



AIHS

Australian
Institute of
Health & Safety

Think forward

Victorian Lead Compliance Code:
Consultation Submission

Acknowledgement of Indigenous Peoples

We acknowledge the Traditional Owners of Victoria and their ongoing strength in practising the world's oldest living culture. We acknowledge the Traditional Owners of the lands and waters on which we live and work, and we acknowledge that sovereignties of these lands and waters were never ceded. We pay our respects to Traditional Owners' Elders past and present, and commit to supporting them and Aboriginal emerging leaders to create more equitable, healthy, and safe workplaces for all Victorians, and in particular for those most disadvantaged.

About the AIHS

The Australian Institute of Health and Safety (AIHS) is the national association for people who work in generalist health and safety roles (practitioners and professionals), and for leaders in health and safety more generally. The AIHS represents more than 1,000 occupational health and safety (OHS) practitioners and professionals in Victoria, and more than 4,000 nationally. Beyond our membership, we advocate for the >20,000 people who work in health and safety across Australia.

On 1 July 2019 our name changed from the Safety Institute of Australia to emphasise the importance of occupational health as well as safety. For more than 70 years we have worked towards our vision of safe and healthy people in productive workplaces and communities.

The AIHS strongly supports collaboration, including with our long-standing strategic partners. We share a common commitment with tripartite stakeholders (e.g. government, employers, and workers) to provide the best possible health and safety policy and practice advice for the benefit of the wider community. Our voice as a profession and association of health and safety experts is often distinct from those of government, employers, and workers. Our focus is on the science- and risk-based practice of health and safety based on best available evidence, to create safer and healthier workplaces.

Att: WorkSafe Victoria Lead Compliance Code Development Team,

This submission is co-developed and endorsed by both the Australian Institute of Health and Safety (AIHS) Victorian Branch, and the Australian and New Zealand society of Occupational Medicine (ANZSOM) Victorian/Tasmanian Branch.

Our submission is informed by discussions with our members who have expertise and familiarity with lead, including those who advise workplaces where lead-risk work is performed.

We appreciate the opportunity to provide comment on an important regulatory instrument developed specifically for lead processes and lead-risk work. The AIHS and ANZSOM acknowledge the risks associated with working with lead, and the importance of the risks associated with lead being managed effectively, for the benefit of industry and the broader Victorian community.

Our recommendations/feedback can be summarised under the following ten points:

1. **Consulted stakeholders** – risk and evidence would suggest that small to medium enterprises (SMEs) and those in construction settings should be consulted further in the development of this code. Additionally, both the AIHS and ANZSOM represent experts in this area who would likely provide value in the development of this code (and others).
2. **Additional targeted guidance** – specific sub-industries (such as shooting ranges) would benefit from targeted guidance relating to their context. These materials would benefit from using more visual communications.
3. **Supporting awareness campaign** – many stakeholders, particularly in SME settings, are unaware of their obligations in relation to lead-risk work. A broader awareness campaign would boost this code's effectiveness.
4. **Simplifying multiple notification requirements** – lead is both a public and occupational health risk. Simplified guidance outlining state reporting and notification requirements would assist duty holders in meeting their obligations.
5. **Exposure driving action rather than blood level results** – a risk assessment approach to evaluating potential exposures to lead should drive workplace actions, not blood level results.
6. **Clarifying terminology** – there is a risk of confusion between lead processes and lead-risk work, particularly in SME settings.
7. **Female reproductive capacity and SME capabilities** – we recommend the written statement provided by a female worker in relation to reproductive capacity should be supplemented by formal advice from a registered medical practitioner. This would assist SME and other employers to better manage potentially complex human resource/industrial relation situations.
8. **Hygiene practices are critical** – whilst hygiene practices represent 'lower-level controls' on the hierarchy, they are often the most challenging areas in large employer, more mature lead-risk work settings, and are often the most reasonably practicable in SME workplaces. They therefore deserve greater emphasis in the code.
9. **Medical practitioner capabilities** – not all general practitioners (GPs) are experts in occupational medicine. Developing a panel of accredited health service providers, who have completed necessary training, would improve health practices and industry responses. Further, assessment and communication templates may support GPs in performing more robust medical examinations and/or biological monitoring activities.

