think if we provide you with a copy of all of the approved forms since they started you will be able to see the level of information that is provided to the employer over the fullness of time. An example that would be in the current form, from my recollection—and Russell might need to correct me—is that it provides an opportunity to say, 'Fit for work', 'Fit for work with constraints,' or 'Fit for work, but additional conditions are imposed,' such as not to work in a dusty environment or, if it is more of a physical related injury, perhaps some other requirement. It does not necessarily provide them with any sort of diagnosis; it is more about what might be the limitations around their duties when returning to the workplace. That is my understanding.

CHAIR: In relation to your last comment, would it be true that, over the past couple of decades, given this NMA situation, that people might have been diagnosed with pneumoconiosis, or suspected of having it, but perhaps the miner—the employee—might not have been told?

Ms Cronin: My understanding from the medical profession is that they have a very robust ethics process about what they must provide to the patients whom they see.

CHAIR: They are also employed by the mining companies, are they not?

Ms Cronin: I understand your question, but I do not think that I am in the best position to answer that. It is something that is probably asked best of a medical practitioner, but my understanding is that they take that process very seriously. I would be very disappointed to find out that a medical practitioner was not honest and forthright with a patient who they were seeing, but I could not answer—

CHAIR: Just following on from what Mr Pearce said there, say a miner has the medical done, gets the report and the box is ticked and he is able to go back to work, even though they might have had X-rays done. The miner themselves may not have been told the details of the outcome of that medical assessment and then the department does not follow up, either. Is that correct?

Ms Cronin: I think that is probably a question best answered by someone from the Medical Board, or even Queensland Health might be able to.

CHAIR: Yes, but you are responsible. You are a senior officer of the Public Service. I want to know, in that scenario, what your role is, or the department's role is in relation to that. The miner themselves, during these past decades, may have been suspected of having pneumoconiosis. We have the proof here in the Rathus report. There were 75 miners who were suspected or diagnosed of having black lung and they fell through the cracks. I want to know the role of your department going back to 1984, or earlier, as to what happened to those 74 miners. Were they told that they had pneumoconiosis? What was instructed to their doctors in relation to their illness? Did they even know they had it? We know there are 75. We have no names. We do not know what has happened with them.

Mr Purtill: Madam chair, your question started out by asking what role we had to play in effectively maintaining the ethical standards of nominated medical advisers. The answer to that is none.

CHAIR: Thank you.

Mr Purtill: The rest of the question, we have already taken on notice.

CHAIR: No, no—

Mr Purtill: That we need to assess that—

CHAIR: Mr Purtill, as director-general, as a parliamentary committee we hold the status of parliament. We are a select committee of the parliament. We can ask you what we like when we like and we intend to do so.

Mr Purtill: Absolutely. That is not in question.

Mr PEARCE: My next question is around the ability of the radiologist to be able to read the X-ray properly in those times. I think we have learned as a result of the existing crisis that that, in fact, was a problem. Again, I go back to the point that the medical officer is employed by the mining companies. We also have the inexperience of the radiologist. It is a bit of a pit there for a lot of problems. I know that it is not your guys' fault, but we have to understand it just so the committee understands the background to why I believe we have this hole in the system.

Mr SPRINGBORG: Madam Chair, before we move on, I think we might have to do something procedurally. As the time is just approaching 10 o'clock and we had set out the time frame for the department to give their briefing in this block, I propose to move that we extend beyond 10 am—no specified time limit—so members can finish their questions, if that is okay.

CHAIR: Yes, but I need a seconder.

Mr COSTIGAN: I am more than happy, Madam Chair.

CHAIR: There being no objection, that is so moved. We will continue past 10 am. Would you like to answer that question?

Ms Cronin: As a component of the Monash review, it was highlighted there were shortcomings in the radiology. I think if I paraphrase, the language is that we have moved from a screening program to a diagnostic program and that we needed to revert back to a best practice screening program for radiology. During the review process where the Monash team looked at a number of X-rays held with the department, and with the support of the University of Illinois, there were comments made about the exposure, the way the images were taken, that perhaps the pictures were not taken with the person positioned in the right positioning to necessarily undertake the best diagnosis for coalmine dust lung disease and a number of recommendations had been made about the radiology. What we have done is put in a requirement that all X-rays must be read to the ILO standard and we gave effect to that as soon as that information came to light. We have also made sure that going forward all X-rays are second-read in the US, but I think some of the observations made—and, again, drawing on the advice from our colleagues at Queensland Health—about best practice screening programs is that the X-rays should be reviewed by a smaller number of radiologists and that they need to see a volume in order to improve their reading competency. I think Queensland Health could talk to you about BreastScreen.

Mr PEARCE: I am happy with all of that. It is back in that period of time that is where the problem is.

Ms Cronin: You are right.

Mr PEARCE: Thanks, Chair.

Mr SPRINGBORG: I know that you have been pointing very much at this very extensive report, the Ratus report, to the Queensland Coal Board commissioned by them in 1984. I have been reading through that report since I have seen it this morning and it is extremely competent in what it aims to achieve—the questionnaire to the coal worker and also the intention to notify the coal worker with a very significant prescribed process—and I do understand and support the need to follow up and to do that to make sure that what was required was in there. A couple of issues have come up this morning that I just want to follow up. In response to the member for Greenslopes's question earlier on regarding whether concerns had been raised with the department over black lung disease—or, more specifically, I think the concern was raised to Mr Albury around whether unions and others had been raising concerns about the conduct of miners—is any panellist here today specifically aware if the union representatives of coal workers or others had raised concerns prior to the diagnosis of the case in 2015 about potential problems with regard to black lung disease? Had concerns been raised previously? We know that there are always safety concerns and issues over dust, but I am referring specifically to concerns around black lung disease. Are you aware of it? If you cannot answer that today, I am happy for you to take that on notice.

Ms Cronin: To the best of my knowledge, no, we have not been made aware. I know we had been asked a variation of that question previously and we have tabled that before parliament, but I can go back and pull that and bring that forward again.

Mr SPRINGBORG: Prior to that there had been issues, to the best of your understanding, and there had been concerns raised by maybe unions and others around general safety issues or the regulation or administration of mine sites but not specifically around black lung and its re-emergence or concerns over it?

Ms Cronin: To the best of my knowledge, no.

Mr SPRINGBORG: We talked to you before about process and you went through a very defined process about what necessarily happens. It seems to me that what we have here is a case of process for process but we just do not have a case of where the process actually gets followed up if there is any sort of clarion signal or light that just pops up and says 'Case of black lung.' We can tick all the boxes and say that we have a process, and that is that we receive this information and put it in a box and put it somewhere else, so it is compliance with the process of the law rather than what it actually shows. Are there any concerns around that?

Mr Purtill: There is definitely concern whenever a system has the sorts of shortcomings that have been highlighted in the Monash report. What I do not believe is widespread—and, because of the number of records, I can never go with complete certainty to 100 per cent—is that diagnoses of any type of occupational disease have been made on an assessment form which has effectively been filed away. It appears from the work that Monash University did that the shortcomings have emerged perhaps over time—I am not sure—but have emerged in the actual assessment methodology over time and that is certainly the focus. I am sure you have all probably already had a look at the Monash review report, because they were able to go into extreme depth about where all of those shortcomings are and that is why, again, you will hear that we will reiterate that every one of the recommendations in there has been picked up and pursued vigorously because of what we are discussing this morning. Some of it is very difficult to comprehend how we got to a point where we got to, but we are here to fix it.

Mr SPRINGBORG: Particularly with diagnostic techniques in 1984 basically being Stone Age compared to what we have today, and that is not taking away from what we had at that time. It is just like the world has revolutionised in that area. Just for our benefit—

Mr Purtill: Mr Springborg, for example, the fact that we are getting X-rays read by NIOSH accredited ILO accredited readers in Chicago attests to that. That would not have happened in 1983.

Mr SPRINGBORG: Yes, but we used to be able to read them here.

CHAIR: Yes.

Mr Purtill: That is right.

Mr SPRINGBORG: Before we had CT scanners, PET scanners, MRIs and all of those sorts of things. This was pretty rudimentary, but we could deal with it in 1984. Some 32 or 33 years down the track, we have to outsource that somewhere overseas. That is something that I really struggle to understand and comprehend. You cannot really tell me that we have gone forwards if we have gone that far backwards. The other issue here just for our own benefit and everyone out there is this: is there a legislative or statutory or regulatory requirement to report suspected cases of black lung or confirmed cases as we have with regard to—and maybe we can ask this question to our Queensland Health representatives, but I would imagine that there would be some knowledge—certain other diseases such as TB, legionella and those sorts of things?

Mr Purtill: A notifiable disease, yes.

Mr SPRINGBORG: So it is notifiable but did not get notified potentially?

Ms Cronin: Currently coal workers' pneumoconiosis is not a notifiable disease under the health framework and it has not been a notifiable disease under our framework until recently. We have made regulatory amendments that take effect on 1 January which make it a notifiable disease.

CHAIR: With the regulatory framework coming in on 1 January, the department of mines might be notified but it still will not be a notifiable disease to the health department. Is that correct?

Ms Cronin: My understanding is yes, but you are probably best to ask that question of process to Queensland Health.

CHAIR: We intend to, so you will be notified—Mines—but Health will not be? Thank you. I have another couple of questions before I go to counsel assisting in relation to the Rathus report again. Page 19 of the report says—

Chest X-rays should be performed periodically at intervals of not less than five (5) years for the express purpose of detecting early evidence of pneumoconiosis.

That is in their report of 1984 and that may have been ignored by the department because you are saying that recently with the medical reports they do not necessarily have to have chest X-rays; is that right?

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Ms Cronin: My understanding—and I will ask Russell to correct me if I have misstated—is that a health assessment is required every five years and a chest X-ray is required with consultation with a nominated medical adviser based on the level of exposure to dust and other respiratory elements.

CHAIR: Okay, so this recommendation from 1984 basically has been ignored because it is not in your framework?

Mr Albury: It would be normal for an underground person to be subject to that rule. I think where some of the—

CHAIR: It is not a rule, is it?

Mr Albury: I think where some of the issues have come in it requires the employer to mark down on the form that this is an underground worker. That has not always happened.

CHAIR: But now we have a situation where we have a miner who works in an open cut who has black lung, so it is not just underground. We now have an open-cut miner. What is the situation with open-cut miners? Have they been required to have chest X-rays or is it just assumed that they are not going to get black lung?

Ms Cronin: We do have a number of chest X-rays for open-cut workers and I can provide you with what statistics we have on the proportion of that workforce being X-rayed.

CHAIR: But, again, coming back to the Ratus report, the Ratus report recommended that there be chest X-rays at intervals of not less than five years. Can you please find out in your exploration of the archives and the documents, wherever they may exist, what actually came of that recommendation? I just want to briefly go on to retired miners. Obviously there are a lot of retired miners not only in my electorate but also in the electorates of Mirani and Whitsunday. Just in relation to that, I notice that since the gravity of black lung has been made public over recent months your department is going back to talk to retired miners about their health. Can you just take me through that process of what the department has been doing please?

Ms Cronin: We have undertaken an awareness campaign where the Chief Health Officer for Queensland has been provided a notice or advice—Queensland Health could provide you with the exact language—to medical professionals and GPs to draw attention to workers who may have worked in the coalmine industry to highlight the concern around coal workers' pneumoconiosis. We have also done some promotional campaigns in areas where we understand retired workers might necessarily reside to raise their awareness. We are engaging with any workers, retired or otherwise, who necessarily contact the department seeking support.

CHAIR: My understanding of it is that the department, with the approval of the retired miners, can go and have a look at their hospital records; is that right?

Ms Cronin: If a retired worker gives us permission to go back through some of their records or provides us with access to them, we can do that in conjunction with Queensland Health if we are given that express permission.

CHAIR: But the department is specifically not seeking access to the retired miners' chest X-rays. You are looking at the clinical notes only. Is that correct?

Ms Cronin: I do not know that I can necessarily answer that question precisely. We would review the information that we were given.

CHAIR: But when the retired miners are giving you permission to go back and have a look at their entire medical records, my understanding is that you are having the clinical notes looked at but that you are not having the X-rays re-read. For example—and I know Mr Kelly would understand this being a nurse with decades of experience in hospitals—there would be many retired miners who may have or been diagnosed with emphysema, with pneumonia, with asthma or with any other respiratory diseases.

