COAL WORKERS’ PNEUMOCONIOSIS
SELECT COMMITTEE

Members present:
Mr CD Crawford MP (Acting Chair)
Mr JN Costigan MP
Hon. LJ Springborg MP
Mrs J Gilbert MP
Mr J Pearce MP

Counsel assisting:
Mr B McMillan (Barrister at Law)

Staff present:
Dr J Dewar (Research Director)

PUBLIC HEARING—INQUIRY INTO COAL WORKERS’ PNEUMOCONIOSIS

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 25 NOVEMBER 2016
Mackay
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Committee met at 9.03 am

ACTING CHAIR: Good morning. I declare open the public hearing in the coal workers’ pneumoconiosis inquiry. Thank you for your attendance here today. My name is Craig Crawford. I am the member for Barron River and I am the acting chair today, replacing Mrs Jo-Ann Miller, the member for Bundamba, who is unfortunately not well this week. The other committee members here with me today are the Hon. Lawrence Springborg MP, member for Southern Downs and deputy chair of the committee; Mr Jason Costigan MP, member for Whitsunday; Mr Jim Pearce MP, member for Mirani; and Mrs Julieanne Gilbert MP, member for Mackay, who is standing in today for Joe Kelly, the member for Greenslopes. We also have with us Mr Ben McMillan, who is counsel assisting on the committee.

I want to let you know who we are and what we are doing visiting your community. The purpose of the public hearing today is to receive evidence on the committee’s inquiry into the emergence of coal workers’ pneumoconiosis, or black lung disease, amongst coal workers in Queensland. We are a bipartisan committee. Our purpose is to assess whether the current arrangements to eliminate and prevent CWP are adequate and to look at the roles of government agencies, mine operators, dust-monitoring procedures, medical officers and unions in these arrangements now and in the future.

The hearing is a formal proceeding of the parliament and is subject to its standing orders and rules. The committee will not require evidence to be given under oath, but I remind you that intentionally misleading the committee is a serious offence. Those here today should note that the hearing is being transcribed by Hansard and that media may be present, so you may be filmed or photographed. Before we commence, I ask that mobile phones be switched off or put on silent mode. For the benefit of Hansard, I ask that witnesses state their name and position when they first speak and speak clearly and into the microphone.

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

BULGER, Mr Creswick, Inspector of Mines, Mines Inspectorate, Department of Natural Resources and Mines

DJUKIC, Mr Fritz, Inspector of Mines, Occupational Hygiene, Mines Inspectorate, Department of Natural Resources and Mines

STONE, Mr Mark, Executive Director, Mine Safety and Health, Department of Natural Resources and Mines

ACTING CHAIR: I welcome our first witnesses and I invite you to make an opening statement.

Mr Albury: I thank the committee for allowing me the opportunity to appear before it once more. The committee has understandably shown an interest in compliance and how enforcement is undertaken by the Mines Inspectorate, particularly in relation to the management of respirable dust at coalmines. I would like to take this opportunity to outline the inspectorate’s approach to enforcement action in relation to excess coal dust.

First, we need to be clear about how the legislation applies to excess coal dust. When, according to the legislation, can we say that a coalmine has exposed workers to excessive respirable coal dust? The committee is familiar with the concept of occupational exposure limit. This is how we measure the level of dust in a mine. The occupational limit is a time weighted average of workers’ exposure to coal dust in the mine and is the measured concentration of respirable coal dust in the mine’s atmosphere.

It is important to be clear that we are referring to personal exposure. You cannot just walk into a mine, look at a meter and say that the worker’s exposure to coal dust in the mine is a certain value. That is because the concentration of coal dust in a mine will vary from place to place and time to time. It is not uniform throughout the mine and the hazard is specific to the mineworker’s exposure. If you minimise exposure, you minimise the risk of harm.
When we talk about dust limits being exceeded, what we mean by that is the average worker’s exposure being at a higher level than the exposure limit. When that limit is exceeded, what does the legislation say? It is important to be clear that there is no specific offence provision in the legislation for excess coal dust. The act does not say, ‘You must not exceed the occupational exposure limit and if you do that is an offence.’ If we were going to think about prosecuting a mine for excess dust, the question is: what would we be prosecuting?

We have spoken before about the requirement for mines to have a safety and health management system. It is an obligation under the act that applies principally to the site’s senior executive at the mine to ensure that the mine has that system in place to provide ways for ensuring risk to persons at the mine is at an acceptable level. One of the specific requirements of the safety and health management system is that it must provide for ways of ensuring that workers’ exposure to respirable coal dust does not exceed the occupational exposure limit. That is section 89 of the regulation. A failure to do that—to fail to provide for ways of ensuring the occupational exposure limit is not exceeded—would be a breach of a safety and health obligation, and that is an offence. That is what we would be prosecuting if we were to prosecute for excess coal dust—a breach of a safety and health obligation.

I have discussed before the inspectorate’s compliance process and the committee has asked some questions about why there have been no prosecutions for coal dust issues. Typically, if we find that a mine has been unable to manage respirable dust, we begin a process which may involve issuing directives to that mine. These can include directives for the mine to review its safety and health management system, or review the effectiveness of dust controls, or reduce cutting speed or reduce shifts of cutting time maybe, all the way up to suspending operations. Issuing directives and taking mines through a compliance process requires immediate response from the mine aimed at correcting the deficiency and changing behaviour. We want the mine to focus its attention and resources on doing that so that the risk to workers is minimised. Regulation is about changing behaviour. There are many tools of enforcement designed to change behaviour. Not every breach or incidence of deviant behaviour requires the same enforcement tool to be applied to get the desired change.

Implementing directives can have significant financial impact on the mine. Depending upon engineering modifications the mine may need to make to comply with directives, its expenditure could be in the millions. The impacts on cash flow and lost revenue where operations are slowed or suspended can also be significant. In some circumstances, it is not unreasonable to put a figure of $6 million a day of lost revenue if we were to suspend the operation of a longwall. Compare that with suspension can also be significant. In some circumstances, it is not unreasonable to put a figure of $6 million a day of lost revenue if we were to suspend the operation of a longwall. Compare that with

It is true that, if we can demonstrate that the breach resulted in bodily harm, grievous bodily harm or death, that maximum penalty increases, and it is true that excessive and long-term exposure to respirable coal dust can cause those consequences—but, remember, coal workers’ pneumoconiosis has a long latency period. By the time any of the consequences of exposure have manifested themselves, we are years, possibly decades, down the track. Again, that is why the inspectorate puts its attention on requiring the mine to focus its efforts on getting things right in the mine with immediate effect. I suspect that is why the parliament gave us those powers in the act to do those things. I would not say that we would never prosecute or that prosecution has no place, but I just wanted to give the committee a full explanation of our approach to this matter and the rationale.

I am happy to take questions from the committee. Before I do, if I may, I want to very briefly mention the retired miners who appeared before the committee at Ipswich a few weeks ago. I know some of these gentlemen personally through my work history or I am familiar with their stories. Allan Berlin is a Box Flat survivor and is well known to people who have been in the industry for a while. I worked with Allan at Oaky Creek. Bevan Kathage has a long history in the industry and continues to do important work in his role with ACARP. Bevan was also the general manager of the mine where I started my mining career. All of these gentlemen have a story to tell.

My point is that I and my inspectors, two of whom are here with me today, have worked with these people or people like them. Their industry is our industry. We have come from mining backgrounds. We still go down into the mines as part of our duties. We know these blokes and over time we have formed relationships with them. My inspectors and I care about what happens here. It is not just a job giving out tickets and rapping people on the knuckles. It is real to us that people get injured and that some sadly lose their lives. It is also real to us that this industry supports communities,
so we really do care about it being a safe, healthy and enduring industry. That is all I have prepared to say. I hope that Fritz, Cres and I can assist the committee today in its continued work in relation to this issue.

**ACTING CHAIR:** Thank you. Who would like to go next?

**Mr Bulger:** I am an inspector of mines within the Department of Natural Resources and Mines. I have been in this role for almost four years—in two weeks time, it will be four years. Prior to joining the inspectorate, I worked in a number of open-cut coalmines in the Bowen Basin in a number of roles. I started off as an equipment operator and I progressively worked my way through to a management level. I have a number of competencies relevant to open-cut coalmining, including an open-cut examiners certificate and an SSE certificate, both of which are statutory positions within an open-cut coalmine. I also have a diploma in business and leadership and a diploma in auditing. Given my background in competencies, I concentrate mostly on open-cut coalmines as an inspector. Also, earlier this year I chaired and facilitated a subcommittee that developed the draft recognised standard for monitoring respirable dust in coalmines. For the purposes of today, I am happy to assist with the answering of any questions the committee may have.

**ACTING CHAIR:** Thank you, Mr Bulger. Mr Djukic, would you like to make a statement?

**Mr Djukic:** Thank you for the opportunity to appear here today before you. I have prepared a brief statement which I will go through now. I am an inspector of mines in occupational hygiene. I am a certified occupational hygienist who has worked predominantly in the coal industry over the last 20 years, as a consultant with Simtars, in the private sector and more recently as a regulator. As an occupational hygienist, I am focused on those hazards, both chemical and physical, that have the potential to impact on the health of mine workers in both the coal and metalliferous mining sectors.

Since joining the Mines Inspectorate, I have given particular attention to personal exposures to airborne contaminants, including respirable coal dust, as these airborne contaminants are commonly present at mine sites and must be effectively managed and controlled to ensure mine worker health. My work has included extensive reviews of personal exposure data, reviews of management systems and the validation of certain dust control technologies. I believe that the inspectorate in recent times has been quick to respond to the upward trend in respirable coal dust exposure levels. This work commenced prior to the re-identification of this terrible disease and it continues to be one of our major focuses.

In August this year I gave a presentation at the Queensland Mining Industry Health and Safety Conference entitled ‘Risk based legislation and dust exposures on Queensland longwalls: Does it work?’ I understand that that presentation has been provided to the committee and that some content has been referenced in submissions and in evidence provided by witnesses who have appeared before this committee. I also understand that the committee’s interest in this presentation is one of the reasons that I have been requested to attend here today. My presentation summarised some observations about risk based legislation and as it relates particularly to respirable dust management.

I opened my presentation with the unequivocal statement that I believe risk based legislation can be applied successfully to control dust in underground mines. Some mines have embraced principles of risk based legislation and demonstrated control over time. This should be recognised. However, I clearly acknowledge that risk based legislation has not consistently delivered acceptable exposures on our longwalls particularly in recent years. Some of the issues I highlighted in my presentation have since been addressed in amendments to coalmining safety and health regulation and in the development of two recognised standards, relating to dust monitoring and dust control. These regulations and the dust monitoring standard will commence on 1 January 2017, with the dust control standard to commence shortly after. Importantly, this will also include the development of an occupational exposures database to allow for the central storage and analysis of personal dust exposures by a tripartite standing dust committee. I believe that these changes will do much to enhance the robustness and transparency of the regulatory framework for both the monitoring and the control of respirable coal dust in our mines. Again, I thank the committee for allowing me and Cres to appear before you today. I will assist the committee in any way I can, by providing information and answering questions as you see fit.

**ACTING CHAIR:** We will come back to the presentation that you did shortly, but first I will ask Mr Stone for his opening remarks.

**Mr Stone:** Acting Chair, I do not have any opening remarks.

**ACTING CHAIR:** No worries. Fritz, do you have a copy of that presentation?

**Mr Djukic:** I have a copy of the printed slides here.
ACTING CHAIR: Can we spend five minutes running over that? I will ask the members to pull out their copies. Can you walk us through some of the key points of that, for a maximum of five minutes?

Mr Djukic: Generally, the theme of the conference was ‘A past forgotten is a history repeated’. I took the opportunity to look back at dust disease in the industry previously and presently, as we have had the re-identification of this disease. In particular, I wanted to focus on how effective the current regulatory framework has been in controlling dust exposure. I looked at the legislative framework we previously worked under, which most recently was the General Rules for Underground Coalmines 1983. You will note that the exposure limit back then was still three, but there were subtleties to the legislation. There was some more prescription about the way that dust would be controlled. I moved forward to discuss section 89 as we know it now, the risk based approach to legislation that is essentially the plan, do, check, act model. It is really up to mines to monitor and control dust. You will note, if you read the legislation, that there is no detail there on the frequency of when monitoring is to occur or who is to be monitored. It talks about controlling dust, but it does not specify how to control dust. That is essentially what risk based legislation is: it is for sites to identify hazards, assess the risk and manage those risks.

In order to actually understand if that had been effective with hazards in the occupational hygiene sense, there is a very good way of assessing effectiveness of controls, because we measure exposures. I looked back since the inception of that legislation in 2000-01. A colleague and I asked mines to supply all their exposure data. It is quite an exhaustive number of data points. In order to get this done in a timely manner, I decided to focus on the high risk or what is considered to be, and I would suggest is, the highest risk exposure, which is on our longwall operations. That would be the best test to see how effective we have been in applying this. I am sorry if I am jumping about here. I also looked at some of the exposures under the previous legislation. There was a study by Professor Cliff, who I believe has appeared before the committee. He also reported some exposures in the mid-1990s. I looked at how we had performed over that period. It was quite extensive. As I said, we had approximately 10,000 personal dust measurements collected across mines. We analysed all those data points by mine, by year.

In summary, what I found very early on in the piece was that there are requirements on mines to manage health records. I could see that that was not being done well by the fact that they were not able to easily supply this information. There is a requirement to keep these records for 30 years. That was a very early observation. In some cases, I had to go back to sites and ask, saying, ‘I’ve seen gaps in your data.’ I was able to understand that very clearly, because at some of those sites I had actually done the monitoring in a previous life when I worked for Simtars. I knew I had been there in those years and there was a shortage of what I could see of data.

Overall the major observation I found is that generally in the first decade there were occasions where a particular mine over the year exceeded the average. Generally mines were working below the average, but particularly after the first decade there were instances where some mines started to indicate an upward trend, and that was very heavily focused around 2014-15. I think it is about probably slide 8 or 9 where you will see the data over the 16 years. It is this one here. You will see that there is reference drawn to a red oval where, particularly around 2014, there was a concentrated upward surge in exposures. My main observation is that, while mines generally were monitoring and doing that part of the risk based process, it was the failure at some sites to actually review these exposures and do the most important part: implement control.

I mention that at that point the inspectorate was already issuing directives. We were in the field actively operating in this sense to reduce these exposures and they did start to fall, as you can see, in 2015-16. That was the year to date as of July, when I presented this paper. Essentially, it was my observation that, in this instance, there are some elements of the legislation that, in order to achieve consistency, we needed to be clearer on. That has not resulted from my research, but it has been recognised in the department. Hence, we do have regulatory amendments, we do have these recognised standards and we do have the exposure database.

On the issue of records, it will make my job and the job of my fellow inspectors much easier, because we will have exposure data and we will be able to make timely and statistically significant assessments on compliance. Now there is no requirement for mines to periodically supply data. Of course we do request it, but there is no mechanism in the legislation. It is done at our request, whereas this will be an automatic process and there are time frames around that. There are very strict guidelines on how to set up a monitoring program and who must be monitored. The frequency is risk based and that will drive consistency, and it should also focus monitoring on where it is really required. Then we will be able to track and trend these exposures to enable us to regulate more effectively, I believe.

Mackay

25 Nov 2016
ACTING CHAIR: You mentioned that some mines were not able to provide some of their data, even though they had to hold it for 30 years. Was that very many?

Mr Djukic: No, I would not say that was widespread. Certainly it was an observation because, as I mentioned, there were sites where I had conducted the monitoring. It was not widespread, but it certainly was evident. We make the assumption that the dataset is complete, but there was quite a lot of data, as you can see.

Mr SPRINGBORG: Mr Albury, in your opening comments you mentioned the department’s response to a particular threat. Is it true that the department did not place the same degree of priority on a dust threat as it would apply to a more immediate physical threat that could come from an issue identified in a coalmine, because you were not able to clearly put your finger on what the effect of the dust was going to be?

Mr Albury: We would place a higher priority—I am not sure whether ‘priority’ would be the right word. We would react more—how do I put it? I will use stopping an operation as an example. We would stop an operation more readily if it was a gas issue than if it was a respirable dust issue, yes. That is all based on the fact that if you get gas wrong the implications are immediate.

Mr SPRINGBORG: Would it be true that over a significant period of time there has been a cultural view within all aspects of industry that dust was not as serious, so you worked around it?

Mr Albury: ‘Worked around it’—I am not sure I know what you mean.

Mr SPRINGBORG: As in there is this view of acceptance that dust was a part of mining. Therefore, you did not provide the same immediacy and the same priority of response.

Mr Albury: I can only speak for my tenure in the job. Since I have been in the job I would not agree with that statement, no.

Mr SPRINGBORG: Also, when you were talking earlier you indicated that one of the concerns for the department in responding to the need to take action was the financial impact on the mine operator. That could be significant. It would impact upon production. It might impact upon the viability. Therefore, there was a reluctance to take that immediate shutdown action. On the other hand, prosecution was something that would take such a long period. What was the principal hierarchy of priority that you went through when you decided to respond to, say, an identified ongoing dust issue in a mining environment?

Mr Albury: We had this discussion when I first appeared. If we talk about a longwall, for example, stopping it mid-block, as we discussed earlier, creates other issues—that is, spontaneous combustion, strata issues. That is a part of our thinking when it comes to affecting the revenue and stopping the longwall. Because we are in a situation where if we do stop it we create another risk, we could be in a worse situation. I do have to correct things here. We have issued directives for two mines to suspend operations on a longwall because of dust. We have in our deliberations with two others made it very clear that if it does not change they will be stopped. That is the way we have approached it.

Mr SPRINGBORG: If there had not been such an established cultural view that black lung was a thing of the past and that it was an ever-present threat, do you think there would have been a different response when it came to the issue of addressing dust in mines?

Mr Albury: I cannot answer that from what has happened in the past. Possibly.

Mr SPRINGBORG: Mr Djukic, thank you very much for assisting the committee before and also for the information that you have provided us. It was very useful. I note that you indicated that in 1983 there was a more prescriptive response to dealing with issues of coal dust in the mines. You believe that a risk based approach can work. As we have moved away from a prescriptive to a risk based approach, has that created a greater risk to health and safety or a negative impact for those who work in the industry, particularly in the area of dust diseases?

Mr Djukic: I will try to answer that as best I can. I made the statement that risk based legislation can work. At the sites where I saw it work effectively they had the right expertise at that site in terms of my field of occupational hygiene. There was probably a greater focus at those sites on the actual results that were coming through the monitoring systems and they were responding to those results. It is not only evident in this review I have done on respirable dust. It is also evident in reviews I have done on diesel particulate exposure. I have done those extensively over the last few years as well. I believe it can be effective. I still believe that it could be, but right now, because of recent events, I think there is an opportunity to provide some more rigour and guidance around the monitoring and review process and the reporting process.
Mr SPRINGBORG: From your observations, do you believe that complacency has slipped into industry oversight, regulators, as a consequence of the move towards a risk based approach—that is, it is a 'tick a box' because they do not feel that there is the same sort of prescriptive threat as there was before?

Mr Djukic: I will only talk on dust and my field here in respect of respirable dust. Like many people in this room, I have worked in the industry in a period where there has not been dust disease. We have had faith in a health scheme—

Mr SPRINGBORG: We did not know that there was dust disease. We chose not to know that there was dust disease.

Mr Djukic: That is correct—apologies. There were no reported cases of dust disease. I can say that, certainly working in an organisation like Simtars in my field, it has always been the view that exposure should be tightly managed and controlled because the hazard is still there. I cannot say if there was complacency. Certainly, as part of the regulatory framework under which I work, the inspectorate under which I work, it has always been something that we have addressed as part of inspections and as part of information we have provided.

Mr SPRINGBORG: Can I ask if either Mr Djukic or Mr Bulger could step us through the process they follow when they go out and inspect a coalmine. We have been hearing some rather interesting stories during the last week or two. I am intrigued to know how you go about it, particularly with an unannounced visit.

Mr Djukic: I will speak first. Cres will probably be able to help you more in this space. I am a specialist inspector. I work across coal, surface, underground, metalliferous and quarries. While I am an inspector, my speciality is in certain areas. It is largely a technical role—an advisory role to other inspectors. Usually when I do inspect mines it is as a result of an issue. I am not, as you say, a classic inspector who will have a process and will conduct unannounced inspections. I have done them in the past, particularly in small mines and quarries. With reference to coalmines, generally when I attend a site it is as a result of an incident or when a directive has been issued and I want to look at systems, look at results and talk to certain people.

Mr Bulger: For myself, I am expected to carry out a number of unannounced inspections. I have done that. I guess it is more around what the issues are at the mine as to whether we make an announced inspection or an unannounced inspection. If there are concerns raised by coalmine workers that certain things are happening, we will do an unannounced inspection. A lot of the time when we go to a mine to do an inspection we want to go through documentation—elements of the safety and health management system and records of sampling results. We will notify the mine the day before and ask them to have that documentation ready.

Mr SPRINGBORG: When you come along, do you get driven around where they want to take you or do you say, 'I want to drive along this part of the mine or that part of the mine'? What do you actually do?

Mr Bulger: Usually what I do when I get to the mine is sit down with the management team. I ask them what operations are taking place at the mine. I will select elements of those operations that I wish to visit. Sometimes I get the feeling that they are trying to steer me in a certain direction. Mostly I will select the operations I want to go to on that day.

Mr SPRINGBORG: When you select the operation and you say, 'I want to go alone here to have a look,' that is fine? You get taken along there?

Mr Bulger: That is fine, yes.

Mr SPRINGBORG: Are you aware of concerns amongst coal workers, particularly when it comes to unannounced visits, that the most frenetic activity involves an air blower and a broom and they run around and clean it all up?

Mr Bulger: No. I am not aware of that.

Mr SPRINGBORG: We heard lots of it. They say that there might be other bits and pieces where there might be an obvious physical threat but also dust issues and it is all sort of rushed around with great activity. That is something that we have heard over and over and over, and probably from my perspective it has to go beyond anecdote, surely. What about with regard to vehicle inspections? We have heard story after story after story with regard to the suboptimal safety environment that coal workers work in when it comes to their vehicles, and we have actually seen pictures of seals on doors which have been clogged up using paper bags or paper in situations where there has not been proper maintenance done of the filtration systems in air conditioning and all those sorts of things. Is that something that enlivens your interest or jurisdiction or is it other areas that you are more concerned about?
Mr Bulger: It does. I guess when I go to a mine I periodically check their sampling results, and usually the people who carry out the sampling in their report will make recommendations and give advice on remedial actions. I check whether the mine has done those remedial actions. I also inspect equipment. In isolated cases I have found dust inside machines and addressed that through the mine record entry and a commitment from the site senior executive that it will be addressed and I have been back to mines and followed up that it has been completed.