10. **Personal health information** – blood lead levels fall under the Health Records Act (2001). The requirements associated with this Act are more challenging to manage in SME and/or regional rural settings. This is particularly the case when information relating to reproductive capacity is considered. This code could provide greater focus on this issue, to support duty holders in meeting their information management obligations.

As the peak bodies representing those who advise workplace stakeholders on health and safety risks including lead, we look forward to seeing the code being finalised and implemented. We are willing and able to contribute to any further consultation prior to the release of this final version.

Thank you for the opportunity to contribute.

Yours sincerely,

Andrew Heinrichs
AIHS Victorian Branch Chair

Dr Harry Chow
ANZSOM Vic/Tas Branch Chair

Our responses

a) General comments about the code

We support the development of the code and are of the view that the code is generally well designed. We provide the following general feedback:

1. Consulted stakeholders

We are of the view that both the AIHS and ANZOM represent critical stakeholders in this area. We encourage WorkSafe Victoria to consult with us in greater detail as future codes are developed. Noting the stakeholders listed in the consultation webpage, we also encourage code developers to consider representatives from the SME sector.

Further, a 2014 Safe Work Australia report (<https://www.safeworkaustralia.gov.au/system/files/documents/1702/review-hazards-health-effects-inorganic-lead-report.pdf>) identified half of those likely exposed to lead as working in the construction industry, through tasks such as plumbing works, soldering, and painting. The stakeholders listed do not appear to allow for or focus on these workgroups specifically.

2. Additional targeted guidance

Our contributors noted that the lead industry is a broad, multi-faceted entity, with a range of businesses working in varied ways. This includes shooting ranges, vehicle radiator repair shops, fishing sinker manufacturers, and lead lighting facilities. These specific work settings may benefit from targeted guidance, for example that developed by the Victorian Department of Health (DH) for gun shooting locations (<https://www.health.vic.gov.au/publications/lead-information-for-gun-shooters>).

3. Supporting awareness campaign

In the experience of our contributors, smaller organisations are often unaware of the obligations they and others hold as duty holders in relation to the management of risks associated with lead. Therefore, we recommend that these groups are targeted by a comprehensive awareness campaign as this code is released.

4. Multiple health reporting requirements

COVID-19 has highlighted the gaps and inefficiencies in the regulation of risks to human health. For many health risks, identifying causation is almost impossible.

Lead is a public health risk, as well as an occupational health risk. This means there are multiple notification obligations to multiple government authorities. Whilst since 2018 medical practitioners are no longer obligated to notify DH of cases above 5µg/dL, pathology services (e.g. laboratories) are still required to notify within five days of diagnosis (<https://www.health.vic.gov.au/site-4/environmental-health/lead-and-human-health>). Therefore, we recommend including simplified guidance, potentially in the form of a flowchart, to support stakeholders and help ensure compliance with reporting requirements.

b) Do you have specific comments about the Preface?

No comments.

c) Do you have specific comments about Part 1: Introduction?

5. Approach to risk reduction

Lead-risk work is defined as a process that is likely to cause a worker's blood lead level to reach a particular threshold. Whilst this framework is used in Victoria and elsewhere around Australia, it does not allow for exposure to drive action at the workplace level. Further, workers have varying baseline levels of lead within their bodies. Blood lead levels do not so much as reflect whether a process is high risk or not, but whether controls are adequate and/or effective.