My understanding is that your department is going back and looking at the clinical notes, but your failure even to date is the fact that you have not pulled the X-rays of those retired miners and sent them to the United States or wherever else to be reread to see whether those miners do in fact have black lung. You are relying on the clinical notes and you are relying on the diagnosis of the doctors within hospitals, but you are not sending the chest X-rays over to America.

Ms Cronin: Chair, you may be referring to an initiative we undertook with Queensland Health to do a crosscheck of hospital records against known coal workers on the coal worker database. That may be what you are referring to. I am not sure; I am making that assumption.

CHAIR: Yes.

Ms Cronin: We provided the names to Queensland Health and they undertook a review of hospital records. That information was never provided to the department because of the confidential nature of it. Queensland Health recruited I believe it was a respiratory physician. You would have to perhaps get the details more specifically from them. They went through the hospital records they had access to. I could not tell you whether it was just the file, just the X-ray. I could not provide you with that level of detail. They have provided some advice back to us as to whether there was any concern for pneumoconiosis in that review. While they indicated that there were some probable cases, we had discussions with Queensland Health about the steps to undertake next. I think Sophie Dwyer might be talking to you at the next session. She might be able to talk to that in a little bit more detail.

Mr KELLY: To follow up the member for Dalrymple's questions, the trigger for a chest X-ray is an assessment made by the medical officer. What information does that medical officer have other than the pure clinical information that they can use by directly assessing the symptoms of the patient in front of them to determine whether that worker is at an increased risk, has been exposed to excessive levels of dust?

Mr Albury: The other information he will have is that the employee is to fill out a part of that form that says, 'Does he smoke? Does he have heart disease? Does he have this? Does he have that?' As far as whether he is a high-risk worker or not is concerned, that would be filled out by the employer. We would expect that—for example, if he is a surface worker—to determine whether he is in a high-risk task, we would expect the operator or the coalmine to do some form of risk assessment to determine what tasks on their site are high risk.

Mr KELLY: If there have been instances reported of high levels of exposure of dust, are they captured and put on to that form that is given to the medical officer?

Mr Albury: Presently no.

Mr KELLY: A decision is being relied on by a doctor who does not necessarily have the full information in terms of that worker's work history. They may have been in low-risk jobs or high-risk jobs. Is that relatively correct?

Mr Albury: Sorry, could you—

Mr KELLY: The doctor is relying on incomplete information in terms of making that assessment around the level of exposure of that worker.

Mr Albury: If the form is not filled out diligently, that is possible.

Mr KELLY: Is the worker given a copy of that form and allowed to view that form before the doctors see that form?

Mr Albury: Yes.

Mr KELLY: Are workers told if they have been exposed to high levels of dust?

Mr Albury: If a mine does monitoring and an individual wears the monitor, which is normal practice, and the results come back that he was exposed to high levels of dust then he would be told, yes.

Mr KELLY: It seems to me that we have a doctor who does not have complete information operating in an environment, in a culture, where we have said, 'This disease is eradicated.' The symptoms look like 20 or 30 other respiratory conditions I could name off the top of my head. If someone comes in short of breath, coughing, with or without mucus, having difficulty walking up and down stairs, it could be a whole range of other things. We are not looking for black lung because we have been told that is eradicated, and the doctor is part of that culture as well. They have not been given full information. Let's say a worker started working in the mines at 19. By 23 or 24 they are getting their first health check. They have no medical training. They have no real understanding of the history of this disease. They are in a culture where they are told there is no such thing as black lung disease anymore. Is this a recipe for misdiagnosis and failure to actually recommend a chest X-ray?

Ms Cronin: Generally a health assessment is undertaken before somebody enters the workforce so that we do have a baseline. To draw on some of the observations from the Monash review, they have highlighted that there are opportunities here for us to improve the process with training nominated medical advisers, recognition and a greater emphasis on respiratory health. I believe they also made some comments around perhaps an increased focus on coalmine dust lung disease as opposed to looking for perhaps the more lifestyle related issues that might be associated with smoking and other respiratory issues. Those points were made in the review.

Mr KELLY: My final question is—and you can take it on notice if you like—you have referred to the Monash review. There is a Senate inquiry. There has been a whole range of recommendations. Has the department implemented those recommendations or are they working to implement those recommendations?

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Ms Cronin: We are working towards implementing those recommendations.

Mr Purtill: Of the Monash review.

Mr KELLY: Are you able to issue a report on what has been done to date in relation to all of those recommendations?

Ms Cronin: Yes, we can provide you with an update. I am happy to take that on notice.

Mr KNUTH: I refer to a retired coalminer. He is at home. He may have black lung. Is there an awareness campaign? What drives him to go and get checked?

Ms Cronin: We have been running an awareness campaign. Addressing the health of retired workers is a gap in the current Coal Mine Workers' Health Scheme that was identified, but we have done some awareness campaigns.

CHAIR: In relation to the Rathus report, again, Ms Cronin, recommendation 3 states—

All miners and others with significant exposure to coal dust, should be required to have a Chest X-ray performed on retirement from the industry, and the result reported to the person concerned, and filed for future reference by The Queensland Coal Board.

That is an extreme gap. I suggest to you that there is an extreme gap in relation to the process that you have currently underway with regard to Queensland Health, because I am aware of cases where Queensland Health is not getting the chest X-rays of retired miners who have been diagnosed, for example, with pneumonia, emphysema and other matters. There is a real gap in there at present. I would now like to go to our counsel assistant.

Mr McMillan: For the record, my name is Ben McMillan. I am counsel assisting the inquiry. Director-General, you made reference in your opening statement to the notion of a confirmed case. I think you explained that under the Coal Mine Workers' Health Scheme that had a particular definition. Is that definition documented?

Mr Purtill: Departmentally, yes. I could provide it if you want. It has been done because there has been so much speculation about whether an individual had coal workers' pneumoconiosis or not. Various people were reporting instances and we needed a mechanism by which to, if you like, structurally and formally ensure that we knew when a case had been confirmed.

Mr McMillan: What stakeholders had input into the formulation of that definition?

Mr Purtill: None. It was an internal department process so that we would have a clear and shared understanding of when a case was a case.

Mr McMillan: Was the definition intended to exclude suspected or potential cases?

Mr Purtill: It is not relevant to suspected or intended cases. Those cases become confirmed once diagnoses are presented to our physician, which is part of the workers' health scheme. Then it is a confirmed case. It is not intended to exclude. Its purpose is not to capture someone who thinks they may have the disease until such time as the coal workers' health scheme and the medical health assessment process has been run.

Mr McMillan: Is it correct that a confirmed case requires essentially the sign-off or authorisation of the departmental physician?

Mr Purtill: Yes.

Mr McMillan: What particular qualifications does the departmental physician have, for example, that exceed the limitations that have been observed in the Monash review?

Mr Purtill: Dr David Smith is an occupational physician. I would have to get him to attest to his bona fides. I think Rachael can provide some clarity for you, Mr McMillan.

Ms Cronin: I might be able to provide some clarity. When an individual is referred by the NMA to a radiologist and the X-ray is taken, the NMA has generally referred them on to a respiratory physician. Then that respiratory physician has provided a written confirmation of that diagnosis. That diagnosis comes into the department. Essentially, based on that diagnosis, we will confirm it. We are just making sure that the information provided to us is coming from a medical professional with appropriate qualifications.

Mr McMillan: Is the departmental physician involved in Queensland Health's work in attempting to re-educate or better educate other nominated medical advisers about how to properly assess and diagnose black lung disease?

Ms Cronin: Currently my understanding is that the advice that has been given to general practitioners is the advice that has been issued by the Queensland's Chief Health Officer, Jeannette Young. At this point our physician does provide information to nominated medical advisers, but we have not yet undertaken a program to improve the competency of nominated medical advisers. We are

working with the Thoracic Society of Australia and New Zealand and the Australian College of General Practitioners around a competency program. I think it might be best if I provide a bit more detail on notice. I do not have that information handy.

Mr McMillan: Director-General, you mentioned I think in answer to an earlier question from the chair that the original case—and I think you were referring to the first confirmed case in 2015, and I am paraphrasing your evidence—was 'with the former executive director of Mine Safety and Health' and 'the current team has taken action'. Have I accurately paraphrased your evidence?

Mr Purtill: Yes, but I cannot quite remember the context of the question around the case. I did make the comment that that case came in prior to the current executive director being in position—I cannot quite remember the context of why we were talking about that.

Mr McMillan: What did you mean by the original case was 'with the former executive director' but 'the current team has taken action'?

Mr Purtill: It came in whilst the previous executive director was in place.

Mr McMillan: Does that reflect a concern or suspicion on your part that the previous executive director did not take any action?

Mr Purtill: No, just lack of knowledge as to exactly what he may or may not have done at the time—at this hearing.

Mr McMillan: You also said in your evidence when discussing inspectors employed by an inspectorate that many of the inspectors come from industry. Is it also the case that many or some of those inspectors return to industry after the period of their employment as inspectors?

Mr Purtill: Russell might be able to give you a view on that.

Mr Albury: That certainly has happened, yes.

Mr McMillan: What measures are in place then to ensure proper independence of those inspectors during and after the period of their employment as inspectors?

Mr Purtill: As I mentioned in answer to Mr Kelly's question, we have the full suite of normal public sector code of ethics, training expectations and internal training specific to that. We also have, of course, peer related work practices to ensure that people are not working, if you like, in complete isolation with a particular operator, for example. I can understand the line of inquiry. I think it is always a very, very delicate balance between having people who do not know anything about an industry and those where you may have concern that there is capture. The issue is alive and not just for this but for any regulatory function of government across any sector.

Mr McMillan: Are there any particular measures or prohibitions on inspectors returning to the industry immediately after being inspectors?

Mr Purtill: Not that I am aware of.

Mr McMillan: So is it possible, hypothetically, that a person could be employed by a coalmine operator, apply for a job as an inspector and be successful in obtaining that job, inspect the mine that they were formerly employed by and then, immediately after their employment as an inspector, return to the employment of that mine? Is that possible?

Mr Purtill: Yes, I guess so.

Mr McMillan: Does it strike you that that inherently poses a significant risk of challenging the independence of that person while they were an inspector?

Mr Purtill: I think that is a hypothesis that could be applied to any regulatory function of government between industry and government, so I would agree on the basis that that hypothetical situation could occur across a full suite of areas where there is not specific noncompetition requirements in place. It is something that we are definitely alert to as a regulatory agency.

Mr Albury: Our practice is that if we bring in an inspector or employ a bloke as an inspector from industry, from a mine, he does not go near that mine for at least six months.

Mr McMillan: That is what I was asking initially, when I asked what measures are in place. Are there any other measures like that that you can tell the committee about?

Mr Albury: No.

Mr McMillan: That is the only one? After that initial six-month period, that inspector may well be assigned to the mine that they were formerly employed by in their ordinary duties?

Mr Albury: Yes.

Mr McMillan: Director-General, you also gave evidence that, to your knowledge, there were no issues in terms of the resourcing of the inspectorate. A number of members asked questions about that. Are you aware of the duration of investigations or the length of time it takes for the Mines Inspectorate to investigate fatal accidents on mine sites?

Mr Purtill: Yes, I am aware.

Mr McMillan: And you are aware that those investigations can exceed two and three years?

Mr Purtill: Yes.

Mr McMillan: Does not that suggest that there is a resourcing problem in the inspectorate?

Mr Purtill: I wish throwing more humans at those cases could contract the time frames, because I find those time frames very long as well and very frustrating with court processes. We are in the business of keeping people safe and healthy, so protracted court cases do not deliver the objective of this agency. I would agree with you, but it is not a matter of having more individuals collectively moving forward. Many of our processes, I would say, are frustrated by the ability of a court process, with mentions to be deferred and so forth, and they are protracted. Of course, in the face of fatalities we also have a whole raft of additional issues that will come to bear on the timing of those actions, such as the Coroner's involvement and so forth.

Mr McMillan: Are the inspectors who are required to conduct the routine health and safety inspections at mines also involved in those protracted investigations of incidents?