Mr SPRINGBORG: Have you seen these examples of poorly sealed vehicles?

Mr Bulger: No, I have not.

Mr SPRINGBORG: We might be able to assist you along the way with regard to those sorts of things.

Mr Albury: Can I make a bit of a comment on the unannounced inspections?

ACTING CHAIR: Sure.

Mr Albury: One of the triggers for us for unannounced inspections—and there are a number—as Fritz and Cres mentioned, is complaints from coalmine workers. We have a system to take in complaints from coalmine workers and industry if there is an issue that they either cannot deal with by other means or they do not feel they have the ability to raise internally. If a coalmine worker contacts us with a complaint similar to what you are saying, that will prompt, in cases, an unannounced inspection.

ACTING CHAIR: In relation to that, is that complaint from an employee kept confidential from the company, because we have heard a lot of testimony over the last few days about concerns of raising health and safety issues for fear of reprisal?

Mr Albury: It is confidential.

ACTING CHAIR: If you do get a complaint and you send an inspector out, is that employee’s details—

Mr Albury: Absolutely.

ACTING CHAIR: It is kept confidential?

Mr Albury: Yes.

ACTING CHAIR: Thank you. I will go to counsel assisting for some questions.

Mr McMILLAN: Thank you, Mr Acting Chair. I want to pose some questions first of all to Mr Djukic about this presentation. Thank you very much for providing it to the committee. Can I ask you first of all what started you on the journey of preparing this for the conference?

Mr Djukic: In the past, following certain events it has triggered reviews. Unfortunately some of these have been tragic events like Moura No. 2 review of the legislation and more recently the re-identification of CWP triggered the Monash review. In this case, my event was 2014-15 dust exposures in that there was a significant upward trend that was of concern to me.

Mr McMILLAN: How did you become aware of that upward trend in 2014?

Mr Djukic: I anticipated some questions down this line, so I have made some notes, if that would assist, to help me—

Mr McMILLAN: You are very welcome to refer to your notes. That is fine.

Mr Djukic: Okay.

Mr McMILLAN: It is not intended to be a memory test at all.

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Mr Djukic: No. I just wanted to make sure that I outlined the process as accurately as I could. Back in March 2013 I was requested to attend before the Coal Mining Safety and Health Advisory Committee, CMSHAC, which is a tripartite committee with functions under the act, and principally that is to advise the minister on matters relating to health and safety. I was requested to appear there to give an update on matters of occupational hygiene that I thought were impacting industry or potentially emerging and so forth. At that meeting I provided a presentation and, among other matters, I expressed concerns specifically about respirable coal dust and in particular the increasing incidence of CWP in the US.

With regard to the alarming findings from the Upper Big Branch report, which I believe has been raised here, I was looking at changes to our mining methods such as the introduction of top coal caving and what impacts that would have. I had also seen some other areas where I thought we needed to focus our monitoring efforts, not always just on production activities but the other higher at-risk activities across sites. I posed a series of questions to this committee for their consideration.
and gave some key messages. Later that year the first of our top coal cavings was introduced and shortly after that I issued two directives to that mine based on their respirable dust exposures. Following the second—

Mr Mc MILLAN: If I can stop you for a moment there, did you believe that those directives were necessary because of the introduction of top coal caving and the consequential increase in occupational dust exposure?

Mr Djukic: I issued those directives based on exposure data that was provided to me by the mine at my request.

Mr Mc MILLAN: At your request?

Mr Djukic: Yes.

Mr Mc MILLAN: Thank you. Please continue.

Mr Djukic: The following year, in 2014, a second mine was in the process of implementing a top coal caving operation. They were having significant difficulties in achieving some consistent production with regard to the new technology and other issues at the mine. Once they started to produce, I then issued those mines with directives as well because, based on exposure data, that was a short time after they got some consistent production. To date both of those mines were top coal cavings.

While dust is dust and the exposures were unacceptable, I had some rationale in my mind the reason for those elevated exposures. I am not sure if you are familiar with the top coal caving process, but the way it is set up I could see reasons why there could be increased dust. However, shortly after I had issued that directive there was another inspector who issued what we call an SCP at another mine which had a conventional longwall about dust exposure, and that time I had real concerns because this was not just isolated to top coal caving operations. I raised my concerns to the regional meeting of inspectors and following this I arranged to address the Chief Inspector of Coal Mines at the time, Andrew Clough, and I presented him with my views and concerns and at that point I suggested that it would be prudent that we ask all mines to supply their data for their underground exposure data so we could review it.

Mr Mc MILLAN: Roughly when did that meeting with Mr Clough occur?

Mr Djukic: I have the date. That meeting was 14 August 2014 and we sent out a letter in September for that data.

Mr Mc MILLAN: With regard to the journey to that stage, you had initially raised some concerns in 2013; is that right?

Mr Djukic: That is correct.

Mr Mc MILLAN: Over the next 12 months you explored those concerns, issued some directives and ultimately met with Mr Clough in August 2014?

Mr Djukic: In 2013 when I raised those concerns at CMSHAC there was no suggestion that there were dust exposures that were unacceptable. They were based primarily on experience in the US and the pending introduction of a new mining technology. It was not until the actual exposure data was available and this technology was implemented that my concerns were confirmed.

Mr Mc MILLAN: Did you feel that the coalmining advisory committee took your concerns seriously in 2013?

Mr Djukic: I am not a member of that committee. I cannot answer that. I believe that my presentation was provided to the committee and they had discussions, but I am not privy to that information.

Mr Mc MILLAN: I think you presented this PowerPoint presentation in July this year; is that right?

Mr Djukic: August.

Mr Mc MILLAN: In August this year. How long did it take you to gather the data that you needed to prepare that presentation? Walk me backwards in time in terms of when you first started requesting that data.

Mr Djukic: Prior to that presentation, I undertook reviews in 2012 to 2014 and then again in 2015. They were of current concern of what was occurring now in recent trends. That particular exercise commenced early this year.
Mr McMillan: As part of that exercise, you went further back than your initial inquiries in 2013 and 2014?

Mr Djukic: Correct.

Mr McMillan: And you requested data all the way back to 2000?

Mr Djukic: Correct.

Mr McMillan: As a result of that, your slides indicate that you got data from some 10,500 samples.

Mr Djukic: That sounds right.

Mr McMillan: Do I take it that those samples were not already in the possession of the department? You had to request them from the relevant mines?

Mr Djukic: Under the current legislation there is no requirement for mines to supply data. It is their responsibility to monitor and manage exposures.

Mr McMillan: That applies even if the exposure is above the occupational exposure limit set out in the regulation?

Mr Djukic: That is correct.

Mr McMillan: At the moment?

Mr Djukic: At the moment.

Mr McMillan: When you went on this journey over the last two years, it was really on your initiative that you gathered this data and were able to then see a trend in relation to exposures of above the OEL across the coalmining industry?

Mr Djukic: I would say that it was on the initiative of my professional judgement but also in my capacity as an inspector.

Mr McMillan: How long have you been an inspector since you left Simtars?

Mr Djukic: I was appointed an inspector in December 2011.

Mr McMillan: How long in your professional capacity as an occupational hygienist did you work for Simtars?

Mr Djukic: I would be speculating, roughly—

Mr McMillan: Roughly is fine.

Mr Djukic: Eight years.

Mr McMillan: You would have been working for Simtars over a really significant period of the results that you have subsequently gathered as an inspector?

Mr Djukic: I started there in the late 1990s. I left Simtars in early 2005.

Mr McMillan: Can I ask you as a case study, if that is reasonable, what is the highest result that you saw from a coal dust reading in a longwall mine while you were an occupational hygienist, or while you were working in that capacity rather than as an inspector? I understand that you are still an occupational hygienist.

Mr Djukic: You mean when I was with Simtars?

Mr McMillan: Yes.

Mr Djukic: I would only be guessing, in all honesty. I would say that I have seen results above 10, but it is not common.

Mr McMillan: This committee has heard evidence this week from miners who have seen results of 14 or 15 on longwall mines. Have you seen results that high?

Mr Djukic: I have processed results that high and issued directives on results that high.

Mr McMillan: Can I take a step back there. You say that you have issued directives that high. You do not issue directives when you are working for Simtars, do you?

Mr Djukic: No.

Mr McMillan: Have you worked for other independent companies where you have conducted hygiene monitoring in coalmines?

Mr Djukic: No.

Mr McMillan: When you were working for Simtars, had you seen results that high?

Mr Djukic: Like I said, I would have seen results of the order of 10. I am not sure. It was not common, I know that.
Mr McMillan: Since the removal of that hygiene monitoring process from a departmental regulatory environment to the self-regulatory environment under the current legislation, what is the process when you, as an independent monitor, get a result that high? You report it back to the company. Is there any further follow-up from you as the hygienist to see what happened as a result of that, or is it simply reported back to the company and it is up to them then to follow up?

Mr Djukic: I will answer that. I just want to clarify that Simtars was an independent organisation when I worked there.

Mr McMillan: Yes.

Mr Djukic: We were engaged by the mining to do sampling. We would conduct the sampling. We would stay underground with the operators. We would then take those samples, analyse them and report back to the mine with recommendations.

Mr McMillan: When you came to be an inspector in December 2011, did you come to that job with a background concern about the occupational exposure to coal dust that coalminers in Queensland were facing?

Mr Djukic: No, I did not. I did not come there with a concern at that point in time. From my personal experience, I believe that exposures predating the turn of the century had been high at one point. I remember this, because I was working with Simtars and at that point the industry formed a dust committee. I remember that the frequency of monitoring rapidly increased so that I would be on site almost every day, Monday to Friday, conducting sampling. I do remember in my time at Simtars, as I said, into the early 2000s, that results were much better.

Mr McMillan: Can I take you then to the data that you gathered. I am looking—just for everybody else’s assistance—at the slide that is headed ‘Historical exposure data’ with the total numbers of samples. I think it is about five pages in. The data that you gathered—

Mr Djukic: Yes.

Mr McMillan: You have found that? I want to ask you, first of all, about the difference between total samples and valid samples. What makes a sample invalid?

Mr Djukic: This is a methodology, and it is prescribed in regulation, which we measure and conduct sampling against. It is Australian Standard 2985. There are certain requirements in that standard, such as the flow rate, tolerances within that flow rate. It is possible that in field there might be samples that are not valid because a pump stops working, so it is a battery issue, or when you calibrate a pump at the start of a shift and at the end of the shift the flow rate has dropped significantly and if it is outside tolerance you cannot count that. It is not a quantifiable sample.

Mr McMillan: The committee has heard significant evidence in the past week from multiple miners who have indicated that when they wore the dust monitors and the results came back high they were declared invalid. There is clearly a concern among the mining workforce that high results are just invalidated so that the overall results look better. Can you explain to us why miners might have that concern? Is there some problem with the monitoring system that means that high results get invalidated?

Mr Djukic: To suggest that a mine was voiding samples because they were high would be a serious concern. If that were the case, we would need to know about that. When we see results come back to the mine—like I and other inspectors—that are marked as invalid, we request the reason those samples were marked invalid.

Mr McMillan: Without going into minute detail, have you generally been satisfied with those explanations?

Mr Djukic: Generally, if it is around in-field invalidations, for reasons that I have mentioned, then that does not raise any suspicion or concern to me.

Mr McMillan: The committee has heard significant evidence in the past week from multiple miners who have indicated that when they wore the dust monitors and the results came back high they were declared invalid. There is clearly a concern among the mining workforce that high results are just invalidated so that the overall results look better. Can you explain to us why miners might have that concern? Is there some problem with the monitoring system that means that high results get invalidated?

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Mr Djukic: Generally, if it is around in-field invalidations, for reasons that I have mentioned, then that does not raise any suspicion or concern to me.

Mr McMillan: The numbers that you have gathered from your review of the data suggest that only eight per cent of the samples that were reported back to the department were invalid samples. You have already said that you had some concerns that not all of the samples that had been taken over the past 15 years had been retained and subsequently provided to the department. Are you at all concerned that other invalid samples have not been provided and that, in fact, that invalid number is higher than eight per cent?

Mr Djukic: In this particular exercise that you refer to, this dataset, I am not concerned about that, because in most cases the mine has charged the organisation such as Simtars to retrieve that information for them. I am very confident in the ethics and the operational processes that Simtars undertakes.
Mr McMillan: The results that you gathered in relation to longwall similar exposure group exceedences over the past 15 years shows that 20 per cent of the samples over the past 15 years exceeded the occupational exposure limit. That suggests, at least to me, that there has been a much bigger problem since the start of the self-regulatory system than was anticipated or acknowledged by inspectors, or even by the industry at large. Would you agree that you are now realising that the problem is much bigger than you thought it was—not you personally but the industry as a whole?

Mr Djukic: I think we have learned a lot in recent times, but I would touch on relying on the marker of a single exceedence as a really good indicator of compliance. Single exceedences should be investigated and there should be actions put in place once they are identified. For example, in recent years there is a high proportion of single exceedences and that is largely due to the fact that the inspectorate has put very onerous monitoring requirements on mines that were noncompliant. The data of recent years, and I guess overall, is skewed by that as well.

Mr McMillan: We do not have the breakdown of numbers by year, but over 15 years you have recorded 554 individual exceedences above the occupational exposure limit. That is a significant number, is it not?

Mr Djukic: The number sounds big, but you have to understand that is across multiple mines. It does not indicate that exceedences are occurring every day.

Mr McMillan: How many longwall mines is that across?

Mr Djukic: At present we have 11 operating mines, but that has fluctuated through time.

Mr Albury: Between 11 and 13.

Mr McMillan: Over 15 years?

Mr Djukic: Yes.

Mr McMillan: If you turn over a couple of pages to the graph that you referred to earlier that has all the coloured lines on it, those different coloured lines represent the longwall mines in Queensland over that period of time, is that right?

Mr Djukic: Correct.

Mr McMillan: When you look at that you can see a significant number over 15 years have exceeded the occupational exposure limit. While it is difficult to identify, in a de-identified way it would appear, at least on first blush, that several of those mines consistently have results exceeding the occupational exposure limit. Is that a fair observation?

Mr Djukic: I think on one instance I can see your point, and it goes back to the analysis of my findings from that, that mines have on occasions failed to review and implement control based on their own data.

Mr McMillan: Can I ask you, Mr Bulger, about the open-cut environment, which I think you have indicated is your primary focus as an inspector. The committee has heard evidence over the past week from a number of mine workers who work in the open-cut environment. I think I can fairly summarise their evidence in this way: they have given evidence that the focus upon occupational dust exposure, at least in the last few years, that has been in the longwall environment or underground environment has been completely absent in the open-cut environment. Can you comment on any change that you have seen by mine operators in trying to manage respirable coal dust in the open-cut environment over the past two years particularly?

Mr Bulger: I guess I strongly oppose that perception. We periodically check the dust-monitoring results at open-cut mines. I have documented mine record entries that go back to when I started with the inspectorate of periodically checking them. In some cases I have found issues with them and had those issues addressed. In July this year the inspectorate ran two seminars for open-cut mine managers and site senior executives and I can go on the record as talking at those two seminars and informing those managers of the proposed changes coming up in the recognised standard and saying that open-cut mines are not exempt from the hazard of dust, always where it is there.

Mr McMillan: What actual changes have you seen in the last two years?

Mr Bulger: I have not seen any changes, really, in the last two years.

Mr McMillan: So your evidence rejecting that suggestion really is evidence that in your view the entire time you have been in the inspectorate there has been an appropriate level of recognition of respirable coalmine dust in the open-cut environment?

Mr Bulger: I believe so.
Mr McMillan: Workers have given evidence before this committee about the matters that were raised by the deputy chair: the presence of dust in work vehicles, poor seals, the fact that personal respiratory protective equipment was not mandatory in different production areas in open-cut mines and that monitoring of respirable coal dust was scant at best. Has that not been your experience during your inspections?

Mr Bulger: I guess I will touch on some of the issues I have identified in inspections. You spoke before about door seals. I identified an issue this year where an overburden drill I was inspecting—I noticed what I thought was excessive dust inside that drill. Upon investigating it further and talking to the operator it was revealed the drill had operated for approximately seven days with no air conditioner working and that particular contractor that owned that drill had not reported it through to the mine owners—the senior management team. I issued that mine with an SCP and a commitment was given by the site senior executive to address the matter and I received the response that they did address it. That was one instance. At another mine I was at I witnessed overburden drills drilling without using water suppressant. Most overburden drills have a tank of water on them and they pump water down the hole with the air to suppress the dust that is generated. I witnessed these drills drilling with a lot of dust around them and they were not using dust suppressant. I captured that in my mine record entry and I got a commitment from the SSE that it would be investigated and corrective actions put in place. They are two examples, I guess, of equipment.

Other things I have picked up in inspections are: when I look at the sampling results occasionally I am not happy at the cross-section of people who have been sampled. From my experience there are areas in open-cut mines where you could assume there is higher potential for dust, such as in a drill and blast area, working around stockpiles, working in a laboratory, those types of areas. I have picked up in some cases where the sampling has not included, say, someone in the blast crew or someone on overburden drills and it has all been captured in mine record entries and mines followed up on it. Another issue I picked up was a report given by a sampling company did not identify the pieces of equipment the samples were taken from so that did not allow the mine to go and investigate the individual samples. Once again I put that in a mine record entry and got a commitment from the site senior executive for that to be changed and it was. They got a new supplier to do their sampling. It was addressed.

Mr McMillan: Can I ask you about announced and unannounced inspections. One of the submissions to this committee—and I am having trouble finding the exact figures. The submission from Anglo American coal has set out the occasions of inspections by the inspectorate at their underground mines—and I appreciate that that is not your particular area—over the last two years. They have indicated that in 2015, of some 16 inspections conducted by the inspectorate only two were unannounced inspections, and of 15 inspections in the previous year only one was an unannounced inspection. Is that consistent with the general ratio of announced to unannounced inspections across the inspectorate? I think Mr Albury may well be able to answer better for you.

Mr Albury: Having a look at the records, at the moment we are running at about five per cent unannounced inspections.

Mr McMillan: Is that too low?

Mr Albury: There could be an argument that that is too low, yes. As I said before, we use them mostly in very specific circumstances. If there was a mine that we were dealing with and we had a sense that their monitoring for dust was not as good as it could be or we have seen the fact that there is a lot of dust around—there are leaking door seals or whatever it is—and the information we are getting from the mine is contrary to what we are seeing, an unannounced inspection is very appropriate in those circumstances to validate our suspicions and get the evidence to deal with it.

Mr McMillan: We can see from the graph that Mr Djukic has prepared that in 2015 three mines had respirable dust concentrations in excess of the occupational exposure limit and one in 2016 was well above the occupational exposure limit. In that case—and of course we do not know what specific mines those were—does that trigger a higher level of unannounced inspections by the inspectorate at that particular mine?

Mr Albury: Possibly. I will answer the question by saying that, when it comes to respirable dust, there are probably two elements to it. You go to a mine and you can see increased dust or there is a lot of dust around. When it comes to change in the behaviour and issuing directives, that is based on the data of the monitoring. That is when you really know what the dust levels are. That is what we tend to do with dust. Seeing dust around is one thing, but the real kicker is the monitoring data, knowing what the exposure to workers is.

Mr McMillan: You would agree that for the system to work it is essential that the workforce have faith in it?
Mr Albury: I agree.

Mr McMillan: Do you think the workforce has the potential to have a greater faith in the system if they think there is a higher than five per cent rate of unannounced inspections that the mine cannot get ready for?

Mr Albury: I can see that argument, yes. I would also say to you that there are avenues available outside of unannounced inspections for those workers to make their concerns known to us and others so they can be dealt with.

Mr McMillan: I am not a coalmine worker, clearly, so this question may be silly. You indicated earlier that a complaint made to the inspectorate is confidential. I am concerned about the prospect that a shearer operator working at a particular underground operation has concerns about extreme dust levels on the shift that he worked at. He makes a report to the inspectorate to say, ‘Last night I was operating the shearer at X mine and I couldn’t see two feet in front of my face.’ The next day an inspector comes to that mine and asks about the dust level on the shearer on the night shift the night before. Is it not pretty obvious, then, the small group of people who could possibly have complained about that?

Mr Albury: That is correct and we are cognisant of that.

Mr McMillan: What is done about that to protect those people’s confidentiality?

Mr Albury: We would have to think about how we approach it when we go to inspect the mine. It may well be that we have an inspection plan for that mine in the near future anyway, and that is how we would approach it.

Mr Stone: Could I just add that one way that we could better protect the confidentiality of those workers is not by doing it unannounced rapidly after the event is raised; it is by factoring it into the next routine inspection, which might be within 20 or 30 days. That might be the most appropriate action for us to take.

Mr McMillan: Is another way requiring mines to report dust exceedences to the department?

Mr Stone: Absolutely, and that is recognised in the regulation amendments. The obvious context is: in order for the legislative framework to be effective, the response to what Inspector Djukic has presented this morning is to put that prescription into the regulation and to require uniform, consistent reporting of data. That lets the data be viewed by the tripartite committee, it gives it a lot more visibility and the inspectorate is able to better act on that information.

Mr McMillan: Mr Acting Chair, I realise I have taken quite a bit of time. Thank you very much. I may have some further questions later.

Mr Pearce: Russell, would you be able to provide the committee and any mineworkers who might be here with an overview of the procedures which take place with regard to a mineworker coming into the industry in terms of ongoing X-rays to determine their health and fitness for work? I would like to also know what happens if a mineworker has an X-ray taken and there is a detection or it is picked up that he could possibly be diagnosed with black lung. What is the reporting back process, so that we have a good understanding of exactly what happens?

