Russell, Vicki

To: Russell, Vicki

Australian Chemical Trauma Alliance
NSW.

PRODUCTIVITY COMMISSION

CHEMICALS AND PLASTICS REGULATION – ISSUES PAPER – COMMENTS.

The major concern I have about Australia's regulatory system for chemicals and plastics is the lack of attention to human health impacts and the resultant disregard that is displayed. I continually read the need to protect human health from the risks of chemicals but in reality this is far from the case.

THE CASE FOR CHANGE

Why has it been so difficult to achieve fundamental reform of chemicals and plastics regulation despite advice from numerous reviews and government efforts to address the concerns?

What specific barriers to reform should the commission focus on in order to raise the likely effectiveness of its recommendations?

I feel the basic problem in achieving fundamental reform of chemicals and plastics regulation has been a lack of political will, our politicians and government instrumentalities appearing to continually bow to industry lobbying. Interestingly individuals with vested interests in the chemical industry seem to be consistently involved in the various committees set up addressing chemical issues, steering the debate. In all this, lip service only has been displayed to the financially under resourced community representatives who dare bring the human health factor up.

Given the criticisms of the existing system, are there grounds for preserving structural elements of the status quo (for example, are there good reasons for variations in State and territory regulations?)

In dealing with individuals suffering human health impacts of chemicals from all around Australia, one frustration is the inconsistency of regulations between the states. Examples such as prior notification of chemical use, spray drift which differs between the states, and in some cases between council areas. I would like to see consistency in regulations Australia wide, especially where it involves protection of human health.

THE NEED FOR EFFECTIVENESS

Is there a need to make a more extensive use of a risk-based approach to regulation in parts of the system?

It would be laughable to use a risk-based approach under the current assessment methods. The basis of such an approach is to fully define all the hazards then define the risks. If there are so many chemical products not even adequately assessed let-alone possible falsification of results as has occurred several times in the past then what hope is there of a meaningful approach. Furthermore, with so many chemical products being used in our every-day environment (not just in pesticides) there has not been any meaningful attempt to assess synergism: assessing each chemical on its own is not in the real world.

The outdated lethal dose levels, threshold level, etc bear no relation to the subtle affects on such aspects as depressing immune system functioning which then can precipitate a variety of unrelated symptoms which are treated on their own. Thus if this and other aspects are not even assessed then how can one relate hazard/ risk?

Studies and survey in both Australia and overseas consistently nominate around 3%-5% of the population as

being diagnosed with severe chemical sensitivities with a further 16%-25% moderately to mildly affected (see appendix 1): this is the portion of the population that are sufficiently educated to discover the link between chemical exposures and their health effects. Thus to carry-out any risk assessment one must first define what an acceptable risk is. With the current assessment process aiming to relate health effects to an average healthy adult the statistically significant portion of the public that is more chemically sensitive are discriminated against. An acceptable risk should not disregard such a statistically significant portion of our population.

The population needs to be educated as to the hazards of chemicals. They need to be educated to the fact that there are over 40,000 industrial chemicals that can be used in Australia that are unassessed, or not fully assessed, for their health and environmental risks. They need to be educated to think critically where chemical use is concerned, as they are lulled into a false sense of security, by all levels of government to think that these products are 'safe'.

The needs of the sensitive members of the community, children, pregnant and lactating women, the elderly the immune suppressed, the individual with chemical sensitivities, need to be related to the wider community. The misconception that because one can purchase it in the supermarket (or purchase it generally) then it will have no impact on human health, especially of the sensitive members of the community, needs to be addressed.

Is the regulatory system sufficiently flexible to incorporate and respond to changing knowledge and understanding of issues over time? (the following discussion relates to the rest of the questions in this section).

In relation to health issues NO – this can be seen especially in relation to the impact of chemicals on children and individuals with multiple chemical sensitivities. Health professionals with practical experience in dealing with chemical injury need to be consulted by our regulatory system. I wish to deal in more detail, these two issues that are presently not being adequately addressed by our regulatory system, especially in the light of the fact 'that there are over 40 000 industrial chemicals that can be used in Australia despite being unassessed, or not fully assessed, for their health and environmental risks'.

