Industrial Relations Commission of New South Wales

CITATION:	**Holcim (Australia) Pty Limited v. Transport Workers' Union of New South Wales [2010] NSWIRComm 1068**
PARTIES:	APPLICANT Holcim (Australia) Pty Limited RESPONDENT Transport Workers' Union of New South Wales
FILE NUMBER(S):	IRC 1863 of 2007
CORAM:	Connor C
CATCHWORDS:	industrial dispute - transport industry - contract drivers - supply of ready mix concrete in agitator vehicles - drug and alcohol testing - workplace and road occupational health and safety - contest between urine samples and oral testing for drugs - expert evidence - desirability of proper accreditation for testing - urine testing preferred - application for variation to contract determinations rejected at this time - direction for further discussions
LEGISLATION CITED:	Industrial Relations Act 1996 Occupational Health and Safety Act 2000 Passenger Transport Act 1990 Rail Safety Act 2008
CASES CITED:	BHP Iron Ore Pty Limited v. Construction, Mining, Energy, Timberyards, Sawmills and Woodworkers Union of Australia (1998) 82 IR 162 Caltex Australia Limited v. Australian Institute of Marine and Power Engineers [2009] FWA 424 Refinery Operators Shell Refining (Australia) Pty Limited Award Case [2008] AIRC 510 Ruddell v. Camberwell Coal Pty Limited [2010] FWA 8436 Shell Refining (Australia) Pty Limited v. Construction, Forestry, Mining and Energy Union [2009] AIRCFB 428 Transport Industry - Mutual Responsibility for Road Safety (State) Award and Contract Determination (No.2) Case (2006) 158 IR 17 WorkCover Authority of New South Wales v. Hitchcock (2004)

135 IR 377

HEARING DATES: 27/10/2010, 28/10/2010, 03/11/2010, 04/10/2010, 02/12/2010

DATE OF JUDGMENT: 23 December 2010

LEGAL REPRESENTATIVES:
APPLICANT
Bruce Miles

RESPONDENT
Andrew Metcalfe

DECISION:

INDUSTRIAL RELATIONS COMMISSION OF NEW SOUTH WALES

CORAM: CONNOR C

Thursday, 23 December, 2010

Matter No IRC 1863 of 2007

Holcim (Australia) Pty Limited and the Transport Workers' Union of New South Wales

Notification under S.332 of the Industrial Relations Act, 1996 re random drug and alcohol testing

DECISION

[2010] NSWIRComm 1068

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Introduction

1 This dispute concerns the issue of drug and alcohol testing in the transport industry. The matter has a lengthy history which has involved many attempts by the parties to resolve by conciliation which have ultimately proven to be fruitless. The matter commenced on Tuesday, 2 October, 2007 with a notification of an industrial dispute pursuant to the provisions of Part 4, Dispute Resolution, of Chapter 6, Public Vehicles and Carriers [S.332], of the 1996 Industrial Relations Act. The resolution of the issue in dispute has been complicated principally by two matters, viz:

> (i) The operations in question - the supply of ready mixed concrete by contract drivers of concrete agitators - have moved initially from Readymix Holdings Pty Limited to Rinker Australia Pty Limited who lodged the S.332 notification in the first place and then to Cemex Australia Pty Limited which took over the operations and subsequently Holcim Australia Pty Limited which ultimately took

over the operations from Cemex.

(ii) It was considered appropriate for some time to await the decision in similar proceedings in the Federal industrial jurisdiction - firstly, before Hamberger SDP of the former Australian Industrial Relations Commission whose decision on the matter was handed down on Monday, 25 August, 2008 in the Refinery Operators Shell Refining (Australia) Pty Limited Award Case (2008) AIRC 510 and then subject to appeal to the Full Bench of the Australian Commission (Giudice P, Harrison SDP and Larkin C) whose decision in Shell Refining (Australia) Pty Limited v. Construction, Forestry, Mining and Energy Union (2009) AIRCFB 428 was handed down on Friday, 15 May, 2009.

2 At issue in these proceedings is the drug and alcohol testing regime that has been introduced nationally by Holcim. An industrial dispute had initially arisen between Rinker and the Transport Workers' Union of New South Wales over Rinker's proposal to implement a programme of random drug and alcohol testing for contract drivers engaged by Rinker. The S.332 notification was lodged for and on behalf of Rinker and the matter was allocated to me.

3 Whilst the TWU and the contract drivers do not oppose random drug and alcohol testing for the contract drivers, there is a concern over the conditions under which that testing is to be conducted. Simply stated, the issue in dispute centres chiefly around the type of testing to be performed. Rinker (and later Cemex and finally Holcim) proposed that urine samples be taken but that was opposed by the TWU which had proposed instead oral testing - saliva swabs. The TWU argues that oral testing is less intrusive and more convenient than the urine sampling method and it is its view that oral fluid more accurately reflects *recent* drug use and the consequent risk of impairment of the drug user in driving his vehicle and is therefore the more reliable test to apply.

4 I set the matter down for the first of many conferences required by S.315 on Friday, 5 October, 2007 but conciliation failed to settle the matter at that time. I programmed it for arbitration in a hearing on Tuesday, 11 December, 2007 and Wednesday, 12 December, 2007 but vacated those dates when there were delays in responding to my directions for the filing of evidentiary material on the part of Cemex, which had carriage of the matter at that time and had inherited the S.332 notification. I set the matter down for a further mention and for programming instead on Friday, 29 February, 2008 and ultimately for a hearing scheduled for Monday, 26 May, 2008.

5 That hearing did not proceed, however, and in subsequent proceedings before me on Monday, 16 June, 2008 and Thursday, 24 July, 2008 I made further directions concerning this matter and rescheduled a hearing on Monday, 27 October, 2008 and Tuesday, 28 October, 2008. Further discussions were taking place in the interim concerning general features of the drug and alcohol policy of Cemex but the issue in dispute still centred around the type of testing - urine sample or saliva testing. The entire policy being implemented was up for review in the meantime.

6 In light of a request made for and on behalf of Cemex to amend the directions I made concerning this issue, I reconvened the proceedings on Wednesday, 20 August, 2008. I convened further mentions and conferences on Tuesday, 28 October, 2008, Wednesday, 19 November, 2008, Wednesday, 11 February, 2009, Thursday, 9 June, 2009, Wednesday, 9 September, 2009 and Wednesday, 30 September, 2009. There was a further conference for conciliation (unsuccessful) on Monday, 2 November, 2009 and mentions on Friday, 25 November, 2009 and Thursday, 17 December, 2009. A hearing was arranged again on Wednesday, 31 March, 2010 and Thursday, 1 April, 2010 but it

was vacated again at the request of the parties and mentioned again on Thursday, 13 May, 2010.

7 In the proceedings on Thursday, 13 May, 2010 I made directions to bring this long outstanding matter to a conclusion. Holcim, which had taken over the operations in the meantime and adopted the S.332 notification had provided a statement outlining its position. I directed that the TWU respond with its own statement concerning the issue by no later than Thursday, 3 June, 2010 (and, following a suggestion by the TWU that there be further conciliation, I set the matter down for a further conference on that day). But I did not wish to depart any further from the programme proposed by Holcim in the proceedings on Thursday, 13 May, 2010. To that extent, Holcim was to file and serve its evidentiary material by no later than Monday, 14 June, 2010 and further expert evidence by Thursday, 1 July, 2010. The TWU was to have until Thursday, 12 August, 2010 to file and serve all affidavit evidence (including expert evidence) in reply and Holcim's response to that material was to be provided by Thursday, 9 September, 2010.

8 On Monday, 31 May, 2010 the TWU wrote to me informing me that it had requested from Holcim its drug and alcohol policy, which it regarded as essential to prepare its statement. It requested an adjournment of the conference until Thursday, 10 June, 2010 and for it to be given until that date for it to provide its statement. Solicitors representing Holcim wrote in reply to the TWU indicating that Holcim drug and alcohol policy remains unchanged since it was earlier provided to the TWU and it was opposed to the adjournment of the proceedings. However, the solicitor indicated that if I did grant the extension of time for the TWU to provide its statement and to adjourn the conference until Thursday, 10 June, 2010, it wished to preserve the remainder of the directions I have made. I acceded to that request.