Mr Albury: Thank you for the question. When a person comes into the industry, he has a health assessment. Once he is employed in the industry he has a health assessment. The reason for that, as I have discussed before, is that then the individual knows what his role is going to be. If he is going to be an underground coalminer or open-cut coal worker, for example, the NMA then has an idea of the risk associated with things like black lung. They would have their health assessment—chest X-rays, spirometry. If he is an underground coalmine worker, every five years he has another. If he is open cut, it would probably be around the 10 years that he has another.

If he goes to a health assessment and the radiologist picks up that he has the onset of black lung, that would be within the medical report that his NMA receives. At the back of the health assessment form there is a document that the NMA signs off on that talks about the limitations, if any, that have been picked up in the assessment for the worker. That information is given to the employer. If there is a black lung problem, you would expect that there would be something on that document that says something like ‘keep him out of the dust’ or whatever so that the employer can then do what he has to do to look after the worker.

Mr Pearce: What is the inspectorate’s position with regard to a mineworker who has gone off for that second X-ray and is not getting any information back about the outcome of it, that they are not being told the status of their potential condition?
Mr Albury: I think there is a breakdown in the system. If you go to your doctor and you have a test done, you would expect that the doctor, when you go back to see him, would say, ‘This is the result.’ That is what we would expect to happen.

Mr Pearce: I want to go back to the dust issue. Does the inspectorate have confidence in the integrity of the monitoring of dust in mines? We have heard reports that monitors are set up in different places in the mine where there may not be any dust or the dust is at a level that is acceptable. Therefore, the workforce has no confidence. They do not really trust the system. Have issues been raised with the inspectorate about the integrity of the monitoring, where it goes and who does it? You talk about independence with that process. I think there are quite a few here today who would have some real concerns about the integrity of some of the people who do things in a mine and do not have their outcomes, their end result, monitored.

Mr Albury: There is a lot in that question.

Mr Pearce: Yes, but I know that you are very capable.

Mr Albury: Over this journey we have gone on, I have got to know some of the hygienists in the industry. I have to say that the hygienists themselves, even those who work for contractor companies, are very good at what they do and, to me, display a high degree of ethical behaviour. Of the hygienists themselves who do the analysis for the companies, I would have to suggest that I would be surprised if their behaviour was not as it should be when it comes to monitoring of respirable dust.

Mr Pearce: Does the inspectorate get an opportunity to audit those reports or to take a look at them to see what they are reporting, or does that just go straight to the company?

Mr Albury: It does go straight to the company, but—

Mr Pearce: You can ask for them?

Mr Albury: Yes.

Mr Pearce: How often do you do that?

Mr Albury: Quite often when we get the monitoring data from these mines we get photocopies of the handwritten reports. Quite often we do ask for them because, as you quite rightly point out, when we have a look at a mine’s monitoring data quite often, if there are questions or if there is a sample that does not make sense, one of Fritz’s first questions is to ask how that sampling was done. We have gone to the point of asking for those reports so that we can look and see what the individual was doing on the shift and if there are any anomalies in the way he was sampled. We do not do that with every sample, but certainly we do see that.

Mr Pearce: I want to ask you a question about the mine records and, in particular, those entries that are made by deputies or open-cut examiners. When those particular people sit down to write out a report, is that report duplicated in a book? Is there a duplication of that report?

Mr Bulger: It varies from mine to mine. I guess up until a few years ago it was always duplicate copies. Nowadays, some of the mines have moved to electronic copy, so it is filled out electronically. There is an electronic copy maintained. Some of the mines still use the old system and there is a duplicate kept in the book.

Mr Pearce: Do you have every confidence that the person who has made the entry would be able to go back and have a look at that entry that has been made and be satisfied that the things that were out of order or not in place had been taken care of by management?

Mr Bulger: That is correct. I often check open-cut examiner records. I would expect the mine to be able to produce the open-cut examiner’s report for any given shift and it would be documented who the statutory person was in charge of that shift.

Mr Pearce: I might come back to that, Mr Acting Chairman, if we have enough time.

Mr Costigan: Good morning, gentlemen, and thank you for appearing today. Mr Albury, you spoke about the two longwall operations that had been issued directives. Which mines are we speaking about here?

Mr Stone: If I may, we are able to provide the information, the identity of those mines; however, that information has some restrictions under our legislation. If you would like us to provide the identity of those two mines, we would ask that it is provided in a private session.

Mr Costigan: Thank you, Mr Stone, but I am not chairing the meeting.
Mr Stone: Acting Chair, the question was asked whether we could provide the identity of the two mines for which their longwall operations were suspended. I was just saying that we are able to identify the names of those mines, but we have restrictions on disclosure of information under our legislation. Therefore, we would ask the committee to consider taking that information in a private session.

ACTING CHAIR: We are happy to accommodate that, Mr Stone.

Mr COSTIGAN: Thank you, Acting Chair. Notwithstanding the situation there, Mr Stone, could you advise the committee when those directives were issued by the relevant officers? Perhaps Mr Albury might answer?

Mr Albury: If you give me a moment, I will find that information for you.

Mr COSTIGAN: Furthermore, Chief Inspector Albury, what precipitated those directives? By that I mean: how bad was it?

Mr Albury: It was bad enough that we were concerned that we should stop the mine until I got it sorted.

Mr COSTIGAN: In layman’s terms, throw the book at them?

Mr Stone: By definition, a directive to suspend operations is at the high end of our compliance program, so it would infer that the mine operator has not been able to achieve an acceptable level of risk in prior meetings. It is at the upper end, as Mr Albury described in his opening. It is at the upper end of our compliance.

Mr COSTIGAN: Thank you, Mr Stone. Mr Albury, are you trying to glean some information that will help with the question?

Mr Albury: Yes, I am getting there. One was issued on 9 October 2015 and the second one was 29 October 2015.

Mr COSTIGAN: Coming back to my earlier question, it was bad enough to throw the book at them; do you agree with that sentiment?

Mr Albury: It was bad enough that we were not seeing a change in behaviour, yes. We obviously deemed that we needed to get some serious response from the mine to get it changed immediately.

Mr COSTIGAN: Is it the closest that we have come in the Queensland coalmining industry to seeing a mine shut down or suspended, notwithstanding the financial implications that have been outlined earlier this morning to the committee? We have not seen that before, have we? This is as close as it has come to that situation?

Mr Albury: I think that would be accurate, yes.

Mr Djukic: Can I just clarify: that is in respect to respirable dust.

Mr COSTIGAN: Yes, thank you, Inspector Djukic, for clarifying that. Chief Inspector Albury, do you accept the line of questioning by Counsel Assisting earlier today in relation to unannounced inspections, that that level or percentage of unannounced inspections is out of step or out of touch with community expectations?

Mr Albury: Again, to this point in time I can accept that there is a perception that it is not enough.

Mr COSTIGAN: Thank you. Chief Inspector Albury, how big is the Mines Inspectorate team today and where are your officers or inspectors located across the state?

Mr Albury: Our inspectors are located mostly in Rockhampton and Mackay. We have some inspectors in the southern region, in Brisbane, who look after the mines around Chinchilla, Dalby and that area.

Mr COSTIGAN: Do you believe that the Mines Inspectorate needs to be beefed up in terms of resourcing to counter the issues that have emerged with the re-emergence, if you like, of black lung?

Mr Albury: I would answer that by saying we are reviewing that at this point in time.

Mr COSTIGAN: There is every possibility that your resourcing may well change going forward, given what has been happening?

Mr Albury: I do not want to speculate on that.
Mr Stone: As executive director for mine safety and health, I have accountability for the resourcing across the inspectorates. We currently have 22 inspectors in coal, and that number has remained relatively flat over the last several years. Of those 22 mines inspectors for coal, we currently have two occupational hygienists, of which Inspector Djukic is one. The appropriateness of the resourcing of the inspectorate is continuously under review. It is a function of the hazards present in mines, it is a function of the mines’ ability to manage those hazards and it is a function of industry levels of activity.

With the recent trend and the work ahead of us with the recognised standard and the changes in the regulations around more robust dust-monitoring reporting, I think it is fair to say that we are looking pretty closely at making increases around occupational hygiene, but we also keep a very mindful view of all of the other hazards present at mines. We look across the inspectorate’s resourcing including succession and certain specific skill sets.

Mr Costigan: Chief Inspector Albury, given we have no requirements for mine operators to supply data at the moment, are you looking forward to the day when you have that data, and how beneficial would it be for your team to have that data in terms of addressing the issues at hand?

Mr Albury: Yes, absolutely. There are two things: the reporting of the information and the database for the analysis purposes, absolutely.

Mr Costigan: That day cannot come soon enough; would you agree with that?

Mr Albury: I would, yes.

Mr Stone: I would add, if I may, that it is for the benefit of all. The workers, industry, inspectorate and unions—everybody is looking forward to having more visibility around that.

Mr Costigan: Chief Inspector Albury, you spoke earlier of this mechanism whereby coal workers can phone in—I assume they can phone in—or email. Is there a dedicated hotline? Do you believe most coal workers and their families are aware of this avenue of putting complaints in on the quiet, if I may put it that way, to you?

Mr Albury: Is every family and coalmine worker aware of it? I would have to probably say no. It is a good point. Certainly it is well known in the industry but how well known is questionable.

Mr Costigan: Mr Stone, what has been the department’s role in the government’s community awareness program in relation to coal workers’ pneumoconiosis? Has it been in collaboration with the Department of Health? Can you enlighten the committee as to your role in relation to these matters?

Mr Stone: I can certainly say a few things on that. Around the advent of the Monash review—the interim findings in March of this year and then the full report in July—Natural Resources and Mines collaborated with the Department of Health to do a number of things. The Chief Medical Officer for Queensland wrote to GPs to raise the awareness of black lung—that it could be a prescribed condition, particularly in retired workers, so it was awareness raising. We also put out information in the form of pamphlets, postcards and advertisements in a number of papers. I think it is something that we are looking to do again later this year and will do going forward at regular intervals.

Mr Costigan: Do you think you have done enough?

Mr Stone: I do not think you can ever communicate enough. From reviewing some of the transcripts of recent sessions, it is clear through the anecdotes and experiences of mineworkers in particular that the level of awareness is not where we would want it to be.

Mr Costigan: Would it be fair to say that the CFMEU has done the heavy lifting in terms of bringing it into the public domain and making people aware in the community and the department or the government has been playing catch-up in relation to this community awareness?

Mr Stone: I would certainly recognise the significant information put out by the CFMEU. I think that is a real positive. I do not think it is appropriate for me to comment on whether the government has been playing catch-up. I think as a generalism we undercommunicate—by ‘we’ I mean the broader ‘we’—and there is certainly more that we will do to raise and maintain awareness.

Mr Costigan: Thank you, Mr Stone. I have no further questions.

Mrs Gilbert: This is my first session on this committee so I apologise if somebody has answered this question on previous days. Mr Djukic, in looking at your graphs I was interested in the different mines that have been below the acceptable level of respirable dust concentration levels. What do those mines have in place that is preventing the dust that other mines do not have in place?
Mr Djukic: I think there are differences between all mines. It is not as cut and dried as ‘what works here works there’. Some mines encounter different conditions. Some mines drain their coal, take the moisture out and make it duster. Essentially, on our longwalls we really rely on suppression of dust through water, operator positioning, ventilation, how we direct the ventilation and wetting agents.

There are a number of various control mechanisms that mines utilise. I think in some respects in recent years we are getting to a stage where, because of the extent of drainage, we are really making it harder to wet that coal and to suppress it. That is probably one of the key challenges facing the industry. What worked in the past may not work now so we have to be smarter in the way that we try to suppress our coal.

I do not think it is simple, because what you will see is that there is evidence where some mines have been compliant and have drifted out of the compliance but have come back in—perhaps there has been a focus that they have taken off that particular hazard or they have encountered certain conditions which have made it more difficult, whether it is strata conditions or things like that that have implicated on those exposures.

Mrs GILBERT: Do you believe there have been resources taken away from those mines where you have seen a spike? You did say that on some sites where they have the right mix of experts there are fewer hazards.

Mr Djukic: Generally, those mines that have had that expertise have always had that expertise. It has not been that it has been taken away from other sites. That expertise has always been considered part of the operator’s business plan, and it is an integral part, in my view, of managing exposure risks. I do not think it is so much that it has been withdrawn; it is just that it has probably not been there.

Mrs GILBERT: You said that some practices have had to change which has changed the risk of dust. Are there some practices out there that just should not happen in coalmines because it is too unhealthy for the workers?

Mr Djukic: I suppose in a very general sense that, wherever possible, you try to place yourself outside of a dust cloud, but for particular practices, particularly underground, that would indicate being wherever possible out by the shearer or out by advancing shields and those kinds of things. In my view, the most critical controls are engineering controls that aim to suppress dust when it is generated. Personal protective equipment and administrative controls do not remove the hazard. They are an integral part of the overall control process, but it is really about trying to suppress dust where it is generated.

Mrs GILBERT: I do think prevention is better than trying to play catch-up and whistleblowing down the track. We should have the safest possible workplace for our miners.

ACTING CHAIR: We are over time but I will go to counsel assisting.

Mr McMILLAN: There was one question that I omitted to ask Mr Djukic. One of the miners who has given evidence before the committee spoke about the use of the Airstream helmet in the underground environment and raised a concern that, when asked to wear a personal dust monitor and it is placed in the breathing zone, it is in fact in the exhaust zone of the helmet, thus not giving a true reading of the amount of dust exposure at that particular point. Is that a fair concern and, if not, can you explain how it is not?

Mr Djukic: What I think you are saying is that they are sampling inside the helmet.

Mr McMILLAN: That is the way I understood the concern to be raised, yes.

Mr Djukic: I am very clear that any results provided to us that are taken inside the breathing apparatus are not included in the statutory monitoring. They are not used in our assessment of regulatory compliance. I do not prevent sites from doing that. My view is that I understand they are trying to maybe assess the effectiveness of those devices but I would never compare those results against the limit. It is clear that those samplers should be placed in a breathing zone outside the respiratory protective equipment.

Mr McMILLAN: Mr Acting Chair, can I add something for the purposes of Hansard. Mr Albury responded to a question I posed earlier where I made reference to announced and unannounced inspections, and I misspoke. I incorrectly identified the numbers that I referred to as from a submission by Anglo American coal. They were in fact from the submission by Caledon and my reference to the Cook mine at Blackwater. The correct numbers were 18 visits at the Cook mine in 2016 including two unannounced inspections, and 16 inspections in 2015 of which one was unannounced. I do not think it changes Mr Albury’s response, but I should in fairness give him the opportunity to change his response if he wishes to. I apologise for the error.

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Mr Albury: Since we are in the mode of clarifying a couple of things, I would like to clarify two things. Mr McMillan referred to our legislation as self-regulating. I would put to you that that is probably not accurate. We prefer to use the terminology ‘risk based’. There is a difference.

In relation to the initial conversation I had with the deputy chair, I want to clarify something in terms of when we were talking about prosecution and compliance against stopping an operation. We are not concerned about the financial impact on a mine. Our concern is the safety and health of people. I just want to be clear that we are after change in the behaviour of the mine, and we believe in this instance that financial impact gets the result rather than prosecution. That is the point I want to make clear.

ACTING CHAIR: We will have two more questions. I have had a request from the member for Mirani and also the deputy chair to ask a final question each.

Mr PEARCE: I missed a dot point in my first question last time. When this issue first came to the surface there was a lot of comment based around the data that had not been entered on the system. Where are we with that at the moment?

Mr Albury: Do you mean with health assessment data?

Mr PEARCE: Yes. It was a massive number.

Mr Stone: The department has what I would call two milestones. The milestone that we passed on 1 July this year is that we entered the backlog of coalmine health assessments for underground workers. That has been completed. All of that information is on the system and can be now searched as a database; you should expect to be able to. We prioritised those underground records over open-cut records, and we have added significant resources to that task. Our second milestone is going to be June-July of next year, just the sheer number to clear that backlog.

Mr SPRINGBORG: Mr Albury, if I remember rightly, in response to a question earlier regarding the requirement for chest X-rays, you indicated that the practice should be that workers not working in an underground environment should have a chest X-ray every 10 years. Did I misunderstand that or you would encourage that?

Mr Albury: I would encourage that.

Mr SPRINGBORG: Do you have any figures that you can provide to us for the number of chest X-rays which have been performed on non-underground miners within that period of time other than their pre-employment X-ray? For us, it is a bit like trying to find Big Foot. We are hearing about it but we cannot really find it.

Mr Albury: I am sure we could get that information, but I do not have it at hand at the moment.

Mr Stone: We can take it as a question on notice to provide that to you. We do not have it here today.

Mr SPRINGBORG: The feedback we are getting from a lot of the above-ground miners is that it is just not being offered to them and they have not had it. We would be interested in that.

ACTING CHAIR: Mr Stone, are you still happy to provide that information the member for Whitsunday requested earlier in a private session?

Mr Stone: Yes, I am.

ACTING CHAIR: We will close this session and take a 10-minute break. Gentlemen, we would appreciate it if the answer to that question on notice—and I believe there was just one question—could be provided to the committee by close of business on Friday, 2 December. We will take a 10-minute break. At the completion of that break, I will ask that the only people present in the room for a closed session will be the four witnesses at the table in front of us as well as the committee. I ask that all media and all members of the public remain outside the room while we have a closed session, and then we will open the room up for the next session after that.

Evidence was then taken in camera but later resumed in public—
SCHIEFELBEIN, Mr Kelvin, Underground Mine Manager, Carborough Downs

VELLA, Mr Andrew, General Manager and Site Senior Executive, Carborough Downs

WILLOWS, Mr Nathan, Health, Safety and Training Manager, Carborough Downs

ACTING CHAIR: I call representatives from Vale Australia. Gentlemen, thank you for making yourselves available to speak to the committee. For the record, can you please state your name and the capacity in which you appear before the committee when you first speak? You are each entitled to make an opening statement. Do you want to start, Andrew?

Mr Vella: Good morning, chair and members of the committee. Thank you for the invitation to be present today and to speak to the parliamentary select committee hearing on the re-identification of coal workers' pneumoconiosis. My name is Andrew Vella. I am the General Manager and SSE of Carborough Downs mine. Beside me is Nathan Willows, who is the Health, Safety and Training Manager, and Kelvin Schiefelbein, who is the Underground Mine Manager at Carborough Downs. I would like to thank the committee for finding the time to visit Carborough Downs mine on Tuesday. I hope the committee found the exercise useful. From our perspective, we think it was a very useful exercise and we enjoyed sharing our thoughts with the committee on how to tackle this very important issue.

Vale Australia has owned a small number of coalmines in Australia since 2009. In Queensland Vale currently owns Carborough Downs underground mine, and a 50 per cent stake in the Eagle Downs mine project. Vale is in the process of divesting its interest in Carborough Downs mine to Fitzroy Qld Resources Ltd. The transaction is expected to complete at the end of this month, on 30 November 2016. The mine will continue to operate under Fitzroy with its current senior management team who have been dealing with this issue. Senior Fitzroy representatives met with the committee on Tuesday to acknowledge the committee and the importance of this issue and show support for and commitment to the ongoing actions and plans already implemented by Carborough Downs with respect to this issue.

Since the re-identification of coal workers' pneumoconiosis first came to Vale Australia's attention in 2015, its No. 1 priority has been to work with our employees, the government, the CFMEU and other relevant authorities to ensure that it is doing everything in its power to address this issue. We will continue to work diligently on this issue to safeguard the health of our workers.

As the committee is aware, all confirmed cases of coal workers' pneumoconiosis have been identified in employees at Carborough Downs. As the committee is also aware, those four employees remain employed at Carborough Downs. Since coal workers' pneumoconiosis was re-identified in 2015, Carborough Downs has consulted extensively with the stakeholders. We have attempted to provide our employees with as much information as possible around the condition. This has included Dr Cohen from the United States to speak with our workforce and answer their questions. In addition, we have had open and regular communication with the workforce, CFMEU and Queensland Department of Natural Resources and Mines. We have hosted the Minister for Natural Resources and Mines, Dr Anthony Lynham, for a detailed site visit; facilitated briefings to the workforce by our NMA; and, as I said earlier, hosted Dr Robert Cohen, a renowned coal workers' pneumoconiosis expert from the United States, to address the workforce.

The committee would be aware from your visit to the site of the number of initiatives that have been undertaken to ensure that our employees have been properly screened. Vale Australia, like everyone in the industry, was shocked to learn that coal workers' pneumoconiosis was not eradicated. Vale Australia supports the work of this committee and appreciates the opportunity so far afforded by the committee for Vale Australia and Carborough Downs mine to participate in the inquiry and be part of the solution.

Given that the committee had a long session at the mine on Tuesday, I do not propose to repeat the presentation that we gave to the committee, but I welcome any questions from the committee arising from your visit and any clarification on any of those matters. As a representative of Vale Australia, we thank you for providing this opportunity to discuss these matters in the forum.

ACTING CHAIR: Gentlemen, do you have an opening statement at all?

Mr Willows: I do not have an opening statement.

ACTING CHAIR: Mr Vella, thank you for your statement. There was a lot of information given to the committee at the presentation out at Carborough the other day. The subject that I am very keen for you to touch on again for us today is the four cases of CWP that you mentioned. When we were
at Carborough the other day you gave us a de-identified rundown of what those were, particularly the work history and the diagnosis stage of those. Could you run through that again for us today so we have it on the record?

Mr Vella: No worries. Case A was first diagnosed in May 2015. He joined the Carborough team in 2009 and a pre-employment X-ray was taken by an Australian radiologist. Abnormalities were reported in a CXR when renewing his Coal Board Medical in 2014. The one in 2009 was actually clear at that time and he was given the okay to go to work without any restrictions or any issues. In 2014 a CT scan was then also undertaken because of those abnormalities in the 2014 scan that our NMA and radiologist found. It was initially misdiagnosed as sarcoidosis by an Australian specialist. Those scans were sent to a B reader in the USA and also utilised a respiratory specialist in Queensland, Dr Bob Edwards. A biopsy was performed consequently because of that and coal workers’ pneumoconiosis was identified in that particular case. The 2009 X-ray was sent to Dr Cohen for review and subsequently that X-ray then identified the patient to have pneumoconiosis as well. It was misdiagnosed in 2009. He is currently working in the CHPP. He has been redeployed; he is not working underground. He is working in the CHPP as an operator there in a controlled dust environment.