Mr Albury: Yes.

Mr McMillan: Therefore, does not it follow then that, while they are involved in those protracted investigations of incidents, they are taken away from the very important duties that they have in inspecting the health and safety of mines?

Mr Albury: For a period, yes, that is correct.

Mr Purtill: The compliance plan that we will put together for each year, since we have a reasonable history of the type of workload, will always allow contingency for an expected amount of investigation versus proactive auditing, for example. That does not preclude a particular period. For example, in financial year 2015-16, there were no fatalities in the industry, but already in this financial year there has been a fatality, so it does change.

Mr McMillan: I think, Deputy Director-General, you gave some evidence, along with Mr Albury, about the process by which a worker is deemed to be at risk from dust exposure in the context of health assessments. If I have written down your evidence correctly, you said that workers deemed to be at risk from dust exposure are the ones who are X-rayed and others are subject to routine health assessments; is that right?

Ms Cronin: Generally speaking, yes. As they go through the medical assessment, if they are considered to be at risk my understanding is that that is the process.

Mr McMillan: So the use of the expression 'workers deemed', that is—

Ms Cronin: It is not meant to be a legislative definition. It is just common vernacular; I apologise.

Mr McMillan: You are referring to the doctor who conducts the assessment of that work?

Ms Cronin: Yes.

Mr McMillan: In terms of whether or not they are at risk, I think Mr Albury gave some evidence a few moments ago that the employer fills out a section on the form 4, which is critical to the assessment of whether or not that worker is at risk?

Ms Cronin: The employer fills out a section on the approved form. The form 4 or section 4 is the last part of the form that is shared, that the medical practitioner fills out, and it is given to the employer.

Mr McMillan: Is it the case, then, that it is really the employer who determines whether or not a worker is at risk?

Mr Albury: Essentially that is correct, yes.

Mr McMillan: You would expect that the doctor who is conducting the assessment relies upon that assessment to determine what investigations to undertake?

Mr Albury: Yes. I am sorry: I would also expect that the doctor would have a conversation with the employee who is sitting there in front of him, but you cannot guarantee that that question is going to be asked.

Mr McMillan: How does that deeming process and that assessment of risk allow for coalminers who work across multiple employers as contractors and who may be at risk in one particular place of employment, but not in another?

Mr Albury: Yes, that is an interesting question. That is difficult to capture in the present scheme.

Mr McMillan: Is it your evidence essentially that it is not captured in the present scheme?

Mr Albury: Yes.

Mr Purtill: Mr McMillan, one of our goals with the recommendations around nominated medical assessors, and particularly in reducing the number of those, is to provide a far more fulsome medical assessment around the circumstances by which people are presenting for those assessments, their work history, whether they have been in and out, and then to provide either for external spirometry or external radiology or any other external services far more context around the worker history that is being presented, so that people have a far more conscious awareness of the individual, their work history and what we are trying to achieve in the medical assessment process. I think the Monash review pulled no punches in showing the recommendations that were required to deliver on some of those shortcomings.

Mr McMillan: Finally, Madam Chair, if I may: Mr Stone, you gave some evidence about the proactive role, if I can describe it that way, of the inspectorate in assisting industry to be aware of risks. You gave evidence particularly that there are nine present guidance notes issued by the inspectorate to the coalmining industry. Are any of those notes specifically dealing with coalmine dust?

Mr Stone: No, they are not, but I would add that there is a recognised standard. Before I move to guidance notes, which really provide advice and set out the expectations of the inspectorate and guide industry, the recognised standard which describes how industry can achieve an acceptable level of risk, the recognised standard for respirable dust monitoring and another recognised standard on the control of dust are in a very late stage of a draft and will be part of the new legislative framework commencing 1 January, specifically addressing that point and providing a level of prescription around consistent reliable monitoring and reporting and the provision of that data to the department.

Mr McMillan: But those standards are not in place yet?

Mr Stone: They are not.

Mr McMillan: As at the present time and over the past decade or more, has there been any standard or guidance note issued to industry expressly addressing coalmine dust and identifying it as a hazard for which mine operators have obligations to prevent?

Mr Albury: We might have to take this on notice.

Mr McMillan: Finally, you are aware of the notion of hazards and principal hazards under the coalmining safety and health legislation.

Mr Stone: I am.

Mr McMillan: Does coalmine dust above the acceptable level institute a principal hazard?

Mr Albury: It could be argued that way.

CHAIR: Yes or no?

Mr Albury: It could be argued that way.

Mr McMillan: The definition in section 20 of the legislation provides—

A *principal hazard* at a coal mine is a hazard at the coal mine with the potential to cause multiple fatalities.

Surely you would accept that coalmine dust above the acceptable level would constitute a principal hazard?

Mr Albury: We have had that discussion amongst the advisory committee exactly on that point. The reason why I say it can be argued either way is that it was split down the middle. I appreciate how it is worded, but the intent of that was to take in hazards that have an immediate consequence or imminent impact as opposed to one that has a latency. That was the original intent, but given the words, yes, you could argue that it is a principal hazard.

Mr McMillan: Thank you, Madam Chair.

CHAIR: Before I go to the concluding question of Mr Kelly, please advise the committee whether any coalmining company in Queensland has been prosecuted for excess dust in the coalmines?

Mr Albury: No, there has not.

CHAIR: Why not?

Mr Albury: It is an interesting discussion. We would argue that when you are talking about respirable dust, and CWP is the result of a long latency period, it is more effective to go through a compliance process and the last step of that compliance process is to either stop the operation or affect the productive capacity of the mine, rather than go through a long protracted prosecution case that can go on for a couple of years and not necessarily get a result.

Mr SPRINGBORG: They always comply? At the end of that compliance process, they have always absolutely complied?

Mr Albury: To this stage, yes.

CHAIR: Have you ever shut down a mine in relation to excess dust?

Mr Albury: No, we have not, to this point.

CHAIR: Why not?

Mr Albury: We have got to the stage with two mines where we have said that we have given them a short time frame to get under the exposure standard otherwise they will be stopped or their production slowed down, et cetera. The issue with underground coalmines and longwalls especially is that there are other hazards hanging off it other than respirable dust that come into play. They are gas management, spontaneous combustion, strata problems. If I stop a longwall mid block, I could actually create more hazards than I am trying to fix. All those things need to be taken into consideration.

CHAIR: So you have never prosecuted a mine?

Mr Albury: I personally have never prosecuted a mine for respirable dust, no.

CHAIR: Director-General, has the department ever prosecuted a mine for excess dust?

Mr Purtill: For excess dust levels, not to my knowledge, Chair.

CHAIR: Can you please take that on notice, come back and confirm that?

Mr Purtill: Sure.

CHAIR: Has the department ever gone to the stage of collecting evidence and going to crown law or your own legal advisers in relation to excess dust in coalmines?

Ms Cronin: Yes, we have referred to our own in-house legal counsel in relation to compliance matters.

CHAIR: In relation to taking it as far as a prosecution?

Ms Cronin: I could not answer that question specifically, but I can say that, in relation to respirable dust, we have engaged with our in-house legal advisers regarding compliance steps. I cannot answer the question specifically about prosecution or not. I can take that on notice.

CHAIR: Director-General, I know that we cannot ask for legal advice, but can you please give us a list of the coalmines that have had excess dust levels whereby the inspector of coalmines has gone to the stage of speaking with them and trying to get that under control—way back to 1980.

Mr KELLY: In relation to the form that you referred to, is that a departmental form or does each company develop its own?

Mr Albury: No, it is a departmental form.

Mr KELLY: Could we have a copy of that supplied to the committee please?

Mr Albury: Certainly.

CHAIR: Thank you for attending today. We will have a short break while we set up for the Office of Industrial Relations.

Proceedings suspended from 10.46 am to 10.57 am

GOLDSBROUGH, Mr Paul, Executive Director, Safety, Workers Compensation and Policy Services, Office of Industrial Relations, Queensland Treasury

HILLHOUSE, Ms Janene, Director, Workers Compensation and Policy Services, Office of Industrial Relations, Queensland Treasury

CHAIR: I now welcome representatives from the Office of Industrial Relations. Thank you for making yourselves available. Mr Goldsbrough, would you like to begin by giving your evidence?

Mr Goldsbrough: Yes, thank you. I would like to make an opening statement. With the chair's agreement, I do not intend to go into minute detail on the workers compensation scheme—I am aware many of the members have detailed knowledge of it—but I would like to hand up an information paper—

CHAIR: We will table those documents.

Mr Goldsbrough: The Queensland workers compensation scheme supports workers for all related injuries, whether an injury is a traumatic injury resulting from a single event or develops over time from multiple events or is a latent onset disease resulting from exposure to chemicals or hazardous dust at work. A latent disease such as CWP, or coal workers' pneumoconiosis, is covered by the workers compensation scheme in the same way as other onset dust diseases or latent onset dust diseases such as asbestosis, mesothelioma or silicosis—that is, workers in the coalmining industry diagnosed with CWP can claim no-fault statutory compensation and can access common law damages regardless of the age of the worker or whether the worker has retired or is no longer in the mining industry. The worker can still access benefits under the scheme for CWP. Latent diseases are treated differently from traumatic injuries. The date of injury is the date of diagnosis. In the case, for example, of an 85-year-old worker who develops mesothelioma, the point at which the doctor diagnoses them as suffering from mesothelioma would be the date of injury, which means they are captured by the scheme.

A worker's claim for CWP may be lodged with and managed by WorkCover Queensland or a relevant self-insurer depending on the worker's employer. WorkCover Queensland has established a specialist team dedicated to the determination and management of CWP claims. On receipt of a claim, a team member will contact the worker within 48 hours to step them through the process. Depending on the worker's circumstance, they may be entitled to compensation for lost time earnings and reasonable medical expenses, including hospitalisation, surgery, rehabilitation, medication and medical aids.

What I would like to do, rather than going through the specific quantum of how much people are entitled to, is really focus on the four cohorts that have been raised earlier. The first relates to a retired mineworker. Where a worker is no longer working or retired, they are still able to make a claim under the scheme. There are no age limits that apply to making a claim. You will see in the material that we have recently had a claim from a 67-year-old worker. A retired worker can also access medical expenses for worker related injury. Further, if the worker's injury is stable and stationary—that is, the worker's condition is not likely to change over the next 12 months—they are assessed as having a permanent impairment and may be eligible for lump sum compensation, or common law damages, or both.

The second scenario is a coalminer with simple CWP who does not have any incapacity for work—and we have seen in the media that there has been some conjecture about this. A coalmine worker may be diagnosed with simple CWP. That requires the worker to be removed from the dusty environments. Once removed from these dust related work environments, the worker may no longer have an incapacity to work. We have seen that with a number of the people diagnosed to date, where they have been moved to above-ground duties or other duties.

It has also been reported in the media that some of these claims are being opened and closed at the same time—so immediately after. That is not the case. I want to reassure the committee that we certainly take our obligations under the legislation seriously. In these circumstances, a worker will be compensated for weekly wages until the worker is able to be redeployed to a dust-free environment, or the insurer may accept the claim for medical expenses and rehabilitation treatment only. In this instance, the insurer will have paid all relevant medical expenses leading up to the diagnosis in acceptance of the claim and will have informed the worker that there is no entitlement to lost time earnings, as the worker has not lost any earnings as a result of the injury. The worker remains able to inform the insurer if this situation changes in the future in that the insurer will reopen the claim of statutory compensation.

The worker is also able to request an assessment for permanent impairment when their injury is considered stable and stationary. The worker may be eligible for lump sum compensation, or common law damages, or both. Following a permanent impairment assessment, workers who experience economic loss—for example, reduced income—may make a claim for this through common law.

Public Briefing—Inquiry into the Re-Emergence of Coal Workers' Pneumoconiosis Amongst Coal Mine Workers in Queensland

The third scenario is coalminers with CWP who are working on a suitable duties program. If the worker is working fewer hours because of an incapacity from the work related injury—or CWP—than they previously worked, they are paid for their lost wages. The relevant insurer will also pay the worker's medical and rehabilitation treatment for the work related injury. When the worker's condition is stable and stationary, they may be assessed for permanent impairment and the worker may be eligible for lump sum compensation, or common law damages, or both. Following the permanent impairment assessment, workers who experience economic loss—for example, reduced income—may make a claim through the common law process.