9 Ultimately, I set the matter down for further mention and programming on Friday, 9 July, 2010. Because much of the dispute between the parties centred around the evidence of experts called in support of the conflicting positions, I had suggested to the parties that they consider that evidence being adduced concurrently which I believed would have streamlined the proceedings and crystallise and confine the issues actually in dispute between the parties. However, for such arrangements to be put in place some preliminary steps would need to have been taken: some agreed position between the expert witnesses prior to the proceedings and a more interventionist approach by me. That suggestion for concurrent evidence was not ultimately pursued, however.

10 I set the hearing down over five days - Wednesday, 27 October, 2010, Thursday, 28 October, 2010, Wednesday, 3 November, 2010 and Thursday, 4 November, 2010 (for evidence) and Thursday, 2 December, 2010 (for final submissions). In the hearing Mr Miles represented Holcim and Mr Metcalfe represented the TWU. Annexed to this decision is a list of the witnesses called to give evidence in the hearing.

The Work in Question

11 Holcim engages 140 contract drivers of agitator vehicles in the supply of ready mixed concrete in New South Wales. The bulk of the contract drivers (102 contract drivers) operate throughout the Sydney metropolitan area but there are also contract drivers in regional area of the State - Newcastle (10 contract drivers), Wollongong (13 contract drivers), the Northern Rivers area - Grafton to Brunswick Heads (4 contract drivers and a further contract driver of a mini vehicle) and the Tweed River area (11 contract drivers). Their task involves mixing concrete, transporting it and delivering it to customers on request in concrete agitator vehicles.

12 The specific elements of the tasks performed by the Holcim contract drivers are detailed in a series of job safety assessments [JSA's] which are reviewed annually. It is trite to suggest that there are inherent safety issues for the contract drivers (and the general public) in the performance of their duties. Mr Scott Buchanan, the operations manager for the Sydney metropolitan area of Holcim, who was called to give evidence in the hearing by Mr Miles, outlined in an affidavit which formed the basis of his

evidence:

> "....concrete truck drivers are exposed to a number of potential safety and environmental hazards on a daily basis, given the nature of the tasks that they perform. The three primary tasks by concrete carriers: mix, transport and deliver concrete, pose a number of potential health and safety hazards to the drivers and/or third parties, including:
>
> (a) when mixing and loading concrete: (i) entering and leaving a site via a driveway safely to ensure no pedestrians come into contact with the truck and (ii) drivers may slip or fall when entering/exiting their truck or when walking on slippery/uneven surfaces in or near the load bay;
>
> (b) when transporting concrete negotiating traffic on busy public roads may pose a risk of accident;
>
> (c) when delivering/discharging concrete: (i) pedestrians, site workers, site obstacles and other vehicles and machinery on a work site may pose additional safety risks, (ii) soft, uneven ground and road surfaces may pose a risk of accident, (iii) traffic congestion on sites may pose a risk of accident, (iv) the requirement to reverse trucks may pose risk of crush injuries, (v) a driver climbing up or down agitator ladder may fall or slip; and (vi) low hanging power lines may pose risk of damage and/or electrocution.
>
> In order to perform these tasks effectively and safely, based on my knowledge and belief, concrete drivers need to be physically and mentally alert and focused while performing their tasks..."

13 For the drivers of any heavy vehicle on New South Wales public roads, the requirement is an alcohol level of less than 02 [2ng/mL] - not 05 [5ng/mL] for other drivers. Any confirmed indication of cannabis at all is not acceptable for drivers of heavy vehicles on public roads.. A driver of a heavy vehicle who does not meet that standard may lose his licence to drive a heavy vehicle.

The Available Testing Regimes

14 Mr Darron Brien is the managing director of an organisation providing drug and testing operations [Fit 4 Duty Pty Limited] at various worksites, including those of Holcim. He was called as a witness in the hearing by Mr Miles and outlined in his evidence the procedure he has adopted for testing for drugs by way of urine sampling. Mr Brien described Fit 4 Duty as a leading drug and alcohol testing service provider. It engages a variety of specialists, including forensic toxicologists, scientists and other experts to provide specialist expertise, such as the interpretation of alcohol or drug testing results. It provides on-site drug and alcohol testing services across the country and manages and stores confidential information for clients.

15 Accreditation for on-site collection and screening of samples for the purpose of testing for drugs and alcohol in urine and oral fluid samples is provided through the National Association of Testing Authorities [NATA]. Mr Brien recorded in an affidavit

which formed the basis of his evidence:

> "....NATA is the authority that provides independent assurance of technical competence through a proven network of best practice industry experts for independent accreditation, as required by both the Australian Standards for urine and oral fluid drug testing. NATA provides assessment, accreditation and training services to laboratories and technical facilities throughout Australia and internationally.
>
> Fit 4 Duty holds the highest possible level of accreditation available in Australia for conducting on-site collection and screening of samples for the purpose of testing for drugs in urine. Fit 4 Duty also holds the highest level of accreditation in Australia for collection, storage, handling and dispatch of oral fluids. It is not yet possible for any organisation to achieve compliance with on-site screening of oral samples for the purpose of testing for drug or alcohol use. This is due to the fact that no on-site screening devices for oral fluid have been independently validated at this stage to operate in compliance and conformance with the requirements of the Australian Standard for oral fluid: AS 4760:2006
>
> Fit 4 Duty recently sought NATA accreditation for the on-site screening of oral fluids. However, although Fit 4 Duty's systems and procedures have satisfied all other NATA's requirements for this component, NATA has advised Fit 4 Duty that the issue of independently validated screening kits is a prerequisite for the granting of accreditation... The reason for this is that the available technologies for on-site screening of oral fluids is not yet available to a standard that meets accreditation requirements for NATA...
>
> NATA have certified Fit 4 Duty's urine testing processes in respect to the testing methods, systems and reporting of results and quality system as compliant with the current Australian Standard for urine testing, which is AS/NZS 4308:2008 (and additionally AS 4633:2004 (ISO 15189:2003) Medical Laboratories - particular requirements for quality and competence. The current Australian Standard for oral fluid testing is AS 4760:2006.
>
> Based upon information that is publicly available on the NATA website (www.nat.asn.au) as at Saturday, 3 June, 2010, no testing facilities in Australia were NATA accredited to conduct on-site initial oral fluid testing under S.3 of the Standard. Further, only four facilities (including Fit 4 Duty) have been accredited for collection, storage, handling and dispatch of oral fluid samples pursuant to S.3 of the Standard. In addition, only three facilities have been accredited to conduct laboratory initial screening tests under S.4 and only five facilities have been

> accredited to conduct confirmatory testing procedures under S.5 of the Standard....."

16 Ms Dezra Fullarton is the national manager of another organisation (Mediscreen) which also provides workplace drug and alcohol testing services for a range of employers at particular worksites by oral testing (or urine testing). She was called as a witness in the hearing by Mr Metcalfe. Ms Fullarton asserted that, whilst Mediscreen may be involved in urine testing, all but one of client it engages has opted for oral testing in their workplace.

17 In her evidence Ms Fullarton demonstrated a system of oral testing that Mediscreen uses for random drug tests (Oraline). It involves testing of saliva externally, as distinct from saliva swabs in the mouth. The person being tested provides a sample of saliva which is placed in a small dish attached to the apparatus and it is subject to testing from that dish. In that manner, Ms Fullarton believes that the problems that may arise with oral swabs, which I will discuss later in this decision, are avoided. In fact, there appears to be a range of oral testing devices currently in use with what appears to me to be varying degrees of sensitivity to the drugs being tested.

18 Ms Fullarton recorded in an affidavit that prior to her employment with Mediscreen she was aware of a 12 month pilot study of workplace drug and alcohol testing utilising the Mediscreen system for oral testing at the request of a prominent steel distribution company (OneSteel) at two of its worksites in Western Australia. OneSteel is supportive of the testing carried out by Mediscreen. Ms Fullarton indicated in her affidavit that:

> "....Mediscreen utilises the ChemCentre, the Western Australian Government forensic laboratory (in accordance with AS 4760.2006) for confirmation of initial in field non-negative results for saliva and the ChemCentre provides consultancy and expert testimony, if required, on behalf of Mediscreen... Mediscreen engages registered nurses through a working alliance with Drake Medox, the medical recruitment arm of Drake International. Drake recruit suitable nurses, conduct security and competency checks before recruits are referred to Mediscreen for detailed training in the system prior to being given a field assignment.
>
> The Mediscreen system of processes, procedures, test devices, consumables and documentation is identical throughout Australia, ensuring a high level of consistency in protocols and procedures with strong technical support. The Mediscreen system is utilised by several high profile national companies...and a number of medium size companies, including aviation companies and an airport management company operating under the Civil Aviation Safety Authority (CASA) legislation. In this respect Mediscreen has a presence at every major airport in the country.
>
> Mediscreen supports both urine and saliva testing and their services are delivered in compliance with the Australian Standards AS 4760.2006 and AS 4308.2008. Initial on-site preliminary results of oral fluid drug testing are confirmed by the ChemCentre and correlation between initial immunoassay results and laboratory GC/MS results is extremely high..."