Case B was diagnosed in December 2016. This came as part of the review process that we initiated in October 2015 around utilising Dr Cohen to review all our X-rays of our employees. He joined Carborough in 2011. The pre-employment X-ray report was clear from the Australian radiologist. Coal workers’ pneumoconiosis was identified by the B readers in the United States—Dr Cohen and his colleagues—in December 2015. This guy had a long-term history working in underground mines—greater than 35 years, including 20 years in the UK. As with the first case, he was an ex-UK miner with extensive experience in the UK and obviously in Australia as well. The second case is currently working as our longwall move coordinator, away from production areas where he is not exposed to any more than one milligram per cubic metre which is the advice we received from our NMA, Dr Foley, and also Dr Bob Cohen. They said that would be an acceptable level of risk and we monitor to ensure that happens.

Case C was diagnosed in May 2016 and joined Carborough in 2010. The pre-employment X-ray was clear at that time by an Australian radiologist. Again, we sent his X-ray over to the United States to Dr Cohen, and his X-ray from 2015 was diagnosed with pneumoconiosis. Again, we sent his 2010 pre-employment X-ray to Dr Cohen as a consequence of that and that came back positive with pneumoconiosis as well. Again, it was misdiagnosed before he started at Carborough Downs. He had a long-term history of working in Queensland and New South Wales underground coalmines, including 20 years at another Queensland coalmine and several in New South Wales, and he has been at Carborough Downs since 2010. He is working as a mineworker in the outbye areas on the surface as we currently speak and we are working towards a program to introduce him back to the underground environment but in a controlled manner at this stage, but he has been working on the surface since that time.

Case D was diagnosed in September 2016. He joined Carborough Downs in 2010. His pre-employment X-ray was clear from the Australian radiologist. His X-ray was sent to the United States again and it came back as being positive for pneumoconiosis. Again, he had a long-term history working in underground mines—greater than 35 years including 20 years plus in the UK as well. He is currently working as a deputy in the outbye area away from production areas and in a low-dust environment. He is being monitored to ensure he does not go over that one milligram per cubic metre of dust. Those are our four cases.

ACTING CHAIR: Correct me if I missed it. Was case D also misdiagnosed?

Mr Vella: No. Out of the four, two were misdiagnosed. In terms of the other two, their previous X-rays did not show it at that time.

ACTING CHAIR: Once Carborough first got the confirmed cases of CWP, step me through the company’s response to that in relation to dust management and what changes you made to practices and the like.

Mr Vella: There were several. Obviously communication was critical in the whole process to ensure that our employees understood what our plans were going forward in regard to trying to ensure that we do not have any further cases going forward. Given that it is a long-term disease, obviously there are things that are out of our control in regard to that. What we could control is the environment our guys worked in, the education we provided them in regard to PPE and people positioning, and a whole raft of engineering controls that we implemented to ensure they were maintained to the adequate process.
We went through a holistic review—and I will refer to my notes. Firstly, I will go through the timeline that we had. It goes back before pneumoconiosis. In 2013 we had obviously a formal health risk assessment and baseline monitoring program that we had conducted back in 2010. That continued to be reviewed over time which provided a baseline statutory monitoring program across randomly selected areas.

The exceedences of dust were communicated to the workforce and that was normally by a letter that was issued to those guys and so forth. Various existing dust controls were already in place at that time, including scrubbers especially on the longwall, scrubbers on the crusher, various sprays, obviously ventilation is critical to any longwall mine or any mine in general. All those things were in place prior to 2013.

In 2014 we ramped up our investigation process. We seen a spike in our exceedences in 2014 and the problem we found with monitoring was that we did not get the results back normally for two weeks after the fact which obviously causes considerable issues in regards to trying to identify the specific issue at that time. Back two weeks ago when you would do an investigation you would sit with the employee and ask a variety of questions and two weeks later a lot was obviously forgotten as such and the conditions change. As I explained the other day, an underground mine is very dynamic and complex in regards to dust generation and how it occurs. It could be there one second, it could be gone the next. It doesn’t just remain there for the whole time. Obviously trying to understand and pinpoint that is very complex, especially when you don’t get the results until two weeks later. So we went through that process. We tried to beef up our investigation process to understand it more and work with the monitoring company to get our results a lot faster.

Given the nature of gravimetric monitoring, which is the way the Australian Standard prescribes, there was no real way to do that and we started investigating around real-time monitoring. We purchased six to eight real-time monitors that were used not so much in the coal industry but in other industries. We tried to use that so we got an instantaneous reading so we could understand if a person was standing in the right position or where the dust was being generated from and a whole raft of analysis that we went through. We also engaged Dr Brian Plush, who is an Australian renowned expert in dust mitigation especially in longwall mines, to come on board and help us do that. His method of diagnosis and analysis was around using gravimetric but in a static form to measure dust with controls and without controls and see the effect of those controls. We were going through that process as a consequence.

In 2015, as I mentioned earlier, we had our first case. In July 2015 we stepped up the monitoring to two days a month based on a directive that we had received from the inspector in regards to ramping up our monitoring. We were doing monitoring as per our risk assessment, but because we saw that spike in the exceedences we agreed that we would ramp the monitoring up as much. In October we engaged the services of the ILO B reader, as I said. We started that whole workforce education program as such and I will go into a little bit more detail on that later on. We implemented dust controls for longwall seven. In October 2015 we had another directive that the increased monitoring that we had done was still showing that we had some exceedences so we had a directive on us to come up with a strategy that we had to put forward that we would have additional controls in place before we started our longwall seven. We were in the middle of a longwall move at that time, a six-week period as such, so we went through that whole process and had various experts come to site to help us through that process and we ramped up our engineering controls a lot further as a consequence of that.

In December 2015 we had our second case confirmed, as I said earlier. In January 2016 we still had the monitoring issue of not getting the results straight away. We had the real-time monitors in place that were helping us work through those process, but we also introduced our own gravimetric monitoring. Even though not NATA accredited that was still an indication for us to be able to react straight away rather than wait two weeks down the track to try and understand what the issue was as such. The problem we found with the real-time monitors was that they were very unreliable and at times very inaccurate. Sometimes not reading high but reading way low. They used a photometric type arrangement where light was reflected off dust particles but it also measured water and a whole raft of issues. Hence why we decided we were going to try to use a real-time and a gravimetric at the same time and try and compare to see how our monitoring was working and whether it was accurate or not. What that meant, by introducing our own gravimetric monitoring, we had to set up a dust lab on site with our own weigher and obviously train people as such to be able to do that. As I said, we were still not NATA accredited and we have not gone down that path as such. It was more of an indication. Obviously throughout the whole process we increased our monitoring from a statutory perspective as well, using an independent third-party to do that monitoring. Initially weekly we were...
doing that and then once we started getting some confidence around the controls that we had put in place over the years we put that out to two weekly and we still currently do that every two weeks now and it’s done once every fortnight as such. It was through that process I suppose up to May we had a confirmed case again. It was our third case. Then in September we had our fourth case. Our continuous improvement process is ongoing through that whole process.

I suppose I can touch on some of the engineering controls that we have done in regards to that. Obviously the strategy around our dust was to reduce dust at the source. That was the best way to ensure that we were not exposing our people to exceedences. I must clarify that when we say we have an exceedence it does not necessarily mean the person was exposed to high dust levels. I mean, they were not necessarily breathing that dust in. Obviously PPE was worn. It wasn’t mandatory prior to 2015. It was supplied and Airstreams were supplied from the inception of the longwall at Carborough Downs as such but it was not mandatory. We actually mandated it as a consequence of the pneumoconiosis cases from that point of view and various other initiatives around face-fit testing for respirators. We introduced a different type of powered air respirator, a CleanSpace they call it. They gave the guys some options around what sort of respirators because they are not the most comfortable things to wear. They are fairly bulky, but it was something that we all agreed had to happen, it had to be mandated. We had a clean shaven policy introduced as well as per the Australian Standards and a whole raft of other things.

Our strategy was to reduce dust levels was critical—that was the key to any success we were going to have; identify dust generation or liberation sources; increase volume and dispersal of water was critical; increase application of sprays at the point of dust creation was obviously a big part of that; automate our dust suppression sprays—we spent a lot of time and effort and money in regards to automating the dust suppression along the whole face rather than just in certain areas; improving operator position we found was critical. With the real-time monitoring and other gravimetric monitoring, by an operator standing one metre further towards the tail gate or one metre further towards the main gate made a huge difference in regards to their dust levels being recorded in the monitors as such. Having that education process throughout the whole place, because over time people got, I suppose, complacent and comfortable with what they were doing in regards to where they could stand operating a piece of machinery, whether that is a continuous miner or a shearer on the longwall and the operating shields as well. We had to change that culture, that you can’t go past certain points. We had no-go zones initiated and reinforced as such that were tightened up a lot more than what they were.

In terms of regular and systematic workplace inspections to make sure that control effectiveness was correct, what we also found throughout our whole process was that, over the years, we have always focused our attention on the dust source and tried to mitigate the dust. What we found was that it was float dust that was causing us a considerable issue as well. Float dust is dust that collects on certain bits of equipment. It is from the shearer when they are cutting the coal. It settles down and when guys are leaning through over chock legs or cleaning up bits of equipment, that dust gets raised back into the air again and that is obviously exposing them.

Part of the whole engineering process was to ensure that we suppressed that dust as well as suppressed the dust at the source. That was a critical issue, hence why we introduced a deluge system across the whole face where, as the shearer got into a certain position, sprays would come on automatically to kill dust that is generated at the source but also any float dust that was going to be generated. It was suppressed and became wet. It was not then stirred up easily. That whole process works in an automated fashion. We also have the ability for the guys, when they finished the shift, to hit a button and the whole face is sprayed down and wet over to be able to make clean-up a little bit easier and also stop that float dust, because we found that that was a critical issue in our analysis over time.

Ongoing consultation with the workforce and training in dust mitigation controls was critical. If we implemented all of these engineering controls, we needed to make sure that we maintained them. If they became ineffective, they had to stop. We had a TARP process that we introduced. There were checklists and inspections introduced that the guys had to sign off on a daily shift basis. Again, like I said earlier, we had external consultants come through and review people positioning and dust generation over the whole longwall.

I must also reiterate that it was not just the longwall; we had out by areas that we were monitoring and doing some work on in regard to sprays on transfers, conveyors. We had our roadway dust that we needed to control, so dust suppression use on those roadways and that sort of thing was ongoing at all times as well.
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ACTING CHAIR: I might just pull you up there, Andrew. We want to ask you some questions. How long have you been the manager out at Carborough?

Mr Vella: Since 2014.

ACTING CHAIR: And where were you prior to that? You were in the industry?

Mr Vella: I have been in the industry for 20 years in various roles—in open-cut, prep plant—CHPP—that was a huge part of my background and recently, since 2013, in the underground environment.

ACTING CHAIR: What was your personal reaction when these first cases of CWP started to get confirmed? Did you find that quite alarming? Were you of the opinion, like everyone else, that this was something that had disappeared some 30-odd years ago?

Mr Vella: Yes, obviously, very disturbing—and disappointed as well. The whole industry was under the understanding that pneumoconiosis was a thing of the past. It was very alarming for not only me but the whole Carborough team and the whole Vale team in general. It is not something that we took lightly and tried to fob off by any means. It was the kick in the pants that we needed to get to where we are today, unfortunately.

ACTING CHAIR: Were any of you gentlemen working at Carborough back in 2009, 2010, 2011?

Mr Vella: At Carborough?

ACTING CHAIR: At Carborough. Had those CWP cases been confirmed as they should have been back in 2009, 2010 and 2011, if those scans had been read by a B reader at the time, the Queensland coal industry could be in a whole different place from where it is right now—essentially five years ahead. Instead of sitting in a room in 2016 having this hearing now, we potentially could have been having this hearing five or six years ago. I am interested in comments from your personal perspective in the industry about that, if your view.

Mr Vella: Obviously, in hindsight, what we know now, it definitely would have been a different story back then—if that process was working and pneumoconiosis was being identified back then. Unfortunately, we do not have hindsight and it was not the case. I must also state that there were always controls around dust. Whether they were to the level they needed to be is obviously going to be a very subjective conversation that everyone will have—whether that is between management, the operator, or the workforce, the employees. We know now that the controls that we have implemented over the last 18 months, two years, have taken our previous controls to the next level. We have seen a significant difference in our dust levels and we have data to show that from the monitoring. If that had happened five years ago, obviously, it would have been better for the industry as a whole and better for every individual who has worked in a coalmine.

ACTING CHAIR: Gentlemen, thank you, and thank you for the opportunity to have a look around and for the discussion the other day. I will go to the deputy chair for some questions.

Mr SPRINGBORG: Thank you very much, acting chair, and thank you very much gentlemen. Can I say that I found the visit to your mine the other day to be very useful in being able to understand its operations as much as you can in such a short period of time. I also appreciated your open and candid communications. I am particularly interested in the placement of those who have been diagnosed with CWP in your mine environment. You have indicated that you have a special program in that you make sure that you put them in dust reduced environments with the necessary protective equipment around them as well. Do you have ongoing, regular communications with them as mine management, or those who they report directly to, to make sure that, if they have any concerns, that they are being addressed, that they are being kept up to date with what is going on? The medical assessment and that ongoing monitoring is one part, but the other issue is to make sure that their concerns in a workplace environment are being regularly communicated, or that they know that management is really concerned about them and is not just putting them in that environment where they reduce the risk.

Mr Vella: I can say, yes, we do. Obviously, we monitor those guys probably a little bit more than our other members of the workforce, specifically so that we do not further expose them to any unacceptable level of risk. It is a very emotive fact in that, because they have pneumoconiosis—whether that be the low level or whatever it is irrelevant; they still have it as such—we need to ensure that we give them not special preference but they are monitored a lot more closely to make sure that we do not further advance it or aggravate it in any manner.
That process is ongoing. Some of the guys have suitable duties plans in place that we review on a monthly basis to ensure if there were any steps that we need to change in regard to their work activities. This is predominantly the underground mineworkers with the out by deputy. They are being introduced back into the underground and have the potential to be exposed to dust. Like I said, it is very complex. Even though the tasks that they are performing on a day-to-day basis did not expose them, there could be external influences that cause them to be exposed to dust, like a loader working in an area where it should not be or something like that. There is no silver bullet to fixing the whole process. That is why it is a continuous improvement process. Those concerns from the employees are reviewed on a monthly basis.

The guy who we put into the CHPP has regular monitoring. It is a fairly close-knit team down there, so he is able to talk to his supervisor and manager down there and, obviously, my door is always open. I have had several conversations with the guys on regular occasions. I believe that that process is underway. Could it be improved? There is always room for improvement for everything, but I have not heard any concerns from those guys in regard to how we communicate with them, or anything like that.

Mr SPRINGBORG: I have one other question that relates to inspections of the mine environment, whether it be announced or unannounced. We have heard testimony from coal workers during the course of our visit here that if there is an announced visit where notice has been given that results in a significant flurry of activity to potentially address things that the inspector may not be quite impressed with. What sort of process does your mine operation follow when you have a notified visit from a mines inspector to make sure that they are getting a true representation of what is actually happening there?

Mr Vella: I read the transcript from the guys from the other night saying that we go into a flurry of action around housekeeping and so forth. That is an ongoing and daily thing that we do on a regular occasion from a safety perspective but also from our housekeeping and standards that we maintain at the site. Regular hosing of the face is always conducted, whether that is through the shift or at the end of shift or specifically by the bull gang. That is normally part of our task to hose the face down at the end of night shift for the bull gang for the day shift guys to come in to a clean face. That is part of their routine. Sometimes that obviously gets waylaid depending on the priorities of other actions, but we do not go over and beyond because there is an inspector coming. I am just trying to think. I know we have only had probably one unannounced inspection over the last two-year period. I think that was in May 2015 or somewhere around that time frame. Most of our inspections are announced but, again, our housekeeping and standards are obviously critical and we are regularly commented on for our roadway conditions, our stone dusting conditions and just our general cleanliness of the mine. It is not a one-off thing when an inspector comes; it is an ongoing thing that we pride ourselves on.

Mr SPRINGBORG: Thank you.

Mr PEARCE: Do you have a dust committee?

Mr Vella: We have a health safety committee which covers dust.

Mr PEARCE: Who is on that committee?

Mr Vella: It is not specified members as such; it is a combination of workers, contractors, staff members and management that come together once every three months to obviously discuss all issues where it is minuted and any concerns raised by the representatives on the day are able to then be actioned.

Mr PEARCE: Is there a report-back time when you actually talk about the actions that have been taken?

Mr Vella: Sure. Every meeting we report back on the actions in terms of whether they are completed, if they are overdue, whether they need to be extended or any new actions that come out of that specific meeting.

Mr PEARCE: The QRC submission states—

There is a need to disentangle the issue of screening for occupational disease from fitness for work.

How do you feel about that?

Mr Vella: Sorry; can you repeat that?

Mr PEARCE: It says—

There is a need to disentangle the issue of screening for occupational disease from fitness for work.
Mr Vella: Disentangle? Obviously part of the health scheme is that every five years you have to have a Coal Board medical and part of that process is specifically for underground mineworkers or any worker that may be exposed to dust to have a chest X-ray. Out of that process we receive a section 4, which is the Coal Board medical, and that determines whether that person is fit for work or fit for work with restrictions or vice versa. When you say ‘disentangle’, they have to go hand in hand obviously. If someone is not fit to perform their duties because of whatever reason, whether it is pneumoconiosis or a back problem or whatever, there needs to be that association because we do not want to further aggravate any existing injuries or pre-existing injuries or anything like that but we need to work through that process.

Mr PEARCE: How do we improve the overall importance of this particular issue within the health management of mineworkers? Are you confident that there is enough exchanging of new innovation towards improving dust control and would the workforce be involved in any ideas that you had?

Mr Vella: With regard to a continuous improvement process, the workforce is obviously always involved in that process. Was there enough data transfer and information transfer between mines? I think that was the question you asked.

Mr PEARCE: Yes, that is part of it, yes.

Mr Vella: Traditionally, no. Traditionally we have probably worked in silos to a degree and have not cross-referenced each other’s practices as good as we should have. I have seen a step change in that recently with the reinvigoration of the SSE forums and the dust workshops that the QRC went through. We need to do more of that. Also, we had representatives from Carborough Downs that were on the dust regulation boards where they were developing the recognised standard for dust mitigation. There was a lot of information transferred between pits and that transfer. Can it be improved? It always can be improved.

Mr PEARCE: With regard to the use of contractors—labour hire companies—and the experience that those people have and, often, an inability to raise safety issues, how important do you and the company believe having people with experience and the ability to come forward and raise issues is to the overall safety of the mine?

Mr Vella: It is paramount. I can probably use an example. In 2013 we had our highest production year ever at Carborough Downs. We had our lowest dust levels from a longwall perspective in that year. We had the highest amount of hazard reports by not only contractors but employees around dust. The more information we can receive, whether it is a contractor or an employee, on a significant issue that we can fix there and then obviously helps everyone. If we do not know about the issues, then we cannot fix them obviously so it is paramount. What I have found, specifically with the contractors and their experience, is that there are a lot of contractors out there that are very experienced and have been in the industry just as long as any permanent employee that we have. Are they treated any differently with regard to how they report incidents? No, they are not, and I can only say that from my personal opinion obviously. We probably have a very small contractor base compared to other sites, but those contractors that we do have on site are willing and able to come and tell us about those issues and we have various reports from them that show that. I have no issues with regard to them being singled out by any means as such.

Mr PEARCE: I asked that question because during the last few days there has been a lot of comment coming from workers with regard to that particular issue—that is, contractors or labour hire company employees not willing to step forward because they are concerned about the consequences of raising an issue—but I thank you for your response.

Mr COSTIGAN: Good morning, gentlemen. Mr Vella, given your experience in open cut prior to coming to underground three years ago as an SSE, do you believe the dust suppressing methods that have been implemented at Carborough Downs are as good as any mine operating today?

Mr Vella: I think we are leading the industry in that sense, and that is not only my personal opinion but that is feedback I have received from various external stakeholders such as CFMEU members and the inspectorate. Obviously with the first cases of pneumoconiosis we acted earlier probably than everyone else and trying to share that information is now critical to make sure that those other mines get up to where they need to be, and obviously we are learning off them in other areas as well. We are not the be-all and end-all by any means, but I think we are definitely up there as industry leaders.

Mr COSTIGAN: I note your surname is a pretty strong local name. Given the international flavour of your workforce and other mines across the Bowen Basin—we hear of miners who have come from the north of England and from other jurisdictions across the nation—does Valet support the concept of a national screening program in addressing the issues at hand?
Mr Vella: Personally, I do not know.

Mr COSTIGAN: Do you have a view on this personally?

Mr Vella: My personal view is that obviously a multinational company would have a policy or should have a policy on screening, no matter what industry they are in, in regards to mining, because obviously there are hard-rock mines, silicosis and all those sorts of things. I am sure they should have, definitely. From a site-specific perspective, if you look at Valet, the site is bound by various standards and regulations, corporate governance and so forth. I would assume that they rely on that predominantly, rather than having a worldwide screening process, because every regulation is different in the states. We see that between New South Wales and Queensland, with regulation changes and so forth. My view is that there would be an overarching thing, but if it gets into the detail of specifics as to what levels, standards and so forth, I think that is probably more so at a country level than even a state level.

Mr COSTIGAN: Finally, in its travels this week across the Bowen Basin coalmining communities and most recently at Middlemount yesterday morning, if I recall correctly, the committee has heard about the impact of CWP in terms of the mental health and wellbeing of mine workers. Mr Vella, could you or your colleagues enlighten the committee in relation to what Valet is doing in that space to assist workers, not just with X-rays and putting them into other areas of the operation but also in terms of addressing the issue of mental health? This is in the context that everyone thinks you blokes are all 10-foot tall and bulletproof, being big burly miners. However, as we have seen this week, it is affecting the mental health of coalmine workers and there is no doubt about that.

Mr Vella: Definitely. I have seen that first-hand. Obviously, we have an EAP program available to all our employees and their families, so it is not just bound to the individual; their wives or their children can use it, as well. That is obviously the first process and that is all kept confidential. With the guys we have still working at Carborough Downs who have pneumoconiosis, we have tried to keep them in the workforce as normal and not single them out, so that they are segregated by any means. That is why we are trying to introduce them back to the underground. They want to go back to the underground. They have spoken to me personally and said, ‘I want to go underground’. Obviously I still have an obligation to make sure that they are not exposed to an unacceptable level of risk. There is a process that we need to go through in that whole thing. We have suitable duties plans trying to go through that. We have a fitness for work program. We have company policies and procedures around that process. There is a raft of things.