In February 2006, the International Conference on Chemical Management adopted the Dubai Declaration on International Chemicals Management. Section 23 of that declaration states - 'We recognise the need to make special efforts to protect those groups in society that are particularly vulnerable to risks from hazardous chemicals or are highly exposed to them. Section 24 states - ' We are determined to protect children and the unborn child from chemical exposures that impair their future lives.'

Strategic Approach to International Chemicals Management (SAICM) in its Statement of Needs 7© states - 'Risk reduction measures need to be improved to prevent the adverse effects of chemicals on the health of children, pregnant women, fertile populations, the elderly, the poor, workers and other vulnerable groups and susceptible environments.

(By the way, I whole-heartedly agree with the SAICM Governance 16 (g) To promote and support meaningful and active participation by all sectors of civil society, particularly women, workers and indigenous communities, in regulatory and other decision-making processes that relate to chemical processes. AND (h) To ensure equal participation of women in decision making on chemical policy and management. – I hope our 'authorities' take note.)

The Australian Chemical Trauma Alliance (ACTA) is a support group for individuals suffering chemical trauma, more specifically individuals suffering Multiple Chemical Sensitivity (MCS). The mechanisms of Multiple Chemical Sensitivity are gradually being understood. Basically the work of-

Gail McKewon-Eyssen et al "Case – control Study of Genotype in Multiple Chemical Sensitivity: CYP2D6, NAT1, NAT2, PON1, PON2 and MTHFR" International Journal of Epidemol. Advance Access July 15, 2004 and the work of Robert Haley et al "Association of Low PON1 Type Q (Type A) Ayrlesterase Activity with Neurologic Symptom Complexes in Gulf War Veterans" Toxicology and Applied Pharmacology 157, 227-233 (1999)

Leads into the work of

Martin Pall “NMDA Sensitization and Stimulation by Peroxynitrite, Nitric Oxide, and Organic Solvents as the Mechanism of Chemical Sensitivity in Multiple Chemical Sensitivity.” The FASEB Journal Vol 16 Sept 2002

Martin Pall “Elevated Nitric Oxide/Peroxynitrite Theory of Multiple Chemical Sensitivity: Central Role of N-Methyl-D-Aspartate Receptors in the Sensitivity Mechanism.” Environmental Health Perspectives Vol 111 Number 12 Sept 2003.

This work in turn creates the neurogenic problems hypothesized and documented by

William J Meggs “Neurogenic Inflammation and Sensitivity to Environmental Chemicals” Environmental Health Perspectives Vol 101 Number 3 August 1993.

And

Hajime Kimata “Effect of Exposure to Volatile Organic Compounds on Plasma Levels of Neuropeptides, Nerve Growth factor and Histamine in Patients with self-Reported Multiple Chemical Sensitivity” International Journal Hygiene, Environmental Health, 207 (2004) 159-163

The work of Hillert gives an explanation for the low threshold of odour processing

Hillert L et al “Odor Processing in Multiple Chemical Sensitivity” Hum. Brain Mapping 2006 © 2006 Wiley-Liss,Inc

ACTA grew out of a need for support for these victims as society structures are unable to offer any support for them. There is a complete failure of our medical and regulatory system to help or protect these victims. As previously mentioned there have been many studies and surveys indicating the prevalence of MCS/chemical sensitivity in our society. Two such ones are:-

‘Caress S and Steinemann A “2005 National Prevalence of Asthma and Chemical Hypersensitivity: An examination of Potential Overlap.” Journal of Occupational and Environmental Medicine – 47:518-522. This study estimated that 11.2% of the population experienced hypersensitivity to chemicals with 7.4% diagnosed with MCS.

‘The Australian Population, NSW Adult Health Survey 2002’ identified 24.6%of the population experiencing hypersensitivity to chemicals with 2.9% diagnosed with MCS.

This represents a lot of people presently not taken into consideration by our regulatory system (let alone by our health system).

