STANDING COMMITTEE ON ENVIRONMENT AND PUBLIC AFFAIRS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
ON WEDNESDAY, 10 APRIL 2002

Members

Hon Christine Sharp (Chairman)
Hon Kate Doust (Deputy Chairman)
Hon J.A. Scott
Hon Louise Pratt
Hon Frank Hough
Hon Robyn McSweeney
Hon Bruce Donaldson

Committee met at 1.30 pm

SOMERS, DR MOIRA,
General Practitioner,
examined:

The CHAIRMAN: On behalf of the committee I welcome you very warmly this afternoon. We have to go through some formalities at the beginning. In what capacity are you appearing before the committee?

Dr Somers: I am a general practitioner who has seen several sick workers and residents from the Alcoa, Wagerup and Kwinana areas.

The CHAIRMAN: You would have seen a document entitled "Information for Witnesses". Have you read and understood the document?

Dr Somers: Yes.

The CHAIRMAN: These proceedings are being recorded by Hansard and a transcript of your evidence will be provided to you. To assist the committee and Hansard, can you please quote the full title of any document you refer to during the hearing for the record. Also, please be aware of the microphones and try to talk into them and ensure you do not cover them with papers and so on. I remind you that the transcript of your evidence will become a matter for the public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request the evidence to be taken in closed session. If the committee grants your request, any public or media in attendance will be excluded from the hearing. Please note also that until the transcript of your public evidence is finalised, it should not be made public. I advise you that premature publication before you have had the opportunity to ensure that it is correct, or any disclosure of public evidence, may constitute a contempt of Parliament. That may mean that the material that is published or disclosed early is not subject to parliamentary privilege and the protection that goes with that.

Having gone through all that, we welcome you. We are very pleased to have you before the committee to help with this very important inquiry that has raised so much public interest.

Dr Somers, the committee has received some written material from you which we have seen in the past 24 hours. Would you like to make an opening statement to the committee?

Dr Somers: Can I read what I have submitted to you?

The CHAIRMAN: Yes, if that is how you would like to do it or you may wish to read parts of it; it is up to you.

Dr Somers: It is probably easier if I just read it. Is that correct?

The CHAIRMAN: Yes.

Dr Somers: My name is Moira Somers. I am a medical practitioner registered with the Medical Board of WA. I graduated from the University of Western Australia in 1979. In 1987 and 1988 I became interested in the management of patients with chronic fatigue syndrome and, subsequently, patients who have had chemical injuries and multiple chemical sensitivities - MCS.

I saw fit to explain to you the process that I go through in looking at patients because I have had a degree of antagonism directed towards me. I would therefore like to go through that process. First, when a patient presents to me, particularly the patients the subject of this inquiry, I have objectively assessed them by taking a very detailed and comprehensive history and conducting a physical

examination. I then applied standard investigations, as necessary, to eliminate any other condition that may have caused their reported symptoms and, where necessary, referred them to independent specialists.

Taking a history from patients allowed the patients to give their own detailed account of what they have experienced. The questions were open-ended and in no way elicited specific responses from the patients. When that process was completed, more direct questions were asked and a specific inquiry of each system was completed. When these patients initially presented to me they presented independently of the others and had not compared notes. Their histories were generally remarkably similar with minor variations and more often than not demonstrated a striking temporal relationship to exposures to refinery emissions, notably oxalate, caustic and liquor burning fumes. Workers consistently reported becoming unwell with exposures to liquor burning fumes and at the same time reported that numerous other employees were unwell and often submitted accident incident reports - AIs - and environmental incident reports - EIs - for the same exposure. Health impacts were not always related to odour. This pattern was repeated to me over and over again. It appeared that the liquor burner would run okay for some time and then workers would become unwell and eventually the unit would be shut down and maintenance performed. Basically, it appeared that the workers were a human alarm system.

Referral to independent specialists is particularly important. Basically, I referred patients to specialist physicians for two reasons. One reason was to further investigate any area in which symptoms or signs pointed to the presence of other disease processes. I investigated them comprehensively but then other specialist tests might have been necessary, such as endoscopies etc. They therefore consulted various specialists, including gastroenterologists, dermatologists, respiratory physicians, neurologists, psychiatrists, urologists and ear, nose and throat surgeons. The second reason for referral to specialist physicians was to provide a second opinion regarding my assessment of these patients and the relationship of their symptoms to the workplace. Not only did I feel an enormous responsibility to these patients but equally a responsibility to their employer Alcoa.

I referred most of the workers to an occupational physician, Professor Andrew Harper. When I had a group of these workers, I asked Dr David Watson, a very respected general physician in Perth, to provide a double check on my assessments. Also, in the last year, it was reported to me by a worker that an objection was raised at conciliation by an Alcoa representative that I only referred patients to the same people and a review by another physician was requested. At that stage I requested Dr Michael McComish, another very respected general physician in Perth, to review the group and provide his independent assessment. I believe he has seen five to seven workers. Some of the patients have also been seen by Dr Alan Glanville, a respiratory physician from St Vincent's Hospital lung transplant team. He comes to Perth periodically to assess patients at Sir Charles Gairdner Hospital. To my knowledge he has no association with Alcoa and is totally independent.

The next area that I have outlined is a general overview of the patients that I have seen to date. The first worker from Alcoa presented to me in December 1997. Since then time I have seen many patients associated with Alcoa. I believe to date I have seen 19 workers and approximately 16 to 18 residents, and other patients are waiting to see me. Some workers live in close proximity to the refinery and are affected by emissions not only at work but also at home. Of the 19 workers I have seen, 17 are from Wagerup and two from Kwinana.

Most of the workers have presented with a multitude of symptoms, including lethargy, fatigue, headaches, epistaxis - which is bleeding from the nose - sore eyes, nose and throat, breathing difficulties, abdominal discomfort, urinary frequency, nocturia - getting up at night to go the toilet a lot, which they report after exposures - myalgia and cognitive dysfunction - which is difficulty with mental function, thinking and working through things - and sensitivity to various chemicals. Three of the workers from Wagerup were contractors and also had significant exposure to refinery

emissions. One contractor has Goodpasture's syndrome and chemical sensitivities; another that I have seen developed Wegener's granulomatosis shortly after he worked at Alcoa; and a third is still under investigation. Interestingly, both Goodpasture's syndrome and Wegener's granulomatosis have been documented in peer reviewed literature to have some causal relationship to environmental factors and there is also an overlap between these conditions medically, which is very interesting.