If a worker has an incapacity from work related CWP that prevents them from doing their job and they are not redeployed or able to find another job, WorkCover or the insurer will pay compensation for lost wages until they are able to be placed in a job. For coal workers who are incapacitated for work—where a worker has no capacity due to CWP—the worker will receive statutory benefits in the form of weekly compensation for lost wages. WorkCover, or the insurer, will pay the worker's medical and rehabilitation treatment for the accepted work related injury. WorkCover may assist with providing relocation or assistance, as do the self-insurers. When a workers' condition is considered to be stable and stationary, the worker can be assessed for permanent impairment.

There have been 19 workers compensation claims lodged since 2006. I am conscious of some of the questioning earlier today. I have requested that the acting director of data and evaluation go back through the scheme and draw all claims data as far back as we can get it for the committee's consideration.

CHAIR: Just repeat that again, Mr Goldsbrough—19?

Mr Goldsbrough: There have been 19 claims lodged for possible CWP since 2006. Two of these are notification-only claims. You see that a lot in relation to asbestos related conditions, where someone may have an exposure to an event and they want it recorded somewhere so in 40 years time, if necessary, they have a record of that. Fifteen of these claims have been lodged with WorkCover and four with self-insurers. In relation to WorkCover, WorkCover has received 13 claims and two notifications. Sorry, if I can stop there for a second?

CHAIR: Yes.

Mr Goldsbrough: I have some detailed information on all of these 19 claims.

CHAIR: Would you like to table that?

Mr Goldsbrough: Yes, I would, but I would ask one thing: while we have deidentified it, because we wanted to give you a high degree of specificity, it is still possible that people could be identified and I would ask that it is kept confidential—

CHAIR: Yes.

Mr Goldsbrough: To the committee.

CHAIR: Yes, we will give you that undertaking. Can I just say to the television present that you please not focus on the documents that are going to be tabled? Thank you.

Mr Goldsbrough: As well as detail on all 19 claims, there is also a flow chart that maps out the process of how a CWP claim is managed and the points at which insurers make decisions in it. I will ask Ms Hillhouse to go through that in a minute.

Just to finish on the claims, of the 13 claims, one was determined not to be CWP but the claim was accepted for a different coalmine dust lung disease. One claim was withdrawn by the worker and one claim was rejected as the worker did not have a work related condition. Of the 10 remaining claims, six claims have involved diagnosis of CWP and the workers' claims have been accepted and the workers are entitled to statutory benefits. In these cases, the worker is fit for other duties above ground and they have been redeployed or found alternative duties. Only one worker was deemed unfit for work and, to date, has been paid a considerable sum—in excess of \$100,000 in wages. One worker left the industry and is pursuing common law rights.

Four claims are still in the process of determination and two are pending receipt of Medical Assessment Tribunal investigations and reports. One of the things there is that we have come to an arrangement with the Department of Natural Resources and Mines so that, immediately the scans identify CWP, that will then be taken into account by WorkCover or the self-insurers as a CWP claim. It is not as if they are going to have to fight a battle over that diagnosis again.

With the claims with self-insurers, four workers compensation claims of possible CWP have been lodged with self-insurers. Three of those claims have been lodged between May and August 2016. One claim has been accepted for simple CWP while two claims have been accepted with a generic diagnosis of industrial related lung disease. Two workers are on suitable duties while the third is off work. All three

workers are currently being paid full-time wages by their employer while permanent redeployment options are being canvassed with the workers. A fourth claim for CWP has subsequently been accepted by WorkCover Queensland, which was originally lodged with the self-insurer.

The other thing that I briefly wanted to mention was that the department of mines and the office of industrial relations have now put in place an information-sharing arrangement. We can provide a copy of the MOU between the two agencies to the committee. Going forward, all claims for CWP to either WorkCover Queensland or a self-insurer will be notified to the Department of Natural Resources and Mines as a priority. That has been put in place but that was done only as late as last week. That is all that I really wanted to add. Subject to the chair's view, Ms Hillhouse is happy to take members through the flow chart.

CHAIR: Okay. Just in relation to the claims that you were speaking about, are they all underground miners?

Mr Goldsbrough: No, they are not.

CHAIR: How many are open-cut miners?

Mr Goldsbrough: We do not have a claim from an open-cut miner.

CHAIR: Okay.

Mr Goldsbrough: There is one claim for an above-ground worker, who does not work in an open-cut mine, that involves coal.

Mr SPRINGBORG: Just to clarify that, there is a claim in relation to black lung disease for a worker who does not work in an underground mine but who works above ground but is not actually a miner?

Mr Goldsbrough: That is correct.

Mr SPRINGBORG: An associate? Based on that, when we are looking at this, is it likely that there is a whole range of other circumstances out there? There may be people employed as a mine geologist, for example, or a driller, or whatever the case may be, and that you might see more of these?

Mr Goldsbrough: Certainly, in our data analysis to 2006 looking at lung diseases, it is always possible, yes. I suppose the heightened attention to the issue at the moment has seen this claim come forward recently. The person has not been diagnosed with CWP; it is a claim for CWP. That will work through a process. I would expect that we will get some claims from individuals where they believe that the claim was related to coal or other dusts and they will just have to be worked through. As to whether they will be CWP, I cannot say.

CHAIR: Thank you. Are there any questions at this point?

Mr KNUTH: Yes. Does the employee have to go to WorkCover, or does the employer or the department refer him?

Mr Goldsbrough: In a normal set of circumstances, generally, if someone presents at their doctor of having breathing difficulties, or whatever, or a general feeling of being unwell, they will talk with their doctor. In the case of WorkCover, where someone presents at their doctor, there is a suggestion that it is work related. Someone with a lung complaint—and we have had some where they have just been referred by GPs and there are no scans to indicate that they have CWP—the doctor will fax a claim form through to WorkCover and then the process commences from there. It is really driven around the doctor in the first instance and the individual worker presenting with some symptoms.

CHAIR: Are there any other questions at this point?

Mr SPRINGBORG: Before we go to Workers' Compensation Policy Services—and I am not quite sure where this fits, but I suspect that it probably fits in your area, Mr Goldsbrough—

Mr Goldsbrough: We work together.

Mr SPRINGBORG: That is good. With regard to the briefing paper that you have put forward, there is an agreement with the Department of Natural Resources and Mines. Specifically, the thing that interests me is at page 9 where you are talking about new processes and those sorts of things. Given that your department has overall responsibility for workplace health and safety and regulation and compliance, notwithstanding other government agencies and the private sector, was there anything that was immediately obvious to you, or that you believe could have been done to ensure that the process of making sure that there was better compliance and protection of workers could have been done? Where are there deficiencies, do you believe? This goes into the next heading of review of workplace exposure and standards.

Where do you believe the actual deficiencies were? Because it goes on to the next heading, review of workplace exposure standards, where you mention that there was a public consultation process which found that workplace exposure standards are out of date and that there was support for

mandating a smaller number of exposure standards on the basis of risk. Something has been found; obviously it takes a circumstance like this sometimes to find it. Where was the failure? What are those standards likely to be which will address CWP in the future and the protection of workers?

Mr Goldsbrough: If I could just clarify my role. I am the executive director of safety policy and workers compensation services, so my role covers workplace health and safety, electrical safety and workers compensation policy. I also oversee prosecutions under those acts and also the Workers' Compensation Regulator, so I have a fairly broad ambit. Safe Work Australia has recognised that a whole range of exposure standards need to be updated to ensure all the protections of workers going forward, and at this stage a company has been contracted to do a review of those. Following that there will be tripartite consideration and technical experts will provide commentary on it. I am not a technical expert in terms of exposure standards and particulate matter and impacts on lungs and so on. We have other people within the organisation who undertake that role for us and they also work with their colleagues nationally on those things.

Mr SPRINGBORG: Do you have a considered view or a concluded view as to who is responsible for this based on your knowledge and because of your overarching role? This morning we heard it was a little bit like that, so who is responsible for this? Where did it go wrong?

Mr Goldsbrough: In fairness to the Department of Natural Resources and Mines, I have not looked at their processes in terms of what was undertaken. What I can say under the Work, Health and Safety Act is that we have a broad framework that really gets representatives of workers, employers and our technical people to the table to consider standards and what should apply and so on. I understand that the Department of Natural Resources and Mines has a number of advisory groups that provide broad knowledge in a similar way to my department, but I certainly cannot say in any detail what process has been gone through because I have not looked at it and whether it is appropriate or not.

CHAIR: In relation to the Senate committee report that you are obviously familiar with, in relation to questioning by Senator McLucas of Mr Stoddart in relation to workers comp or WorkCover the question was in relation to who has paid for all of the travelling, for example, going to different doctors and medical specialists. Mr Stoddart said—

I have paid for all of this myself. All of my travelling, all of my CAT scans, PET scans, the specialists: It has all come out of my pocket. The union paid for ...

—a certain doctor. What I am wondering about is when does WorkCover or the workers comp benefits start to be paid? There would be many people, including retired miners who are on the aged pension now, who simply could not afford this.

Mr Goldsbrough: Yes. The situation is—and this goes for asbestos related cases as well, any long latent disease case—that the workers compensation scheme will cover the costs where a person is diagnosed and has a work related injury. In the first instance with a retired worker my expectation would be that they would go to their doctor and their doctor refers them for some scans or specialist consideration. That would be probably covered by Medicare if they are a retired worker, maybe on the age pension—

CHAIR: Who pays for the gap, Mr Goldsbrough? As you know, there are many GPs, particularly in the mining towns, who do not bulk-bill and there is a gap for specialists in the meantime.

Mr Goldsbrough: My understanding is that would be reimbursed down the track by the insurer.

CHAIR: What if they do not have the money in the first instance to cover these payments? There would be many, many retired miners, Mr Goldsbrough, who, as I said, are on the age pension and could not afford the gap in the payments. Some specialists can charge hundreds of dollars in the gap between Medicare and what their particular fee is. Who pays?

Mr Goldsbrough: We would expect in some of those situations, particularly with a retired worker on the age pension, that the doctor would consider bulk-billing. It has certainly not been an issue that has been raised with us.

CHAIR: I am raising it with you now, Mr Goldsbrough, because there are men in my community who are former coalminers who have not gone to get diagnosed or to get any work done from the medical profession because they are so frightened of the costs involved initially. What it means to them is if they are referred from a GP, they might have a gap payment from the GP for a start and then they are referred to a specialist. It means that, if they are on the age pension and they get this referral, they do not eat for that week. They have to go to the Salvation Army or Anglicare or some other charity to get food for that week because they cannot afford the gap. Where does WorkCover or the workers comp schemes step in for these miners who should be able to retire in peace and not have to worry about black lung anyway?

Mr Goldsbrough: Under the workers compensation scheme in Queensland the insurer will not cover costs unless there is an accepted claim. That is the way the system is. If an individual has expended money that will be reimbursed once the claim is accepted, or Medicare will be reimbursed by the insurer down the track where they have been bulk billed.

CHAIR: Mr Goldsbrough, where do the hospital and health services fit in in this scenario that I have just spoken about? In other words, if they go to the GP and the GP says there might be a diagnosis of black lung, for example, they might send them along to the hospital and health service—for example, in Moranbah or in Mackay or Rockhampton—so they go on a waiting list to see a specialist in the first place. I know you were talking originally about private sector doctors, where obviously retired miners are out of pocket and have huge personal and financial imposts, but where does the public health system come into this?

Mr Goldsbrough: The way we have operated in Queensland in terms of the interface between the public health system and the workers comp scheme has been historically in the past it was always an agreed quantum that would go to Queensland Health each year and any of the workers that presented would automatically be seen. Now the arrangement that has been entered into is on a fee-for-service basis, so what happens is where someone presents at a casualty department or at a hospital and the Queensland Health staff involved identify that it would be a work related claim, a claim form will be taken and forwarded to WorkCover, a medical certificate issued where appropriate and so on, and they will bill WorkCover directly in that scenario. That has been in place certainly for this financial year. What would happen in that situation is that the individual worker would not be charged an up-front cost.