A wide range of products and activities associated with modern times, have had an adverse impact on human health and well being. These products and activities are now considered essential to daily life and the economic wealth of nations. The convenience and wealth they offer is not without a cost. This is apparent with the worsening degradation and contamination of the environment and the resultant adverse effects suffered by a growing number of people.

Based on the hundreds of case studies submitted to ACTA, individuals with MCS can react to chemical exposures at far below the concentration levels tolerated by most people. The case studies indicate that the majority of individuals can identify the specific circumstances which initiated their condition. Over-exposure to one or more chemicals seems to be the usual starting point. It can take the form of an overwhelming chemical exposure such as a chemical spill or massive pesticide exposure, or a long term low to medium level exposure to chemicals, common to our modern way of life, which appear to have a cumulative effect on the individual.

The hundreds of case studies obtained from members also indicate that MCS can begin at any age. This includes many, some quite disabling, symptoms that affect multiple organ systems, especially the

neurological, immune and musculoskeletal systems. Following the initial trigger the sufferer becomes sensitive to a growing number of related and unrelated chemicals and/or non-toxic substances (eg certain foods, pollens). Although the concentration of the chemical involved may be low, in a sensitised individual a reaction can be provoked.

The case studies indicate that the chemical triggers are many and varied. Exposure may come from the air, food or water or through skin contact. All categories of chemicals are involved such as agricultural chemicals, industrial chemicals and chemicals found in personal care products. They include chemicals found in building materials – organic solvents, lacquers, paints, epoxy resins, glues, new particle board and plywood. Chemicals found in fabrics – synthetic textiles, new carpets, carpet glues and binders, dry-cleaned fabric, plastics, rubber pillows and mattresses, mothballs etc. Chemicals found in cleaning products – bleaches, disinfectants, polishers, and air fresheners and deodorises. Chemicals found in pesticides, photographic chemicals, formaldehyde, cigarette smoke, vehicle fumes and pool chlorine. Chemicals found in food – in dried fruit, synthetic food colouring, chemical preservatives etc. Chemicals found in personal care products – scented products in general – found in ointments, perfumes, shampoos, soaps, after shave, deodorants, cosmetics also biological and synthetic drugs (either the drug is a problem or the preservative in it.). Office materials/ equipment – printers, carbonless copy paper, newsprint, textas, correction fluid, glue etc.

The case studies show that symptoms are many and vary among individuals. They include:- chest pain, cardiovascular irregularities, shortness of breath, asthma, ringing/aching/itching ears, chronic throat problems, memory impairment, confusion, headaches, depression, sudden emotional responses, learning disabilities, concentration problems, slowing of reaction times, dizziness, overwhelming fatigue, muscle pain and weakness, joint pain, movement disorders, food intolerance, persistent infections, persistent skin rashes, flu-like symptoms, increased sensitivities to odours, gastrointestinal problems.

Individuals with MCS may become partially or totally disabled for several years or for life. The medical profession does not receive training in environmental toxicology and cannot readily identify the condition. This inadequacy often results in a destructive impact on the MCS sufferer who finds themselves stranded without sympathy, support or recourse to the law for compensation in the absence of medical testimony. Many sufferers live in limbo. The onset of MCS sees the individuals' health continually deteriorate. The case studies consistently indicate that improvement comes when the chemical sensitivity condition is understood and the individual can take appropriate action. Presently there is no single 'cure' for MCS the most beneficial treatment being avoidance. Avoiding the chemicals, which may trigger reactions, thus symptoms, is an essential part of managing MCS.

The case studies show that every aspect of life is affected. Individuals are forced to make dramatic changes in lifestyle at home. Many marriage and family relationships end from the stress of coping with this disabling condition. The majority are forced to leave their job and deal with the devastating loss of income and resultant poverty. Many are forced into social isolation. A few have committed suicide.

Sufferers of MCS need to create a 'sanctuary', relatively free of chemical exposures, within their homes and if possible immediate outside environment. If they can afford it they are forced to relocate. They spend as much time as possible within this environment due to the serious impact of an accidental, unavoidable exposure. They are denied adequate medical and hospital access. As a result they may experience intense isolation, loss of self-esteem and depression from not being able to have an active family, social and community life.