Mediscreen has not yet applied for NATA accreditation but an application for that accreditation is expected in the near future. Ms Fullarton described oral workplace testing as an "...expanding area..." and that a number of employers are coming online with Mediscreen.

19 Ms Fullarton writes on her affidavit:

> "....I have been directly involved in the development and review of workplace safety policies and procedure documents relating specifically to the management of alcohol and other drugs in the workplace and this has included working with committees and key personnel. I have also had the experience of explaining procedures to employees and training key personnel in the associated processes. In my experience I have found that most employers have the strong belief that the primary aim of a workplace drug and alcohol policy and procedure is to raise their employees' awareness and understanding of risk factors through education and training, provide a significant deterrent through uncertainty and unpredictability of test visits and to encourage life style adjustments through the combined efforts and participation of management and workers..."

And she concludes her affidavit:

> "...Because oral fluid testing is less invasive and does not require a dedicated collection area (toilet) and there are no gender issues, site visits can be at more irregular intervals. Testing can take place almost anywhere (CASA contractors conduct testing of personnel by taking the subject aside - outside a building, within an office or work area close to restricted airside operating areas), including roadside, at a client's work site or in a portable site office. Providing confidentiality and privacy and collection protocols are followed, this flexibility creates a greater level of uncertainty and unpredictability, resulting in a stronger deterrent factor. Mediscreen has noted a marked reduction in the incidence of non-negative results for drug abuse at worksites since the inception of testing..."

20 Mr Richard Olsen, a TWU organiser, was called to give evidence in the hearing by Mr Metcalfe. He is aware of certain transport operatives - Tolls Transport Pty Limited, Linfox Logistics Pty Limited, Ceva Logistics Pty Limited and Hy-Tec Industries Pty Limited - who have opted for saliva testing in their negotiations with the TWU because, among other things, it was less intrusive and did not raise privacy concerns. He indicated in an affidavit he supplied as the basis of his evidence that:

> "...the process for saliva testing is not as cumbersome as it is for urine (testing). A contributing factor for Ceva and Tolls in choosing saliva testing was the practicality of testing surrounding gender issues and the impact on efficiency where there are few toilets on site and as many as 30 to 50 employees or contract carriers. I

> am aware that Hy-Tec has a policy to test first using saliva samples and then urine samples. I recall attending a meeting at Hy-Tec where the alcohol and drug policy was explained. The use of saliva testing was again seen to be the practical option for all involved..."

21 However, Mr Olson was also aware that other transport operatives, eg Boral Transport Limited and Hanson Construction Materials Pty Limited, have chosen urine testing for the random drug testing of their drivers. Although random urine testing has apparently been introduced in those transport enterprises without objection from the TWU or its members employed there, Mr Metcalfe understands that the agreement reached in those enterprises was on the basis that the issue could be revisited and replaced by oral testing procedures as they became more readily available. He submitted that I should not regard what had occurred in those other transport enterprises with the introduction of random urine testing of employees and contractors as establishing any precedent for me in this hearing - and I do not do so. All that I may deal with in this hearing concerns only Holcim and its contract drivers, although I recognise, as Mr Metcalfe suggested in this hearing, that what I conclude in this decision may inevitably have some influence for other transport enterprises. The TWU view remains to support random *oral* testing over *urine* testing.

22 I am also aware of the strict drug and alcohol regime imposed for public transport workers - bus and ferry operators - mandated by a regulation made under the 1990 Passenger Transport Act - the 2010 Passenger Transport (Drug and Alcohol Testing Regulation - which prescribes random or targeted urine or blood testing. In particular, Reg.4.1 provides as follows:

> "A test supervisor may require any transport safety employee who the test supervisor has reasonable cause to believe is on duty for the purpose of carrying out transport safety work, or who the test supervisor has reasonable cause to believe is about to carry out transport safety work, to do either or both of the following:
>
> (a) undergo a breath test in accordance with the directions of the test supervisor,
>
> (b) provide a sample of the employee's urine for the purpose of testing for the presence of drugs."

23 A transport safety employee may be required to provide a urine sample whether or not there is any suspicion that the employee has recently taken any drug [Reg.4.3(b)] and the results of the drug testing may be used for the purposes of any disciplinary proceedings against the employee [Reg.4.5(b)].

24 Similarly, and more relevant for the current proceedings, S.19 of the 2008 Rail Safety Act requires a rail transport operator to have a drug and alcohol management programme for rail safety officers which are defined in Ss.4 and 7. In terms of S.19(4) of the Rail Safety Act, the independent body set up under the 1988 Transport Administration Act - the Independent Transport Safety and Reliability Regulator or ITSRR:

> "....may at any time arrange with a rail transport operator for the random testing of any person on duty for the purpose of carrying out, or who is about to carry out, rail safety work for the presence of alcohol or any other drug to ensure that the operator is complying with this section..."

And in terms of S.7(1)(f), rail safety work extends to include:

> "...work on or about rail infrastructure relating to the design, construction, repair, modification, maintenance, monitoring, upgrading, inspection or testing of the rail infrastructure or associated works or equipment, including checking that the rail infrastructure is working properly before being used..."

25 That is, of course, wide enough to cover any contractor, including Holcim contract drivers of concrete agitator vehicles attending State Rail construction projects - and it does cover them. The testing of rail safety workers by way of urine samples is provided by the 2008 Rail Safety (Drug and Alcohol Testing) Regulation. The regime of drug testing for State Rail therefore has particular relevance for the Holcim contract drivers because from time to time they have been called on to work for State Rail projects and when they do they are subject to random urine drug testing. They have accepted that condition in their engagement on such projects (and other projects on which from time to time they may be involved).

26 In his decision in the Refinery Operators Shell Refining (Australia) Pty Limited Award Case Hamberger SDP of the former Australian Industrial Relations Commission indicated a preference for *oral* drug testing and he expressed the view, based on expert evidence before him, that the implementation of a random *urine* testing regime would be unjust and unreasonable in the circumstances, ie it was too intrusive when compared to oral testing. He commented in his decision (at p.23):

> "....[117] Neither party in this dispute sought to argue that random testing for drugs (or alcohol) was unjust or unreasonable. However, both parties also recognised that random testing is an intrusion on the privacy of the individual which can only be justified on health and safety grounds. The employer has a legitimate right (and indeed an obligation) to try and eliminate the risk that employees might come to work impaired by drugs or alcohol such that they could pose a risk to health and safety. Beyond that the employer has no right to dictate what drugs or alcohol its employees take in their own time. Indeed, it would be unjust and unreasonable to do so..."

27 However, the decision of Hamberger SDP was subject to two qualifications: (i) that the laboratories used for oral testing achieve appropriate accreditation according to Australian Standards (something he believed would be achieved in the relatively near future), and (ii) agreement with the relevant trade union - the Construction, Forestry, Mining and Energy Union - and the laboratory concerning what other drugs (eg benzadiazepines) should be the subject of testing and the concentration level for those drugs. He recorded his concerns in that respect in his decision (at p.24), viz:

> "....[123] Firstly, the evidence is that, at this stage, no laboratories have as yet been accredited under the relevant Australian Standard. I note that (one of the laboratories referred to in the proceedings) has applied for accreditation and the lack of accredited laboratories is likely to be resolved in the relatively near future. Nevertheless, the company cannot reasonably expect to implement a random drug testing system based on oral fluids until

> laboratories...have been accredited.
>
> [124] Secondly, there are drugs that the company may wish to test for (such as benzodiazepines) for which AS 4760 does not contain target concentration levels. The company should not be expected to implement an oral fluids based regime until it has the agreement of the union and the laboratory it wishes to use on what other drugs it wishes to test for and what would be an appropriate target concentration level.
>
> [125] Once these two issues are satisfactorily resolved, any random drug testing should be conducted using oral fluids. Until then it would not be unreasonable for the company to implement a urine based testing regime on an interim basis..."