Two patients were diagnosed with reactive airways dysfunction syndrome - RADS. These patients have seen Dr Glanville from the eastern States. RADS is a variant of occupational asthma. Both patients became unwell after exposure to volatile organic compounds in building 30. One of these patients has broadening chemical sensitivities and the second patient has returned to work away from the refinery environment. A third patient has occupational asthma and he most probably initially started with RADS. Another worker presented with predominantly skin complaints. Another patient that I saw had been attending the Alcoa medical centre for approximately two years. I understand he had been told that his condition was psychosomatic. He presented to me and I approached him in the usual manner; that is, I objectively assessed him and determined the exact nature of his problem. The most important component of this process is to take a comprehensive history. On taking that history, he had many complaints similar to other workers but it was striking that his memory loss was more than that reported by other workers. Further investigations revealed that he had a cyst on the third ventricle of his brain. He went on to have neurosurgery and I have not seen him again. This is only one instance that highlights to me the need for independent assessment of workers to avoid industry bias.

Of the workers that I have seen, I believe 10 fit the diagnostic criteria for multiple chemical sensitivity, as described by Dr Mark Cullen in the 1996 *Encyclopaedia of Occupational Health and Safety* and in the 1999 consensus statement published in the *Archives of Environmental Health* 1999: May-June: 54(3): pages 147 to 149. I enclose a copy of both of these documents for the committee. Those are the guidelines I used to assess these patients.

The diagnosis of MCS was not given lightly. Patients have attended over several months, histories taken over and over again and investigations and specialist referrals made.
[1.45 pm]

Nine of these patients are from Wagerup and one is from Kwinana. It has been reported to me that other workers at Kwinana have become unwell since the installation of the liquor burner at the site. I enclose a copy of a memo dated January 1998 from Peter Forster to the management at the Kwinana refinery. Basically it notes that Andy Hacking from the Australian Workers Union indicated that around 30 people claim to have suffered adverse health impacts from exposure to emissions from the Kwinana liquor burner. In the memo Mr Forster discusses the level of concern about this information and the inability to do air monitoring over the next two quarters. One worker from Kwinana was terminated and total and permanent disability was granted at the Superannuation Complaints Tribunal. Alcoa has appealed that decision to the Federal Court of Australia.

With significant emissions from and exposures to the liquor burning plume, workers have consistently reported to me that many others - at times up to 30 others - have suffered ill effects from exposure. It seems that most of these workers have irritant effects that are short-lived; that is, they have nose, throat and eye problems and maybe some chest problems that are short-lived. It was reported to me that often one member of a crew would report the exposure on behalf of the whole crew. This could lead to an underestimation of the health impacts.

Of the residents I have seen, most have reported irritant effects; that is, sore eyes, noses and throats, breathing difficulties, lethargy and headaches. Two of the residents I have seen have multiple chemical sensitivities and two also suffer from significant skin rashes. Some of the workers have developed depression secondary to their work-related injury. They have been prescribed anti-depressant medication and have been referred to a specialist psychiatrist. Several workers have

been assessed by psychiatrists on behalf of Alcoa, and depression has been excluded as having a causative role in the onset of their illness.

I will make some comments about workplace monitoring measurement. Much concern has been expressed about the lack of independent monitoring. Workers have reported to me their constant requests for measurement at times when emissions have been at their worst and their distress at the lack of monitoring at these times. The narrow band of the plume is often reported to me, and it seems that workers can walk in and out of that plume. Monitoring equipment does not measure these instances; that is, there is no biological monitoring of the workers and the air they breathe. One can rely only on the histories provided by these patients, and the histories are very consistent. Both biological and environmental monitoring are recommended by the World Health Organisation. I note that the World Health Organisation also recommends applying the precautionary principle.

The Australian Government publication, "Exposure Standards for Atmospheric Contamination in the Occupational Environment", authored by the National Occupational Health and Safety Commission, outlines the limitations of threshold limit values. They are determined for single agents only, for inhalational exposure and for exposure over eight-hour working days. There are no valid limits for mixtures of more than one chemical, let alone over 300 chemicals. Most of the workers have reported exposure on mucus membranes and skin as well as inhalational exposure. Shift duration is 10 to 12 hours, which results in increased exposure and decreased elimination times and leads to less of a linear increase in levels and possibly more of an exponential increase in levels. This of course does not allow for the situation in which a worker is exposed at his residence as well as on-site. The problem is one of mixtures-additives, synergistic and antagonistic effects that occur within that. I have enclosed a copy of a paper by John Pollak of the University of Sydney titled, "The Problems Posed by Xenobiotics in Chemical Mixtures and the Role of Mixed Function Oxidases". It sounds complicated, but it is not too hard to read.

The next area I will address is multiple chemical sensitivities, which is where a lot of the focus is. A large number of people who work in that environment suffer irritant effects, but a significant small group of patients have become very unwell and have been diagnosed with multiple chemical sensitivities. The onset of multiple chemical sensitivities often comes after exposure to toxic levels of chemicals, often in the work environment, and then leads to the development of a broadening sensitivity to a diverse range of chemicals at low dose. Products that most of us would tolerate without any difficulty cause a person with MCS to become unwell with multiple symptoms, often similar to those experienced when they were first exposed to the high dose of chemicals in the workplace. I have enclosed a copy of Dr Cullen's paper published in the 1996 *Encyclopaedia of Occupational Health and Safety*. It has been my guide to assessing patients with possible MCS. I know that Dr Cullen provided the committee with the book chapter titled, "Low-Level Environmental Exposures", in which he considers history the most important differential tool in considering the diagnosis of multiple chemical sensitivities. He says that a detailed illness and exposure history, repeated and reviewed as often as is necessary, is the most important differential tool; the physical examination and laboratory results play an ancillary role. He goes on to note five historic features that provide considerable diagnostic insight: the spectrum of symptoms, the diversity of environmental circumstances in which reactions are reported to occur, the nature of the environments that are associated with reactions, the predictability of response and the onset of the illness. I have covered all these features over and over again in the histories taken from the workers. Every worker has been remarkably consistent in their reporting of events in relation to, first, the exposures resulting in the onset of their illness and, subsequently, the development of sensitivities to a diverse range of chemicals at low levels; that is, MCS.

Over the years there has been considerable debate in the medical arena about multiple chemical sensitivities. In addition, this debate has a highly political component. According to peer-reviewed literature to 1998, out of 457 peer-reviewed scientific papers and reports, there was a two to one ratio in favour of a physical basis for this illness. As well, at that time MCS had been further

acknowledged by 25 United States federal authorities, 10 Canadian authorities, 23 US state authorities, myriad local authorities, eight US federal court decisions, 20 US state court decisions and countless independent and medical organisations. MCS was listed as one of the top three environmental diagnoses by clinics at Massachusetts General Hospital, Johns Hopkins University School of Medicine, Emory University and many more. In addition, there have been Australian judicial rulings. A Medline search for multiple chemical sensitivities references in 2000-01 by Dr Mark Donohoe, MBBS, FACNEM, FASEM - the title of his paper is "Multiple Chemical Sensitivities: State of the Science" - led him to conclude that the overwhelming majority of the medical and research literature has moved beyond the question of whether MCS exists and is now focused on addressing epidemiology, incidence, disability and pathophysiology.