Some MCS sufferers are fortunate in that, with education and the efforts of their family, community and workplace, they are enabled to return to as normal a life as possible, some are able to undertake paid work, study etc. Unfortunately this is rare. There are a few lucky MCS children who have been able to return to school, with the help of the whole school community. However, this is also rare, with the majority of MCS children being forced into 'Distance Education" or Home Schooling.

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Common comments made by MCS sufferers are:-

'I've suffered rejection by my church, employment, I've become a social outcast"

'Few people are prepared to understand and help you'.

'Improvement in my health came when we moved to an isolated area'

'I'm very reliant on my neighbours' attitude to maintain any quality of life'.

'I lead a lonely life, can't go anywhere, if I do I know I will be crook'

'Trying to find a doctor to listen to you was a problem. They didn't believe that such a thing can happen. A couple told me it was all in my head.'

'I had to leave work and am now on an s/s pension.'

'I'm housebound and trapped in a polluted area in public housing on a disability pension.'

'My husband couldn't accept lifestyle changes – we separated.'

'I can't go out to see friends: they don't respect my needs. My husband is of no support his attitude is 'if I don't see it- it won't hurt me.'

'It seems to me that all doctors can say is –"Stay away from chemicals and don't eat what upsets you'.

Multiple Chemical Sensitivity has a profound impact on the individual sufferer and their family. The impact on society is increasing as the number of farmers, nurses, computer consultants / technicians, teachers, academics, and other skilled workers, once productive members of society, can no longer support themselves or contribute to society. Their loss also translates to loss of money spent in the marketplace and in tax revenue.

MCS is recognised in the USA, Canada, the UK, Sweden and in Germany. Multiple Chemical Sensitivity is also recognised under their ICD-10 (International Classification of Diseases)..

A letter to the then ACTA President Peter Harding in 1997 from the then Disability Discrimination Officer, Elizabeth Hastings, states .."The information available to me suggests that MCS is not a single condition but a range of conditions. It is possible that any one of these might fall within the definition of disability contained in the DDA and therefore MCS is a disability for the purposes of the Act"… There has been little to no improvement to the plight of the individual with MCS over the years. It is still an unmet disability, with its sufferers being marginalised and suffering severe disadvantages in today's society.

Unfortunately MCS/chemical sensitivities is an unidentified problem that has emerged and been ignored for too many years, by our regulatory system. Identifying issues early is critical to allow strategies to be developed that can avoid the build-up of long lived widespread impacts. In the case of the MCS/chemical sensitivity individual, identification of the condition is vital but in Australia we lack the political will to support this identification to allow the development of strategies to prevent widespread impacts. (I have just returned from San Francisco where I attended a MCS Case Definition Workshop. The Australian Government response to the findings of the workshop will be monitored with interest! Especially in light of the Office of Chemical Safety report into MCS).

I am the National Co-ordinator of ACTA and the mother of 5 sons, 2 of whom are chemically sensitive, a condition we were fortunate to identify in them whilst they were very young. I have been confronted with the inadequacies of our regulatory system on a daily basis for over 16 years, via the phone calls I continually receive from chemically injured victims and the personal experience obtained from rearing chemically sensitive sons and in the supportive role given to many families with chemically sensitive children.

Experience with chemically sensitive children over the years has shown that once the child is removed from chemical exposures respiratory problems, gastro intestinal problems, behavioural problems, neurological

problems and developmental problems the child may have been experiencing, improve dramatically and in many cases resolve completely (symptoms returning in many instances on re-exposure). Observation of these children as to the impact chemical exposure have on their wellbeing begs questioning as to the impact chemicals are having on the health of children in our society in general, especially in the light of the increase in respiratory, gastro intestinal, behavioural, neurological and developmental problems documented to be experienced by our children today.