Could it be improved? Like I said earlier, we can always improve. By no means are we ever the best of anyone in those areas, especially around mental health. As you know over the years, it is becoming more and more out there and, hopefully, people can come and talk, whether it is to Kelvin, Nathan, myself or anyone at Carborough Downs about those issues. Back in the day, you were told to go and have a teaspoon of cement and harden up. Those days need to go. They should have been gone years ago. I hope we are big enough and ugly enough to push past those things.

Mr COSTIGAN: Thank you, Mr Vella.

Mrs GILBERT: After the notification of the first case of CWP, what was your response to your permanent workforce and your contractors to ensure their health?

Mr Vella: Obviously, I communicated that to the workforce personally, to each crew as such, to give them an understanding of it. We were all new to pneumoconiosis. A lot of people could not even say it back then, probably. The first thing was communication—that was the initial thing—around dust controls, hazard reporting and risk control. That was critical. The guys are down there on the face. They see what is going on. That is why we have our hazard reports that they can utilise. I mentioned them earlier in regards to that. Our take-five process is the last line of defence, I suppose, in regards to risk control. We are making sure that we do that and, if there are any issues that they report, we obviously try to act on that as best we can.

Mrs GILBERT: You said previously with some of the cases that you outlined before, some had a previous misread diagnosis. Did you go back through the workforce’s X-rays too? Did you send them off to get checked to make sure you did not have any other cases?

Mr Vella: Everyone else, yes. We actually screened every single Carborough employee on site, so permanent employees. The process that we use and we agreed with Dr Cohen, in consultation with our employees and the CFMEU, was to have their last X-ray, whether it was five years ago, four years ago or three years, and also an X-ray that was no less than two years old. Anyone who had an X-ray that was three or two or five years old, we had them have another one. We sent both of them over so that they could compare. They all went to Dr Cohen in the United States.
Mrs GILBERT: What about your casual contract workers?

Mr Vella: We encouraged our contractors to do the same process. Currently, obviously it is a process that has been put in place by the Department of Natural Resources now, whether you are a contractor or not, you have to go to a B reader and be dual read by two B readers. In the early days, we only focused on our permanent employees. Due to the transient nature of contractors coming and going, it would have been a massive job. At times, we could do the whole Bowen Basin’s contract workforce, if they were coming and going. We focused our attention on our permanent workforce, but also encouraged our contractors and the employees of the contractors to take that same process.

Mrs GILBERT: Is that process for the contractors well known across the mining industry, that they can go to the B readers?

Mr Vella: It is mandatory virtually, now. It has been put through the NMAs that that has to occur. That is my understanding.

ACTING CHAIR: Counsel Assisting?

Mr McMILLAN: I ask you, Mr Vella, and each of your colleagues: is there any particular training or education that is required to take up each of your individual roles in senior management in the mine or is it more about experience in the industry?

Mr Vella: No, it is both. Obviously to be an SSE, you need to have an SSE competency, as well as other relevant competencies that come with that: G3, G7, off the top of my head. I will not even try to explain what they are.

Mr McMILLAN: For the roles of health and safety manager and underground mine manager?

Mr Vella: An underground mine manager needs a first-class mine manager’s ticket and for health and safety there is no prescribed competency, but I will let Nathan answer.

Mr Willows: I have a background in human physiology education and a postgraduate masters in occupational health and safety. Although it is not mandated in terms of technical experience and knowledge and lifelong research, that is part of my professional development. It is not mandated by the company, but just personal interest. Also, background wise, I have 11 years in the industry and have actually worked at the face on crew as well, so I have an appreciation for the operational side of things, as well as managerial.

Mr McMILLAN: I take it that each of you attained those relevant qualifications prior to the first diagnosed case of CWP being made public in 2015?

Mr Vella: Yes.

Mr Willows: Yes.

Mr McMILLAN: Prior to that and at the time that you did that training, was there any focus at all upon the risk of respirable coal dust to health as opposed to the risk that dust poses in terms of a visual hazard in the underground environment?

Mr Vella: Not specifically, no.

Mr Schiefelbein: In courses that I have done on mine workers’ diseases, a broad gamut is covered.

Mr McMILLAN: In your education, there has been a general discussion about dust diseases for coal workers?

Mr Schiefelbein: For mine workers, yes.

Mr Vella: In terms of not having a documented case for a period, I suppose it has resulted in a bit of false confidence in the industry. Maybe when you have procedures and policies in place that say if you identify dust as a hazard you should put your PPE on, quite possibly the workers at the face are not fully appreciative of that and in terms of all levels up the chain of command in realising the significance of long terms of exposure, just from that false sense of confidence.

Mr McMILLAN: I suppose what I am getting at is that three senior people at a mine where dust clearly has been a significant hazard over a period of time have not had the benefit of professional training or expertise in your education about this risk before going into those senior roles. Is that a fair statement?

Mr Vella: Specifically around dust, you are correct. Obviously around risk management in general, yes.

Mr McMILLAN: Prior to recent years.

Mr Vella: That is right.
Mr Mc MILLAN: Mr Vella, can I ask you a few other questions about your evidence and also arising from the submission that Vale has produced for the committee. As I understand it, in the last two years, you have instigated a program where any member of your workforce who had a chest X-ray that was older than two years was offered the opportunity to have a new one.

Mr Vella: Yes.

Mr Mc MILLAN: What percentage of your workforce has taken up that opportunity?

Mr Vella: My understanding is 100 per cent.

Mr Mc MILLAN: The submission that Vale has produced refers to a collaborative process with the CFMEU to gain the consent of your employees to undertake those reviews and send them to the United States to be B read by Dr Cohen.

Mr Vella: That is right.

Mr Mc MILLAN: This committee has heard evidence from workers in a number of coalmines across the Bowen Basin over the past four days. In some cases, it would seem that the workforce of a particular mine has very little confidence in the process that that mine has established. That would seem to be the opposite at your mine. Do you think the collaborative approach you have adopted with the union has fostered a level of confidence in that process by the workforce?

Mr Vella: Definitely. If you went about trying to direct or tell them that they are going to do it, then you are always going to be hit with a wall, I suppose. Obviously, communication is critical to anything we undertake at a coalmine. As such, working with the employees, the local lodge and obviously the wider CFMEU representatives helped us get through that process.

Mr Mc MILLAN: You would have heard the question I posed earlier to the officers from the Department of Natural Resources and Mines that the workforce having confidence in the system that protects them is critical to its success. Would you agree with that?

Mr Vella: Definitely.

Mr Mc MILLAN: Have 100 per cent of the X-rays that have been taken for your workforce now been B read by Dr Cohen?

Mr Vella: Yes.

Mr Mc MILLAN: Of those workers, are you able to tell us what percentage of them have been given as 0/1 reading?

Mr Vella: No. We do not actually get those results. I know that I am a 0/1, I will be up-front. That means obviously that it is not pneumoconiosis. Obviously I had a conversation with Dr Cohen around that because we had a lot of concerns around that in regards to 0/1. The next stage was 1/0, which is obviously the early stages of pneumoconiosis. That 0/1 is subjective in a way in that it depends on the X-ray quality. It could be blood vessels or air capillaries and so forth that show up, so it is not necessarily the start of pneumoconiosis as such. The only true definitive way to determine pneumoconiosis is by a biopsy but that is very invasive and we do not want to go down that path obviously for every coalmine worker. That is not going to happen.

The ILO method and standard has some subjectivity about it, and Dr Cohen himself says that it is him looking at X-rays and he could read it differently to another. That is why they have to go through two. If those two disagree, it goes to a third and so on and so on until they get a determination. There is a level of subjectivity to that process.

Mr Mc MILLAN: You would have noticed from reading the Hansard transcript of the hearing in Moranbah—and I think at least Mr Willows was present for this evidence—that at least some of your workers are very concerned that they have got 0/1 readings and they might be on the precipice of a CWP diagnosis. Firstly, did that evidence concern you? Secondly, what is being done to allay those fears?

Mr Vella: Does it concern me? From when I have spoken to Dr Cohen, no, it does not concern me because I am in that same category. It is just going to be an education process going forward. That is critical to that understanding. We will learn over time I suppose as more and more people go through that ILO standard as to a statistical nature in regard to how many 0/1s or 1/0s or whatever, and whether that means that in two years time you are going to have pneumoconiosis or not, that is unknown. Everyone is different. Everyone’s susceptibility is different obviously. It is hard to tell. Education is key too that you have not got it. There are some anomalies in your X-ray reading to determine that 0/1—like I said, the airways and so forth that do show up on X-rays. As technology improves over time, maybe that can be fine-tuned as such. It is communication.
Mr McMillan: Is increased monitoring or screening made available to those workers who have concerns about that?

Mr Vella: They can do. We have, like I said, various monitors on site that we can do our gravimetrics, and we do that now. Above and beyond our statutory monitoring, we can monitor every day if we want to. We have had occasion where guys are concerned with an area that they work in, and we put monitors on them to obviously get the actual data to prove that. We always do that and can do that.

Mr McMillan: I think one of the committee members has already generally asked you about the breakdown of the permanent and contractor workforce. Are you able to give any ratio or percentage breakdown of the portion of your workforce who are contractors?

Mr Vella: I know we have 180 permanent employees—that is staff and underground mine workers. Our contract workforce varies depending on obviously what projects are happening at the mine. With a longwall move obviously we ramp up our contractors. Traditionally, in the underground it is around 30 but it varies. It can ramp up to 60 to 80. In the CHPP and surface projects, that varies as well. Normally, the full-time equivalent contractors at the prep plant are just our contractors who haul our rejects and so forth, which is about 20 people. They are not there all at once. There is normally a crew of 10 on day shift only, so it is whatever that is. It is about 20 per cent probably, or something like that.

Mr McMillan: At least at your mine the workers who are in the higher risk environments working underground during production shifts are predominantly permanent staff?

Mr Vella: At the moment, yes.

Mr McMillan: When the committee attended at Carborough Downs, certainly I noticed that on your notice boards there was information about CWP. Looking at the quality of the paper, it struck me that it had been there for a long time. It clearly had not been put up just for the committee’s benefit. There was also I noticed extensive reporting of dust exposure results across those notice boards. Have you, in the process of your collaboration with other mine operators in recent times, shared that experience and provided the feedback from your workforce to your colleagues in other mines about the success of that communication strategy?

Mr Vella: Not specifically, no.

Mr Schiefelbein: I might correct that. At the Queensland Resources Council meeting, we presented that we do that gravimetric monitoring and give people direct feedback within 24 hours.

Mr McMillan: Can I ask you about dust suppression and the use of water in that task? The committee has heard evidence that in some cases at some mines the amount of water that is available to the mine is an issue in dust suppression. Have you had that problem? What did you do to address it?

Mr Vella: Part of our strategy was to ensure that we had enough water supply. There is no use putting all of these sprays in if you cannot use them as such. That was part of the strategy. We have along the way had occasions where we have lost water supply for whatever reason due to a pipe breaking or something like that where we have had to fix it straightaway. Generally I have not heard of or been aware of any issues where we are short of water when all of these sprays are working as such.

Mr McMillan: Finally, I want to ask a question about dust monitoring inside the breathing zone of an Airstream helmet. I think you might have been present when I posed that question to the mining inspector earlier.

Mr Vella: Yes.

Mr McMillan: The committee has received evidence from at least one worker with a concern that monitoring done inside the breathing zone is in fact also inside the zone that is protected by the apparatus and therefore does not give an accurate record of the dust exposure that that worker was working in at the time. Can you or perhaps Mr Willows assist us to better understand the positioning of personal dust monitors and the reason that it might be done in the way that that worker described?

Mr Willows: I can answer that as best I can. I believe the context that the worker at the forum on Tuesday night in Moranbah was speaking about is that the monitor was having air that was coming out of the exhaust blown onto it—not so much within the breathing space of the air stream helmet—and that may affect monitoring or the reliability of data potentially. The idea with fit-up is that it is fitted in the general breathing zone of the individual. The first time it was brought to my attention was when I heard that. That is an improvement opportunity for us that we can look at and have those discussions.
with our external hygiene consultants on how to get around in terms of the positioning of it. It is very difficult because the helmet is quite large and it does need to be positioned in the breathing zone. We cannot put it on the stomach or the back; it needs to be reflective of that person’s supposed area. That is something that we can definitely look into and improve on.

**Mr Vella:** The monitoring company that we use are bound by guidelines and they are NATA accredited, so they obviously have to abide by a standard as to how monitoring is conducted and part of that is where the monitor is located. Because they are a cyclone type arrangement they need to sit up right as well. There is a whole raft of technical issues around why it cannot be anywhere else. That is the first I have heard that.

**Mr Schiefelbein:** The Australian standard says it must be in the breathing zone.

**Mr Vella:** It is not within the actual helmet. It is not shoved up in there; it is still where you would put it without wearing a helmet, but we need to do some further investigation of that.

**Mr Schiefelbein:** The company that is NATA accredited position it on our workers at the start of each shift. It is not a thing that people can choose. They are there and they are told to keep it in that position for the shift.

**Mr McMILLAN:** A number of you raised a particular issue with members of the committee during its visit to your mine this week in relation to the accreditation of particular types of dust monitors and some hopes that you had in terms of moving that forward. This is your opportunity to place that on the public record and I invite you to do so.

**Mr Vella:** There is new technology—it is probably not new technology, but it is mandated that they wear particular real-time monitors in the United States at the moment, the PDM monitors. They are not intrinsically safe. They are obviously what we call a UPEE device where you have to have a methane monitor with the person trained in the use of that monitor and have a permit to take it underground. It can only go to 0.5 methane levels. Obviously when you are working on a long wall there are occasions where that could be higher. They are trying to get that pushed through the system and have it accredited to be taken underground. From what I understand, the reliability and the accuracy of these units is very good, hence, the United States have mandated it on all their underground mineworkers is my understanding. Obviously if we could get that pushed through sooner rather than later that would be a benefit to the whole industry in general.

**ACTING CHAIR:** Thank you, gentlemen. The time has expired. I want to thank you for your time here today. I now call forward Mr Steve Mellor, Mr Chris Byron, Mr Paul Head, Mr Dave Walker and Mrs Sue Byron.
Mr Mellor: Good morning, committee. I would like to thank you for taking the time to hear our submission today. My name is Steve Mellor. I began in 2005 working in the coal industry as an underground coalminer. Prior to commencing employment at the Oakey No. 1 coalmine I went through an induction process to enable me to complete my work as an underground miner in a manner that preserves my safety and the safety of the men I work with. During the course of these inductions, there was no reference to any risk of my contracting any disease as a result of exposure to coal dust.

Since I commenced employment in 2005, I have worked for eight different contractors at five different coalmines operated by four different coal companies. None of the supervisors under whom I worked ever spoke of any risk of contracting any disease as a result of coal dust. During my 11 years underground I was employed to do secondary support, longwall moves, development and general outbye works at Oakey No. 1, Oakey North, Carborough Downs, North Goonyella and Broadmeadows coalmines.

Throughout my career I was required on a number of occasions to attend a coal board medical. As a result of attending these medicals I had chest X-rays on the following occasions: 4 February 2005, 16 March 2006, 14 February 2007, 14 April 2007 and 11 May 2012. The results of all these X-rays were clear. As a result of all the X-rays up until 11 May 2012 being clear, I never at any stage turned my mind as to why I ever needed these X-rays.

I took some time off from the mines in January 2016 to assist with my terminally ill father who sadly passed away in February this year. In April I was preparing to go back to work underground, so I went and had my chest X-ray done. The radiologist viewed it and reviewed a copy of my 2012 digital X-ray that Queensland X-ray had on file and both of the results returned positive for simple mineworkers pneumoconiosis. I was then referred to a specialist, Dr Robert Edwards in Brisbane. Dr Edwards reviewed my older film X-rays and expressed the view that I may have contracted CWP prior to the X-ray in 2007, only two to three years after I commenced work within the industry.

During this time as an underground miner we were extensively taught and trained on the hazards and risks associated with underground coalmines from pinch points to manual handling, to strata conditions, spontaneous combustion and the different types of gases found within the coalmine. I have never been trained in anything to do with black lung disease or coal dust related respiratory diseases by any coalmine or their respective training partners.

The committee has heard about some of the instances of mines not checking for dust in areas such as longwall and development panels, contractors being sent into returns while the longwall is cutting, extensive housekeeping done days prior to an inspection, personal protective equipment and training restricted and denied to workers or contractors from mine operators, inspectorates only having access on maintenance or shut down days or only given access to areas deemed less dusty. I have witnessed or been involved in all of the above activities at some time during my career as an underground coalminer.

Since being diagnosed as suffering from CWP, I have joined the Dust to Dust campaign as a spokesperson to hopefully gain some information in regard to the disease to help me in the future and to help educate others on the dangers of working in areas where they are exposed to coal dust. With the ongoing medical costs and the uncertainty as to any future employment and how I may be affected in the future, my diagnosis as being a black lung disease sufferer has become a burden both financially and psychologically on me and my family.
Mr Hedley: My name is Paul Head. I have worked at Goonyella Riverside for 31 years in the open-cut mine. On the 26th of the ninth this year I was diagnosed with CWP. I have not been back to work since, for the last couple of months. I am getting medical help.

ACTING CHAIR: You have only ever worked at an open-cut mine, at the one mine?

Mr Head: Yes.

ACTING CHAIR: What was most of the work that you did there? Were you driving machinery? Were you working in—

Mr Head: Mainly in machinery. I started off as a tyre fitter serviceman. I did that for approximately five years. Then I went out on the machinery out in the pits, on end loaders and shovels and that sort of thing. It was all out on the machinery—all air-conditioned cabs, with a lot of leaks.

ACTING CHAIR: I am sure we will have plenty of questions for you shortly.

Mr Walker: My name is Dave Walker. I have been in Australia since 2007. I worked 13 years in underground mining in the UK. I had an X-ray in 2006 for my visa to come to Australia. I had an X-ray in 2007 to start employment with the contracting company that brought me to Australia. I had an X-ray in 2009 for a contracting company. That same X-ray was used in 2010 for my employment with Vale. I worked six months in development and then 4½ years on the longwall up to my medical in March 2015. I had the medical and the X-ray. I was then contacted by the nominated medical adviser to say that the 2015 X-ray had shown calcification nodules and I had to go for a CT scan. I had the CT scan. Then I was sent to a doctor in Mackay, Dr de Silva. The nominated medical adviser sent me to him because he wanted him to send me for a biopsy. The doctor told me to have another CT scan in six months and go back and he would review it then because he did not think I had black lung. That suited me because it gave me another six months of not having to worry about it.

Then the nominated medical adviser rang me on the Monday, as I was due back at work on the Wednesday, and asked me how it had gone with Dr de Silva. I told him what he said. At that point he said he was not happy with what I had been told and he said to keep my phone with me. He rang me a couple of hours later and told me I had to be in Brisbane on Tuesday afternoon to see Dr Edwards because he thought I had black lung. I rang the pit. I told the pit that my wife had to have treatment and put seven days annual leave in, because I should have been back at work on the Wednesday. I paid everything myself. I flew to Brisbane. This was the first case in decades, if you know what I mean. I was worried about what the outcome would be and everything. I went to see Dr Edwards. He then sent me to see a surgeon.

I thought they were going to put a probe down my windpipe and snip a bit of my lung off. I saw a surgeon. He admitted me the next day, on the Thursday. He did video assisted thoracic surgery that went through my chest wall. I came around and was in intensive care for 18 hours before they moved me to a ward. When the surgeon came to tell me the results and I asked him how bad it was, he said, ‘Your lungs are that black they would be the sort they would put in a jar to show students what black lung looked like.’ When finally my X-rays got sent to Dr Cohen, he revealed that in the 2009 X-ray I had pneumoconiosis to 1/0. In 2015 I had it to 2/1 and some large opacities are getting close to the one centimetre for PMF. My drama is the failings in the system to pick it up.

ACTING CHAIR: Thank you, Mr Walker.

Mr Byron: My name is Chris Byron. I was an underground coalminer for approximately 40 years. My story starts back in 2006. I was out of the industry for about six months. To get back in I needed to do a coalmine workers’ medical. In February I arranged with my local doctor to have the mandatory chest X-ray, which you have to do to get the medical. The chest X-ray came back to my doctor and she did not like the results. She said, ‘I am sending you to a specialist.’ I went to a specialist in March. He ordered a CT scan of my lungs. This is in March 2006. The radiologist’s findings were—

These nodules appear quite fluffy and there is no associated calcification. The appearance would be consistent with coal workers’ pneumoconiosis if there is a history of exposure to coal dust for 10 years or greater.

I qualified at that point. This diagnosis shocked my wife and me. We decided we were going to get a second opinion on this. There was something wrong. The specialist arranged for me to go to Brisbane. I went to Brisbane on 27 June, because I had to wait a few months to see that specialist. In the meantime—

ACTING CHAIR: Sorry, was this 2006 or 2016?

Mr Byron: This is 2006. This is all happening in 2006.

ACTING CHAIR: I am just making sure we have the time line right.
Mr Bryon: In the meantime in May the local specialist wrote his findings to my doctor, ‘He may even need a lung biopsy.’ He then went on to say, ‘I do not think that even exposing him to coal dust will change his position over a six-month period even if this is pneumoconiosis.’ My wife and I travelled in June and met with the specialist. After introductions, he said to us, ‘A colleague of mine saw your scan, Chris, on my monitor and asked, “What are you going to do with this patient?”’ The specialist said to his colleague, ‘Nothing.’ ‘Chris, you’re okay to go back and work in the mining industry.’

I applied for a job underground in Central Queensland but pending that job I had to go for a medical. They sent me to their nominated medical adviser. After various examinations and tests, the doctor filled out the confidential work assessment Coal Mine Workers’ Health Scheme. On page 3, for question 2.4(d) the doctor ticked ‘No’ and then ticked ‘Yes’ of having ‘Asthma, bronchitis or other lung diseases’ and signedatured the box. This is on the Coal Board Medical form.