MCS does not have a designation as a disease entity as yet, but it is a well-recognised illness and causes disability. I believe that the international body responsible for disease classifications is looking at this. The fact that it does not have disease entity status does not deny the fact that individuals suffer from this illness and they deserve personal respect, professional objectivity and medical management to the best of our present knowledge. Medicine just does not understand the pathophysiology of this condition, and it may be a long time before we do.

I note that Mr Bell reported to you that internationally, Alcoa defers to the American College of Occupational and Environmental Medicine, the American Academy of Allergy, Asthma and Immunology and the World Health Organisation. The World Health Organisation has neither adopted nor endorsed a policy or scientific opinion on MCS. That statement is from an original document from the World Health Organisation issued on 7 June 1996. Concern has been expressed about industry influence in determining the policy of the American Academy of Allergy, Asthma and Immunology. Many medical bodies have position statements supporting MCS as a genuine illness, and care must be taken to assess the industry influence in policies relating to MCS. Are they the result of scientific objectivity, or are they the result of the improper influences of business interests?

The next area is rehabilitation, about which members probably have questions. There are varying degrees of illness and disability within the group of Alcoa workers I have seen. Generally, most are severely disabled and will be unable to return to work in the refinery environment. Most will also find great difficulty establishing themselves in any form of sustainable employment outside of Alcoa. In most cases, patients have been too unwell to attempt rehabilitation or they have failed rehabilitation attempts due to MCS. In one case, rehabilitation was set up and then withdrawn by Alcoa. As mentioned previously, one worker who has reactive airways dysfunction syndrome is currently working outside the refinery environment. In July 2001, a rehabilitation proposal was presented to Alcoa by the Australian Manufacturing Workers Union on behalf of the work force, and a similar proposal was put forward by Dr Cullen when he visited about a month ago.
[2.00 pm]
The other information that I have provided is a table of the most recent complaints lodged with Alcoa by the Wagerup community health awareness group. I draw the committee's attention to the consistent pattern of reporting. This table has the figures for 1999, 2000 and 2001, and a few of the figures that have come in to date for 2002. What was of most interest to me was the pattern that is reflected equally in each of those three years, in that the bulk of complaints occur in the middle of the year, and then they taper off towards October, November and December. That suggests to me that the people in this community are very genuine in their complaints. The recent media attention that this issue has received is certainly not reflected in the genuineness of their reporting. If the reporting was purely emotional or related to the media, one would see a rise at the end of 2001. However, one sees a consistent pattern of reporting and an increase in the numbers over the time. Therefore, that is an interesting table. I could speak more on the community, but I will finish there for the moment.

The CHAIRMAN: I think you said that 1997 was your first -

Dr Somers: December 1997.

The CHAIRMAN: Has there been an increase in the number of people that you have treated over the years? In other words, are the numbers decreasing, increasing or basically staying roughly the same over time?

Dr Somers: That is a bit hard to answer. The patients were staggered over several months during the first year or two. I suppose there has been a small increase recently, because a lot of people have realised what they are suffering, they have a little more courage, and they have come out of the woodwork, so to speak. I have seen quite a few people more recently. However, they are not reporting just being unwell recently; they have been unwell for a long time, and it pretty much all dates back to about the same time that the others became unwell. I am not really seeing new incidents of people becoming unwell; I am seeing people who have probably been unwell for some time.

The CHAIRMAN: You provided us with a paper from Dr Mark Cullen, in which he describes multiple chemical sensitivity as often having an initiating event. Do the patients with multiple chemical sensitivity whom you have seen all seem to have experienced some kind of initiating event? By that I mean an exposure to emissions that are definitely measurable and considered toxic by all standards, even though subsequent exposures may not have been at such a high level?

Dr Somers: I actually asked Mark Cullen a question about that while he was here. I have seen patients who, for instance, were working in a workshop and were exposed to a significant plume that came into the workshop. They became unwell, went away, recovered over a few days, went back to their work situation and were re-exposed on another day. That pattern has occurred over and again. Gradually, their recovery does not seem to be as good; they do not recover as well between each incident. They have then gone on to develop generalised sensitivity. Most of these patients have had repeated exposures to plumes. They have walked in and out of plumes; when driving their cars, plumes have come into their cars in the yard; and when working in a workshop, plumes have come into the workshop. Most of them have had several exposures, although that is not to say that someone cannot get it from one exposure.

The CHAIRMAN: Could you explain how one would be aware of walking in or out of a plume? Can one see or smell the plume? How can one make that observation?

Dr Somers: First of all, I do not think people can necessarily see it. However, I am not the patient, so I cannot be completely clear. My understanding is that they are just doing their job, and they are suddenly overwhelmed by whatever this plume is. It has been described to me that they virtually walk into it. One patient described to me that he walked into the plume and then became unwell enough to go to the medical centre. On the way back, he walked through a plume again. These things are very fluid; it seems they move around. Patients repeatedly report being hit just doing their normal work. It does not always relate to odour either. Patients become unwell and report. Sometimes there is odour; sometimes there is not. Residents report that too. It is not necessarily an odour-related issue.

The CHAIRMAN: Can you be definite that these plumes and this exposure are the cause of the symptoms that you are treating?

Dr Somers: Nobody knows what the cause of the illness is - the exact physiology and all that. No one knows the exact thing causing it. However, people consistently report exposure to oxalate, caustic or liquor burner plumes. Sometimes people can see these things; they kind of rain down on them, depending on what job they are doing. They are consistently exposed to these things. They then become unwell, with the same reported symptoms each time. They get headaches, lethargy, nose bleeds, tiredness, irritant effects, and sore nose, eyes and throat. It is a consistent pattern that is reported over and again. I have not been to the Wagerup refinery, so I have not had a first-hand look. I can go only on what has been reported to me.

The CHAIRMAN: Have you noticed any pattern or are there similarities in age, sex or any other kind of classification in the people who come to you with symptoms?