28 It is not altogether clear to me whether or not the oral fluid testing has received the laboratory accreditation to which Hamberger SDP refers as a precondition for oral testing: the evidence before me in this hearing suggests that it may not.

29 As far as *random* drug testing was concerned, Hamberger SDP had this to say in conclusion in his decision (at pp.24 and 25):

> "...[127] Random drug testing involves a trade off between the privacy of the individual and workplace safety. Employees should not have to suffer the intrusion into their privacy involved in random testing unless there is a good safety reason for doing so. Accordingly, there is no basis to conclude that it would be unjust or unreasonable for some employees to be subject to testing and not others, if there is an objective reason for this distinction.
>
> [128] The adoption of a risk assessment process to identify which employees should be subject to random testing is entirely appropriate. Moreover, the methodology contained in the drug and alcohol policy does not seem unreasonable. Clearly there is scope for positions to be reviewed to ensure they are designated appropriately..."

30 The Full Bench of the former Australian Commission in Shell Refining (Australia) Pty Limited v. Construction, Forestry, Mining and Energy Union (2009) AIRCFB 428 reviewed that decision and concluded on the review that the decision was free from error. It upheld the decision, summarising the initial decision of Hamberger SDP (at p.5), viz:

> "....[12] The Senior Deputy President made three critical findings. First, he found that a urine test can detect the use of drugs some days, rather than hours, beforehand ('the wide window of detection'). Secondly, he found that oral fluid testing detects recent use and is therefore less likely to detect drug use in an employee's own time. Finally, he concluded that while neither test measures impairment, a positive oral fluid test is far more likely to indicate actual impairment than a positive

> urine test. In the circumstances, his Honour decided that it would be unjust and unreasonable to permit random urine testing, presumably on the basis that an oral fluid test was likely to detect drug use which was in the employee's own time and which was unlikely to involve impairment. Underlying this conclusion is the view that drug use which is unlikely to directly impact on an employee's fitness for work is not the employer's business.
>
> [13] Despite the finding that random oral fluid testing was to be preferred to random urine testing, the Senior Deputy President's decision did not lead to the immediate introduction of random oral fluid testing... The Senior Deputy President permitted the implementation of random oral fluid testing pending the completion of arrangements to ensure random oral fluid testing would be to a proper standard...
>
> [14] It can be seen that the decision was conditional. While random oral fluid testing was to be introduced, random urine testing was to be permitted until a laboratory had been accredited to carry out oral fluid testing and arrangements had been made which identified the drug to be tested for the target concentration levels to be applied..."

31 The TWU indicated in a statement it prepared prior to the commencement of the hearing that it relies on the decision of the Full Bench of the Australian Commission (and therefore the decision of Hamberger SDP which it supported).

Background

32 Holcim has developed a policy of drug and alcohol testing nationally based on urine testing. Mr Ray Childs, a Holcim contract driver and TWU delegate for the Sydney metropolitan operations of Holcim, and Mr Gary Blackmore, another Holcim contract driver and TWU delegate for the country operations of Holcim, were called to give evidence in the hearing by Mr Metcalfe. They were concerned that the policy was being introduced with what they believed was inadequate consultation with them and they indicated that they were not prepared to accept the policy as it stood.

33 The Holcim drug and alcohol policy which has been developed is that an employee or contract driver who has a non-negative test result is stood down until they are re-tested and found to have a negative result. In the event of the first non-negative result, counselling services are offered to the employee or contract driver through the Holcim employee assistance programme [EAP], although there is no compulsion on the individual driver in that respect. Employees remain on pay whilst they are stood down or alternatively, are assigned suitable alternate duties instead of being stood down. Those options, of course, are not available to the contract drivers, however, although they would be entitled to take sick leave which is contemplated under the two contract agreements covering them. It is an issue for Mr Childs, Mr Blackmore and the TWU that they may lose financially whilst they wait for urine testing.

34 Mr Bruce Nicholson, the national operations manager for Holcim, who was called to give evidence in the hearing by Mr Miles, recollected that drug and alcohol testing and training was introduced in Queensland in 2005 partly in response to the discovery of drug paraphernalia at a Queensland quarry worksite and the admission by a particular employee that he was engaged in the use of a drug (marijuana). Mr Nicholson became acquainted with Fit 4 Duty and Mr Brien assisted in the roll out of a regime of random

drug and alcohol testing. Subsequently, Holcim management made the decision to extend the drug and alcohol regime, including the random urine sampling, nationally.

35 Mr Nicholson recalled an industrial dispute with the TWU in Victoria when the random urine sampling was introduced in the Holcim operations in Victoria. He wrote in an affidavit:

> "....The TWU initiated a dispute in Melbourne regarding the testing method used in random alcohol and drug testing - namely, the introduction of random urine testing. The TWU asserted that oral fluid testing ought to be the testing methodology implemented. The company employed approximately 15 drivers in Melbourne. The drivers opposed the introduction of random urine testing and sought the assistance of the TWU to act as their agent to represent them in their opposition to the company's desire to introduce random urine testing in the workplace.
>
> The drivers engaged in a one day work stoppage to protest the introduction of random testing in the workplace on a Friday in or about April, 2008. I spoke with the two driver representatives over the course of the following weekend to attempt to negotiate a resolution of the dispute. I then met with the driver representatives...immediately following the stop work meeting to discuss their concerns and seek to resolve the matter.
>
> I was informed by the two driver representatives over the course of the weekend that the drivers were primarily concerned about two issues. The first issue was how they would be treated by the company if when tested a non-negative test result was revealed. Second, they were concerned about the testing process revealing that some of the drivers were being treated with various heart and other medications that may reveal personal health issues and wanted assurance that the company would not terminate their services as a result. In response to the issues raised, I informed the two driver representatives that the company would provide the drivers with the opportunity to inform the company of any prescription medications that they were taking in addition to any non-prescription medications to minimise the likelihood of a false positive test result. In addition, I assured the drivers that if they were medically cleared to drive by their attending physician, then they would be permitted by the company to drive when taking legal/prescribed medications.
>
> Although the TWU opposed the use of urine testing and pushed for oral fluid testing, the drivers agreed to the use of urine testing and the dispute with respect to the implementation of the alcohol and drug policy was resolved over the course of the week immediately following the stop work..."

36 Mr Nicholson claimed that apart from one incident in the middle of 2008 there have been no issues raised with Holcim over the implementation of the drug and alcohol policy in Victoria since it was introduced. That incident involved a driver who was asked to provide a urine sample but that sample was ultimately rejected by the nurse engaged to test the driver on the basis that the temperature of the sample did not correspond to body temperature, ie it was a substitute sample. The driver was subsequently dismissed for tampering with the urine sample and, although he threatened to pursue a claim of unfair dismissal, he ultimately did not do so.

37 Mr Childs claimed in his evidence that at some time in 2008 he was informed by the local TWU delegate for the Tweed Heads plant that drug testers had arrived there and had commenced random urine testing on contract drivers. Mr Childs' subsequent inquiries established that the testing was being conducted through the Holcim management in Queensland. Mr Childs informed the Tweed Heads management of Holcim to cease the testing and that occurred.

38 As far as the Northern Rivers region was concerned, Mr Paul Noakes, the area manager for the region, who was called to give evidence in the hearing by Mr Miles, commenced the introduction of the Holcim drug and alcohol testing, including random urine sampling of the contract drivers, in late 2007 in consultation with Mr Brien. He and Mr Brien addressed a meeting of all employees and contract drivers at that time, who were given three months notice that random blanket screening would be conducted at worksites in the region. Ultimately, that random testing commencing in late 2008 and Holcim had proposed that it conduct random drug and alcohol testing by way of urine samples every six to eight months from that time.