Then later under section 2.5 there were the examining medical officer’s comments in relation to questions 2.4 and 2.5. In regard to question 2.4(d), he wrote—

A routine X-ray this year revealed pulmonary nodules, pneumoconiosis, sarcoidosis, atypical infection, post-pneumonia changes being investigated and had pneumonia three times in 2004. That was put on my medical assessment. Those were the words. The medical doctor who did the assessment told me I was clear to start back at the work in the underground mines, which I did. My assessment forms I believe were sent to the Coal Mine Workers’ Health Scheme. No-one ever questioned this assessment and that includes doctors, specialists and the Coal Mine Workers’ Health Scheme, until April 2016. I was still getting pneumonia.

I go to 2016. There was a lot of talk on television and in the papers about black lung, which had come back into the mining industry and miners were being diagnosed with it. I thought that this would explain why I had pneumonia 50 times or more in the last 16 years. My family urged me to look into this, as it might explain my lung condition. The pneumoconiosis symptoms are always the same: rigour, followed up by coughing up of blood, and lots of it, for up to 10 days and being very unwell. In 16 years, my breathing has worsened. In February of 2016, I went to the CFMEU office to inquire about procedures I had to take to see if I had pneumoconiosis. I was given a form to fill out, which I did. I went to my doctor and told her the story about what was happening in the industry. She said, ‘I will send you to a specialist and let him look after you’. The specialist ordered a CT scan in February of this year. At the follow-up visit to get the results, the local specialist told me that I could have pneumoconiosis or I could have other lung problems. He said, ‘I will review you in six months’.

In March, I sent the form that the CFMEU gave me to an address in Brisbane. In April of 2016, I received a phone call from a Dr David Smith from the Department of Natural Resources and Mines asking me if I had had any more than three medicals, because they thought they may have lost them. I said, ‘No, that’s all I have had in Queensland’. Also in April I received another call from the same Dr Smith from the department, saying to me, ‘They could not do anything with my CT scan so I will send the scans and the paperwork back to you. Now, I urge you to get your lungs checked out and to take the CT scans and paperwork to the CFMEU, because if I had seen your medical report in 2006 you would not have liked me, but you would not have been allowed to go back into the mining industry.’ I took the CT scans and paperwork to the CFMEU office in Mackay and they arranged to send them to America.

In June, my wife and I went on a cruise. Whilst away I had pneumonia twice. Two weeks after returning, I had pneumonia again. Those are the worst I have had it, as the blood took a lot longer to stop and the medication was taking longer to work. I had to use more medication. In November, on speaking to the CFMEU, I was told they have not received results from America and advised me to see a specialist in Brisbane. On 15 November this month, my wife and I flew to Brisbane to see the specialist who diagnosed me with pneumoconiosis. He looked at my 2006 CT scan and he said, ‘You had it then and your condition has worsened’. I worked another seven years underground without being called up for another medical and I was retrenched in 2013. I am now retired.

You would not wish this to happen to anyone. If regulations are not put in place to stop these practices, more coalminers will get this horrible disease of black lung. I have been totally let down by the system, being the Department of Natural Resources and the collieries, doctors and specialists who did not care about my health.

Lastly, just letting you know that over the years my health has declined. I no longer can do a lot of things. I have always been into sports, into gardening and generally led an active life. In the last 10 years, due to my restricted breathing, my health has very much declined, because what I used to be able to do in a day doing general activities now takes days to complete. When I get pneumonia, it is frightening because I think, ‘This time it could kill me’, and I have to live with this constantly. You can imagine living with wondering if the medication will stop the bleeding and waiting for medication...
to clear up the blood. I get very worried and depressed whilst this is happening. I have panic attacks when I cannot breathe. My wife and I swing from worry, being cranky and shocked at my diagnosis, when it could have been prevented, as we were given the run around for 10 years. Thank you for listening to my story.

**ACTING CHAIR:** Thank you for the story. I will give you a moment to collect your thoughts. Mr Head, I want to come back to you for my first line of questioning. I am interested in your story, because over the past four or so days the committee has been out travelling around different coalmines and very much picked up that the belief amongst the industry was that pneumoconiosis was only for those who worked in the underground and that if you worked in the above-ground or the open-cuts no-one had to worry, and that that opinion still exists out there on the ground today. We heard a lot of testimony from workers who drive equipment in the open-cuts, who talked to us about the seals in doors, rust holes in the floor, being able to see the road and filters that rarely if ever got changed. They said that, when they would raise issues in relation to dust in the cabins, those issues were rarely if ever addressed because of this assumption that CWP did not exist in the open-cut. I am interested to know your story. Where do you think your dust exposure came from, given that you have never worked underground?

**Mr Head:** I have always been in air-conditioned cabs in the machinery and that. Like you said, there are a lot of rust holes and missing door rubbers and things like that over the years. I have been on scrapers and graders and all that, too. I think maybe the dust on the floor getting lifted up when you hit bumps and stuff like that. I have spent more time in air-conditioned cabs than I have out on the ground. I do not really know.

**ACTING CHAIR:** We heard some stories about people who would drive around with the windows down and that sort of thing. You are saying that you have spent most of your time in air-conditioned cabs. Were the air conditioners operating in those?

**Mr Head:** The machines are supposed to be pressurised and that. Over the years they have not been working. They have not been 100 per cent. Another thing: these days with contractors, if the pits get too dusty they just send the permanents to other pits where the water trucks are and keep the temps there, because they know they will not cause any stink. They would be down the road, otherwise. I have been talking to fellows since I have not been out there and they tell me nothing has changed. They said it is still exactly the same as when I left. They have not done anything. I cannot believe it, but that is what they reckon.

**Mr SPRINGBORG:** Thank you very much, acting chair, and thank you very much, gentlemen, for telling us your story today, because you are really at the pointy end of what has been a systemic failure. It is pretty obvious that these things should not have happened, but they have. It is our job to try to work it out and make sure that you get redress and that others never have to go through what you have gone through. I particularly thank you very much, Mr Byron, for telling us your story as well. My understanding is, until you told us your story, that we had 16 confirmed cases of coal workers’ pneumoconiosis in Queensland. You are now No. 17.

**Mr Byron:** Yes.

**Mr SPRINGBORG:** Now we have No. 17. We do not know whether we are going to have Nos 18, 19, 20, 30. We just do not know at this stage. Given the abject failure of the system and the neglect that you had over the years, who knows where it all ends. You said that you had been contacted on a number of occasions by a Dr Smith.

**Mr Byron:** Yes.

**Mr SPRINGBORG:** Representing the coal workers’ health scheme.

**Mr Byron:** Dr David Smith, yes.

**Mr SPRINGBORG:** In the last contact he said that, if he were aware of these things, you would not have been working in the industry.

**Mr Byron:** He would not have allowed me back into the industry, yes.

**Mr SPRINGBORG:** One could assume that, given all the precursor signs were there 10 years ago—you even had radiologists who had made notations on your X-rays saying, ‘It looks like CWP’ and all of those sorts of things—no-one bothered to connect the dots.

**Mr Byron:** Now.

**Mr SPRINGBORG:** The form went down to the coal workers’ health scheme. Was there any indication? It would have had to have gone—
Mr Byron: I would presume that is where it went to, because that is what I had to have. We used to call it a Coal Board medical. I presume that they would have got all the records, because they had some records of me having Coal Board medicals in the past.

Mr SPRINGBORG: Did they give any indication, or did Dr Smith when he was speaking to you, that anything that they had on record indicated your circumstances going back 10 years ago?

Mr Byron: No, only this one I had done in 2006. They said, ‘If I had seen that report’—the one I had in 2006—they would not have allowed me. I do not know—

Mr SPRINGBORG: It is still not clear whether someone down there had that or whether Dr Smith had access to that. One would assume that he might have been able to get access to that—or it got lost somewhere in transit.

Mr Byron: I do not know what happened after it left the provider’s office. I was given the form. They call it the A4 form. I was given that to show to the coalmine I went to and the doctor kept the others, which I presume would have been sent to where it had on the top, Coal Mine Workers’ Health Scheme. That is where it went to.

Mr SPRINGBORG: Which mine did you go to?

Mr Byron: North Goonyella.

Mr SPRINGBORG: I understand, again, that that information goes to the mine company that you are working for, so they would have been aware that there was this suspected diagnosis of coal workers’ pneumoconiosis?

Mr Byron: Normally, yes. My son is a workplace health and safety officer and he does that sort of stuff. He says that someone comes in, they give him the A4 piece of paper, which is the last page, which just says that you can do it. He says that his duty of care is to phone up the doctor, who is a provider, to ask for the rest of the form and then they send it to him, which is the one that goes to the coal workers’ scheme, and he reads all of that. I presume that North Goonyella had the full medical where it says all that.

Mr SPRINGBORG: It is more likely than not that your employer, the mine you work for, was aware of this suspected diagnosis? It is more than likely that those in authority in bureaucracy under the coal workers’ health scheme were aware as far back as 2006 of your likely diagnosis?

Mr Byron: They had the paperwork, yes. I presume that they did know it, yes.

Mr SPRINGBORG: Given the failure of diagnostics and professional specialists in your case and others, did you detect any sort of underlying dismissive attitude at any stage when you were being professionally assessed—‘What are you on about?’ ‘This has never been around before.’ ‘It’s all in your head. You’re a hypochondriac’?

Mr Byron: I did. The specialist I went to in 2006 was the same specialist I went to in 2016. After I had the CT scans, normally you get a report from the radiologist. I never saw that. I still have not seen that report from the radiologist from my last CT scan. The specialist got it and he has not even sent it to my doctor. I do not know what the radiologist said on that report.

My wife and I went into his office to follow up and get his report and he brought out what my wife calls a tome, which is a book about that thick, and went through everything. He knew that I had worked in the mines for 40 years and he was asking me did I work with birds? Did I work in a fertiliser factory? All of these places he was going through asking me to see if I had worked in them and I said, ‘No, mines for 40 years.’ He said, ‘Yes, well, you could have pneumoconiosis.’ He just did not want to say it for some reason. I do not—

Mr SPRINGBORG: There seems to be a bit of that going around, from what I can gather, which is a disease in itself, I think. Mr Walker, I just want to thank you—I have no specific questions for you—for giving us a comprehensive list of your experiences, which was very harrowing in itself. I really appreciate that. Mr Head, the questions that I would have asked you the acting chair did. Mr Mellor, you made an interesting comment when you started off. I think it was you, if I have my sequence right. You indicated that, in your induction, there was just no mention of the hazard of dust in causing disease.

Mr Mellor: Not that I can remember, no.

Mr SPRINGBORG: The only hazards that were ever mentioned were that it might obscure your vision, or it could blow up, or something like that, and cause you immediate physical harm. There was no awareness, no urgency, no focus given to the potential implications of dust causing respiratory disease or anything like that?
Mr Mellor: Definitely not to my recollection, no.

Mr SPRINGBORG: Gentlemen, given your experience, is it a similar sort of thing with regard to dust? It might have been a hazard for your day-to-day operation, but it was not something that is likely to cause you ongoing concern. Maybe in your case, Mr Walker—

Mr Walker: Yes, we knew—

Mr SPRINGBORG: Given the UK experience.

Mr Walker: We knew about pneumoconiosis, yes, as a coalminer in the UK.

Mr SPRINGBORG: It is not something that you had heard about when you were here in Australia?

Mr Walker: Not really. It is like Steve: everybody thought that it had been eradicated here.

Mr Byron: I was a deputy on a longwall and it was mandatory to carry gloves, mandatory to wear glasses, but you did not have to wear a dust mask. Sometimes you could not see your hand in front of your face because of the dust, but it was not mandatory to wear a dust mask. I retired in 2013—or retrenched. The mind said that I could keep going, but the body thought, 'No, you can't handle that anymore.' It was still like that in 2013. I do not know if it has changed now, but that is what it was like. On North Goonyella’s longwall, it is dusty and it was not mandatory to wear a dust mask.

Mr SPRINGBORG: You have inspired me to ask another question, Mr Byron. When you returned to work in 2006 for another seven years, you were exposed to a very high level of dust?

Mr Byron: Yes.

Mr SPRINGBORG: Which, as we know, would have most likely aggravated and worsened your CWP potentially from a more simple version—if there is such—to something that is far more challenging and, obviously, personally devastating and becoming more complex. If you had been diagnosed back then, then steps could have been taken to be able to stabilise it by removing you from that environment.

Mr Byron: That is right, yes. That is what the doctor said in Brisbane this month.

Mr SPRINGBORG: A clear example of system failure. Mr Walker, with regard to the UK experience and the experience here in Australia—you have worked across the two systems—you have said that you have known about black lung in the UK. What is your observations about the difference in the work environment? Are there things that have been done here in Queensland that are different from the UK—the circumstances and the background may be different—to mitigate dust, or protect workers, or is it still a general attitude issue?

Mr Walker: It is a similar scene in that there are still sprays and things like that. I finished mining in the UK in '97 and I did not work in the mines again until 2007 when I came to Australia. I worked on a longwall that was 1.2 metres high in the UK and a longwall that was 4.6 metres high in Australia, so you can imagine the difference in output, the dust made and everything else. It was a different set altogether when I came to Australia from when I was working in the UK with regard to dust amounts.

Mr SPRINGBORG: What is the awareness in the UK? What do they tell you you should do? Do they tell you that dust is a problem—an immediate hazard plus ongoing?

Mr Walker: In the UK we never had the same amount of communication with management as what there is in Australia. The management in the UK came to work in suits and ties—they are obviously away from mining—and you did not really have that much to do with them. The inductions were not as in depth as they are over here. With the dust spray, you had a truck come around every three years and do an X-ray on site, because after your initial Coal Board medical you never had another medical after that but they did monitor your X-rays every three years. In terms of the dust, from your grandparents and stuff like that and other people who worked in mines, you were aware of the risks of airborne dust diseases. Like I said, we never produced coal in the same amounts as what we do over here, so dust was less in the UK than what it is here, but the contact with the management is better, if you know what I mean. In terms of dust suppression, since it has come out there has been a lot done in the mines to try and get it right. However, the failings with their assessments is one of the big bugbears with me, as is the fact that I had to have a biopsy because there is nobody in Australia who could read an X-ray properly. They are missing them left, right and centre. That is one of the things that needs addressing and I think everything is going to America now still for proper assessment and this is nearly two years after.

Mr SPRINGBORG: Thank you.
Mrs GILBERT: Thank you for your personal stories. You have touched on the fact that it is not just having an effect on you but that it is having an effect on your families as well. Mrs Byron, while you are here today, can you tell us your story going through this with your husband?

Mrs Byron: It has just been a nightmare. It goes back before, really, 2006. Chris would come home and be coughing up black muck. It was in his nose and everywhere, but you did not do anything because you were the wife. You washed the clothes. You made sure he had clothes for every day of the week for while they were there and then he started to get sick, and that is when the nightmare started. If you were to see Chris when he gets this pneumonia, it is frightening—and I mean frightening, because you do not know with that breath whether I am going to lose him. Is he going to have a haemorrhage on me? What can I do now, and the rigors are horrific? The only thing I can do is it is panic stations when it happens: racing into the kitchen and turning on that kettle, racing to get him the two big duonas, putting them on, getting on top of him with the duona to try and get him warm and he is just shaking, racing out and getting hot water bottles to put them in, and this goes on. Then you are hoping that he is not going to vomit the medication that you have got from your doctor back up but start the ball rolling before you get to the doctor that day, because it usually starts anything between three and five in the morning and it is the same. It starts off as bright, bright blood and then as we go on and the medication starts to kick in it starts to go browner and you think, ‘Thank you God.’ We have had times where Chris has had pneumonia three times in five weeks. He gets over it and will only be off the tablets a day and it is back there, and so it starts again and this is going on and on. We cannot choose to make plans because we never know if he is going to come down with pneumonia this morning or tomorrow morning. We just do not know.

In terms of going shopping, when he is good he will come in and shop with me for, say, five minutes but then he has to go and sit down, so he sits outside and I do it. It is not a life for him. He goes into the garden. He is down there 10 minutes and he has to come and sit down for another half an hour and you think, ‘Oh dear. Just keep breathing.’ The only thing I can do is I am panicking inside but not telling him. He is having a panic attack in front of me and I am trying to calm him down. I am not the only wife that is going through this. It is all miners’ wives. Miners are a brotherhood. If one is in trouble, that whole brotherhood comes in to help. Behind that brotherhood you have the wives, so they come in to help for the husband and you find that closeness. Because they are out at a mine site and you are in town, you cannot get out there and many a time he has had to come home with this pneumonia, and they have done nothing. We have run around for 10 years and they have done nothing but send us to this doctor, that doctor, fly here and fly there, each time thinking, ‘I wonder if his lungs will explode while we’re in the air.’ It has been a nightmare, and poor Chris is the one that has to put up with this and our family have to put up with it too because when he gets the pneumonia we have to make a phone call saying, ‘Please don’t come over,’ because I do not want him to get any germs. If he was to get another germ on top of what he has got, you know. That is where we stand. If you do not do something, there are going to be a lot, lot more. There has been a huge cover-up here and there have been doctors that their egos have got in the way or they were that ignorant they just did not know that pneumoconiosis was staring at them in the face. That is all I have to say. Thank you.

Mrs GILBERT: Thank you.

ACTING CHAIR: Mr Byron and Mrs Byron, what has been your personal financial cost in respect of your journey?

Mrs Byron: We have never added it up.

ACTING CHAIR: Have you had to pay for all of these services and all of this travel out of your own savings, your own pocket?

Mrs Byron: Yes.

Mr Byron: I went to the chemist yesterday for our monthly $280 and I am on a pension—$280.

ACTING CHAIR: That is your monthly medications?

Mr Byron: For my medications, and some are Sue’s as well, but yes.

ACTING CHAIR: At a ballpark figure, what do you think you have spent when you take into consideration accommodation, travel, medical expenses?

Mrs Byron: Thousands—thousands upon thousands.

Mr Byron: Because I am retired and I am a pensioner, we do get some compensations back. I think we usually get past the—what do you call it?

Mrs Byron: PBS.
Mr SPRINGBORG: Patient travel.

Mrs Byron: We came for that once.

Mr Byron: I think we get there in about March or April and that is it. Most of my medications are free for the rest of the year because that is how quick it adds up. That is how much medication I am on. I take seven tablets every morning—seven—just to keep me alive.

Mrs Byron: Plus puffer.

Mr Byron: Plus puffers. I spoke to my doctor the other day. I now have three specialists and a doctor looking after my health. Thank God I am not an animal. If I were an animal, they would have put me down ages ago. That is how many people are looking after my health at this moment.

Mr COSTIGAN: Thank you, gentlemen, and thank you, Mrs Byron, for your testimony here today. I am sure I speak on behalf of everyone here on the committee and in the gallery. You took the words out of my mouth, Mrs Byron. I was going to ask your husband, or you, or any of the other gentlemen here today this. You used the terms ‘cover-up’, ‘stuff-up’. Both?

Mrs Byron: Yes, definitely a cover-up. No-one will ever convince me any other way and I did say that to Dr Robert Edwards last Tuesday in Brisbane.

Mr COSTIGAN: What was Dr Edwards’ reaction to that?

Mrs Byron: He agreed with me.

Mr COSTIGAN: Mr Walker, you answered some questions from my colleague the member for Southern Downs. You are from the north of England?

Mr Walker: Yes.

Mr COSTIGAN: Around Yorkshire?

Mr Walker: Derbyshire.

Mr COSTIGAN: What would your colleagues back in the Old Dart think of what is happening in Queensland right now?

Mr Walker: They would not believe it. We never had anything like this really over here. It was known about. We all knew people who had pneumoconiosis in the UK, but when it was diagnosed, you were taken straight out of the mine, you were compensated. Then again, it was generally when symptoms start and stuff like that when you were found that you have it. They are finding it before symptoms start, but then you get blokes like Chris here and they are way down the track before they get diagnosed.

I always thought it was an anomaly when I was diagnosed, because it had not been heard of. It obviously had been heard of. Since then it has come out that there had been cases in the past that had been covered up, or hidden away. The fact that people’s X-rays—and they have seen previous X-rays—when you try to go back in the history to find out when they got it and when they had not got it, you cannot find the X-rays. My doctor is supposed to keep these X-rays, but they are not available, or they are corrupted. There seems to be something wrong somewhere altogether—the set-up to diagnose and stuff.

Mr COSTIGAN: Mr Walker, you have been in the country now for not quite a decade. Are you amazed that a First World economy like Australia does not have the people skilled and qualified to do the work that needs to be done in this space?

Mr Walker: That has been the biggest bugbear to me—the fact that I was forced into a biopsy, really. When he rang me, the NMA, he was very forceful—‘You have got to go the next day.’ In hindsight, I probably should have said, ‘No, I can’t afford to go’ and not gone, because I have not heard of people who have had to have a biopsy just to be diagnosed. I do not know whether you have the copy that I sent to Jacqui with all the details on it. If you read that, the CT scan categorically shows black lung. If Robert Cohen had got that, he would have diagnosed me with black lung but, no, I was sent for a biopsy before we even knew about it the B reading system and that. No, to me, it defies belief that I had to go through all of that and now people are just being diagnosed through X-rays being sent to America.

Mrs Byron: Dr Edwards said to Chris that if he were to do a lung biopsy on Chris, because he gets the pneumonia and he bleeds, he could flood the lung with blood and never, ever find out where the source of the blood was coming from. A biopsy was never, ever an option, because it was there in the 2006 scan. If he had it in 2006, did he have it in 2005? 2004? 2003? 2001? When did he have it? You cannot wake up with the disease; you have to have it.
Mr COSTIGAN: Gentlemen and Mrs Byron, do you all support the concept of a national screening program so long as it has the appropriate checks and balances—that goes without saying—at the back end of that?

Mr Walker: Yes, definitely.

Mr Byron: I used to work in New South Wales. Their screening down there was I got a letter from the company and a form to fill out that I had to go for a medical on a certain day. I went down there and that form was signed by the people who did the medical. I took that back to the company. They paid me for the day and they paid for my travel. I had to do that every five years and I think it was up to 45 years of age. After 45 years of age, you had to do that every two years. If you did not come back with that form signed, you were not allowed back down the pit. I am going back to the 1980s with that. When I came to Queensland, ‘Oh, you don’t have to have one every five years and that’s only if they send you.’ I came in 1983. My next medical was 1989 when I went for another job in another pit. The next medical was in 2006.