Many reports now exist documenting the impacts of environmental pollutants on child health. Some are

In Harms Way – Toxic Threats to Child Development. A Report by Greater Boston Physicians for Social Responsibility. Available at http://www.igc.org/psr/

Compromising Our Children – Chemical Impacts on Children's Intelligence and Behaviour. A WWW-UK Chemicals and Health Campaign Briefing June 2004. Available at www.wwf.org.uk/chemicals

Polluting Our Future- Chemical Pollution in the US that Affects Child Development and Learning. National Environment trust, Physicians for Social Responsibly, Learning Disabilities Association of America. Available at www.safekidsinfo.org

Chemical Legacy – Contamination of the Child- Catherine N Dorey, PhD, A Greenpeace Publication

Toxic Chemicals and Children's Health in North America – A Call for Efforts to Determine the Sources, Levels of Exposure and Risks that Industrial Chemicals Pose to Children's Health. Available at http://www.cec.org ISBN 2-923358-35- X

The above mentioned reports (all based on sound research) need to be read and acted upon by all regulatory authority personnel. I do not intend to regurgitate the information set out in these reports as they are easily accessible to anyone interested (just the click of a finger is all it takes). To briefly summarise, the reports highlight the following.

Children's health is the net result of a complex interaction of social (income level, family customs, and behaviour), biological (genetics, age, gender) and environmental factors (diet, smoke, chemical exposure). Children are not small adults. Their unique physiology, developmental and behavioural characteristics make them more vulnerable to toxic chemicals. Compared to adults, children eat more food, drink more fluids, and inhale more air per kilo of body weight thus they have the potential to have more intense exposure to chemical contaminants than adults. These differences must be taken into account when considering the potential impacts of toxic chemicals.

In June 2000 a scientific panel convened by the National Academy of Sciences concluded that as many as 3% of known developmental and neurological deficits in children were caused by exposure to known toxic substances, including developmental and neurological toxins. The Academy also concludes that environmental factors – which include toxic substances – can cause approximately 25% of all developmental and neurological deficits working in combination with genetic predisposition.

Children under one year of age develop more rapidly, physically and mentally, than at any other age, are uniquely vulnerable to the effects of substances that can interfere with the biological systems that guide that development

Developmental and neurological toxins are likely of even greater concern to the developing foetus because of the even more rapid physical and brain development that occurs prenatally.

The last two decades has seen an explosion of neurobiological research into attention, memory and other cognitive functions. The patterns and stages of normal brain development are now well understood. This gives us a better understanding of the vulnerability of the developing nervous system.

Learning and behavioural disabilities result from many complex interactions of genetic, social and environmental factors often during a critical time in a child's development. Toxic chemicals, one of the

many interacting factors, are of special concern because they are a preventable cause of damage.

Animal and human studies show that exposure to some organic solvents as well as lead, mercury, manganese, pesticides, dioxins and PCBs during development can cause hyperactivity, attention deficit disorder, reduced IQ, and learning and memory deficiencies. Many researchers believe they are seeing an epidemic of learning and behavioural disabilities among children.

The reports also indicate that neurotoxicants are not merely considered a potential threat to children. In some instances, adverse impacts are seen at current exposure levels.

Vast quantities of neurotoxic chemicals are released to the environment each year. Environmental releases often lead to human exposures with potential for harm. Historically scientific understanding of the effects of toxic exposure is not sufficiently developed to accurately predict the impact of toxicants, and that our regulatory regime has failed to protect children.

As testing procedures advance, we learn that lower and lower doses are harmful. Most chemicals are not tested for their general toxicity in animals or humans, not to mention toxicity to a child's developing brain.

Even when regulated, the risks from chemical exposure are estimated for one chemical at a time, while children are exposed to many toxicants in complex mixtures throughout development. Multiple chemical exposures often interact to magnify damaging effects or cause new types of harm.

Exposure to environmental agents such as solvents, pesticides, lead, PCBs, benzene have been found to have negative impacts on birth weight. A number of studies have demonstrated increased levels of premature births in communities located near hazardous waste sites or facilities. Low birth weight and premature births have been rising steadily since the mid-1980s

Evidence is mounting that environmental factors play an important role in contributing to the incidence of birth defects and developmental disorders. In addition to the National Academy of Sciences, the Pew Environmental Health Commission lists more than a dozen studies linking a range of toxic substances in the environment to structural birth defects.