39 Mr Noakes indicated in his evidence that since on site urine testing commenced in the Northern Rivers region there have been from 10 to 12 non-negative on-site test results forwarded to the laboratories for confirmation of the test results. He has found that in some circumstances he has had to invoke Holcim's disciplinary procedure after receiving multiple positive confirmations from laboratory testing. He has found it necessary to terminate the employment of one permanent employee as a result of the introduction of the drug and alcohol policy. He recorded the circumstances surrounding that matter in the affidavit which formed the basis of his evidence, viz:

> "....An employee under my supervision was stood down in or about October, 2009, after his first non-negative test result during a random testing process. He was informed and he accepted that in the event of a further positive test, then this would result in further disciplinary action, potentially termination of employment. In or about March, 2010 the employee was randomly tested as part of a subsequent random testing process. The employee refused to submit to the test during the second random testing process, stating that he knew he would fail the test because he had smoked marijuana the prior night. I subsequently determined to terminate the employment of this employee as a result of this incident..."

40 It has been Mr Noakes' experience that when such situations arise, employees (ordinarily casuals) generally chose to resign when they receive a second non-negative laboratory confirmation test result during random testing. He recalls approximately from 6 to 8 employees who have tendered their resignation in those circumstances.

41 The affidavit which Mr Noakes provided as the basis of his evidence was lodged with the Registry on Wednesday, 23 June, 2010 and the TWU became aware of the arrangements in the Northern Rivers region from that time. When Mr Childs and Mr

Blackmore became aware from Mr Noakes' assertions in his affidavit, they travelled to Ballina to speak to the contract drivers for the region. They both assert in the affidavits they provided as the basis of their evidence that they actually travelled to Ballina on Wednesday, 16 June, 2010 but they concede in their oral evidence that date cannot be correct as it preceded the date Mr Noakes' affidavit was lodged with the Registry and the TWU became aware of the situation in the Northern Rivers region. At the meeting Mr Childs and Mr Blackmore explained the position that had been adopted by the TWU in these proceedings before me, ie opposition to urine testing. Mr Blackmore claimed that there were from 5 to 6 contract drivers attending the meeting.

42 The upshot was that the contract drivers in the region indicated their preference for saliva testing in place of urine samples. Mr Childs explained in his affidavit that at the meeting they had with the contract drivers in Ballina they explained to Mr Blackmore and him what had occurred on the previous day, viz:

> "....The owner drivers explained that a van pulled up at the Byron Bay plant with testers and the drug testing process began for the employees. The owner drivers explained...that as all of the employees went ahead, they too submitted themselves to be tested. The owner drivers explained...that Holcim management had not put pressure on them to take the test but then Holcim management did not say that they did not have to take the test due to the current industrial dispute before the Commission.
>
> Mr Blackmore and myself explained to the owner drivers the industrial dispute regarding the drug and alcohol policy that is currently before the Commission. We explained the difference between urine and saliva testing. The owner drivers agreed with our point of view that saliva testing is more preferable due to the privacy concerns of urine testing and the time delays that occur when having to take the test..."

Mr Blackmore gave a similar version of the meeting with the contract drivers in the Northern Rivers region.

43 Finally, as I indicated earlier in this decision, when the Holcim contract drivers perform work in delivering concrete to State Rail construction sites they automatically fall under the regime flowing from the Rail Safety Act and the Rail Safety (Drug and Alcohol Testing) Regulation made under it. Consequently, they may be subjected to random urine testing for such work. This was brought to the attention of Mr Childs and the Holcim contract drivers agreed to being so bound. Mr Childs also described other occasions where the contract drivers have been subject to urine testing when they delivered to other clients - a water treatment plant and a hospital site. The decision taken by the contract drivers was no doubt as Mr Metcalfe described it in his submissions - a commercial decision on the part of the contract drivers, ie *one off* arrangements only, not to be regarded as a precedent, simply to ensure that there were no unnecessary complications in providing the work at such sites.

The Claim

44 Holcim has sought variation to two contract determinations - the Readymix Holdings Pty Limited Sydney Contract Carriers Contract Determination (covering Holcim contract driver in the Sydney metropolitan area) and the Readymix Holdings Pty Limited Country Contract Carriers Contract Determination (covering Holcim contract drivers for country regions in New South Wales) - to incorporate its drug and alcohol testing regime and, in particular, to accommodate random drug testing by way of urine

sampling. Mr Miles argues that it is a matter for the discretion of Holcim management to arrange such testing, consistent with accepted scientific standards. He asserts that it is not unfair, harsh or unconscionable for Holcim to implement its proposed drug and alcohol policy; including the use of random urine testing in the workplace and that the two contract determinations should be varied accordingly.

45 In written submissions Mr Miles emphasises the obligations imposed by the 2000 Occupational Health and Safety Act in that respect, which is placed on Holcim, its directors and managers, viz:

> "....Holcim has a duty, pursuant to S.8 of the OH and S Act to ensure the health, safety and welfare at work of all of Holcim's (employees). In addition, Holcim must ensure that people (other than the employees) are not exposed to risk to their health or safety arising from the conduct of Holcim's undertaking while they are at Holcim's place of work.
>
> In these proceedings there appears to be no issue that there is a necessity for drug and alcohol testing of contract carriers to take place as there is a reasonable foreseeability that a driver affected by drugs or alcohol may injure themselves, employees of the company or members of the public whilst operating a heavy piece of machinery and further, that random drug and alcohol testing would be an appropriate measure to minimise this risk.
>
> In that respect, there are numerous cases of the Industrial Court of New South Wales where defendants (including directors) have been found guilty of breaches of the OH and S Act in circumstances where drivers have had accidents which caused their death or that of a member of the public... Even though the contract carriers are not employees of the company, there is still an obligation upon the company to provide a safe system of work to non-employees and in this case to the contract carriers..."

46 The TWU does not object to random testing for drugs and alcohol. Indeed, it has a well-known opposition to individual employees and contractors involved in the transport industry driving under the influence of drugs and alcohol and has been active to condemn that practice and put into effect measures to eliminate the risk of the impairment of drivers by drugs or alcohol. For instance, the TWU took the initiative in that respect in pursuing a claim for a universal drug and alcohol policy in the transport industry in New South Wales (if not necessarily going so far as random testing), culminating in the decision of the Full Bench of the Commission (Wright J - President, Walton J - Vice President, Sams DP and Tabbaa C) in Re Transport Industry - Mutual Responsibility for Road Safety (State) Award and Contract Determination (No.2) (2006) 158 IR 17.The Full Bench commented (at pp.74 and 75):

> "....[232] We do not consider it could seriously be suggested that the requirement for all transport operators to have a drug and alcohol policy, which includes drug and alcohol testing, is not a highly desirable tool to combat the widespread use of

> drugs by employees in the road transport industry. In many ways, it is most surprising that the initiative in this regard has been from the union. It is trite to observe that there has been a long held resistance from unions on behalf of their members for drug and alcohol testing sought to be introduced by employers.
>
> [233] We would suggest that rather than criticising the proposal, the union's acknowledgement of the need to address this issue should be welcomed. Such criticism, we think, is largely disingenuous.
>
> [234] We do not consider that the employers' criticism of the union's proposal based on a failure to provide for random testing and an insistence on a preferred method of testing is sustainable from a strict reading of the draft proposal. We accept...that the draft proposal is not meant to be prescriptive and does not prevent random testing. We consider, however, that the policy should specifically allow for random testing..."

47 In the written statement provided to me by the TWU as a response to the Holcim claims it commented:

> "....The union condemns in the strongest terms the use of illegal drugs and the use of legal drugs during work hours or in a manner that affects the performance of the workers. The safety of workers and the users of public roads is paramount..."

But it adds in that written statement:

> "...Despite this, the union considers that any testing regime should be well adapted to its proper purpose and only as intrusive as necessary. A poorly designed, excessively intrusive and poorly focused system will not assist the fundamental objective of safety. A testing regime that excessively penalises workers or appears disconnected to the objective of safety will tend to be avoided and will lack the confidence of all concerned. Further, any drug and alcohol policy that has the potential to lead to the dismissal of an employee must be clear, consistent and transparent. The policy is currently unclear, inconsistent and not transparent and therefore it would be unfair to implement it..."

And in the written statement the TWU further comments that:

> "...the union repeats its condemnation of illegal drug use in any circumstances but believes that a zero tolerance policy is not the best approach to achieving the objective of eliminating the risk that contract carriers perform work whilst impaired by the effects of drugs and alcohol..."