Dr Somers: That is just by virtue of where they work. It has nothing to do with the disease. They are virtually all male and young, except that one person is a little older. I have seen people from diverse backgrounds, other than patients who work at Alcoa, who have similar problems. I have seen flight attendants off the BAe146 jet who have suffered similar problems. I have seen panel beaters, painters and an older female art teacher. It has no respect for age or sex. There is a trigger. In most cases it seems to be a higher dose of chemical mixture or single chemicals. In this case it happens to be mixtures. Most of the workers probably tolerate it very well and do not have a problem. They may get sore eyes, sore throat or sore nose. It is transient. They go home, go back to work the next day and get exposed. However, a few people get that exposure at work, and it seems to me that it is consistently reported to be a large exposure. In the workshops, patients have reported significant exposures to plumes that have come in and made the whole crew unwell; it is not just one person. It is a very consistent pattern of reporting that I have seen.

The CHAIRMAN: Looking at the complaints histories that you have described in your submission, I see that you consider that 10 are cases of multiple chemical sensitivity, and that is out of an total of 35 to 37 cases. Can one assume from that, therefore, from your experience in your practice, that the most common illness that is occurring as a result of exposure to emissions at the refinery, presumably, is multiple chemical sensitivity?

Dr Somers: From what is reported to me, probably the most common problem is irritant effects. If the workers become unwell, a large proportion of them become unwell just because the caustic or whatever is an irritant. A number of patients become much more significantly unwell. I just happen to have seen the very unwell people, and I have heard their reports that others -

The CHAIRMAN: In the range of very unwell people who have come to you, is the most common ill health under the rubric of multiple chemical sensitivity?

Dr Somers: I consider that 10 of the 19 have developed that. There is a spectrum of that illness. Some people are a lot less unwell, and others are very unwell. However, in most of those cases they are definitely unwell enough that they will not be able to return to the refinery environment. They will lose their ability to work in that environment. Their trade is basically one that involves work with diesel, oils, all sorts of pipes and the things that come out of those types of situations. That precludes them from working in their trade in most other places. People with this condition have a great deal of trouble being rehabilitated into other workplaces. If they travel into the city by car, they could be sitting behind diesel trucks and be exposed to the fumes, and they could also be exposed to perfumes. Maybe they can be retrained to do something else, but they cannot control their environment. Some of them are far too unwell to even function. Some people are basically on the couch all day because they are very sick.

The CHAIRMAN: Are they people who have what we can call MCS?

Dr Somers: A range of people within that spectrum are unwell.

The CHAIRMAN: I am sorry, I do not know whether you mean the spectrum under MCS or the overall spectrum.

Dr Somers: No, the spectrum under MCS. A large percentage of people in the community do not like perfumes and will avoid them. Other people are significantly unwell and have trouble re-establishing themselves in a work-related environment because they cannot tolerate chemicals at low levels. Within that group of 10 patients from Alcoa whom I am seeing would be a range of illness. Even so, most of the people within that group will have trouble re-establishing themselves in a work environment. They will have trouble studying or retraining because they have problems with their thinking processes. People just cannot work when they are exposed. Sometimes they can be wiped out for a few days because they are inadvertently exposed to a diesel truck on the freeway when they are going to a medical appointment or shopping or somewhere else. People have a lot of inadvertent exposures in life over which they have no control. That makes it difficult to predict what people can and cannot do. These people may hope to be retrained, but they will find that that retraining is very difficult. Some of them will not even be able to entertain that because they are too unwell.

The CHAIRMAN: Given that, I note that you speak about rehabilitation, and Dr Cullen also made that a feature of his recommendations in the report that the committee received recently following his visit here. I wonder to what extent is it possible to rehabilitate people who have MCS, and is enough understood about MCS to actually affirm that, over the long term, full rehabilitation is possible, in the sense of people being able to take up normal lives? Do you have an opinion on that, given that it seems to be an important focus in suggesting what should be done?

Dr Somers: Most of that group of 10 have moved past that stage, basically. I think back to one patient whom I saw probably in 1998 initially. He was really not too bad when he first came to see me, and I said to him, "Listen, the best thing we can do is for you to hightail it out of here and find something else to do." However, these people love their job, Alcoa and their employment. They enjoy what they do - or at least they did - and they do not understand what is ahead. Therefore, they think that they are bigger than it and keep going. We attempted what might be called rehabilitation. I said to both Dr Ken Hay and Rosemary Byrd, "I think this patient has a good chance of moving on, having a productive life and not becoming permanently unwell."

[2.15 pm]

Dr Hay agreed with me and told me he would move him out of this environment; and agreed that was the thing to do. That did not happen. Management stepped in and said, "No, we are not going to put this patient out of this environment. We will leave the patient in the environment", and he stayed there. He was moved eventually to a tower where he did nothing for nine months and he was further exposed to plumes from the Wagerup refinery and has progressively become more unwell. He was happy to try rehabilitation. I suggested to the company that he be retrained. I did not get any response. In the end he tried to retrain himself. However, he had more exposures at the work site. Even in the tower he was exposed to plumes from the refinery as they moved across and he is now not able to work in the trade for which he retrained himself. It has been a bit of a battle really.

The CHAIRMAN: Are you aware of any case histories of people, for whatever reason, who have completely removed themselves from the environment or changed jobs or whatever, and their symptoms have ceased entirely and they have become as well as they were before they experienced their first symptoms; in other words, they have been totally rehabilitated in terms of their health?

Dr Somers: I have patients who were mildly unwell with chemical sensitivities, who have moved out of the environment they were in where they were getting specific exposure and who have managed to change direction in their lives and move along. That is quite possible. People do that. There are degrees of illness with this, like anything else. There are people with mild asthma and people with very severe asthma; similarly with this problem. Certainly there are people who can be rehabilitated into different work structures. However, I believe the people in this particular group of 10 will have a great deal of difficulty doing that because they have a significant degree of disability.

The CHAIRMAN: I do not feel that you have understood my question. I am basically asking whether they can become completely well again.

Dr Somers: There are studies in medical literature indicating that nine years down the track people continue to have the same problem. They seem to develop the illness at a level and that is their level. It is ongoing but not necessarily progressive. Therefore what they are left with at this stage is what they are left with basically. I do not have patients who have got rid of it. The medical literature supports that. As I said, there are nine-year studies that indicate people are unwell in a similar manner. Dr Cullen said in his article that it is a persistent illness but it is not progressive and people do not continue to become more and more unwell. They seem to reach a level of being persistently unwell - for some that is not too bad but for others it is very disabling - and then stay that unwell.

The CHAIRMAN: When Dr Cullen had a recent visit to Perth, I note that he talked about liaising with medical people working in the area. Did you meet with Dr Cullen?

Dr Somers: I presume you are talking about the Department of Health meeting.