CHAIR: Basically you are suggesting to the retired miners of Queensland that they go to their local GP and if they are on the age pension or something like that, that they then get referred to the hospital and health service closest to them and they then fill out the form. What happens then in relation to any waiting list? Do they jump the waiting list because they are a potential WorkCover claim, or what happens?

Mr Goldsbrough: Can I take that question on notice? It is a very good question and I do not have the answer here. The question is whether they are immediately referred for treatment or whether they do go on a waiting list. We will come back to the committee if that is okay.

CHAIR: Thank you very much. If there are no other questions I would like to call council assisting at this point in relation to Mr Goldsbrough's evidence.

Mr McMillan: Thank you. Good morning, Mr Goldsbrough. I wanted to ask you some questions if I could, please, about the schedule that you provided of the currently accepted claims. First of all, perhaps I will start with a general question. Are you able to tell the committee the proportion of coalmine workers that are covered by WorkCover as opposed to self-insurers?

Mr Goldsbrough: We can provide that information. The scheme is broken up. Basically 90 per cent of employers insure through WorkCover Queensland and about 10 per cent through self-insurers, but I can break it down in detail in terms of—

Mr McMillan: Those are proportions across the entire workforce, are not they?

Mr Goldsbrough: Yes.

Mr McMillan: Are you also able to provide to the committee the details of the particular self-insurers that insure coalmine workers?

Mr Goldsbrough: Yes.

Mr McMillan: I notice from the schedule that you have provided I think there are details on the second page of four self-insurer claims.

Mr Goldsbrough: That is correct.

Mr McMillan: I notice in the way that the schedule has been provided that the second or third column from the left is headed 'lodged for'. Do I take it that that is taken from the original application for compensation?

Mr Goldsbrough: That is correct. We have put the column in that way because this is a very complex area in terms of diagnosis. Sometimes people say it is CWP or they might say it is something else, and then subsequently as further medical tests are done it becomes clear. Ms Hillhouse, do you want to comment?

Ms Hillhouse: That is correct. Sometimes the diagnosis can actually change after further investigations have been done and between discussions between the insurer and the work or the worker's representatives.

Mr McMillan: Of the four self-insurer claims that I can see, two of them originally claimed for coal workers' pneumoconiosis but neither of the self-insurers in those cases accepted that claim; is that right?

Mr Goldsbrough: That is correct.

Mr McMillan: What role does the Office of Industrial Relations have in assisting employers to identify work related injuries and notify their workforces that they might have a work related injury?

Mr Goldsbrough: The Office of Industrial Relations, as I mentioned before, is a regulator of electrical safety, work health and safety and workers compensation and industrial relations, so we have a big role in educating employers to common hazards and risks. We run extensive campaigns to that end. For example, this week the minister for industrial relations announced that Libby Trickett would be our ambassador for mental health. As psychological health is becoming a big issue in our community, we do quite extensive work in that regard.

In terms of CWP, we have certainly worked closely with WorkCover Queensland and the self-insurers to make sure that there are robust processes in place and that people are being treated fairly and reasonably. We are talking to them nearly on a day-to-day basis as the regulator of the workers comp scheme. We have two points of access: one is in managing the insurers; the other is having an awareness and education campaign on health and safety. In relation to specifically health and safety in the mining industry, that is the responsibility of the Department of Natural Resources and Mines so that is not one we have gone into. We do joint activities at times with them on safety related matters, one of which is at the moment we are working with them in relation to heat stress. Some of the members may be aware of a fatality and a coroner's recommendation some time ago. Rather than us heading off in different directions, we are endeavouring to work together—and also with Safe Work Australia and other regulators—to ensure we have a consistent theme across all workplaces.

Mr McMillan: In order to access statutory benefits under the workers compensation scheme you advised the chair a moment ago that it required a worker to make a claim and for that claim to be accepted by the insurer; is that correct?

Mr Goldsbrough: That is correct.

Mr McMillan: Is it the case that that requires essentially first of all for the worker to know they have some sort of injury?

Mr Goldsbrough: Yes, most definitely.

Mr McMillan: To consult a medical practitioner about that injury?

Mr Goldsbrough: That is correct.

Mr McMillan: For the medical practitioner to recognise that injury as a work related injury?

Mr Goldsbrough: That is completely correct.

Mr McMillan: And probably for the medical practitioner to give some advice to their patient about the fact that they may have a work related injury?

Mr Goldsbrough: That is correct.

Mr McMillan: Subsequently to that for the worker to synthesise all of that information and make a claim under the workers compensation scheme?

Mr Goldsbrough: I would like to answer that in this way if I can: this can be a complex area of diagnosis for everyone. As part of our functions we also have the reviews of workers compensation claims where insurers make decisions and, if the parties are agreed, it can be referred to us for a review, so I have some knowledge in this area. One of the claims that I followed was a worker that initially presented in 2003 with symptoms. It was not until 2007 that the worker was subsequently diagnosed and then the problem in that case was that it appears that the medico that diagnosed him did not advise the worker that it was a work related injury and it took some more years before it came to our attention and the matter was considered in terms of whether it was an out-of-time claim. The view of the review officer in that case was that the worker had a reasonable excuse to lodge a claim. I think there are a lot of points in the process here where I think it is important that there is education, and I understand from the Department of Natural Resources and Mines they are doing education. It is one of those things that we probably need to do a body of work on in relation to our engagement with doctors, and we have quite extensive engagement with doctors, and one of the areas that we see we need to do so that where they have got those symptoms consideration is given to that.

Mr McMillan: Just to be clear: the Department of Natural Resources and Mines's responsibilities are around the promotion of work health and safety on mine sites?

Mr Goldsbrough: That is correct.

Mr McMillan: It is the responsibility of your office and its predecessors to engage with employers and insurers in relation to the workers compensation scheme?

Mr Goldsbrough: That is correct.

Mr McMillan: Is it then the case that it is the responsibility of your office and its predecessors to engage with industry and with workers in the coalmining industry to help them to understand the possibility that they might have work related injuries arising from excessive exposure to coalmine dust?

Mr Goldsbrough: Yes. As I said before, at the moment we have been engaging with the self-insurance side of the coalmining industry and also with WorkCover Queensland with employers. We have recently had the claim that I referred to before which is from outside the industry and we will have to do more work in this area.

Ms Hillhouse: The other thing that has also occurred is a number of fact sheets have also been produced which have been disseminated to, I believe, workers and are available on the websites which explain the workers compensation process to coal workers so that they can understand the process that they need to step through. There has been some work done to educate—

Mr McMillan: Do any of those fact sheets specifically address exposure to coalmine dust?

Ms Hillhouse: Yes, they are. They are specifically related to CWP.

Mr Goldsbrough: They were done jointly with the Department of Natural Resources and Mines. As soon as this issue started to emerge, the fact sheet was done immediately for that reason because—

Mr McMillan: Can you tell us when that fact sheet was first published?

Mr Goldsbrough: I will take that on notice. It was around July, I think, but I will take it on notice.

Mr McMillan: July this year?

Mr Goldsbrough: Yes.

Mr McMillan: Prior to July this year, what work has the Office of Industrial Relations or its predecessors done to promote awareness of these type of work related injuries?

Mr Goldsbrough: We have done a lot of work in the latent disease area of asbestos and also in noise at different times. Pneumoconiosis only came to our attention when we were asked to look for data to do some data mining because it had not been evident. There are 100,000 claims approximately a year in the workers compensation scheme, so it had not come to our attention as a significant issue.

Mr McMillan: Prior to 2015, are you aware of any claims under the workers compensation scheme in Queensland for an injury arising from excessive exposure to coalmine dust?

Mr Goldsbrough: Yes, and if I could table, Chair, with your approval—

CHAIR: Thank you.

Mr Goldsbrough: Of the 19 claims, can you remember off the top of your head how many were for—

Ms Hillhouse: There was one claim that was from 2006 and then there was a space of probably, I think, five or six years, so the next claim actually was not until probably—

Mr Goldsbrough: 2012 or 2013. What we can do, Chair, with your approval, is provide the number of claims in each year and—

CHAIR: Yes, please.

Mr Goldsbrough: We will get that to the committee.

CHAIR: Mr Goldsbrough, do you want this to remain confidential to the committee?

Mr Goldsbrough: This one, no. That one is fine.

CHAIR: That is fine; thank you.

Mr Goldsbrough: As Ms Hillhouse said, we had a claim in 2006. We had a claim in 2007 that was worked out not to be CWP related, so we discounted it and then it was about five or six years until the next claim.

Mr SPRINGBORG: So the claim in 2006 was in relation to CWP?

Mr Goldsbrough: That is correct.

Mr SPRINGBORG: And confirmed as such?

Ms Hillhouse: Yes.

Mr Goldsbrough: Yes, it was. Yes, it was an accepted claim.

Mr SPRINGBORG: Accepted as—

Mr Goldsbrough: Yes.

Mr SPRINGBORG: So the diagnostics said it was CWP?

Mr Goldsbrough: That is correct. Our specialists that the individual was referred to from the workers compensation scheme would have diagnosed it as CWP, yes.

CHAIR: It was an Australian specialist who diagnosed it?

Mr Goldsbrough: Yes, it would have been. Yes, we would not have sent the individual overseas or the claim file overseas.

CHAIR: Sorry, counsel assisting, but I have a question in relation to the 19 cases. Do you accept just Australian diagnoses of Australian specialists or are you accepting the diagnosis from the US specialists as well?

Mr Goldsbrough: Yes. As I said before, we have met with WorkCover and the insurers and where they are diagnosed in the States as having CWP from the scans that will be accepted here. Quite often they will still need to see a thoracic surgeon or an occupational specialist because one of the complexities for the workers comp scheme is that miners do move around a lot and so you might have 15 years at one colliery and then they might go over to Brazil for a couple of years or somewhere else in the world then Sydney and so on. We have to look at liability issues and all of that and an occupational physician is really important in that process of sitting down and getting the full occupational history of the individual. If the Department of Natural Resources and Mines was to send X-rays to the States and they confirmed CWP, then it will be accepted by the insurers in the workers compensation scheme.

CHAIR: What about those miners or whoever, whatever occupation they were, that might have lodged a claim and there has been an issue in relation to the diagnostics in relation to CWP? What happens to those cases now? Are you going to go back and have a look at them?

Mr Goldsbrough: If you look at the summary sheet that I have handed up to you, of the claims there we have had one denied claim where after all of the occupational assessments it was determined that the individual did not have a work related injury and certainly did not have CWP. I would expect that the data there should give you some confidence that, once a person gets into the workers compensation scheme, we have robust arrangements in place to ensure fairness in terms of that process.

CHAIR: My point is that there has been a difficulty in the medical profession in relation to diagnosing CWP anyway. What I am saying is that there could be potentially years of claims that have come in whereby those claims have been denied based on a missed diagnosis. What happens then?

Mr Goldsbrough: As I said in my opening statement, we did 10 years data which was the initial mine we did to understand what was going on. We will go back further now. In that 10-year period to date we have only found one claim denied and we have been through and looked at the claim and it clearly was one that was not a CWP related matter. I am confident based on this 10-years history that once someone is diagnosed or once someone comes into the workers compensation scheme or applies for workers compensation then they are being treated appropriately.

CHAIR: I understand what you are saying there. What I am saying is what about those who have made a claim but it has been denied based on a misdiagnosis because, as the deputy chair was saying earlier in his questioning, somehow between 1984 and up until a couple of years ago there has been absolutely no-one being diagnosed with CWP in Queensland? What I am suspecting is that you may have claims there that are legitimate but they have been denied.

Mr Goldsbrough: Yes.

CHAIR: What I am asking is will you go back and have a look at all claims for CWP that have been made in your area going back to 1980, say, because I have asked the mines department to go back to 1980?

Mr Goldsbrough: We will go back as far as we can; that is right.

CHAIR: Yes, and to maybe reassess them to see whether they do in fact have CWP.

Mr Goldsbrough: That depends. We could have a scenario when we go back which is similar to this one in the table in front of you where there has only been one claim out of 19 denied. I am not sure, but we are happy to look at it.

CHAIR: Okay; thank you.

Mr Goldsbrough: If we have a substantial number, then we need to look at the process. We will do that data mining—that will be provided to the committee—and then we can look at a course of action from there and certainly advise the committee.

CHAIR: Thank you.