A more 'risk assessment approach' would help employers to better prevent lead exposure through proactive control measures. Rather than wait for elevated blood lead levels to reactively drive action, a greater focus on workplace-based monitoring is more likely to drive workplace improvements. We understand that workplace monitoring is already a feature of the Regulations and the code, however our contributors felt that in their experience across industry there is proportionally a greater focus on reactive personnel health monitoring, rather than preventative workplace risk controls.

6. Clarifying terminology

There is potential for confusion between lead processes, lead-risk work and other terms used, particularly in SME settings. We believe a flow chart may be more useful to help duty holders navigate their requirements. In our experience, SME stakeholders appreciate receiving as clear instruction as possible, without having to interpret open-ended requirements. A glossary of terms and definitions may also assist duty holders (SME-based and others) to meet their obligations.

d) Do you have specific comments about Part 2: Duties of employers?

7. Female reproductive capacity

Our view is that the requirement for women to provide their own written statements advising on reproductive capacity status is open to error in judgement and process. We know that contraceptive measures are not 100% effective. This approach also places greater management burden on SMEs who are less likely to have human resource/industrial relation capabilities to interpret and manage specific situations. We believe that any written statement provided by a female worker should be supplemented by a supporting assessment and statement from a registered medical practitioner. We note that in South Australia, the lower blood lead level threshold is applied to any women of reproductive capacity, regardless of provision of written evidence.

e) Do you have specific comments about Part 3: Controlling risks associated with lead processes?

8. The importance of hygiene practices

The examples provided for various hierarchy of control levels are useful. However, our view is that hygiene-related pathways, such as ingestion from hand to mouth actions, are more likely to cause lead-related health issues for workers. This is because hygiene practices 1) rely on administration-level controls (e.g. workers receiving instruction and 'site rules' which require them to remember to perform, 2) individual worker hygiene practices vary in quality, application and rigour, and 3) hand-to-mouth pathways are insidious insofar as it does not take much for a worker to transport dust or residue to their mouth area. Workplaces with mature capabilities are more likely to have engineering-based controls in place; those with less advanced systems of work are unlikely to have the necessary

resources to make more robust controls reasonably practicable (e.g. work sheds with 1-2 workers). Hygiene practices are therefore critical in many lead-risk work settings.

f) Do you have specific comments about Part 4: Health monitoring for lead-risk work?

9. Medical practitioner capabilities

Many General Practitioners (GPs) are unfamiliar with lead, in terms of common workplace practices, the additional OHS regulatory requirements, the nuances of lead processes and lead-risk work, and details of how lead interacts with the body. Two ways in which this issue can be addressed are:

1. Accredited panel of medical providers – there are training courses available to medical practitioners to improve their state of knowledge in this area. ANZSOM are willing to provide WorkSafe Victoria or other stakeholders with examples of these courses. There is precedent/examples for this in areas like abattoirs and Q-fever in the meat processing industry.
2. The regulatory framework provides more prescriptive processes – where ambiguity exists, the regulatory framework, such as the proposed code, could provide greater detail. For example, a template form for medical practitioners to complete for various monitoring/tests could be provided in an appendix. Safe Work Australia have provided an example of this template (see https://www.safeworkaustralia.gov.au/system/files/documents/2002/health_monitoring_guidance_-_lead.pdf).

10. Personal health information – privacy considerations

Blood lead level results are personal health information under the Health Records Act (2001). This means these records need to be treated with appropriate privacy arrangements. This is likely to be more difficult in regional/rural settings, where smaller populations mean ‘everybody knows everybody’. This is also more likely to be a challenge in SME settings. Information relating to reproductive capacity may also be regarded under the same framework.

Section 204 of the OHS Regulations (2017) provides for records being retained for defined periods. However, no reference is made in this section, or in the proposed code, of personal health information and the associated privacy requirements. This code could provide greater emphasis on this issue, to assist duty holders in meeting their various information management obligations.

g) Do you have specific comments about Appendix 1: The compliance framework?

No comments.

h) Do you have specific comments about Appendix 2: Conversion chart - blood lead levels?

No comments.