Children's bodies are in dynamic states of growth and development. A child's ability to break down and eliminate pollutants is poorly developed at birth, because the liver and kidneys are still developing.

Children are rapidly growing and developing. From gestation to adolescence, there are 'windows of vulnerable' where systems are particularly susceptible to damage from pollutants. Harmful exposures during these critical developmental windows can lead to lifelong alteration in behaviour, disease growth and development For example, a scientific consensus is emerging that the in utero and early childhood period is a 'critical window of exposure' for carcinogens. Current regulatory standards do not reflect this consideration of increased carcinogenicity risk to the foetus and young developing child.

Some chemicals (endocrine disruptors) are thought to alter and interfere with hormonal activity, causing significant health and developmental impacts. They can work at low doses, cause effects in the next generation and might only act during critical windows of vulnerability. Chemicals such as PCBs pentachlorophenol, DDT, bisphenolA and dioxins and furans have been found to have endocrine disrupting capacities. Endocrine disruptors are suspected to be tampering with male and female behaviour patterns of children.

From 'In Harms Way: Toxic Threats to Child Development.' A Report by- Greater Boston Physicians for Social Responsibility note several important themes that emerge:-

1) Neurodevelopmental disabilities are widespread, and chemical exposures are important and preventable contributors to these conditions.

2) Initial understanding of the impacts of neurotoxic substances regularly underestimates the potential for harm. So called 'safe' exposure thresholds regularly become obsolete as research methods improve.

3) Carefully conducted, long-term epidemiological studies have proven to be much more sensitive measures

of developmental neurotoxicity than animal studies.

4) Regulatory policy has repeatedly failed to protect children from widespread harm due to exposures to developmental neurotoxins. Generations of children are at risk, and often harmed before an adequate regulatory response can occur.

5) The failure of the regulatory system to protect public health can often be traced to the influence of vested economic interests upon the regulatory process.

6) Neurodevelopmental disabilities impose social and economic costs upon impacted families and the economy. Preventing these disabilities has the potential to provide major economic benefits.

7) Special interests are not merely tolerated but are actually an integral part of the regulatory process. If we are to successfully respond to the threats posed by the use and environmental releases of neurotoxic chemicals, we must find a way to insulate public health decision-making from conflicts of interest that can corrupt it.

Two Reports suggest ways to begin to protect our children from toxic exposures. They could serve as a starting point for our own regulatory authorities. In adopting policies that protect children, we would be going a long way towards protecting other vulnerable groups in society, such as people suffering from Multiple Chemical Sensitivities, the elderly, the immune compromised.

The National Environment Trust, Physicians for Social Responsibility and the Learning Disabilities Association recommend the following policies be adopted to address the risk to children.

1) Pre Market Screening of New Chemicals. – New chemicals should be tested and found to have no effect or potential effect on the physical or brain development of children before they are allowed on the market.

2) Mandatory Testing of New Chemicals. Chemicals produced in high volumes to which children and childbearing adults are routinely exposed, should be thoroughly tested for safety.

3) Labelling at the Point of Exposure. Substances currently in use that may potentially have developmental or neurological effects warning labels need to be posted on products and near facilities producing them.

4) Better Polluting Reporting. Releases into the environment of developmental and neurological toxins must be reported to regulating authorities, making the information available to the public.

5) Exposure and Disease Monitoring. To allow public health officials and environmental regulators to assess the real effects of toxic chemicals on children, a programme should be implemented to monitor developmental and neurological toxins in the bodies of representative samplings of women and children. The incidence of developmental and neurological disabilities in the general population then needs to be recorded.