The CHAIRMAN: I am not talking about any specific meeting. I am just noting that he said it was important that he liaise with people who were treating those workers who had become sick. I wondered whether you had met him.

Dr Somers: Yes, I spent quite a lot of time with him. Over that whole week I spent 16 hours either listening to Dr Cullen lecture or talking to him personally. Basically, I was affirmed in the methods and processes I had used and the management I had conducted on these patients. He spoke very firmly about Alcoa looking after those patients and genuinely recognising what had happened to them.

The CHAIRMAN: I have a couple more questions and then I will throw it open to other members. You mentioned in your earlier statement that you had been subjected to antagonism. Do you want to tell us a bit more about that?

Dr Somers: It has been a little difficult. Probably the first difficulty was medical reports that Alcoa had obtained from other doctors in the eastern States who are reported to be experts in this area. Alcoa had flown them in to Perth to see patients and they reported that both Andrew Harper and I were deluded and incompetent. I found that very insulting. Patients reported to me that they had been told I was a naturopath; that was also particularly unprofessional. As I said, I had problems with negotiating rehabilitation for patients. I spoke to Dr Ken Hay about two patients, and he agreed with me that we should proceed in certain manners with these patients and that it was perhaps beyond his position. However, management stepped in and decided that other ways of dealing with these patients were better. Both of these patients stayed at the Wagerup refinery and both of them continued to become more unwell because they had repeated risk exposures. Mark Donohoe came to Perth in 2000 and we both asked if we could see the refinery and were refused. There was not a sense that we were really welcome in this whole matter, although we were looking after the patients.

The CHAIRMAN: Who refused you access on that occasion?

Dr Somers: I did not write the letter; I think Mark Donohoe did, so I do not know. Other things have happened but perhaps I could say that in private.

The CHAIRMAN: That is a negative thing but I imagine at the same time you also obviously now have a professional reputation for being somewhat of an expert in the field and you are attracting more and more case histories of a similar type. Is that what is happening?

Dr Somers: It would seem that is what is happening. As I said, I spoke to David Willett about the fact that some people perceive that I have an MCS flag to fly; but I do not. I perceive myself as sitting in the middle of a range of opinion. If a patient comes to me with a chest pain, I try to work out what the chest pain is due to. That is how I see myself sitting in this argument. I try to sit there and work out what is happening with a patient. I have done comprehensive tests, investigations and histories on all of these patients and I think I have done a good job. Ultimately, I am left with a group of patients who provide very consistent stories that are very independent of each other. They cannot possibly make up the stories that they tell me because the subtleties are too subtle. They would not even begin to know how to do that. I am seeing very genuine patients with very genuine illnesses supported by a body of medical evidence. There are industry-based arguments against this and all of that. However, I see a diverse number of patients who present very similarly in a range of other areas, as I said, such as flight attendants, panel beaters and painters. It is a very recognisable problem. I believe that my conclusion has been very objective and has been supported by very eminent people like David Watson and Michael McComish. I rang David Watson and said that if I am five degrees off the mark in my assessment of these patients, I could do a lot of damage to their lives by putting them on the wrong path by assessing them wrongly. So, he assessed them. I do not think I am alone in my assessment. Certainly a big concern, apart from this issue, is the workers

compensation issue generally and broadly because a lot of these patients are not acknowledged in that system; but that is apart from this inquiry.

The CHAIRMAN: Have you undertaken any testing of the hair of some of your patients and have there been any anomalies in the minerals and so on in the hair?

Dr Somers: I have done only standard medical investigations. I do not understand hair analysis. I am not a naturopath. It is not a standard medical test. I said to David Willett recently, because I think people thought I had ordered all these tests, that in 20 years medicine I had never ordered a hair analysis. I would not even know how to go about it. However, the patients come with these requests, but I honestly do not know the limitations and all the various intricacies of interpreting that information. That is not my department; mine is standard medicine.

Hon J.A. SCOTT: Following on from that, I recall an earlier witness in Waroona who said that he had tests that showed chromosomal damage. Can you explain a bit more about that and can you actually detect physical impairment from chemical impairment?

Dr Somers: Those tests came about when I first started seeing this particular group of patients. It is a work-related area and obviously all the information must be correct. Everybody likes science, they like facts and they like objective evidence. I spoke to Mark Donohoe, who is probably the Australian expert in this whole area on the eastern coast. He said that people are currently doing chromosome studies and he told me what those studies were showing. Genetics is a pretty hard science, I thought, so I arranged for all of these patients to obtain chromosome analysis with Judy Ford in Adelaide. I have not got any of her literature with me, so I could not give it to the committee, but I am sure you could obtain it from her. She has done very controlled studies that had normal and abnormal results and she produced information to indicate the rates of chromosome breakages and damage in certain circumstances. I must admit that not all of the patients, but a lot of them, came back with results that showed, compared with a group of similar age and sex etc, damage that suggested they had toxic exposures. That is a range of exposures in life. We all have them, such as radiation and all sorts of things. However, many patients in this group showed chromosome damage. To some extent I wish I had never done that test because it has created a lot of argument. At the end of the day the diagnosis depends on the history and the standard medical tests. It is like one piece out of a 1 000-piece jigsaw up on the left-hand corner. If that piece is not there, it does not matter to the whole overall picture. It does not change my diagnosis one iota whether or not they have chromosome damage. It was an attempt to find an objective measurement; and so it has gone on.

Hon J.A. SCOTT: I asked that partly because of my limited understanding of chromosomes and because of a lot of stuff I looked at yesterday on the web. Obviously that is tied up with cell division and reproduction etc. I am concerned that if patients have that sort of damage, further long-term effects might occur, such as carcinogenic, mutagenic and reproductive problems.

Dr Somers: That would be my understanding too. However, I must say that I am probably as much of a lay person in this as you are because it is just not an area that I am experienced in. I am not a geneticist. I cannot really answer that.

Hon FRANK HOUGH: Dr Somers, treating these people over a period and examining their symptoms, did you have any suggestions of cure? I am thinking at plume time of perhaps sending them back and getting them to wear masks. If they wore masks when they were continually exposed to plumes, that would probably eliminate one section of the problem, probably inhalation. These patients came to see you because they were sick and you treated them and told them what they had. However, did you have any suggestions of a cure?

Dr Somers: There is no recognised treatment available for this problem.

Hon FRANK HOUGH: If it were an inhalation problem, you would wear a mask.

Dr Somers: Apart from avoiding the ongoing exposures, that would seem to make sense. However, I think that personal protective equipment is a last resort in a refinery like Alcoa's.

Hon FRANK HOUGH: It is a start, is it not?