48 Nevertheless, the TWU is opposed to the drug and alcohol policy introduced by Holcim, and in particular, the fact that it relies on urine sampling. As I understand the

TWU position in this hearing, its chief concerns fall essentially under five headings, viz:

(i) it believes that urine sampling is unnecessarily intrusive, invading the privacy of the individual, and it supports instead oral testing which is, in its opinion, more convenient to the contract drivers (and no doubt for the management of the transport enterprises);

(ii) it is concerned that urine sampling would be a slower process than oral testing and, since the contract drivers are paid according to the loads that they actually take, it would mean that any unnecessary time they spend waiting for urine testing would prevent them from obtaining a load of concrete and therefore adversely affect the level of the remuneration they receive: this is not an issue for employee drivers when they are tested because they would be paid during the testing but for the contract drivers, time would mean money to them;

(iii) it believes that the drug and alcohol policy appears to be part of a regime of discipline against the individual driver, rather than looked at as an occupational health and safety issue;

(iv) it is concerned over the outcome of a non-negative testing of a contract driver and Holcim's apparent acceptance that such a finding would automatically support the contention that he was unfit for work: it apparently accepts the proposition which has emerged from the evidence that urine sampling provides a better history of drug taking but that history may not necessarily result in the impairment of the driver at the relevant time of the testing and his driving of the vehicle: it is the actual impairment of the individual driver which primarily raises the occupational health and safety concerns, rather than whether or not he has taken that drug at other times for recreational purposes: and

(v) it is also concerned at the incidents of false positive results from urine testing.

49 Mr Miles asserted during the course of the hearing that the contract determinations covering the Holcim contract drivers provides sick leave arrangements and a contract driver showing a non-negative test result would initially be entitled to rely on those sick leave provisions. He refutes Mr Metcalfe's claim of excessive waiting time for the drug testing. He believes that the process would not be time consuming and that at each worksite there would be insufficient individuals to be tested on each occasion to lead to any real delay. The contract drivers already work to a rotating roster arrangement for the allocation of work to ensure fairness and the random testing could be carried out to accommodate individuals according to that roster.

50 Mr Metcalfe believes that there are a number of points of departure between the proposal advanced by Holcim for its drug and alcohol testing regime and the type of policy contemplated by the Full Bench in the Mutual Responsibility for Road Safety Case and codified in the Transport Industry - Mutual Responsibility for Road Safety (State) Contract Determination, which flowed from it. In particular, no mention is made

in the Holcim policy of the desirability of eliminating professional drug taking amongst contract carriers: the *raison d'etre* for the industry determination was the elimination of professional drug taking by transport workers but that is ignored in the Holcim application with what Mr Metcalfe described as a "two strikes and you're out" policy. Mr Metcalfe also asserted that no provision is made for the involvement of the TWU in training the drivers and he sees that as essential for the development of a proper policy to eliminate drugs in the workplace.

Toxicological and Pharmacological Evidence

51 It is with that background information, I turn now to examine the evidence given in these proceedings concerning the efficacy of urine samples and oral testing, including saliva swabs, to identify the presence of drugs. That has been the main area of contention between Holcim and the TWU. I have been assisted in this hearing by comprehensive evidence from two experts in the field of toxicology and pharmacology. Dr John Lewis, a consultant toxicologist, was called to give evidence in the hearing by Mr Miles. Dr Judith Perl, a consultant pharmacologist, was called to give evidence by Mr Metcalfe.

52 Dr Lewis is a toxicologist with over 30 years experience in testing for drugs of abuse and he asserts that he is recognised as one of Australia's leading experts in this field, who has published a number of articles on the analysis and interpretation of drugs of abuse. He is chairman of Standards Australia CH-036 which is responsible for the development of Australian Standard AS/NZS 4308. He indicated in his evidence that he had spent 10 years in drug testing in canines and 28 years involved in drug testing in humans - in drug and alcohol treatment centres, prisons and workplace drug testing.

53 Dr Perl holds degrees of Bachelor of Science (majoring in pharmacology and physiology) and a doctor of philosophy (in pharmacology) from the University of Sydney. She is a member of the International Committee on Alcohol, Drugs and Traffic Safety and a Fellow of the Australasian College of Biomedical Scientists. Since 1979 her principal area of research has been the effects of alcohol and drugs on psychomotor performance skills (primarily related to driving ability), ie traffic violations, traffic crashes, etc. She was a technical officer at the 2000 Olympics and has been the chairperson of the Appeal Tribunal for Drugs in Cycling for the Australian Cycling Federation.

54 It is essentially the evidence of both Dr Lewis and Dr Perl on which the scientific basis of the conflicting claims before me is to be evaluated. And it appears to be common ground between them that both urine testing or oral samples, including saliva swabs, have their own inherent defects. There are, in fact, many areas of agreement between Dr Lewis and Dr Perl. However, Dr Lewis, on balance, favours urine testing as the more appropriate measure for the Holcim contract drivers the subject of this dispute, whilst Dr Perl gives more support to oral testing. Whilst, as I indicated earlier in this decision, their evidence was not given concurrently, they had remained present in the hearing whilst they gave their respective evidence and were able to advance issues for cross-examination through Mr Miles and Mr Metcalfe to assist in crystallising and confining the main areas of dispute between them.

55 Dr Lewis identified two major drugs of abuse of particular concern in the workplace - methamphetamine and cannabis. In these proceedings, as Mr Miles indicates in his written submissions, there has been a particular emphasis in the evidence on cannabis and the amphetamine class of drugs because those drugs are the two major drugs of abuse of concern in the workplace and, indeed, by police forces. There was also some evidence in the proceedings concerning benzodiazapines, chiefly a supplementary report by Dr Perl which the TWU did not supply until Tuesday, 30 November, 2010 and which I admitted into evidence at the commencement of the proceedings on Thursday, 2 December, 2010 over the initial objections of Holcim.

56 As Dr Perl records in her supplementary report, benzodiazapines are generally

legitimately prescribed drugs, commonly used to treat various illnesses, including anxiety, sleep disturbances, temporary treatment of stress and depression, muscular tension resulting in pain and epilepsy. According to Dr Perl's report, the detection of benzodiazapine in both oral and urine merely indicates past usage of the drug. Both urine and oral fluid screening tests only detect the class of the drug and confirmation by gas chromatograph/mass spectrometry or similar method would be required to identify the particular benziodiazapine present. Dr Perl writes that:

> "....in my 25 years of experience, benzodiazapine abuse is relatively uncommon in the majority of users who are prescribed the drug. However, there is certainly significant abuse of this class of drug by heroin addicts and other recreational uses of illicit drugs. A person using a benzodiazapine as prescribed, on a daily or regular basis, would develop significant tolerance to any of the sedating effects of the drug and therefore would generally not be impaired in their cognitive and motor functions. If there was any impairment, I would expect there to be obvious visible signs of 'intoxication', drowsiness, swaying or unsteadiness, slower actions and speech, possibly slurred speech. These are signs which should be obvious to any person properly trained in conducting any form of body fluid testing..."

57 Methamphetamine is a psychoactive stimulant of the phenethylamine and amphetamine class of drugs with a high potential for abuse and addiction by activating the psychological reward system via increasing levels of dopamine, norepinephine and serotonin in the brain. The particular problem in the transport industry, particularly long distance transport, is not its use for recreational reasons but to meet inappropriate deadlines and avoid the onset of fatigue whist driving.

58 In the Mutual Responsibility for Road Safety Case the Full Bench commented on the findings of surveys (at p.29), viz:

> "...[22] Two national surveys in 1991 and 1998 recorded that the use of 'stay awake' or stimulant drugs was cited by drivers as one of the two most helpful strategies for managing fatigue... Whilst the precise level of drug use in the long-distance trucking industry was unknown, the evidence led to a firm conclusion that it was widespread... Prolonged sleep deprivation/fatigue and drug use may not only increase the risk of truck crashes but also will have long-term health effects on the drivers affected.
>
> [23] Of the 13 driver witnesses, a number openly admitted using stimulants to help them work: others gave evidence of having conversations with other drivers about the use of illicit drugs while working: three drivers spoke of management knowing or encouraging the use of drugs during the course of performing their work..."

59 According to Mr Metcalfe, that should not be such a major issue for the Holcim contract drivers whose work, of course, does not involve long distance travel where the

use of the drug would have the most impact. But, in my opinion, it still would have some relevance in this hearing and remains an issue which I expect would be addressed by the Holcim drug and alcohol policy.