The Report ‘Toxic Chemicals and Children’s Health in North America – A Call for Efforts to Determine the Sources, Levels of Exposure and Risks That Industrial Chemicals Pose to Children’s Health.’ Lists the following actions to protect children’s health:-

1) Monitor and Reduce Releases of Toxic Chemicals to the Environment. Preventing or reducing toxic pollution at the source is the best way to ensure that such substances are not released to the environment and so not contaminate the environment of children. Reducing releases can reduce contaminants that children receive from air, water, soil, breast milk, food or in utero. Pollutant Release and Transfer Registers (PRTR) provide information on a number of specific chemicals, industrial sectors and industrial facilities that could be targeted for further reduction of releases.

2) Monitor and Reduce Exposures to Toxic Chemicals. Information on hazards and exposures to toxic chemicals is needed so we can better assess environmental risks to children. Biomonitoring data on contaminant levels in humans are invaluable for increasing our understanding of exposure and potential links to health. Monitoring of levels of toxic substances through air, water, soil/dust, food, breast and

consumer products is necessary.

3) Track Childhood Diseases that May be Related to the Environment. The lack of a comprehensive disease tracking system handicaps exploring he connections between diseases and environmental exposures.

4) Improve Scientific Knowledge. The United States has demonstrated leadership in research efforts in children's health and the environment. It has established a number of Centres of Excellence in Children's Environmental Health and disease Prevention Research, funded by the National Institute of Environmental Health Sciences and the US EPA. These centres are producing important research that will help inform decisions about reducing children's risks in the future.

5) Increase Awareness of the Role of Toxic Chemicals in Children's Health. Governments and others should help to build individual and community awareness of possible sources and pathways of chemicals to children, and the potential for chemicals to harm children. When provided appropriate information, parents and others in the community can take practical actions to reduce potential exposures to chemicals.

Children have a right not to be contaminated. Parents have a right to expect that the products they buy for their children are safe and harmless. Man-made chemicals should have adequate safety data and should not be bioaccumulative nor persistent

Protecting our children from preventable and potentially harmful exposures requires a precautionary policy that can only occur with basic changes in the regulatory process. There are already international strategies that Australia NEED to take example from in chemical regulation. They are :-

The EU's REACH (Registration, Evaluation, and Authorisation of Chemicals) is based on the principle that industry ensures that the chemicals they manufacture and market do not adversely affect the environment and human health. This requires industry to have knowledge of the properties of their substances and to manage potential risks. Authorities focus resources on ensuring industry meet their obligations.

AND

SAICM – Strategic Approach to International Chemicals Management whose overall objective is 'to achieve the sound management of chemicals throughout their life-cycle so that by 2020, chemicals are used and produced in ways that lead to the minimization of significant adverse effects on human health and the environment'.

CONSULTATION

We remain frustrated with the APVMA and its CCC since its commencement. From its outset, the community representative from our associated organisations have tried to advise of the real situation confronting the people affected by the widespread use of chemicals approved by the APVMA or its previous names. So here we go again saying the same things we've been saying for 15 years: one wonders when the APVMA will actually listen and do something about the real situation.

The APVMA has now approved so many synthetic chemicals in so many products that the average Australian is exposed to thousands of these every day through food residues, vapour drift, spray drift etc. Since the APVMA / TGA will only assess each on their own the total chemical load is unknown and vastly variable and the synergistic affects "are just too difficult to assess"! What is worse is that APVMA and TGA staff actively throw this back at us as a point to defeat us when we try to attribute affects to one or two chemical products alone!

We do not have any confidence in the APVMA both in its ability to protect and represent the public in respect to pesticide exposure. The CCC appears to be nothing but a front to be able to say it has public input. This reflects the lack of confidence by the general public and is a large reason for the failure of the Adverse Experience Reporting Program (AERP). Furthermore, if the APVMA had actually listened to the feedback from ours and other similar organizations over the last 15 years then it would know exactly why the AERP is not working and organizations like us would not need to exist.