Dr Somers: For a lot of the people who do jobs in those areas, they cannot communicate if they have masks on because they use two-way radios. Asking someone to wear a mask in a 10-hour day is a pretty horrendous ask. I think Professor Harper, as far as I remember, had discussions along that line initially but it is just not a long-term solution. Avoiding the exposure was definitely a solution and to that end people were removed from Wagerup and transferred to Willowdale. Some managed to work quite well there for a while.
[2.30 pm]

Then they inadvertently got exposed to inhibitors, XXXX cleaners, diesel fumes and a host of other products to which they were becoming sensitive, and so it went on. They did not seem to be able to recover and the range got bigger. Avoiding exposure is the obvious issue. I do not think personal protective equipment -

Hon FRANK HOUGH: By the time they got to you, their systems had broken down.

Dr Somers: By the time they got to me, they had illnesses that often had been there for some time. They did not become unwell just after they saw me.

Hon FRANK HOUGH: I was not suggesting that.

Dr Somers: I know, but people have.

Hon FRANK HOUGH: As a medical practitioner, it must be frustrating to see people all the time, treat them and know that they are going back into the fire again, if that were the fire.

Dr Somers: I have always endeavoured to get them out of it. We are talking about people with multiple chemical sensitivity. If they have broadened chemical sensitivities and are consistently becoming unwell in that environment, I have always written on their workers compensation certificates that they need to be redeployed to Willowdale or somewhere else. My initial understanding was that Willowdale was a good place to go because it did not have the same emissions and the workers could find jobs that enabled them to remove themselves. Many of these people wanted to be at work. Psychologically, work is a good place to be. They knew what made them unwell. They knew that they could be flexible at that environment. If they were beginning to become unwell, they could remove themselves, so they tended to work around it as well. The attempt was always to remove them from Wagerup, but that was not always complied with. I know that two patients became much more unwell because they stayed there. That was not my desire.

Hon BRUCE DONALDSON: You said that the patients you have seen have been long-term sufferers.

Dr Somers: Most of the patients I have seen have been unwell for some time. The newer patients I have seen recently have been unwell for pretty much as long as the others. They have been scared to come forward, or they have been contractors. Who is going to look after a contractor? They have been residents who have persisted with going to their own doctors and have not gotten answers. They are people who are worried about it and just want to talk about it and see whether this is the problem. In some cases, I have said that there are so many other things happening in their lives that they have to sort them out for a lot of reasons. A small component might be related to their suffering some irritant effects, and a larger component might be related to other ill-health issues. All of the patients have some component related to it. Some are unwell from other health issues, particularly the residents. Others are getting irritant effects and are distressed by the whole psychosocial issue.

Hon BRUCE DONALDSON: Can you give us a breakdown of the 37 patients who are workers or residents for 1998, 1999, 2000 and 2001? Are patients being referred to you by other doctors if they have seen their local general practitioner?

Dr Somers: One patient was referred to me by Dr Brett Watson from Harvey. He has attended the Department of Health meetings. He is very concerned and interested. For most of the other patients, it has probably been word of mouth. The first patient who came to see me met someone who had been to see me years before. Several months later another patient came to see me, and so it went on. I have not been directly referred by anyone, other than Dr Brett Watson from Harvey.

Hon BRUCE DONALDSON: I looked at the figures for complaints lodged with Alcoa via the Wagerup community health awareness group forms as at 20 March 2002. Interestingly, a greater number of complaints were lodged from the end of May to August 2000. About 950 complaints were lodged in the period from April to September 2001. The complaints fell quickly in October, November and December and were relatively low in the early part of the following year. Could that possibly be due to wind patterns, inversion or the relative humidity at the time? There was a difference between the winter of 2000 and the winter of 2001. Because of the high level of complaints during that period in 2001, would you expect to get additional patients, say, 12 months hence?

Dr Somers: I am a GP; I am not a meteorologist. All I can say is that there seems to be a seasonal pattern to this. I understand from workers at Alcoa and residents that it seems to be related to the winds, inversion and all the rest of it. I could not even begin to adequately -

Hon BRUCE DONALDSON: When patients have come to see you, have they said that they experienced these difficulties during the winter months rather than during the summer months?

Dr Somers: Are they coming when they get unwell?

Hon BRUCE DONALDSON: They might have spoken to you about when their symptoms were worse.

Dr Somers: They definitely reported that it had a seasonal relationship. If I remember rightly, last summer was particularly bad. People who had reported problems only in winter also reported problems in the summer, and they related that to weather patterns. I have not graphed when people came to see me or when there was an increase in the number of new patients. I could not tell you that.

Hon BRUCE DONALDSON: The rehabilitation proposal was presented to Alcoa in July 2001 by the Australian Manufacturing Workers Union and Dr Cullen. Are you aware whether Alcoa has adopted that proposal? I know that you said that sometimes a lot of the patients you see are beyond that rehabilitation process. Has that proposal been put in place, and are workers accessing it?

Dr Somers: The two proposals were fairly similar. It is hard for me to know what Alcoa has been doing. The majority of the 10 patients have been too unwell to be at work anyway, so there is no question of rehabilitation. The one patient who got unwell recently due to the volatile organic compounds, but who does not have chemical sensitivity, has been rehabilitated fairly quickly through the system. The other patient is having a little more difficulty. The delays are frustrating. Patients are supposed to meet someone next week but it turns out to be next month. They do not communicate with me about it. I write on their certificates, and then the patients come back and tell me what is going on. There always seems to be an enormous delay in getting down to it and deciding what will happen. It is frustrating for patients.

Hon BRUCE DONALDSON: It is an unfair to ask you about the 37 patients and the complaints in 1998, 1999, 2000 and 2001.

Dr Somers: More new patients have presented recently.

Hon BRUCE DONALDSON: That is what I am trying to establish.

Dr Somers: My general impression is that more patients have presented recently.

Hon BRUCE DONALDSON: Would a certain proportion of the 950 complainants go to a GP and present with the characteristics that have been mentioned?

Dr Somers: Most of the patients I have seen have reported that they have been to their local doctors many times and have not been happy, for whatever reason.

Hon LOUISE PRATT: You said that you referred your patients for second opinions to other respected GPs.

Dr Somers: Specialists.

Hon LOUISE PRATT: Yes, and specialists. Did they have experience with other cohorts of patients in other industries, such as panel beating which you mentioned before, who have been diagnosed with MCS?