Mr SPRINGBORG: Sorry, Mr McMillan, to break up your line of questioning. Until last year the popular myth was that black lung disease had been eradicated—that is what had been said from the department and others—but at the time when we were saying that the department in terms of what you are responsible for had actually been paying workers compensation for confirmed cases of black lung disease.

Mr Goldsbrough: That is correct; a very small number.

Mr SPRINGBORG: How small?

Mr Goldsbrough: We are looking at a couple of claims—two or three.

Mr SPRINGBORG: A couple of claims. In the meantime you were paying workers compensation payments to those workers duly entitled for black lung disease, yet on the other hand the popular mythology was that it had been eradicated. We have a disconnect between what you were doing in fulfilling your statutory obligations—and it is yet to be decided whether there may have been other people that had slipped through that reassessment—in ensuring that people were being paid as confirmed with black lung disease and yet on the other hand we have a situation where the department responsible for compiling this information after coming from the medical professionals was saying that it had been eradicated. There has been a disconnect between what you were doing and what has been happening.

Mr Goldsbrough: That is correct. Of the 19 claims, the majority of the claims have appeared in the last two years. There were a couple of small claims. That is one of the reasons why we endeavoured to get a memorandum of understanding in place where we could share data and had Crown law draft that for me so that we can make sure now when a CWP claim comes into the scheme information will be provided directly to the Department of Natural Resources and Mines by our data and evaluation area. Going forward, that issue has been addressed.

CHAIR: I would like to return to counsel assisting.

Mr McMillan: Just drawing from the deputy chair's question a moment ago, is it the case that when an insurer accepts a claim for a work related injury the insurer advises the workers' employer that that claim has been accepted and the injury for which it has been accepted?

Ms Hillhouse: Yes, that is correct.

Mr McMillan: In the two cases we are discussing prior to 2015 the insurer in those relevant cases would have been obliged to advise those workers' employer that they had had a claim accepted for CWP?

Mr Goldsbrough: Can I take that on notice. The only reason is that, from memory, the 2006 claim related to a defunct business. The colliery was no longer in existence. With latent diseases you will often have businesses that cease to exist. The workers compensation still covers those individuals and they are paid because the employer at the time the individual worked had paid a premium to indemnify them for that injury. We will come back to you on that particular issue about whether the business existed. If the business existed then yes the employer would have been notified and they would have been given detail around the cost of the claim.

Mr McMillan: Under the work health and safety scheme, which I realise is separate from the workers compensation scheme, are those employers then obliged to advise Workplace Health and Safety, which I understand sits within your office, about the emergence of a work related injury arising from their workforce?

Mr Goldsbrough: The Work Health and Safety Act 2011 requires employers to notify a range of things, including significant near miss incidents. The demarcation between the Mines Inspectorate and the general work health and safety inspectorate means that we would not take those notifications. The expectation is rightly so that the Mines Inspectorate would be advised of that.

Mr McMillan: Assuming that employers were still functional businesses at the time that these injuries were diagnosed—and you have told us that we do not know that for certain—can we also expect that the process would have been this: the claim is accepted, the insurer advised the employer and the employer would have then had an obligation to advise the Department of Natural Resources and Mines of the existence of injury?

Mr Goldsbrough: I would have expected so, yes.

Mr McMillan: So flowing from that, assuming that all of those things are accurate, the Department of Natural Resources and Mines should have been alerted in 2006 and 2007 to cases of coal workers' pneumoconiosis?

Mr Goldsbrough: In 2006 and then the cases were later on. The 2007 one was not a CWP claim. Yes, I would expect that to be the case.

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Mr McMillan: Are you aware of the Rathus report from 1984?

Mr Goldsbrough: Vaguely. I do remember looking at it at one stage many years ago in relation to some other issues.

Mr McMillan: You were present this morning during the evidence given by the officers from the Department of Natural Resources and Mines?

Mr Goldsbrough: That is correct.

Mr McMillan: You would have heard during that evidence the discussion that some 74 coalminers were identified in that report as being suspected of having or diagnosed with coal workers' pneumoconiosis in 1984? You heard that evidence?

Mr Goldsbrough: Yes.

Mr McMillan: The fact that, as we understand it, there is not another claim accepted or made under the workers compensation scheme until the mid-2000s for that particular type of injury—have I understood that correctly first of all? Between 1984 and the mid-2000s there is not another claim accepted?

Mr Goldsbrough: No, that is not correct. What I said at the outset was that when this initially came up I asked for some data mining to be done. We did 10 years. What I said to the chair in my opening statement is that we will now go back as far as possible and we will provide the information in a similar way to the information we have provided so that you will have a picture of how many claims there have been, how many have been rejected, how many have been accepted and so on, whether the businesses are in existence—

CHAIR: Year by year.

Mr Goldsbrough: Yes, absolutely.

Mr McMillan: Assuming that there are not 74 claims that you are able to find, does that not suggest to you that there is a significant problem historically with workers understanding that this disease is a work related injury capable of compensation under the scheme?

Mr Goldsbrough: It is not just workers. It would depend whether they are working at time, whether they are retired, what the role of the doctor is in advising people, what the role of the union is, what the role of the employer is. I think it is a multifaceted problem to be honest.

Mr McMillan: Would you agree that all of those different people involved in the administration of the scheme have had a lack of awareness and understanding of the fact that this is a work related injury?

Mr Goldsbrough: If we were to go back and be able to get back as far as 1984 in terms of the data and it showed no claims then I think that would certainly be the case. It would depend. If we have a number of claims where the 1984 report said it was CWP and then an occupational thoracic physician or whatever has said that they think it is something else then it could go either way. Certainly, if they are just rejected, I share your concern.

CHAIR: I now call the member for Mirani, Jim Pearce.

Mr PEARCE: Earlier you mentioned between 2006 and 2014. Were you talking about no claims being submitted or no claims being accepted?

Mr Goldsbrough: No, I am talking generally in terms of submitter claims. Yes, I do believe there were some in that period. I want to come back to the committee with precise years because there was a gap of about five years between 2006 and the next claim. I did not specifically carve it up by year for today's hearing. I am happy to provide that.

Mr PEARCE: It is a bit concerning that we have such a big gap there and we are uncertain now as to whether there were any claims lodged or whether there were—

Mr Goldsbrough: No, if they are lodged we have that information. What I am saying is that there was a gap of about five years when there were no claims lodged.

Mr PEARCE: What has changed in that period so that there were no claims lodged? Did the wording in the documentation change? You might pick that up when you go back and have a look at it. For me as a former mine worker, I ask myself why we went through an extended period without claims being lodged when it is very obvious that the problem has been there for a long time and it has not gone away, as the media would have us believe or the system would have us believe? The time that I was in the industry, I did not see things change that much that would lessen the risk of miners being impacted on by dust. I think when you are going back through your process, if you would not mind having a look to see what changed in that period when people did not claim or had a claim accepted.

Mr Goldsbrough: Sure.

Mr COSTIGAN: Thank Mr Goldsbrough and Ms Hillhouse for your contribution and your evidence here today. Mr Goldsbrough, I wanted to go back to what you said before. You said you think it is important that there is education. Where is the ownership in relation to education—is it your department or your office, DNR, the health department?

I worked a lot of my life, not in coalmining industry like Mr Pearce and the chair's family—and I say that with the greatest respect to both those individuals here today—in the media. Given the heightened awareness that we have with black lung, I cannot recall the public awareness campaign? What is the media schedule? I read newspapers all the time. I am sure you do too as do people in the gallery today. I am across regional media, radio and television. What is happening there? I am not sure if I have picked up on much in terms of public awareness given what we are here discussing and trying to eradicate black lung.

Mr Goldsbrough: Prevention is obviously the best approach. In Workplace Health and Safety Queensland and the Electrical Safety Office we are very much involved in extensive prevention campaigns. It is Health and Safety Month at the moment. In fact, we have Shane Webcke in Mackay this morning speaking at a breakfast. That is very important.

I also think that we need to get better education with our doctors and our allied health professionals so that these things are more easily identified. We have to look at the workers compensation scheme now to see how we can get that information out there. We are doing a lot of work with the Australian Medical Association and specific doctor specialties at the moment. It is one of those issues that we need to take back and work on. From that end, the Department of Natural Resources and Mines has indicated earlier this morning that they are running some education campaigns in terms of prevention in the first place.

Mr COSTIGAN: I accept that. Perhaps my question should have been of the DNR people at the time. We have cyclone season starting in less than three weeks time. We talk about road safety campaigns and what not. I cannot see anything about this at the moment. If I go home to Mackay tonight and watch the television, I do not see anything about black lung or government advertising appealing to retired mine workers about how to tap into the system and come forward. I think we are in coma. That is my take on it. Do you have any response to that?

Mr Goldsbrough: My take home from today is that we need to work more closely with the Department of Natural Resources and Mines to ensure that we can cover off better in terms of education on what it means for people when they start to have the symptoms and what the process is in terms of the workers compensation scheme that can dovetail with their education campaign up-front to reduce exposure levels.

CHAIR: Can we now go to the evidence from Ms Hillhouse.

Ms Hillhouse: What I would like to do is walk the committee through the flow chart that you have been given and give you a little bit more information about how the claims process actually works. I think the committee has probably cut across a number of different issues here.

The first step is that the scheme is initiated once a claim for CWP is actually received. That claim can be made by the worker themselves by telephone. It can also be made by the worker's doctor. They are actually able to lodge that on the worker's behalf.

That claim can be made either to WorkCover Queensland or to one of the self-insurers. The first thing that a self-insurer will usually look at doing in terms of considering a claim is look at the date of diagnosis and which employer last insured that particular worker. Was it WorkCover or was it a self-insurer? We make sure that the claim goes to the right place. The worker is then advised if they are in the wrong jurisdiction and they need to make the claim to another insurer.

The second question that an insurer will actually look at is whether the claim was lodged within the legislative time frame. As Mr Goldsbrough said earlier, with latent onset injuries the date of diagnosis is seen to be the date of the injury. A worker has six months from the date of being diagnosed to make a claim. However, if a worker is outside that time line, there are a number of exceptions. The insurer can extend that time if they believe there has been a mistake or if the worker was absent from Queensland or if the worker has a reasonable excuse.

As Mr Goldsbrough mentioned earlier, we have had a situation recently where a worker was not advised as to the work relatedness of his injury at the time. It was not until some time after receiving the diagnosis that he really understood that connection. An extension of time was given in that circumstance.

The insurers also look at the base issue of whether the worker was a worker. Generally, a worker is somebody who works under a contract where the employer is required to withhold PAYG tax. The insurer then looks at the question as to whether or not the actual injury that the claim has been submitted

for has actually been confirmed by the relevant specialist. This is where the insurer will work with the worker to make sure they have seen the relevant specialist. For example, have they seen a thoracic physician, have any X-rays been seen and confirmed by an approved radiologist? They work through that process.

The insurer may actually require that the worker have an independent medical examination to confirm what the nature of their injury actually is. This is sometimes claims where you can see a little bit of time between the claim being lodged and acceptance. The parties are actually getting a true picture of the actual injury the workers has. If there is a dispute between a number of positions, an insurer is able to refer the matter to the Medical Assessment Tribunals which are able to make a determination on what the appropriate injury is. There is a mechanism in the legislation or in the scheme to manage that process.

The final consideration is whether at the time of exposure employment was a significant contributing factor. This is the area where insurers will get an employer report to understand the nature of the work that the worker was doing and to understand what sort of exposure the worker may have had to determine the work relatedness to that particular employer. If a claim is rejected as a result of this determination—and we have had only one—that worker would have been given the ability to seek a review of that decision with the Workers' Compensation Regulator in the Office of Industrial Relations and they would have had a three-month period to do that. If the claim is accepted, the employer likewise would have a three-month period to seek a review of that decision.

Once a claim has been accepted, an insurer will notify the worker as well as the employer, and the insurer will also explain to the worker what benefits they will be entitled to. Mr Goldsbrough went through some of the base scenarios in relation to that earlier. It really depends on the level of incapacity that a worker has as to what benefits they will be entitled to. If a worker has no incapacity other than not being able to work in an underground or a dust filled environment, then largely their claim will be a medical expenses only claim. However, the insurers will ensure that the worker receives weekly benefits until such time as they are able to be redeployed into a new position. The worker does not miss out during that gap. In terms of the medical expenses, they will be covered from the time the worker was assessed as having the injury. The worker will not be out of pocket going backwards from that point onwards.