60 In his report Dr Lewis highlighted the fact that while a person was in the withdrawal phase of the use of methamphetamine there was still, in his view, an impairing effect from the drug, viz:

> "....Low blood concentrations of methamphetamine did not exclude the possibility of impairment. There is a relationship between blood levels and corresponding saliva levels of methamphetamine; this is known as the plasma:saliva ratio. For methamphetamine, this ratio is highly variable, meaning that in some individuals the saliva concentration could be very low if the plasma (blood) levels are also low. Thus...there is evidence of impairment once blood levels drop to very low amounts. It follows that saliva levels could also be very low and possibly undetectable by on-site devices. By contrast, there is a greater possibility of identifying this recent use by way of urine testing..."

61 Dr Perl had already given evidence in other proceedings before this Commission concerning the effects of methamphetamine on drivers. For instance, in the decision of Walton J - Vice President of the Commission in WorkCover Authority of New South Wales v. Hitchcock (2004) 135 IR 377 her evidence is described by his Honour (at p.429) in the following terms:

> "....[181] Dr Perl agreed that methamphetamine was psychologically addictive and that a long-term user may believe that they had to take the drug in order to stay awake when in fact this may not be the case.
>
> [182] According to Dr Perl, during the acute stimulant phase following use of amphetamines there is a marked increase in wakefulness, alertness and euphoria: perceptions and judgements are altered and there is commonly an increase in risk-taking behaviours. High doses lead to hyper-reflexia, restlessness, talkativeness, sleep disturbance and insomnia, headache, hypertension and palpitations. The user may experience hallucinations and paranoid thoughts. When the over-stimulation of the brain wears off there is a reactive depressive stage referred to as 'crashing', the most common symptoms of which include extreme fatigue, sleepiness and depression.
>
> [183] Methamphetamine can impair driving abilities in two different ways: by impairing judgement and increasing risk-taking behaviour, or due to the fatigue and hypersomnolence as a result of withdrawal. Often this second stage impairs driving ability to a greater extent than the initial stimulation. The drug-induced fatigue or depression is exacerbated by the natural fatigue the driver was masking in the first place. Like all stimulants, it produces physiological effects such as palpitations and hypertension, thereby increasing the risk of a

cardiovascular accident (such as a cardiac arrest or stoke).

[184] Dr Perl agreed under cross-examination that even low doses of methamphetamine in some individuals could produce a stroke or even some form of a heart attack, and agreed that given the presence of methamphetamine in (the driver's) liver, a cardiovascular accident may have been a factor in the crash..."

62 Dr Perl gave similar evidence in these proceedings, highlighting the risks associated with the use of methamphetamine by transport workers and going further to explain her views on urine testing and oral testing for that drug, viz:

Mr Miles: ...It's been reported...(particularly from Dr Perl's evidence in WorkCover Authority of New South Wales v. Hitchcock) that truck drivers use stimulant drugs to temporarily delay the onset of fatigue and sleepiness and they use them in response to occupational pressures to meet unreasonable driving hours, rather than for recreational reasons, such as to alter their mood.

Dr Perl: That is correct.

Mr Miles: So you still have that opinion?

Dr Perl: Yes.

Mr Miles: And that methamphetamine can impair driving abilities in two different ways?

Dr Perl: Yes.

Mr Miles: It can impair judgment and increase risk taking behaviour during the acute phase?

Dr Perl: Yes.

Mr Miles: And it can lead to fatigue and excessive sleepiness as a result of withdrawal?

Dr Perl: Yes.

Mr Miles: And I think your evidence was that the withdrawal of it can, in fact, be a greater level of impairment than the initial phase?

Dr Perl: The acute phase, yes.

Mr Miles: And you'd agree, wouldn't you that the use of methamphetamine by a truck driver should be a concern to a transport company?

Dr Perl: Yes.

Mr Miles: And the concern is not simply limited to whether they are impaired right now, is it?

Dr Perl: No. Well, the concern is that there is a potential, but whether that person is a risk would depend on when they used it, how often they used it, what particular matrix you're using to detect it. So there are a lot of variables in that.

Mr Miles: But the use may be professional (ie occupational) use?

Dr Perl: It may be for occupational reasons, yes.

Mr Miles: ....That any level of detection for a transport company may give you an indication that a person is using (the drug) for occupational reasons?

Dr Perl: It may.

Mr Miles: It's certainly something that the company should be aware of?

Dr Perl: I would think that, yes. A company should be aware if somebody is a regular user, yes.

Mr Miles: Or even an irregular user, shouldn't they?

Dr Perl: ...Look, there are truck drivers who use (the drug) recreationally in their own time for their recreational pleasure but generally...truck drivers tend to use (it) for professional occupational reasons.

Mr Miles: And so if your goal is to eliminate the use of methamphetamine for occupational reasons, that a longer window of detection would be preferable?

Dr Perl: If it's as a deterrent, yes, and to change behaviour, yes.

Mr Miles: And even to identify that there's a problem?

Dr Perl: That there's a potential problem, yes.

Mr Miles: Yes, that there's a potential problem. And would it be accurate to say that a positive oral fluid test is consistent with the first stage of impairment that you spoke about?

Dr Perl: With recent use, yes.

Mr Miles: And what about the second stage of impairment?

Dr Perl: You're not likely to find methamphetamine in the oral fluid when the blood levels have fallen to very low levels, at which stage there may be still that rebound impairment or that crashing phase.

Mr Miles: So that's likely to be a day or two after the use?

Dr Perl: That is correct.

Mr Miles: So it's still likely to be detectable in urine in that stage?

Dr Perl: Yes, it is more likely to be detectable in urine.

Mr Miles: So that if a person gives a negative test to oral fluid for amphetamine or methamphetamine, let's be precise, you couldn't be confident that the person is not impaired?... I think your evidence is that a positive test for oral fluid, you can be confident the person is impaired?

Dr Perl: Yes.

Mr Miles: What I'm putting to you is that a negative test for oral fluid, the person might still be impaired?

Dr Perl: They may be impaired for many reasons, including fatigue.

Mr Miles: Yes, but they may be impaired by the use of methamphetamine?

Dr Perl: They may be.

Mr Miles: And you can be confident, can you, that a person who returns a negative urine test, they're unlikely to be impaired by methamphetamine?

Dr Perl: No. Not if the levels have fallen to below detection limits and the person is in the withdrawal phase.

Mr Miles: Does the withdrawal phase last for longer than two or three days?

Dr Perl: I suppose it depends on...how heavily the drug was used prior, but yes its possible that you could have a withdrawal state that lasts several days and the urine levels may fall below the detection limit and you may still have some residual impairment.

Mr Miles: But it's less likely than with oral fluid, isn't it?

Dr Perl: Well, it's less likely, but it's still there. The risk's still there.

63 Cannabis (marijuana) remains the prevalent illicit drug used throughout the community and much of the scientific evaluation of the testing regimes before me in this hearing, and much of my decision, concerns it specifically. Tetrahydrocannabinol [or THC] is the major active cannabinoid found in cannabis and it is responsible for the

majority of the intoxicating effects of smoked cannabis. There are, in fact, numerous cannabinoids and it is only the *inactive* metabolite delta-9-tetrahydrocannabinolic acid in cannabis [or delta-9-THC acid or simply - and confusingly - also referred to as THC] which is measured in urine. That is not the primary *active* element of the drug responsible for the impairment of cognitive and motor functions, however - although the *inactive* THC would not, of course, be present in urine unless the individual being tested had some contact with cannabis.

64 Dr Perl nevertheless sees that issue as a fundamental flaw in the use of urine samples to confirm actual impairment from consumption of cannabis. She wrote in her report:

> "....It is asserted by Holcim that they have accountability under relevant legislation and common law 'duty of care' to ensure a safe workplace and safe systems of work for persons accessing or working on their sites. The policy is based on 'fitness for duty' in relation to alcohol and other drugs. Holcim proposes urine testing for its workforce of contract carriers engaged in carting ready mix concrete. If the policy is designed to eliminate the risk of 'performing work whilst impaired by the effects of drugs or alcohol' then urine testing is an inappropriate sample..."

It follows, as Dr Perl indicated, that the presence of THC, ie delta-9-THC, in urine is not, of itself, sufficient grounds to establish conclusively impairment of the individual person at the time of his being tested.