Dr Somers: I sent most of the patients in the first group to various specialists to exclude other causes as contributors to whatever these people were considering. That is a general standard medical referral. To my knowledge Andrew Harper has vast experience of patients with chemical injuries. He has worked overseas in this area. He is very objective and well respected, so I have sent patients to him. David Watson is a general physician. I cannot say whether he has seen patients with multiple chemical sensitivity. As far as I am aware, he is very involved in writing guidelines for the management of chronic fatigue syndrome and is a very well-respected physician. That is why I chose him; I knew he would be objective and independent and would tell me honestly what he thought was going on with these people. It was similar with Michael McComish. They do not have agendas about anything.

Hon LOUISE PRATT: That was not the reason for my question. I am interested in comparing the workers at Wagerup with cohorts of other patients in, say, the panel beating industry and whether the types of conditions are vastly similar or whether there is much variation. You have already said that there is a lot of variability within the Wagerup cohort.

Dr Somers: Not for the really sick ones. They are similarly unwell, but some are more unwell than others.

Hon LOUISE PRATT: Do those patients experience something similar to that which someone in the panel beating industry has been diagnosed with?

Dr Somers: It is virtually the same illness. Dr Mark Cullen addressed that issue when he was here. This is a highly recognisable condition for people who are used to seeing it. It is very recognisable in people who come into my office and give me their history, but they have not spoken to anyone else with a history of MCS. Similarly, my patient who is a panel beater is unwell in virtually the exact manner as patients from Alcoa, painters etc. A range of people become unwell with this illness. It is a recognisable condition.

Hon LOUISE PRATT: Do those patients have similar issues in getting acknowledgment from their employers about their condition?

Dr Somers: They have enormous issues with the workers compensation system because, first, there is no item number and, secondly, the insurance industry is extremely proactive in sourcing reports of people who argue that this condition does not exist. Two patients unrelated to this issue came into my office this morning: one is a clerk who was exposed to pesticides and the other is a teacher who was exposed to paint products, turpentine and a whole lot of products. It is easy to find people who say that this does not exist and that we are making it up. That is not the case. It is well recognised in medical literature.

[2.45 pm]

Hon LOUISE PRATT: With those who have multiple chemical sensitivity versus those who are experiencing irritant effects, does anything lead you to suspect that the cause of MCS versus irritant effects is the same, different or are you unsure?

Dr Somers: I am not a chemist. I could not possibly answer that. However, I have heard the people from Alcoa say that caustic is an irritant. However, I would not know if it is limited to just that. I could not possibly begin to answer that.

Hon LOUISE PRATT: Would caustic be a trigger implicated within MCS or only within irritation?

Dr Somers: I could not answer that.

Hon KATE DOUST: I have come across a couple of words. Can you explain to me what Goodpasture's syndrome and Wegener's granulomatosis are? You have listed symptoms for a whole range of problems, but are there symptoms that are peculiar to those things that you have not already listed; and what are the outcomes? How do those health problems present, and are they long term?

Dr Somers: Goodpasture's syndrome basically is an autoimmune disease. Something triggers the body into reacting against itself, and particular autoantibodies are present - antiglomerulo basement membrane antibodies - which attack the lungs and the kidneys. Basically, the person is extremely unwell. The kidneys do not work and the person is on dialysis three times a week, awaiting a kidney transplant. It is a significant illness and is well recognised in peer reviewed medical literature to have environmental factors implicated in causation.

Hon KATE DOUST: It would be very unusual to contract that type of health problem in most occupations.

Dr Somers: It is a rare health problem.

Hon KATE DOUST: What would be the most common cause? What line of work would usually involve an exposure in which that would present?

Dr Somers: I cannot answer that. Getting back to the Wegener's granulomatosis, that is also an autoimmune disorder, and it is also noted to have environmental factors as causation in some cases. Both of those diseases have an overlap. Medically, they have a common autoantibody.

Hon KATE DOUST: I refer to those patients of yours who presented with respiratory problems and so on, and pick up on the issue of personal protective equipment raised by Hon Frank Hough. At any point, did those people go back and talk to their employer about providing some sort of temporary PPE, job rotation or any other short-term solution to get them out of that exposure area, to give them respite, if you like? Were any of those measures put in place - I suppose linking up with their rehabilitation as well?

Dr Somers: When they came to see me, most of them were already quite unwell and struggling in the environment that they were in. They needed to be pulled out of that environment and moved somewhere else. Removing them from the exposures was much more important than putting some PPE on them. I understand that one patient, for instance, had many reports to the medical centre, well before I was involved. I would have thought that the onus was on the employer to see what was happening with these patients. Why were they presenting? Why would someone go to a medical centre with problems for two years and not be looked after properly?

Hon KATE DOUST: I note that in your submission you refer to the exposure standards for atmospheric contaminants. Are you aware whether there is any sort of push on the National Occupational Health and Safety Commission to address this issue of multiple chemical sensitivity and to deal with the fact that people are exposed to multiple types of problems?

Dr Somers: I am a busy general practitioner in Mt Hawthorn. I am not aware of that.

Hon KATE DOUST: Yes, I appreciate that. With all your involvement in this, I just wondered whether you had come across anyone who discussed the fact that perhaps it was time to deal with that issue and then look at preventive measures.

Dr Somers: That would be a vast task. In the world literature, people are only beginning to look at combinations of one or two chemicals. An interesting study came out of the Gulf War. In fact, I have the paper with me. A pathologist looked at the Gulf War and compounds that people were exposed to. He did a study of the individual agents to which those people were exposed and then of a combination of chemicals. He took the rats and cut up their brains - he was a pathologist. There was a definite increase in the amount of neural damage with the combination of chemicals. I understand that the risk was increased even more when those rats were in adverse circumstances. This sort of research is starting to happen with one or two chemicals in laboratories in universities in America. I just read the document, and that is what it says to me.

The CHAIRMAN: Would you provide the reference for that paper?

Dr Somers: I can provide the committee with the paper. It is titled "Locomotor and Sensorimotor Performance Deficit in Rats following Exposure to Pyridostigmine Bromide, DEET, and Permethrin, Alone and in Combination". That is written by Abou-Donia, who is a pathologist at Duke University Medical Centre.

Hon J.A. SCOTT: You may not be able to answer this question. We talked about the different industries in which there might be exposures that are causing this problem. Are you aware of the Department of Health carrying out any research into industrial illnesses caused by chemicals on an industry-by-industry basis to get a sense of which industries might need to bring in some ameliorating, regulatory or technical reforms?