Mr COSTIGAN: Given the nature of the way the world has evolved, with people coming up from the Hunter coalfields and the Illawarra and people from the UK coming into the Bowen Basin or wherever, are you amazed that we do not have a much more coordinated national approach to these matters?

Mr Byron: Yes. I thought of it then back in 1983 when I started at Blackwater—‘How come you don’t have to?’ They said, ‘No, no, you don’t have to.’ I was amazed at that.

Mr COSTIGAN: I have one final question. I will conclude by acknowledging Mr Mellor and his public advocacy work with the victims support group. I commend you on that.

Mr Mellor: Thank you.

Mr COSTIGAN: I open it up to the gentlemen and Mrs Byron. The question relates to the issue of compensation. It is an opportunity today to hear what you think when I throw up the term ‘compensation’, given what you have been through and what you continue to go through.

Mr Mellor: I cannot speak for everybody else, but since I have been diagnosed I have not received any compensation from any sources or anybody at all.

Mr Head: I have not received anything yet. I am still getting paperwork and that in.

Mr Walker: I have not received anything, but I think the system is that, until you start to get ill, WorkCover is saying that you are not going to get any compensation. That is nothing for the fact that you have it hanging over you and it is never far from your thoughts, or what the future holds if you lose your job, or if you never want to get another job in the mines. That is a big thing in your life. Nothing is the same after you get diagnosed.

Mr Mellor: The only thing that I have received from anybody is a number and I was given the number 10. That is the only thing that I have got from anybody.

Mr COSTIGAN: Thank you, Mr Mellor. Mr and Mrs Byron, would you like to contribute to this?

Mr Byron: I am retired. As you can imagine, I have been to see a solicitor over this. He tells me that I have a case against the doctors, against the coalmines, and I have already applied for workers compensation.

Mrs Byron: Yesterday.

Mr Byron: Yesterday, but if I get some money from workers compensation because of this and then go and sue either the doctor or the coalmines, I have to give that money back. They are the rules.

Mrs Byron: It is the law.

Mr Byron: It depends. For instance, if I get, say, $300,000 and we decide, ‘Yes, we’re going to sue the mine, or the doctor,’ he said, ‘My fees go up.’ I am suing these people. They have big lawyers et cetera. He said, ‘Say you get $700,000 from them. You have to give $300,000 back to the compensation lot. My fee might be $200,000. You have only $200,000. You have lost.’ You have got to say, ‘Forget that. I can’t sue the doctors and I can’t sue the coalmines.’ They are sitting back. They get away with all of this mismanagement that they have done and I just have to cop whatever I get from compo.
Another thing with that is, if I am really sick and have to go to hospital and be looked after by the hospital, I get nothing. If I am fifty-fifty—if I am well like Steve here—if I could do everything that he can do, I would also get nothing, because I do not need any care.

_Mrs Byron_: They find where it is in the middle. It is up to them where you are in the middle.

_Mr Byron_: Apparently, there is a $250,000 fee for care for me. If I do not need any care, like Steve, I do not get anything. If I need a lot of care and have to go to hospital, I do not get anything. I have to find a middle ground in terms of care. With the Queensland government I have a care plan. I have a medical and they go through all my medications et cetera. They have asked me on two occasions whether I need somebody to come in and clean my house, mow my lawns and do those sorts of things. It is run by Queensland Health. Twice I have said, ‘No, my wife and I can handle it. I have family in town who can help us through some of the things that I cannot do.’ I have not accepted any of that. My solicitors say I may get something or I may not. They make that decision no-one else does. As far as compensation goes—

_Mrs Byron_: You do not win whatever way you go. You can have the disease and you still will not win.

_Mr Byron_: We have to toss the coin and see what happens.

_Mrs Byron_: The medical certificate that the colliery got and that the coal board got was not looked at. They put it in the file and they closed the draw.

_Mr COSTIGAN_: And pretended it did not exist?

_Mrs Byron_: They pretended it did not exist. You were working there in the safety area and it was hidden in files that you did not know about it. You never went through it. You left and somebody else came in and it still sat there. It sat there for years. That is how it goes. Cover it up.

_Mr PEARCE_: I will ask a couple of questions in a moment. There is something I need to say. I do not know whether I am supposed to be saying it, but I am going to say it. I think most of you realise that I am an ex-miner myself. I sit here today listening to stories and I have to tell you that my guts have been almost ripped out. You should not have to be going through these issues. This committee will be doing everything it can to make life easier for you guys.

As you know, if you are in the mining industry you have brothers and sisters and we try to look after one another. By you people turning up here today telling your stories you are still working. You are trying to help your former workmates. I do not feel very comfortable about this at all.

Whilst I am not a full-time member of this committee, I will be doing everything I can to make sure that compensation happens quicker than what is happening at the moment. We lost a member in the last few days. He did not get any compensation and his family is not going to get any compensation. We need to make sure that happens.

I do have a couple of questions. You just spoke about compensation and the problems that that is causing you, Mrs Byron. I will ask a question that is a little different to normal. I know I am dropping this on you all of sudden, but I would like to hear from you what you think this committee could do in terms of making recommendations that would make life better for you and also make the system better so that we do something positive and do not have more miners in the same position. I have put this on the table now, if you cannot answer it now we will let it go.

_Mr Mellor_: I would have to take that on notice.

_Mr Head_: I think more X-rays need to be done. There are not enough done. I only had two over the 30-odd years I was there.

_Mr PEARCE_: Were you underground all the time?

_Mr Head_: No, open cut. More X-rays need to be done. That is all I can add.

_Mr SPRINGBORG_: Was one of those X-rays conducted at the time of your pre-employment?

_Mr Head_: Yes, as far as I can remember; right at the very start.

_Mr SPRINGBORG_: Basically, you actually had one X-ray after you started—over your 30 years in the industry—other than your pre-employment one?

_Mr Head_: From what I can remember, yes.

_Mr Walker_: The US are the benchmark that we are using now, but I think we need to be adopting the ILO system and getting our radiologists trained to the same level as the Americans. I cannot see why it should be that they are so much better at it than we are.

_Mr PEARCE_: I think you have a lot of support there.
Mr Byron: I came from New South Wales. Their system seems to work. I cannot understand why Queensland does not have a similar system. At the moment, I have heard the companies say to you, 'You have to go for a medical.' You have to arrange it. You have to fix it all up. They do not give you anything. To prove you have had the medical there is nothing there. We need to put some onus back on them to say, 'You have done the medical; we are right, they are covered.' As far as compensation is concerned, I think the system at the moment favours workers compensation. It does not favour any of us whatsoever.

Mr Head: Getting back to the X-rays, when Dr Foley told me that I had CWP, I said, 'Why did they stop doing X-rays like they used to do? They used to be compulsory.' He said, 'The company decided there was more chance of getting radiation from the X-rays than there was of getting black lung.'

Mr PEARCE: Do you think that was because there was a period when they thought black lung or being dusted was gone and it did not happen anymore?

Mr Head: That is what they believed.

Mr PEARCE: Steve, you do not really have to take it on notice. If you are happy to get back to us you can.

Mr Mellor: There is a culture with the X-rays obviously being read properly. I have noticed a lot of people asked about surface workers. A lot of my friends and family are surface workers or have worked at surface coalmines. To my knowledge, none of them have ever had chest X-rays. It was not common practice. If you went to a doctor and you were getting a chest X-rays the doctor assumed you were an underground coalminer. They knew why we were having the chest X-rays. They knew that we were there for them. Obviously they did not want to test the surface workers for whatever reason, but they knew the X-rays were there. I do not know what they were checking them for.

Mr PEARCE: After all, there are plenty of confined places in open-cut mines. That is me finished, but can I say that I feel sorry for you. I am sorry.

Mr McMILLAN: Mr Byron, can I start with you. Do you mind if I ask you some more detailed questions about your work history?

Mr Byron: Yes.

Mr McMILLAN: I think you said you started in the industry in 1970?

Mr Byron: 1970, yes.

Mr McMILLAN: And you worked for 13 years in New South Wales?

Mr Byron: Yes.

Mr McMILLAN: So from 1983 onwards you have been working in Queensland coalmines?

Mr Byron: Yes.

Mr McMILLAN: Do you recall whether you had an initial chest X-rays when you started in the Queensland coal industry?

Mr Byron: I had to have a medical in New South Wales to get the job in Queensland.

Mr McMILLAN: Did that include a chest X-ray?

Mr Byron: Yes.

Mr McMILLAN: Do you remember whether you were told the results of that X-ray at the time?

Mr Byron: No, I would not have a clue what the results were. I was only given the back page which I handed to the South Blackwater officials when I got there.

Mr McMILLAN: You started working at a colliery in Blackwater when you came to Queensland?

Mr Byron: Yes, later.

Mr McMILLAN: You worked there for how many years?

Mr Byron: Until 1989.

Mr McMILLAN: Did you go to a different mine site after that?

Mr Byron: I went to Oaky No. 1 in Tieri.

Mr McMILLAN: Were you required to have another medical to get access to Tieri?

Mr Byron: Yes, I was. That was my first medical in Queensland.

Mr McMILLAN: Do you remember whether you were asked to have an X-ray for that medical?

Mr Byron: I had to have an X-ray for that.
Mr McMillan: Do you remember whether you were given the results of that X-ray at the time?
Mr Byron: I do not even know if I got the results. I would not have a clue. I think that was Dr Foley in Tieri. I lived in Blackwater and I had to travel to Dr Foley's office in Tieri to have that medical.

Mr McMillan: You worked at Oaky Creek for eight years until 1997?
Mr Byron: Yes, 1997.

Mr McMillan: Were you did go after that?
Mr Byron: I was retrenched for the third time in 1997. We went to Townsville. I worked in a shop for four or five years, I think it was. Then I went to get back into the industry. I got a job contracting. I got my deputy's ticket in 1989, so I got a contractor's job, taking longwalls off and that sort of stuff, in 2002 I think it was. Then I started in North Goonyella in 2003.

Mr McMillan: When you came to start at North Goonyella, you had to go for another Coal Workers' Health Scheme medical assessment?
Mr Byron: Yes.

Mr McMillan: You have given the committee some evidence about having a CT scan in 2006. I think you read out from that report. The report, I think you said, contained a view by the radiologist that your lungs had nodules that were consistent with coal workers' pneumoconiosis if there is a history of coal exposure for 10 years or more?
Mr Byron: That is right.

Mr McMillan: You went to a medical assessment with the nominated medical adviser for Peabody North Goonyella in June 2006.
Mr Byron: Yes. August, I think it was.

Mr McMillan: That doctor had a copy of the radiologist's report, to your knowledge. Did you talk about that radiologist report with him?
Mr Byron: He must have had it, because he wrote down on the assessment form that I had pneumoconiosis.

Mr McMillan: But he nonetheless certified you as fit to return to work in an underground coalmine?
Mr Byron: Yes.

Mr McMillan: And the job that you were going to have at North Goonyella, which was written on the form, was an underground deputy?
Mr Byron: Yes.

Mr McMillan: Is that a job that requires you to work in a dusty environment?
Mr Byron: I went straight on the longwall.

Mr McMillan: Sometime later that year, did you apply for a job at Xstrata Oaky Creek?
Mr Byron: Yes, I did.

Mr McMillan: You went back to see the same nominated medical adviser for a health assessment for that job, didn't you?
Mr Byron: I cannot remember. I think I did. I cannot remember because I did not take the job.

Mr McMillan: It was Dr Keith van den Heeven?
Mr Byron: Yes.

Mr McMillan: Again, he certified you as fit to return to work in a coalmine?
Mr Byron: I got the job back at Oaky Creek No. 1, but I cancelled it a couple of days before I was supposed to start.

Mr McMillan: There is no question that, when you were certified as fit to work in an underground mine on those two occasions, the doctor who did so knew anything about pneumoconiosis, is there, because he had a report telling him that you had pneumoconiosis or symptoms consistent with it?
Mr Byron: That is right, yes. That came from the radiologist to say that I did have it.

Mr McMillan: In the next seven years that you worked in underground coalmines, were you asked to have another coal workers' health assessment in that time?
Mr Byron: No.
Mr McMillan: Was there any follow up at all from the companies that you worked for or the nominated medical adviser about your respiratory health in that seven years?

Mr Byron: No.

Mr McMillan: At any time during any of your medical assessments, have you been asked to provide a description or a history of the amount of dust that you have worked in over the course of your mining career?

Mr Byron: No.

Mr McMillan: Just to be clear, the radiologist put a condition on his opinion. It was conditioned upon you having worked in the industry for more than 10 years. Just to be clear, the doctor who certified you as fit to work twice had your full occupational history at the time, didn’t he?

Mr Byron: Yes. I have the forms here. I had to put down what mines I had worked in and how long I had worked in each mine.

Mr McMillan: At that stage, that doctor knew that you worked underground in coal mines in Australia for 36 years.

Mr Byron: Yes.

Mr McMillan: Thank you very much, Mr and Mrs Byron. I will ask some questions of the other gentlemen at the table. Mr Head, first of all, did you say that you have worked in the same open-cut mine during your career or was it multiple mines?

Mr Head: No, the same mine.

Mr McMillan: Which mine was that?

Mr Head: Goonyella Riverside, Moranbah.

Mr McMillan: How long did you work at Goonyella Riverside?

Mr Head: Thirty-one years.

Mr McMillan: How many times did you have to undertake a coal workers’ health assessment?

Mr Head: Every five years. I may have missed one right at the very start when Riverside and Goonyella amalgamated. I think quite a few missed out then, in the changeover.

Mr McMillan: Across those multiple health assessments, you only were asked to have an X-ray once after your initial pre-employment X-ray?

Mr Head: Yes, I had one when I started and the next one was when they found this. It was only a couple of months ago.

Mr McMillan: In-between those two X-rays, at not stage were you required to have another chest X-ray?

Mr Head: Not that I can remember, no.

Mr McMillan: Did any of the nominated medical advisers who did your four or five assessments in those intervening years ask you about the dust that you worked in or your exposure to dust in the workplace?

Mr Head: No.

Mr McMillan: At any stage, did any of those nominated medical advisers suggest to you that it might be prudent to have a chest X-ray, just to check out where you were at?

Mr Head: No, they never. The only reason they picked this up was that a company doctor said I could not blow in the blowing thing real good, and he said, ‘Oh, well you’re a smoker. We’ll get you to do an X-ray to see how much damage you have done from smoking.’ That is what came out of it.

Mr McMillan: Thank you, Mr Head. Mr Mellor, you are at somewhat the other end of the spectrum. You were asked to have, I think, five X-rays in seven years.

Mr Mellor: I have had six. Six chest X-rays and one CT.

Mr McMillan: Including the most recent one?

Mr Mellor: Yes.

Mr McMillan: You had five X-rays between 2005 and 2012?

Mr Mellor: Yes.
Mr McMILLAN: At any stage, were you ever told that those X-rays were to investigate the possibility of black lung or coal workers’ pneumoconiosis?

Mr Mellor: All five of those reports I have here say that the X-rays are clear and there is no abnormality.

Mr McMILLAN: Were you told why you were being asked to have those X-rays at such frequency?

Mr Mellor: During the boom, contractors would move from mine to mine or employer to employer. Certain companies would want specific NMAs to do it, so we would have to go and get another one done for a particular coalmine.

Mr McMILLAN: Do you understand that the purpose of the Coal Mine Workers’ Health Scheme is to monitor coal workers’ health.

Mr Mellor: No. We always assumed it was more of a fit-for-duty type legal sort of thing.

Mr McMILLAN: Over the course of seven years, you were exposed to radiation for chest X-rays on five occasions and on none of those occasions did you get an accurate result?

Mr Mellor: I have all the results, but they all had inconsistencies with them.

Mr McMILLAN: Has your 2016 X-ray been B read by Dr Cohen?

Mr Mellor: No.

Mr McMILLAN: Has it been be B read by anyone?

Mr Mellor: Not that I am aware of. The three doctors who I have seen are Dr Robert Edwards, Dr Brown and Professor Anthony Breslin.

Mr McMILLAN: Did any of those doctors express to you an opinion as to when you likely contracted CWP?

Mr Mellor: I probably want to submit this to counsel. It is probably easier than explaining, because I have three different doctors and they have all given me three general—

Mr McMILLAN: I will ask the committee to receive that in due course.

ACTING CHAIR: The procedure is that you want to seek leave to table the document?

Mr Mellor: Yes, please

ACTING CHAIR: Is leave granted? Leave is granted.

Mr McMILLAN: Perhaps I can put it to you this way. Has anyone told you, like some of these other gentlemen, that, in fact, you had CWP at times when these scans were previously taken, these X-rays?

Mr Mellor: Yes.

Mr McMILLAN: Could I ask each of you individually whether you have made a claim for workers compensation as a result of your diagnosis of CWP?

Mr Mellor: Yes, I have and it is on the medical only. There is no payment.

Mr McMILLAN: That claim has been accepted?

Mr Mellor: Yes.

Mr McMILLAN: How long did you wait between your initial application and the acceptance of that claim? Roughly is fine.

Mr Mellor: A couple of months. I think.

Mr McMILLAN: Mr Head? Have you made an application?

Mr Head: I have, but I have still yet to put the paperwork in. Probably today I would say that I would be putting it in.

Mr McMILLAN: Mr Walker?

Mr WALKER: Yes, the same again. It will only kick in if you start getting symptoms. They have reimbursed me all the money that I spent going to Brisbane for the biopsy and everything.

Mr McMILLAN: They have not reimbursed you?

Mr WALKER: No, they have, except for $500 that we are still arguing about.

Mr McMILLAN: How long was it between your initial claim and the acceptance of that claim for medical expenses?
Mr WALKER: Six weeks, two months and then after that I got the expenses back—probably two months after that.

Mr McMILLAN: Mr Byron or Mrs Byron, I think you indicated that you have only recently made your application?

Mr Byron: And it has been accepted already.

Mr McMILLAN: Promptly. That is encouraging. Can I ask you, Mr Mellor, in the five health assessments that you had over seven years, did the doctor who performed those health assessments ask you about the type of work that you were doing and your occupational exposure to dust in that work?

Mr Mellor: No, definitely not.

Mr McMILLAN: At any stage?

Mr Mellor: No. A lot of the time I did not even see the NMA who signed it off. You would see another doctor and he would tick and flick the form and hand it back to the NMA and then you would get a copy of it.

Mr McMILLAN: Just to be clear about that, the doctor who certified that you were fit to work was not the doctor who did the assessment?

Mr Mellor: No—not all of them, but some of them.

Mr McMILLAN: On occasion that has happened?

Mr Mellor: On occasion that has happened, yes.

Mr McMILLAN: Can I ask the other three gentlemen, have you had that experience as well?

Mr Walker: Yes.

Mr McMILLAN: That the doctor who signs your authority to work is not the doctor who did the assessment?

Mr Walker: Yes. He is in Brisbane and you did the medical at Mackay.

Mr McMILLAN: I take it from that that, similarly, the doctor who authorises you as fit to work has not taken any kind of occupational history from you about your exposure to dust?

Mr Walker: No.

Mr McMILLAN: Yet he is the person who purports to authorise that you are fit to work in the underground environment, or in the open-cut environment, in the case of Mr Head?

Mr Mellor: Whilst we were going from job to job in the boom—sorry, I have forgotten—

Mr McMILLAN: That is all right. If you think of it before we close the session, feel free to ask the chairman to make a further contribution. Thank you, Mr Acting Chairman. Those are my questions.

ACTING CHAIR: Are there any other questions? Gentlemen, can I certainly thank you on behalf of the committee for sharing your stories—very private stories—in a very public manner and I wish you all the best for the future. We are going to take a break for some lunch. We are running behind time. We will reconvene at 10 to 2.

Proceedings suspended from 1.34 pm to 2.00 pm
FARLOW, Associate Professor David, Clinical Dean, Mackay Clinical School, James Cook University

LEIBOWITZ, Dr Bruce, Radiologist, Queensland X-Ray

SCHOFIELD, Professor Louis, Director, Australian Institute of Tropical Health and Medicine

ACTING CHAIR: We will reconvene. Welcome, gentlemen. I invite you to make an opening statement and then the committee may ask you some questions. Who would like to go first?

Prof. Farlow: I will do that; thank you. I am here representing James Cook University and the Tropical Australian Academic Health Centre. We are here today to propose to the inquiry a potential solution to a lot of the issues that are being grappled with and this model that we are going to propose to you as a group of three is in relation to three main areas: firstly, the clinical services; secondly, the clinical governance; and, thirdly, research. We have developed this model based on really walking in the miners’ shoes. Whilst we have had interest and followed the progress of the inquiry, we are looking at proposing a model to you focusing on the future solutions.

ACTING CHAIR: Other gentlemen, did you want to make any opening statements?

Prof. Schofield: Just to backup what has been said by my colleague. The Australian Institute of Tropical Health and Medicine captures all the health and medical research within James Cook University and in partnership with health and hospital services under the aegis of the Tropical Australian Academic Health Centre. We have a governance structure to bring clinical services and research under the same structure. We believe that that offers an opportunity to address the issues of governance, clinical service and research.

ACTING CHAIR: Dr Leibowitz.

Dr Leibowitz: I am a radiologist in private practice. I have been here for the last 26 years. Not only am I in private practice; I am a visiting medical officer at the base hospital and at BreastScreen Queensland. I am on the register of readers that are eligible to read according to the ILO standards, but probably the most germane thing is that I am probably the only radiologist or doctor in Australia who has actually attended a NIOSH B reader course. I just returned four weeks ago from having completed a course. I state very carefully that I have completed the course; I have not got my exam results yet, so I cannot say that I have passed the course. I probably have the most recent insight into how the American system works, how it compares with our system and if you want to ask me any questions about it I am quite happy to answer them. I also am very keen on the idea of having a one-stop shop for coalminers. The American system is very much focused on having a closed system whereby you get two readers and then you get the patients who are assessed and it is associated with good quality lung function test—spirometry—and so it is really to our advantage to have a well set-up system where the results are reproducible every time and the people are credible.

ACTING CHAIR: I have some questions in relation to the B reader.

Dr Leibowitz: Of course.

ACTING CHAIR: Is that something that you embarked on yourself? Did you make the decision to say, ‘I want to go and learn more about this’?