In terms of those injuries, if the worker is stable and stationary an assessment will be done as to whether they have any lump sum entitlements and whether or not they may be able to access common law damages. One of the things that we have noticed in these claims is that there has been a recognition by thoracic physicians that, due to the nature of the condition, a worker may not be stable and stationary for a number of years. In a number of these cases, their claims will remain open for medical expenses only for the duration of that time until their situation is seen to be stable and stationary.

As Mr Goldsbrough said earlier, if they have some inability to work, they will be compensated by loss of wages for any time they are unable to work to the extent of their incapacity. If they are able to work a shorter week only, the workers compensation insurer will pay for lost time wages in that circumstance. If the CWP is a terminal condition like other terminal latent onset injuries, the worker will be entitled to a lump sum payment in the vicinity of somewhere up to \$600,000 and their dependants will be entitled to lump sum payments.

Mr Goldsbrough: That is irrespective of age.

Ms Hillhouse: If a worker's incapacity changes throughout the claims process or a worker's condition becomes terminal, then the worker may be entitled to further statutory benefits or common law damages. The scheme is able to adjust while a claim is open.

CHAIR: For the benefit of the committee, we are now in a subcommittee because we have gone over the time limit. It being past 12 o'clock, the remaining members now form the subcommittee of the select committee.

Mr PEARCE: With the self-insurers, are you able to get access to the reasons why there was a rejection of a claim or are you just advised?

Ms Hillhouse: Yes, we are.

Mr Goldsbrough: What will happen is that we can get full access to that claim file as the regulator. If the individual then disputes the rejection of the claim, it will go into our review area and the whole file, including medical reports and so on, are required to be provided as part of that review process.

Mr PEARCE: Who makes that decision—somebody down the ladder or somebody like yourself?

Mr Goldsbrough: In terms of whether it goes to review or not?

Mr PEARCE: Yes.

Mr Goldsbrough: That is the decision of the worker and maybe their legal representatives or their union. If a worker is aggrieved by the decision of the insurer to reject their claim, they do have three months, as Ms Hillhouse indicated, in which to lodge a review application. The regulator then gets the full file—all the decision-making consideration and so on.

Mr PEARCE: I think our counsel said that we identified two workers who have lodged a claim with an insurer; is that right?

Mr Goldsbrough: We have four with self-insurers.

Mr PEARCE: And two of those have been accepted?

Ms Hillhouse: I believe three of those have been accepted.

Mr Goldsbrough: And one is still pending, I believe.

Mr PEARCE: I am happy with that.

Mr Goldsbrough: In that particular table there we have specified—

Ms Hillhouse: You will notice that in that table two of the three were for an alternative diagnosis.

Mr McMILLAN: I have one question arising from the question by Mr Pearce. Is there any consequence flowing from the change in diagnosis from CWP to industrial related lung disease for the purposes of the compensation scheme? Does that have any consequence on the benefits that the worker is entitled to?

Ms Hillhouse: No.

Mr Goldsbrough: No. It is one around clarity. I suppose it depends on the medical evidence and advice, but it certainly does not have any impact. They are both latent diseases, so they are treated in the same way.

Mr McMILLAN: Does it have any consequence for the worker's entitlement to common law damages after the statutory phase of the compensation claim?

Ms Hillhouse: It shouldn't do, no.

CHAIR: Thank you very much for your attendance today.

DWYER, Ms Sophie, Executive Director, Health Protection Branch, Prevention Division, Queensland Health

HUXLEY, Dr Suzanne, Senior Medical Officer, Health Protection Branch, Prevention Division, Queensland Health

CHAIR: I now welcome representatives from Queensland Health. I would like to thank you for making yourselves available today. Sophie, would you like to start your evidence?

Ms Dwyer: Thank you very much for the opportunity to be here. I will make a short statement to introduce our issues, and then I am able to answer questions or take questions on notice. Queensland Health's role is primarily in this case the provision of health services and management of non-occupational public health risks. Hospital and health services provide routine clinical services to coalmine workers when required, as they do for any member of the community. In addition, a limited number of health and hospital services have been providing radiography services—that is, taking X-rays—on a fee-for-service basis for private occupational health service providers under the scheme, predominantly in Central Queensland. However, the reading of X-rays, and particularly their interpretation of results, is the responsibility of the requesting clinician.

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. I can get more information on that, although I recommend that the committee consult a specialist thoracic physician for detailed information on treatment of the disease.

CHAIR: For the benefit of the committee, we will be retaining two thoracic specialists.

Ms Dwyer: Excellent. The question is often asked about our regulatory system and notifiable diseases. That falls within the Public Health Act 2005, which is there to support the management of public health risks. The scope of those public health risks does not include those associated with mining dust in the occupational setting. It also provides for the management of notifiable conditions and the maintenance of a notifiable condition to register. The purpose of this register is primarily to identify outbreaks of communicable disease and to help with the identification of persons who have or may have contracted a notifiable condition so that Commonwealth, state or local governments can take steps to protect public health—that is, respond to that notification. Given it is a communicable disease, that means you are following up with people on a more urgent basis to prevent the spread of disease. It is also used to supply data that assists in monitoring and analysing the instances and patterns of notifiable conditions; to study the efficacy of the management and treatment of the notifiable conditions; and to increase public awareness.

Notification to that system is predominantly through clinical diagnosis or pathological diagnosis, pathology requests for testing or provisional diagnosis. Most of the conditions that are notified to Queensland Health are on the basis of pathology reports rather than information directly from clinicians, but the predominance is through that method. The schedule is outlined in the public health regulation. The conditions on that register are predominantly, as I said, communicable disease conditions, and the ones that are not relate to adverse vaccination events, ciguatera poisoning and lead levels, mainly because they require an immediate follow-up. That, in conclusion, summarises our approach to notifiable conditions. The Public Health Act also provides for a number of other registers including the cancer register and the Pap Smear Register as examples. As I mentioned, they are outside the scope of occupational disease.

In summary, Queensland Health's predominant role is in the management of occupational disease of patients who present to our services. Often we will see those patients many years after they have been exposed to coal dust because the conditions requiring inpatient treatment may occur many years after initial exposure. The focus of our regulatory effort is around broader public health risks rather than occupational exposure.

CHAIR: Thank you very much. I would now like to ask the member for Greenslopes if he would like to ask any questions because he has to leave the committee fairly soon.

Mr KELLY: I appreciate that, Chair. CWP is not a notifiable disease. Are there any plans to make it a notifiable disease?

Ms Dwyer: Not at this stage, no.

Mr KELLY: In terms of other types of diseases where there might be a public health response or conditions or things in the community like smoking, Queensland Health does drive a public health response in relation to certain matters, doesn't it?

Ms Dwyer: Yes.

Mr KELLY: Within a workplace, there is no public health responses initiated or driven by Queensland Health?

Ms Dwyer: No. We may support in regard to communicable diseases because of our special knowledge base or in radiation safety, but it is within the context of Workplace Health and Safety law. We would support Workplace Health and Safety in those matters.

Mr KELLY: We have heard evidence from the previous witnesses that they have had compensation claims confirmed in relation to CWP, dating back to 2006 I think was the time frame roughly. There would be no obligation or no reason for Queensland Health to be specifically notified that CWP had occurred at that point.

Ms Dwyer: No.

Mr KELLY: Really your role is simply related to treating the symptoms of patients who may present to one of your services. Is that correct?

Ms Dwyer: That is correct.

Mr KELLY: In relation to radiography services, the Senate inquiry identified that there was a skills gap in Queensland radiographers—I do not know whether that was Queensland Health or the private sector—in terms of being able to address or identify CWP. Since that inquiry has occurred, has the organisation taken steps to try to address those deficiencies in the workforce, if in fact they are there?

Ms Dwyer: No, not at this stage. The focus of that education would be through more clinical training at the specialist colleges rather than specifically Queensland Health.

Mr KELLY: There are a number of reports and inquiries that have made a number of recommendations. Has Queensland Health taken any action in relation to any of those recommendations? Do any of those specifically relate to the organisation and have you taken action in relation to those?

Dr Huxley: Not specifically to Queensland Health that I am aware of, but we can take that on notice and refer back.

Mr SPRINGBORG: With regard to the competencies and the training around those involved in the diagnostics of this, I imagine that the College of Radiologists would have a fair bit to do with this. Given that the department regularly has interaction with the various colleges over emergent issues—requirements and potentially changes in regulation whether they be state or national—has there been any discussion with the College of Radiologists at all in light of this?

Ms Dwyer: Not by Queensland Health specifically, no. It would be more with respect to the broader effort, the whole-of-government effort, in regard to improving the skill set of radiologists. Queensland Health on its own would not specifically focus on that, but it is aware that Natural Resources and Mines has also been focusing on addressing this issue as part of the response to the recommendations.

Mr SPRINGBORG: Based on that, you would expect that that department has discussions with the College of Radiologists.

Ms Dwyer: Yes, or make efforts to deal with the skill set. It was referring to the B readers in particular.

Mr SPRINGBORG: There is no overarching role with regard to the Public Health Act in Queensland or the statutory powers and responsibilities of the Chief Health Officer in Queensland which are rather significant and unique, and they should be to ensure that those sorts of issues—whether they be in their area of population health, communicable diseases, occupational health—are addressed through discussion with colleges.

Ms Dwyer: There is no statutory role, no.

Mr SPRINGBORG: Would you be able to indicate to us, and I am happy for you to take this on notice, how many cases of CWP that you are aware of, regardless of the severity, where public health facilities in Queensland are treating those patients—we do not want the specific identities of those patients—and over which particular time frame? Is that possible?

Dr Huxley: It may not be possible. As part of our looking into the issue, we looked into our outpatient hospital coding. One of the codes in the international classification of diseases is J60 coal workers' pneumoconiosis. We thought that would actually be useful to look up. Unfortunately, in the way that is coded, a very small number of those people coded may be miners with coal workers' pneumoconiosis. From what we saw, the majority of those were individuals who had a pathological diagnosis of black pigment in lymph glands or lung, and that has many other causes that have nothing to do with coal workers' pneumoconiosis. As far as identifying individual cases, the only way we could do that is probably to go to every respiratory physician and ask them if they are aware of any.

Mr SPRINGBORG: How many respiratory physicians would you have—

Ms Dwyer: We would have to go and look at that.

Mr SPRINGBORG: Would that be possible? What we have here today potentially is the tip of an iceberg. We have seen today—and we note that you have been here since the start of this—that there is a major disconnect in this process, and coal workers obviously are the losers with regard to this. There is a lack of coherence with regard to a competent policy process and framework to ensure the protection of people in the community. That has failed in some way. I think we have already seen enough of that come forward today. It would be very useful as part of this information-gathering stage if you could assist us in that area to undertake to do that.

I was also interested before in the discussion with Mr Kelly, the member for Greenslopes, around what was a communicable disease or a notifiable disease. I understand that where you have a risk of transmission from one person to the next within the community. Notwithstanding that, we also have lung cancer obviously and other forms of cancers where the risk is not of going from one to the next but it is an overall risk within the community—awareness of what we do with our planning. I refer to things such as Q fever, where it is not communicable from one person to the next but there is a requirement to notify it and to follow up. It is largely an occupational disease. Therefore, why is that occupational, non-communicable disease notifiable? Obviously it is environmental, soil borne and all those sorts of things and there are risks, but it is not communicable from one to the next and it is largely occupational, but we make it notifiable. Is there a disconnect with regard to this?

Dr Huxley: I do not really have an answer for how things get on to the schedule within the regulations.

Ms Dwyer: Normally it is, as I said, a focus on communicable disease. It is an organism. It fits within that context. You are quite right that Q fever sits often in the occupational setting. It can sit in a community setting as well. It would require some immediate response to try to determine the cause of it. If there started to be a pattern, you are looking then at the patterns of something like Q fever. In an occupational setting there is also vaccination. That is a failure of a preventative program.