An attitude change needs to come from the APVMA, TGA and Health Departments in respect to the recognition of health effects from chemical exposure especially low level exposure to the sensitive portion of our population. There is presently a huge reluctance and active-avoidance by such bodies to even admit the potential of injury from chemical exposure. How many times have we heard public comments / down-play, as well as in hundreds of individual responses concerning chemical exposures by such departments to the effect that such chemicals have been “properly assessed”, or are at “safe” levels, or there is “no-evidence for such effects”, etc. Little wonder with such white-washing that you have no feedback and no evidence if the concerned public is continually treated this way. A downplay exists in such departments on any affected-individual’s suspicion, in respect to their symptoms or sensitivities, being the result of a chemical exposure, especially at low levels.

An attitude change also needs to occur among the general public regarding chemical use. Just because it can be purchased in the supermarket or produce store doesn't mean it is safe and will not cause health problems. Many times one sees the home gardener spraying pesticides in thongs, singlet and shorts, with children playing around them. There remains insufficient public education and labeling on such aspects.

A comprehensive education programme is needed for the general public educating them about the dangers of pesticide use and exposure, and how to identify poisoning symptoms and where they can go for help and treatment.

Doctors, emergency depts., and Medical personnel in-general are not trained to recognize chemical poisoning: Comprehensive training needs to be put into place. Such training is not presently part of University courses. Medical staff are also unaware of the types of tests needed to be done on a suspected chemical exposure case, let-alone how to interpret the test results and how to treat the injured person. The doctors themselves need support.

Medical personnel seem to 'panic' when the patient mentions/suggests that chemical exposure may be the cause of their symptoms. Doctors who try to support the chemically injured tend to suffer prejudice and victimisation by their peers. An education programme needs to address this negative attitude toward chemical injury / sensitivity.

We encounter many people who have been traumatized by their experiences and treatment by medical personnel and government departments. They fear going through any more intimidation: especially in going to the government department which approved the chemical in the first place.

The online reporting form itself could be more user-friendly and less intimidating: especially for a member of the public wanting to report an adverse experience. Chemically injured individuals would find it overwhelming to try to provide the data that is required. Having to obtain the name of the pesticide, the batch number etc requires the victim to front the individual who poisoned them in the first place. This type of action typically results in intimidation of the victim with the perpetrator retaliating with further poisoning. This retaliation occurs not only on a neighbour basis but by councils, pest operators and farmers as well. The victim either 'puts up' with it and gets sicker, or has to move: which is usually not possible.

The APVMA must implement a body burden project as was undertaken in the US Centre for Disease Control Exposure Report. This needs to be made widely public to illustrate to all, especially the APVMA and TGA, that the public has significant pesticides exposure. To not proceed with such an approach will further illustrate how the APVMA is not really interested in the public’s pesticide exposure.

Our experience with NICNAS Community Engagement Forum (CEF). Again is this shaping up to be yet another ‘front’ to appear to appease the public? After years of lobbying, the Office of Chemical Safety (OCS) undertook a review of Multiple Chemical Sensitivity (MCS), as previously mentioned, in 2006. The MCS community as a whole indicated it objections as to the way it was conducted etc to the OCS. The report was to be released in February 2007. After lobbying by the MCS community it was suppose to have been released to the CEF in June 2007. Today we are still waiting to see the report despite contact with CEF members who appear just as frustrated.

The existing chemical review programme – well- . One only has to look at the number of chemicals

reviewed over the past decade, the length of time it takes for each review and compare it to the 40 000 industrial chemicals that can be used in Australia that are unassessed or not fully assessed for their health and environmental risk and ask how effective is it??????????????

We were involved with one review ‘Ethylene Glycol MonoButyl Ether’(2BE) back in 1995-96. This was after it was discovered being used in cleaning products in schools with students, school personnel and cleaners reporting adverse health impacts. Briefly, the resultant report was a frustration and did not appear to address the health issues experienced, leaving us quite cynical about the process. We subsequently have dealt with reports of health problems from this chemical on several occasions since. The most notable, around 2001 with the plight of Sydney Government Bus cleaners, using products containing 2BE, highlighted by the media. The most recent being reports from an Aid agency with office workers and cleaners reporting adverse health events from exposures to cleaning aids containing 2BE. One wonders the effectiveness of the review conducted back in the mid 90’s!