Dr Leibowitz: I did. We have been reading chest X-rays for a long time—I have done many thousands—but we have not been reading them in a categorical way as the B readers do. There is a system that you go through. It is not a perfect system. I do not know if you want me to go into how it is good or how it is bad, but I decided that because everybody was insisting that they wanted just to read by the ILO system I should get to know the ILO system completely and read according to their description.

ACTING CHAIR: Congratulations on that and I hope you pass your exams. I think there are thousands of coalminers around this area that are waiting with bated breath.

Dr Leibowitz: There is a pass rate of 50 per cent, so a failure rate of 50 per cent.

ACTING CHAIR: We are happy to see the presentation if you like.

Prof. Farlow: Rather than a presentation we are really talking to the model. Probably the critical part of this is really the idea of a one-stop shop. We are currently establishing what is called the Tropical Australian Academic Health Centre. It is a collaborative and it is not new across the world—certainly in America and London—but in Australia it is reasonably new. It is based on the principle of combining clinical services with research so that it becomes the one area for advancing.
In terms of the model that we are talking about, virtually it is a clinical pathway for the miners. I have had quite a number of phone calls from miners because of our research around this saying, ‘We just don’t know where to go. We get told one thing from one GP and then we get told another.’ We believe that combining it and having the one area for research and clinical services in the one town of Mackay is certainly the way to go so that miners are looked after in the one site. The other component to this is of course data research, and this is Professor Schofield’s area. It is all based on accurate data and right now it is near impossible to do research on black lung. We have already had quite a lot of discussion between us with the various interest groups in this. Professor Schofield and I visited Malcolm Sim in Melbourne. We had a lengthy discussion with Malcolm Sim about the concept of the research component at Mackay. He has agreed in principle, Louis—

Prof. Schofield: Very much.

Prof. Farlow:—to act as a high-level support for the ongoing research. He emphasised as well that the lack of data makes it difficult. He also agreed with the concept of a one-stop shop. We have had discussions with the CFMEU from a union perspective and were given full support for the concept of a one-stop shop. We have also had discussions with the Queensland Resources Council with Michael Roche prior to his departure, but I just spoke to them this morning and they are very happy to support the research component and in terms of clinical services or clinical governance they would need to see more detail before giving a commitment to that. The other areas that I think this ties into is that if we provide this one-stop shop for the miners around the research and clinical governance it can double as research and clinical service and governance to other aspects of OH&S. We have been in discussion with the collaborative research centre, which is a federal government initiative where $74 million has been allocated to the northern development of Australia. It is available around industry, agriculture and health. Government departments cannot apply, but universities and academic health centres can. We see the potential of developing this specialised one-stop shop could potentially value-add to other areas of OH&S like silicosis and other areas of industry. I could pause at that moment because I have plenty more.

ACTING CHAIR: Just to put it in perspective, if I was a 20-year-old—which I almost am—looking to go into the mine, over the course of my employment history from first filling in application forms all the way up through retirement, how would your proposal look for me as an employee moving through?

Prof. Farlow: Exactly. The moment that you are employed there should be a registration, in other words, a database, and that is logged into the database quite similar to the mammography service from the point of view that everyone is logged and there is a follow-up system that is put in place. Bruce is probably the best to talk to with regard to the screening processes, representing the College of Radiologists, but you would then be followed through and then during the course of your life as a coalmister at some point in time if your investigations or review by the nominated medical adviser shows either changes in radiology or—Bruce will talk about this—changes in the respiratory function, then that automatically flags the potential of this being early black lung. Part of that one-stop shop is to offer all of the advice, not only the clinical services, but if the person was unlikely enough to progress to the severe stage of black lung we can then offer support services around that.

The question arises of the capability of Mackay as an entity or a town to offer tertiary level services. We do video conferencing all the time; we have linkages with all the tertiary centres. We would manage that miner with black lung and if we needed a tertiary level, we have linkages with them. Ultimately the treatment of black lung is actually not a difficult treatment; obviously, prevention is the aim. As you watch the progress of this, as has been noted in America, they have had an increase in lung transplantation for black lung, and ultimately that is one of the end results.

Dr Leibowitz: NIOSH emphasises the fact that high-quality spirometry lung function tests are as important as chest X-rays in the ongoing management of the patient, and they have specific criteria that you have to do and the specific way that they do it on their website. They were saying that 99 per cent of spirometry is not performed correctly and—

Mr SPRINGBORG: What percentage was that again?

Dr Leibowitz: Over 90 per cent, yes, of spirometry, and out in the sticks there is no doubt that they are not doing spirometry correctly. I think it is very important because if a patient has a high-low classification of 0/1 and they have normal lung function tests, then we regard this patient as normal. Anything with a zero in front of it is normal—once you get to the ones, mild; twos, moderate; three is severe—we then would titrate the chest X-ray against the lung function test. If the patient has a 0/1 but has an abnormal lung function test he needs to be further evaluated, probably by high-resolution CT. Having said that, a lot of the miners are smokers and they also have poor lung function tests and
they also have nodules, so it really makes it much more difficult. Ultimately these people need further evaluation, so you need one area where you can get reproducible results every time, particularly from spirometry, and from reading of chest X-rays. We will be reporting by the high-low classification, and that enables us to accurately track what is happening with a patient over the years. If it changes from a 0/0 to 0/1 to 1/1, then you are getting progressive disease. But it is important that it all gets done properly and all gets read properly.

Mr SPRINGBORG: Thank you, gentlemen, for your suggestion and the work that you have put into this. Just trying to step it through practically, what you are advocating is a centre of excellence based here in Mackay funded through moneys that are made available through the Commonwealth Government and the resources industry and state government and—

Prof. Farlow: In terms of the model, this is a proven model in terms of combining that with the one-stop centre of excellence. In terms of what do we currently have, Dr Schofield, would you like to talk about the Australian Research Council?

Prof. Schofield: When AITHM was set up a few years ago by the generous contribution of funds from both state and federal governments—I think about three years ago now as you recall—we identified occupational health and safety in Mackay as a priority area for us, one of the six main themes for the institute, and so we put $1.5 million of ARC money into establishing an occupational health and safety unit here. That is in the process of being established, so we do have some existing capacity already in that space. We certainly think that there is an opportunity for CRC for northern development money, but we would not want to be the final determinants of contributions by other parties into it. We have not modelled the entire cost or the potential contributions by other parties, but certainly we are in a position to contribute already and the academic health centre, which has already been alluded to, provides the governance structure to do that.

Mr SPRINGBORG: Basically, as was alluded to by the acting chair as well as yourselves, this is the one-stop shop where records are basically kept, any new data is input and it creates that particular flag. You mentioned clinical governance, and that is about making sure that people actually know what they are doing rather than not having a clue.

Prof. Farlow: Absolutely. A major finding from the Malcolm Sim review was with regard to the nominated medical advisors and their governance. The James Cook University has the capacity and the capability of doing the training, the credentialing process, the ongoing professional development and the adherence to standards by audit process. The university has the capability at the moment to do that. We believe, as per Bruce, that the respiratory function, the processing of a mining medical, has to be done according to the same process, the set standards. If you look at the miner going through that clinical pathway, quality services really depend on replication of process, and the whole intent of this one model is to have exactly the same process for everyone going along that pathway.

Mr SPRINGBORG: You mentioned the NMAs. From what we can gather, most people reading the images did not have a clue what they were reading either, so how will that dovetail? Will that will be up to the colleges and its accreditation? Dr Leibowitz, you will be probably one of five accredited B readers in Queensland?

Dr Leibowitz: I do not think there are any—

Mr SPRINGBORG: No, but that is what they are aiming for, around about that, isn’t it?

Dr Leibowitz: In America there are something like 150 B readers for the entire population, so it is a very small number and you want people who are reading a lot of these films so they maintain their competence. Five may be a little too few, because you get people going on leave etcetera. At the present moment I am probably reading anything between eight and 20 chest X-rays a day and I am reading maybe between two and six HRCTs a day, but when I go on leave there has to be somebody here. Certainly five would be great, but what we are doing is sending two people off in the next six months to go and do a B reader course as well, and we will be continuing that. I think we also have in-house education. I have given a couple of lectures already to my colleagues in Queensland and also in Newcastle, New South Wales, on what I have learned in the NIOSH course etcetera, so there will be ongoing in-house education. There is always the possibility that we could set up a school here. We certainly would want to pick up our game.

Mr SPRINGBORG: As I understand it, the College of Radiologists now recognise they have a problem with regard to training and competency in this area. I think it is around about 30 nationwide or something?

Dr Leibowitz: Yes, that would be correct.

Mr SPRINGBORG: Five or 10 in Queensland.
Dr Leibowitz: Yes.

Mr SPRINGBORG: Just going back to the acting chair’s point about what it means if you are just about to enter the mining industry, let us say you are a miner or someone starting off on your journey in the southern part of Queensland. You might be wanting to work at Acland at the next stage hopefully when it gets off the ground or wherever else it may be. What does it mean there? Where it is located will not negatively impact upon someone’s ability to have the same replicable standard across the state?

Prof. Farlow: Absolutely not. If you have a miner who has just started in Roma or wherever else, if there is a one-stop shop for data, research and setting of clinical standards, then you ensure that that miner has access to videoconferencing. They still have to go to a nominated medical adviser before they can work in the mining side, and so this is where we provide the protection statewide if we train and accredit the nominated medical advisors—we are not talking about the radiology—we are talking about the GPs, the specialists in doing the medicals, doing the review, doing the respiratory function, those nominated medical advisors will be operating under our standards.

Dr Leibowitz: Also, the X-rays should only be done at an accredited practice and it will be sort of the hub and spoke where the images will be transferred digitally to a reporting—

Mr SPRINGBORG: Yes.

Prof. Farlow: Bruce, can you talk about the mammography screening side and the mobility?

Dr Leibowitz: With the mammography system, they send out vans. In fact, in America the NIOSH do exactly the same thing. They go to mine sites, and they have a mobile X-ray unit which is called an A reader—that is why you get B readers. A readers are the guys on site who have a look at the films and see if it is a good film and that all the factors are correct and then it goes back to a B reader. We could send a van out and set up little satellite areas that are static at Moranbah or a central area where miners do not have to come all the way into Mackay to have their X-rays done. Obviously it is not good for the mines and it is not good for the workers if they lose time.

Mr SPRINGBORG: I have one further question. You are very enthusiastic about this. It certainly makes sense on the surface. You have indicated that you are doing work as to what it may finally cost. This committee has the power and responsibility to make certain recommendations in relation to what is in our terms of reference. What do you want from this committee and what is required from the state to make something happen like this? Are there regulatory or legislative requirements with regard to sharing information across jurisdictions? We have all these insane barriers within our internal state system let alone across the various jurisdictions. What have you identified as being the barriers?

Prof. Farlow: Today was about presenting the model. In terms of the micro detail and the costings, we have not gone into that side at all. From the point of view of barriers from a legislative point of view, we do not see any major barriers to this. Obviously if there was acceptance or recommendations from this group to look at this model, we would then come back with a feasibility study with all the costings, the risks, any barriers with legislation, privacy, data sharing et cetera. We did not believe it was really the point to go to that level at this point in time. We wanted to check that all the people who had an interest in this process—the Queensland Resources Council, the unions, the miners and Malcolm Sim, as the expert—agreed with our concept. I think we have lined up all the stars, so to speak, to tick. If there was a recommendation from this group, we would then progress to the next phase.

Mrs GILBERT: I would like to start by saying congratulations; you see Mackay as a centre of excellence. There are three of us here on the committee who would agree with that. It is a great place to start. I have a question to see if I understand your concept correctly in terms of how you are going to organise this. When workers have their X-rays done, they will be able to go to the private sector as well as the public sector and then they come back to you with their information?

Prof. Farlow: I might comment on the public versus the private sector. This model can be completely done in the private sector because usually with mining and mining medicals it is not related to Medicare or general health services. It could be done all in the private sector, it could be done all in the public sector or it could be done as a public-private partnership. Again, we have not really explored that, so the public sector has not really had a chance to respond to our modelling.

Dr Leibowitz: If I can break in there, as far as I know there is going to be a tender going out in the near future for the provision of X-rays to the mining industry. That is probably all going to be in the private sector.

Prof. Farlow: That is specifically radiology. In regard to the other components, again, that can be set up in either sector.
Mr SPRINGBORG: That tender has been initiated by whom?

Dr Leibowitz: Good question.

Prof. Farlow: I understand that was the department of mineral resources but do not quote me on that. We could take that on notice.

Mr SPRINGBORG: That would be good.

Mr COSTIGAN: Good afternoon, gentlemen. Let me get this right: You have put forward to the select committee a model—a one-stop shop—and you have engaged the Queensland Resources Council, albeit under the then CEO before the change in leadership, the CFMEU and Professor Sim, and everyone, to use layman’s terms, is up for it; is that right, Professor Farlow?

Prof. Farlow: Yes, absolutely, with the comment that the Queensland Resources Council—

Mr COSTIGAN: Or the disclaimer.

Prof. Farlow: —fully support the research component—

Mr COSTIGAN: I did note that.

Prof. Farlow: Apart from that, it has helped generate our enthusiasm when we go to these different groups and say, ‘We developed this again based on walking in the shoes of the miner.’ That has been our focus. I have been in clinical practice on the floor for 25 years in the Proserpine-Whitsunday area.

Mr COSTIGAN: I know.

Prof. Farlow: When we look at the design of anything, it is not rocket science. You step in the shoes of the patient and what you would want done as a patient as opposed to the other aspects.

Mr COSTIGAN: The top brass at James Cook University are up for it. That is a given and then some. It has been kicked around and is eagerly anticipated; would that be right, Professor Schofield?

Prof. Schofield: That is correct. Of course there is detail, but we were able to attest to training, accreditation, research and through the academic health centre, of which we are all members, the strong joint governance of bringing those things together.

Mr COSTIGAN: You mentioned the CRC for Developing Northern Australia. What level of discussion has taken place with the interim chair, Councillor John Wharton, or other members of that entity that has been set up? If you are not in a position to disclose information, I understand, but how far down the track are you in relation to those matters?

Prof. Schofield: We have spoken to Councillor Wharton at some length. We put forward a number of areas for investment given that health and medicine was an integral part of the CRC. He has certainly been apprised of the concept of setting up a one-stop shop, a centre of excellence for black lung. It is part of our formal submission both at the level of the university and the Institute of Tropical Health and Medicine. It has gone forward to him. As you would be aware, we do not know what is happening with that process. It has been submitted as a funding model but there are obviously issues there. You need to get agreement about the CRC. It is one potential way in which some contribution by the federal government could be made through that mechanism.

Mr COSTIGAN: If I recall correctly, I think Councillor Wharton and the CRC people were in Mackay some time ago. Was this concept flagged or this model put forward at that point in time?

Prof. Farlow: I can talk to that. We attended that. At that point in time the concept around this had not been developed. We attended that as part of the Mackay Hospital and Health Service some time before with the previous chair of the board. What we gained out of that meeting from Queensland Health’s or the Queensland government’s perspective is that this process is a federal government initiative and that any departments within the Queensland government were not eligible to apply around those three areas—industry, agriculture and health. That is government. That is apparently part of the rules that underpin the CRC at this point in time. However, universities, the Australian Institute of Tropical Health and Medicine and other such academic health centres can apply for that funding.

Mr COSTIGAN: Professor Farlow, I draw your attention to comments that you provided to the Senate select committee some months ago in Mackay in relation to the issue at hand here. In relation to the health service’s capacity to deal with cases of black lung, you said—

In Mackay we have a strong public and a strong private system to manage.

But I believe we have the capability within the public and private systems here to manage.
What about in outlying communities? We were in Collinsville at the start of the week, as you would appreciate, as we conduct our inquiries in relation to these matters. How skilled up and resourced are those health facilities, including hospitals, in dealing with coal miners who might come in off the street and want some assistance in relation to black lung or CWP?

Prof. Farlow: In terms of my representation today, I am representing the university and not Queensland Health. I know it is an unusual situation. I would prefer to take that on notice to get advice.

Mr COSTIGAN: I appreciate that.

Mr PEARCE: Will the people who would be within the organisation or company or whatever you are going to call be independent?

Prof. Farlow: I think the great part about this model that we are presenting is that it is at arm’s-length from mining companies, it is at arm’s-length from the unions, it is at arm’s-length from the different government departments. Obviously there has to be a linkage and networks. We are talking about an academic health precinct—research, clinic services, clinical governance. Being at arm’s-length it gives confidence to the miners that they are going to get a service that is not influenced by any number of the multiple vested interests in this process.

Mr PEARCE: It would be run at ILO standards?

Dr Leibowitz: Absolutely, it is a basic minimum that we all do it that way.

Mr PEARCE: How do we propose to fund the operation?

Prof. Farlow: We have not presented or brought to you a business case today. However, in terms of the research component, as we have already heard Professor Louis Schofield indicate, we have been allocated funding from the Australian Research Council and potentially others around research. Of these three components of the model, I think you can say research, tick. It would be great to see further funding come into that with the science department et cetera, but that component is easy from a funding point of view.

The clinical governance which requires standards, monitoring and training of the nominated medical advisers we would have to wrap a business case around. The clinical service side I see that as fairly straightforward from a funding point of view. Currently the clinical services with anyone, either the mining medical or anyone with black lung, is a workers compensation situation and so the costs are borne by the private sector. I do not see major issues around the potential funding. As I have said, we have not brought to you a business case.

Mr PEARCE: I believe that the mining industry, and particularly the workforce, would strongly favour a levy on industry. That is probably something you need to take into consideration. Do we have radiologists in Mackay who have the skills to do this sort of thing?

Dr Leibowitz: I will stick my hand up. I have done the course. As I said, I am also involved in teaching the other radiologists. We have all passed exams. I think the problem with black lung now is that we are taught to recognise overt signs of florid black lung, but black lung has changed over the years because of the three parts per cubic metre requirement. Exposure is not as great as it was. We are not seeing gross cases of black lung. We have seen the more subtle cases. We have to learn to recognise the early subtle cases. In that way, the B reader course was superb. It teaches us where the nodules first occur, what to look for, the progression and how to report it. I have come back a better reporter of black lung than I was before. I am certainly spreading the word. There will be more of us who do the course.

Mr PEARCE: Locally?

Dr Leibowitz: Yes.

Mr PEARCE: I am pleased you have done the course. I hope you pass. We will be looking for your results. Will they be printed in the Daily Mercury?

Dr Leibowitz: Do not worry, it will be on the rooftops.

Mr COSTIGAN: It goes without saying, good luck for your exam results—fingers crossed. Well done to the Australian Research Council on its leadership in this space. Professor Schofield, how soon could this one-stop shop be established if all the stars lined up?

Prof. Schofield: We would need some understanding of the scope, some agreement and some direction from the committee or we could go away and prepare a business case. It is hard to say, but I think it would take a few months to get the case together and put it forward, notwithstanding the Christmas break coming up.
**Prof. Farlow:** Some of the research component we are starting. As we speak, we are about to appoint the first senior research fellow in black lung to commence early next year, regardless of the outcome of this. That side we are commencing now. I agree that we probably need, especially over the Christmas period, two to three months to do that. Depending on what your recommendations are, we would definitely come back with a solid feasibility study and business case wrapped around it.

**Mr COSTIGAN:** If it happens do you envisage the one-stop shop will provide some much needed piece of mind for coalminers and their families not only of course in the Bowen Basin but also in the Surat Basin and the yet to be developed Galilee Basin moving forward?

**Prof. Farlow:** Absolutely; 100 per cent. That is why we have developed this based on being in the shoes of a miner. If I were a miner working in the industry I would want to be able to think where do I go for this and only have to remember one area.

**Mr COSTIGAN:** I commend you on your great work. As an advocate for the city of Mackay and our region, I think it is a project of great merit. In principle, I certainly support it too. Well done.

**Mr SPRINGBORG:** You mentioned you are about to appoint your first research fellow in black lung?

**Prof. Farlow:** Yes.

**Mr SPRINGBORG:** Will that be a first for Australia?

**Prof. Schofield:** Yes, to the best of my understanding.

**Mr SPRINGBORG:** Obviously there would be similar positions in universities in the United States and possibly the UK?

**Prof. Schofield:** I might remind you, as has already been mentioned, that we have consulted very closely with Professor Malcolm Sim going back some time—before the release of his report. It is safe to say, I think Malcolm Sim is extremely supportive of the idea. Our view would be that he would be a stellar high level collaborator and intellectual lead for these areas, but he needs local capacity to deliver. We would be bringing together both Malcolm Sim and his international contacts, including professors in the United States.

**Mr SPRINGBORG:** I was not challenging you for any justification. I am intrigued to know what other examples there may be. I think it is an excellent idea because it puts some academic learnings and clinical focus on it, which is essential to build our obvious deficiency in this country.

**Prof. Schofield:** James Cook University identified occupational health and safety in Mackay as a priority for our business case going back some years and long before black lung. We saw the need. It is still there. It is an excellent opportunity to add value to the local region. It is a way in which the Mackay Health and Hospital Service, James Cook University and the Tropical Australian Academic Health Centre can work together towards a great social need.

**Mr SPRINGBORG:** Obviously you have the resources to continue that research fellowship?

**Prof. Schofield:** The word ‘research’ has been kicked around. We do not mean something airy-fairy. By research we mean data collection so you know exactly what you are doing. It means epidemiology and embedding everything in a very rigorous, quantitative and sound structure. With respect, there is more to do on the research. Specifically, largely that database collation is not funded, but certainly it would not be onerous within the context—

**Mr SPRINGBORG:** With fellowships you often have the fellow and then you will have—

**Prof. Schofield:** You need students.

**Mr SPRINGBORG:** You want to expand and get additional fellows?

**Prof. Schofield:** Absolutely there will be studentships and things like that. It is worth building up—not an empire—a focus group. Working on this particular problem requires a certain amount of input.

**CHAIR:** Thank you, gentlemen. The committee would appreciate that answers to any questions on notice—and I think there was one earlier—be provided by the close of business Friday, 2 December. That concludes our hearing today. We thank you for your time. We certainly value your input. We especially thank all the speakers and presenters. Hansard will make a record of what you have said today. It will be available on the parliamentary web page. Thank you to our Hansard reporter. Anybody who is interested in putting in a submission on the CWP inquiry can do so. You need to check the Queensland parliament website. I now declare the committee’s public meeting in Mackay closed.

**Committee adjourned at 2.40 pm**