Mr SPRINGBORG: Again, we are dealing here with something where there is significant value of a preventative program. It is non-communicable, like Q fever, for example, but has exactly the same sorts of dynamics and parameters that underpin it—preventable, occupational, non-communicable but nevertheless quite devastating. If you look at black lung disease, it is probably more devastating because the consequences down the line as this progresses can be terminal. I do not mind disclosing that I am a person who has suffered from Q fever, so I understand this quite significantly. I see a very significant disconnect between the policy and the requirement that underpins this as a notifiable disease. If you look at all of those things—and there are probably other examples out there compared to CWP—I see this as another example of a public health or a policy disconnect across the various agencies.

I would be very interested to know with regard to the issue of black lung disease whether you are aware of any population health studies or risk studies that have been done across a particular profile in the community—you may not have this but you may have read some research—where there is a greater degree of susceptibility of an individual based on certain types of backgrounds. It may be an ethnic background or it may be a background as a smoker—whatever the case may be—that increases a person's susceptibility to CWP, because that may help inform us as well. There may have been international studies around this.

Dr Huxley: The only one that I am specifically aware of is rheumatoid factors. Individuals who have rheumatoid factor seem to be more susceptible to developing coal workers' pneumoconiosis. In that case it is called Caplan syndrome. Smoking, of course, may not make you more susceptible, but the combination of the two is an issue.

Mr PEARCE: I want to go to nominated medical advisers. There is a list that Queensland Health has.

Dr Huxley: No. It is held by DNRM.

Mr PEARCE: Do you get access to that list at all?

Dr Huxley: No.

Mr PEARCE: You do not know who they are. I was wanting to find out who nominates the people on that list.

Dr Huxley: My understanding is that it is a contract between the employer and the nominated medical adviser.

Mr PEARCE: Which means what?

Dr Huxley: They tell DNRM who the NMA is.

Mr PEARCE: After they have been appointed.

Dr Huxley: Yes.

Mr PEARCE: My next question—I probably know the answer before I ask it, but just for the record—are you aware of any special qualifications that those people need or is there ongoing training with regard to diseases like pneumoconiosis?

Dr Huxley: Not to be an NMA. I am hoping that that will be addressed in the new processes. I am aware that, when someone is nominated as an NMA, DNRM used to provide a pack of information to that individual—just information on occupational lung disease. Beyond that, I have no awareness.

Mr PEARCE: Are you aware whether Queensland Health at all has ever been asked to be involved in the process? I am asking the question because I see it as very important. We need to understand what happens in the coalfields where mining companies have these nominated medical officers not only to look for different diseases but, once a worker is injured or sick at the mine, they are then in the hands of the nominated medical officers right through the process until they get a clearance to come back to work. I have some real concerns about the integrity of the process. You are saying that Queensland Health has virtually no involvement with those doctors at all?

Dr Huxley: No.

Mr COSTIGAN: We heard from some of your interdepartmental colleagues earlier—it might have been Mr Goldsbrough—talking about Libby Trickett and her work as an ambassador for mental health. We have heard this morning about my old mate from Rugby League, Mr Webcke, doing work in another space—in Mackay, in fact. Has Queensland Health identified someone to perhaps be an ambassador in relation to black lung? I asked before about public education and making people aware of what they can do—retired mineworkers, particularly in the regions—and the cut through, particularly in regional media. People still like reading the local paper—in this day and age, that is not insignificant—or listening to the radio. What is Queensland Health doing to support our other colleagues from other departments, whether it is the office of industrial relations, or whatever, in terms of making people aware of what they can do, or should be doing, in light of what has become a big issue, particularly across Central Queensland, especially in the coalfields and on the coast where we have those retired mineworkers?

Ms Dwyer: When it comes to managing advice to the community about particular occupational risks, that is normally managed by Workplace Health and Safety or, in this case, it would be NRM. I think where we come into play is we can assist other agencies. We often provide an advisory role rather than a regulatory role. Certainly, where we can assist is particularly in the area of smoking and smoking related impacts. Obviously, if a person has been exposed to coal dust the worst thing they can do for their health is to continue smoking. We would like to assist them in quitting smoking. There is a range of programs that Queensland Health runs in that regard. Certainly, that could easily be made available to any agency or health service or whatever in terms of promoting quitting smoking.

Mr COSTIGAN: I am going to go back to Mackay this afternoon and it will be as clear as mud from my point of view, with the greatest respect to you and your colleagues from the other departments, as to what the media schedule is—and I have taken notes here, like all of us here today—in terms of what is being done to encourage people to come forward and what their options are. I cannot imagine the worry, the dread and the stress for people to come forward and say, 'Look, this is what you can do. This is what we would like you to do.' If they are listening to their favourite radio station, or picking up the paper; there are all sorts of stories going around shopping centres about black lung and the dust and all sorts of stuff. Maybe they are old wives' tales. I am not a medical expert like the member for Greenslopes with his nursing background. Today, I am going to go away and not be any the wiser. I am just wondering who is taking responsibility for it and what is the plan in terms of the awareness program, the public awareness. We hear about cyclone season coming and road safety blitzes. What are we doing in relation to black lung?

CHAIR: Do you have any response to that?

Ms Dwyer: As I said, Queensland Health would happily advise NRM if they were to run such a campaign on matters that would help and obtain technical information for them. That is predominantly our role in a circumstance like this.

CHAIR: Can I just bring up another couple of issues in relation to Queensland Health? If a miner or a retired miner turned up to the hospital and was treated as an outpatient, or treated as an inpatient, for CWP, does the hospital and health service then notify you or notify the department of mines as to the fact that they are treating a person with that disease?

Dr Huxley: They would not be expected, because it is not notifiable. If it were notifiable under either act, whether it was the mine health and safety act or our act, then that would be an expectation. One of the difficulties—and I think it was mentioned earlier—is the fact that this would be a clinical notification. Actually getting an individual clinician, wherever they may be, to make that notification is quite difficult, as we have seen with our own Public Health Act and getting people to make clinical notifications.

CHAIR: There could very well be people in hospitals right across Queensland, but I am thinking particularly in the Bowen Basin area like Mackay and Rockhampton, who could be currently being treated for CWP but that information is not aggregated from a health perspective and they have no requirement to advise the department of mines; is that correct?

Dr Huxley: The other issue is that there may be people who are being treated for lung disease—say coalmine lung dust disease, whatever that may be—who do not realise that the actual diagnosis may be coal workers' pneumoconiosis, because the presentations are quite similar. Without linking an occupational history—however long ago that may have been—with the actual presentation and the latency that it presents, yes, it would not be unexpected that people would be then treated for lung disease that may have been caused by exposure to coalmine dust.

CHAIR: Just to take that up a bit further, certainly, anecdotally, I have been advised by some retired mineworkers that they have been treated for pneumonia, for example. When you have a look at the lung X-rays, there is scarring on the lungs et cetera. The doctors have a look at the lung X-rays but, as we know in Queensland now, there has been misdiagnosis. They have been treated for, say, pneumonia when it could, in fact, now be CWP. What role does the health department have to do with that?

Dr Huxley: I am not aware of specific cases like that. What would our role be?

Ms Dwyer: I think the role of the department in dealing with misdiagnosis is a complex one and a lot more complex issue than specifically coal workers' pneumoconiosis. I think one of the challenges is that there are possibly different perspectives on how a doctor treats a particular patient. Whether they have the diagnosis absolutely right, I think, is a bigger question than CWP. The person, it would be fair to say—and I would consult my clinical colleague on my right—may well have pneumonia anyway.

Dr Huxley: They may have both.

Ms Dwyer: They may have both. They may well be needing to be treated for pneumonia, and that is quite correct, while having pneumoconiosis. The focus of the clinician is about treating the symptoms—the consequences—and if they do not take an occupational history they will not understand that the derivation of those clinical symptoms are, in fact, from exposure to coal dust. Does that make sense? At that stage, it is chronic obstructive pulmonary disease type symptoms.

CHAIR: Again, a coalminer turns up to a hospital, the hospital does not necessarily ask that person whether they have been, or are currently a coalminer. That is correct?

Ms Dwyer: That is correct.

Dr Huxley: That is a possibility, yes.

CHAIR: Any other questions? I will go to counsel assisting now.

Mr McMillan: Just flowing from the chair's questions—I only have a couple of questions arising from that—you heard my questions earlier to Mr Goldsbrough in relation to the sequence of people who need to be aware, first of all, that the symptoms being presented are possibly CWP. First of all, the worker themselves needs to have some awareness that possibly their symptoms are something other than pneumonia or other general lung disease issues. The doctor assessing that person has to have some awareness that the potential is for the symptoms that they are observing to be work related injuries—and that is precisely the point that the chair just highlighted—and, further, that employers, coalmine operators, need to have some awareness of CWP as a potential cause of a workplace injury. Is it your evidence that the Department of Health does not have any role to play in any of those three respects to change the level of awareness that currently exists?

Ms Dwyer: I think our role would be in supporting efforts to ensure that clinicians are informed, but that operates within a professional college context. We do not specifically—and Dr Huxley can confirm this—always go out and be responsible for the clinical competence of each physician in our system, their clinical training. We assess them—are they appropriately trained—and credential them.

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Getting to that level of detail, I think we can support efforts—and we would do that—of NRM or raising awareness among clinicians that occupational disease is an important factor. We would support that effort with them and advise them how to reach colleges and build those relationships.

Mr McMillan: In relation to other illnesses and conditions, do the colleges ever request the assistance of the Health Protection Branch in raising awareness among their members?

Ms Dwyer: No. We may advise, for example, GPs about specific issues. For example, we will send notices out, whether that be of communicable disease issues or, for example, asbestos related disease, because we have access to GPs. We normally have a close relationship with health service providers. We are often the vehicle by which people reach health service providers. That is what I mean about Queensland Health can offer to assist other agencies in reaching that population of clinicians, but we do not normally supplant the role of professional bodies.

Mr McMillan: Can you perhaps take this question on notice whether the Health Protection Branch has offered that assistance either to the Department of Natural Resources and Mines—

Ms Dwyer: We did. We assisted.

Dr Huxley: With the distribution of the fact sheets.

Ms Dwyer: Yes, we assisted with the distribution of the fact sheet to GPs as an example.

Mr McMillan: When was that?

Ms Dwyer: What month was it? Earlier this year.

Dr Huxley: It was January or February. It was a fact sheet that was produced as part of the Monash review. The Monash University team that was doing the review produced a fact sheet for GPs relating to occupational lung disease, specifically coalmine dust lung disease, which we distributed for them to general practices.

Mr McMillan: Has the Department of Natural Resources and Mines otherwise made any request to the Health Protection Branch for assistance in this regard?

Ms Dwyer: On educating clinicians, no. We have assisted on other matters like how much you arrange training of radiologists, who might be available and things like that. Because we have some knowledge of how these systems work, we make that information available and assist them in helping them join the dots between themselves and whether that be training bodies or colleges and the like.

Mr McMillan: If a mineworker or a former mineworker presents at a public hospital with chest symptoms and asks for assistance, who is it who is responsible for ensuring that the people who assess that person and treat that person are properly informed about the possibility that their symptoms are CWP? Whose responsibility is that?

Ms Dwyer: It would fit within the clinical skills of the treating doctor. They are credentialed by the respective hospitals that they are capable of doing the role that they are assigned—if they are an orthopaedic surgeon, that they are appropriately trained. That would rely on the appropriate training of their college and that assessment process. They are responsible as clinicians for their professional development. While we might provide information to clinicians, it is expected that clinicians take responsibility for their own competency and maintaining that professional competency. We might provide advice on particular issues if that is particularly necessary.

Mr McMillan: In terms of the colleges that this committee might wish to seek information or evidence from, we are talking about the college of general practitioners?

Ms Dwyer: Yes.

Mr McMillan: Emergency physicians?

Ms Dwyer: Yes.

Dr Huxley: Potentially, yes.

Mr McMillan: Radiologists?

Ms Dwyer: Yes.

Mr McMillan: And thoracic physicians.

Dr Huxley: And occupational physicians.

Mr McMillan: And occupational physicians. Thank you.

CHAIR: Thank you very much. Are there any other questions? Thank you very much for coming today, Ms Dwyer and Dr Huxley. I now declare this session of the select committee closed. Thank you.

Committee adjourned at 12.44 pm