Dr Somers: I am not aware of anything here, but I know that when I search literature on dry-cleaning, for instance, there are lots of records of people becoming unwell following exposure to dry-cleaning agents. It is an area that needs a huge amount of work. Many people are working in negligent circumstances, and they need to have this whole matter addressed. The workers compensation system should look at it. I attempted to ring government bodies when I was getting a critical mass of patients and was thinking that this is what was happening. Of course, the response I got from them was, "No, this is not my responsibility; it is their responsibility." I finally got to the former Department of Minerals and Energy and did not really feel -

Hon J.A. SCOTT: Tied up with that, do you think that the regulations governing the different levels of chemicals are up to scratch or out of date?

Dr Somers: I could not comment on that. I do not know. Obviously, they need lots of work and revision. However, I cannot comment.

Hon FRANK HOUGH: You referred to the World Health Organisation in your submission and said -

> One can only rely on the histories provided by these patients, and they are consistent. Both biological and environmental monitoring are recommended by the World Health Organisation. I would also like to note that the World Health Organisation recommends applying the precautionary principle.

Does WHO apply it to Alcoa, or did you apply it to the workers?

Dr Somers: My understanding is that there was a worldwide meeting - if I remember rightly, it was a Rio de Janeiro declaration. Many countries decided that if they do not understand the science of something, rather than go ahead, they would prefer to step back, take time and maybe not progress industrially, so that they have more time to judge the outcome and how it will affect people. That is my understanding of the precautionary principle. It is a worldwide principle that is applied in many countries. It is obviously not applied here.

Hon FRANK HOUGH: The only reason I ask is that you said -

> I would also like to note that the World Health Organisation recommends applying the precautionary principle.

I thought that when treating these patients you might have suggested that to the union or Alcoa or someone. I know it is not your job to do that, but after treating hundreds of patients, I thought you might have done that.

The CHAIRMAN: She said 35 patients.

Hon FRANK HOUGH: I am talking about the total number of visits. Is there any reason that you did not write to the union or Alcoa?

Dr Somers: About?

Hon FRANK HOUGH: About the precautionary principle.

Dr Somers: In general terms, every time I have approached Alcoa via a workers compensation certificate, I have said, "This is the way we should manage this patient. We should pull him back from the exposure and find something else for him." That is the precautionary principle applied in a microcosm - the level at which I operate. The precautionary principle is a worldwide application.

Hon J.A. SCOTT: You mentioned that there is not a wide understanding in the medical community about clinical injury, and I think you were talking particularly about multiple chemical sensitivity. Do you think there is a need for a greater level of training of medicos in that area in this State, given that thousands of new chemicals are coming onto workplaces and into the general community every year and that most of them have not been tested for carcinogenesis or mutagenic capacities etc? Is an upgrading of the training needed?

Dr Somers: It would be absolutely wonderful if more doctors understood this condition. It would be just like a patient walking in with chest pain and being assessed objectively. That would be fantastic. Everyone would then understand it. It would be good. I would not have to see huge numbers of patients who are very -

Hon KATE DOUST: Based on your interaction with those patients, the types of problems they presented with and your discussions with them, what do you think was their level of understanding of the types of chemicals they were working with and the potential exposures from and potential outcomes of working with those chemicals? Do you think they knew what they were working with and that they had been provided with adequate training and knowledge about the potential hazards of working with those chemicals? Was it adequate or not?

Dr Somers: From what I understand, they were not told about the breakdown of what they were working with. I think earlier on Mr van der Pal showed some slides to the committee that demonstrated that. My understanding is that they were not told. Basically, they were told that it was a pretty safe environment.

Hon KATE DOUST: Did they ever talk about having access to information about the chemicals - material safety data sheets?

Dr Somers: I am not sure. I never asked them about that.

The CHAIRMAN: You said that if someone has symptoms of MCS, whatever workplace they may come from, the symptoms are similar and easily recognisable. What are they?

Dr Somers: Basically, people will give a history of some exposure, whether it is an individual exposure or several exposures over a period that seem to be rather large. With each exposure, they will present with headaches, tiredness, and sometimes muscle aches and pains. Some people present with abdominal discomfort, urinary tract problems and headaches. Blunting of their mental function is a big one. Many people report speech disturbances. This is a subtle symptom that they cannot make up. I will ask them in an open-ended manner, "Do you have any trouble with your

speech?" They will say, "I can't think of the word I want to say. I get stuck in the middle of a sentence, can't remember where I am, and words come out back to front." The whole mental function is blunted when they are exposed. They are tired, cannot recover, and cannot seem to ever get back to their former level of health. Basically, there is a multitude of symptoms. That is why we must try to make sure that there are no other causes for it. Eventually, they start to discover that their wife's perfume or deodorant produces the same symptoms. They might fill up at a petrol station or be behind a diesel truck on the freeway, and they get the same symptoms over and over again. It is exactly the same pattern. Basically, that is how it happens. Dr Cullen agreed that they are easily recognisable by people who are used to looking at them.

[3.00 pm]

The CHAIRMAN: Is there anything else you want to tell us?

Dr Somers: Dr Cullen said both in his report and after he visited Perth and it was stated in literature produced by Alcoa that there are no long-term effects from this sort of exposure. I do not know what they mean by "long-term effects". When someone cannot work adequately, cannot support their family, cannot go out and socialise, cannot recreate, cannot play football with their children, cannot socialise to meet their future spouse and are continually unwell with a documented persistent illness, that to me is a long-term effect of a serious nature. Often these people cannot be retrained into a new job; that is a long-term effect. I object to the statements that there are no long-term effects. These people have long-term effects from this exposure.

Another issue relates to the consultation process with the community. I gather that the members of the community who are affected by this problem very much feel that they are not being communicated with properly. They have had very little communication since Dr Cullen visited. The Department of Environmental Protection was directed to have a consultation process with them, which was not a genuine consultation process at all. The consultation was basically railroaded to a discussion surrounding licensing issues. The community was very upset by that and proceeded to write a statement of concern about that issue to the meeting. I have a copy of that for the committee.

The CHAIRMAN: Could you please table that copy?

Dr Somers: Yes. After the meeting of 19 September the community got together, with the help of a social anthropologist, and put forward a submission on what they wanted in a consultation process. That was tabled shortly after that at their second meeting with the DEP. It was noted as tabled but nothing was done about it, apart from an approach two days before Christmas to say they had two days to sort it out. That was an impossible ask of the community. Alcoa basically needs to improve its communication because it is not helping people's responses and their feelings of being respected.

Also in the area of work-recorded injuries, I do not know whether all of these people are recorded as lost-man time. They are paid from the employee assistance scheme. Does that put them in a limbo in which their injuries are not recorded as work-related? I do not know. Perhaps the committee could address that question. That is all I can think of at the moment.

The CHAIRMAN: Thank you very much indeed for your very important and valuable information. The hearing is now closed.

Committee adjourned at 3.04 pm