65 Dr Perl indicates in her written report that Australian Standard AS/NZS 4308 relating to urine sampling confirms that the standard "...has no relevance to the issue of impairment...". Dr Perl comments in that written report that:

> "....the presence of a drug in urine merely indicates some past usage of the substance and in some rare instances may even indicate mere exposure to a substance, such as cannabis. For example, a positive result in urine for cannabinoids can occur if the subject was exposed to intense cannabis smoke, for example in an enclosed space with a heavy cannabis user...although, generally following a single exposure, the amount of smoke exposure will not result in a concentration high enough to be above the screening cut-off limits proposed in the Australian Standard AS/NZS 4308. There is a higher risk of a positive result if the exposure is regular and intense. Thus, to avoid a positive urine result, the worker not only needs to avoid smoking or ingesting cannabis, but must also avoid being in the close vicinity of a heavy user of cannabis."

66 Dr Lewis points out that a single dose of a drug may be detected in urine for from 4 to 5 hours after ingestion and up to several days later. Most drugs are eliminated within 2 to 4 days after use but cannabis (marijuana) is an exception. Dr Lewis claimed that a naive user, ie one who is a very infrequent cannabis user, will eliminate the drug within hours following a single smoke but frequent users take a few days and chronic users may take up to three weeks to totally eliminate cannabis metabolite - the *inactive* and harmless component of the drug.

67 Nevertheless, Dr Lewis has claimed in a written report that urine testing has been shown to be highly effective in identifying *recent* drug use and testing methods which comply with Australian Standard AS/NZS 4308 (as Fit 4 Duty urine testing clearly does) are in his opinion accurate. In her report Dr Perl takes issue with that claim concerning *recent* drug use by Dr Lewis, viz:

> "....The issue of 'recent drug use' is highly questionable in the case of cannabis. From my personal experience, many long-term, very heavy users of cannabis who cease using cannabis have detectable THC in blood for only a short period of time (generally, no more than days,) but the inactive delta-9-THC acid can be detectable in urine for several months. Several months is not 'recent'..."

68 The following relevant comments were made by Ms Fullarton in her evidence on her oral testing regime:

> Commissioner: I gather that oral testing that you arrange doesn't actually pick up a history of drug use where urine testing does?
>
> Ms Fullarton: That is correct.
>
> Commissioner: Is that an area of possible concern with some drugs in your expectation?
>
> Ms Fullarton: With the companies that I do testing for, I've been part of their inductions as well. Their concern when a person shows up for work is that they are fit for work when they show up for work.
>
> Commissioner: At that time?
>
> Ms Fullarton: Absolutely.
>
> Commissioner: ...Bearing in mind these are random tests, and I don't mean to put it on the basis of a lottery, but if a person is using THC, marijuana, smoking marijuana regularly, but just not on that particular day, is that an area that could be a cause of concern?
>
> Ms Fullarton: It doesn't seem to be of concern to the companies that I am dealing with and that's through aviation, transport, manufacturing. Their primary concern is that a person is showing up fit for work and most of the programmes are called fit for work.

69 Dr Lewis also spoke in his evidence of what he described as the "hangover effect" with cannabis, ie after the initial period of impairment when the drug would be likely to be detected by oral testing, the individual may nevertheless still be adversely affected and yet give a negative result to oral testing. Dr Lewis spoke of this question of impairment with cannabis consumption in his evidence, viz:

> Commissioner: The impairment of the individual, that would vary, would it?
>
> Dr Lewis: Well, my understanding of impairment is we have what we call acute impairment, which is

> the immediate euphoric effects which are agreed to be up to about six hours. So after someone has smoked a cigarette, you are impaired for up to about five or six hours. There is a second period of impairment which is less understood where you have what we call a hangover effect. In other words, the after effect of a substance. And it's probably more so if a person is using it on a more frequent basis. And the simple analogy is someone who has a caffeine addiction or a nicotine addiction. If they suddenly stop using, they are going to be impaired because the blood levels drop and they are going to feel very uncomfortable. So I think it's very important that when we understand what impairment is -
>
> Commissioner: You're talking about an habitual user in that?
>
> Dr Lewis: Habitual users, that is correct. And that's all part of the impairment...
>
> Mr Miles: The extent of any withdrawal or hangover effect would vary tremendously, based on the different drugs. Is that -?
>
> Dr Lewis: It would. It would.

70 Furthermore, Dr Lewis speculates in his report that the identification of "...irregular or habitual users of cannabis..." still highlights potential risks to safety in the workplace and he spoke in his evidence of a possible loss of cognitive functioning and motor skills for habitual users of cannabis. He commented in his written report:

> "....For cannabis impairment, there is strong clinical evidence of impairment following regular and long-term (chronic use)."

> And he refers to conclusions reached in various academic studies on the consequences of cannabis use and the impairment effects in cannabis users, including both cognitive and psychomotor impairment and that the heavy use of marijuana was associated with persistent decrements in neorocognitive performance even after 28 days of abstinence. He relies on comments made that "...recent studies in Australia on fatally-injured drivers suggest that drivers with THC concentrations over 2ng/mL are more likely to be responsible for the crash..." and that "...drivers with significant THC in blood (probably over 2ng/mL) tend to present as impaired and culpable..." [Drummer O, The Forensic Pharmacology of Drugs of Abuse (at p.207)].

71 Dr Lewis adds in his written report:

> "....There is a direct relevance of the coroner's findings and reviews of blood THC levels detected in drivers involved in vehicle accidents to Holcim's assertion that oral fluid testing is an inappropriate means of identifying risk of accident in its contract with drivers. In a study involving controlled experiments in smoking cannabis [Huestis M and Cone E, Relationship of delta-9-Tetrahydrocannabinol Concentrations in Oral Fluid

and Plasma after Controlled Administration of Smoked Cannabis. J Anal Toxicol 28 394-399 2004] reported on the relationship between plasma and oral fluid concentrations over time. They found a parallel in the decay of plasma and oral fluid levels of THC in a subject smoking a single cannabis cigarette. After approximately two hours, both plasma and oral fluid levels dropped to less than about 5ng/mL. One would expect these levels to drop lower in the ensuing 2 to 4 hours, a time frame within the accepted period of acute impairment.

The issue for Holcim to consider is that blood and therefore oral fluid levels of THC fall to very low levels within the period of acute impairment and these levels have been implicated in motor vehicle fatalities. There is no existing on-site device for oral fluid that is capable of identifying THC at these levels. I am of the opinion that there is a far greater likelihood of an on-site oral fluid test producing a negative result for cannabis than there is of identifying a positive one and thus not identifying a risk of impairment..."

72 In his report Dr Lewis spoke of a study and a theory to the effect that:

"....There is...evidence for an 'amotivational syndrome' in chronic heavy cannabis users. These symptoms include apathy and the inability to carry out complex long-term plans or concentrate for long periods of time. It is apparent that there are a number of impairing effects of cannabis long after the initial euphoric effects have subsided. I am of the opinion that studies into blood levels of both methamphetamine and THC (active ingredient in cannabis) highlight a naiety in those who assume that impairment equates only to the immediate euphoric effects of a drug..."

However, Dr Perl asserted in her evidence that the views of that study on which Dr Lewis based his comments are still controversial.

73 In his written report Dr Lewis further describes urine testing as a "mature discipline", with much support by overseas guidelines and in toxicological journals over the previous 20 years and "...on-site screening which has followed the well-established and existing highly developed laboratory-based immunoassay screening procedures...". For instance in the United States of America guidelines established by the Substance and Mental Health Service Administration [SAMHSA] which originally included oral fluid (saliva), sweat and hair as alternative matrices for the detection of drugs has subsequently deemed them inappropriate because of inherent difficulties in laboratories to reliably detect drugs at the required cut-off levels and the unavailability of quality controls and quality assurance programmes.

74 A report on a study of oral testing for drugs from Belgium [ROSITA Final Report (Eds) Verstraete A and Raes, Elke. Ghent University Belgium, March 2006] concluded:

"...At the end of the study, no device was considered reliable enough in order to be recommended for roadside screening of drivers. However, the

> experience in the State of Victoria in Australia shows that random roadside oral fluid testing of drivers for methamphetamine and cannabis using...has a deterrent effect. Government officials should carefully weigh the pros (deterrent effect) and the cons (risk that drivers will realise that they often test negative after having used drugs due to the limited sensitivity of the test) of introducing random (oral) drug testing with the current available devices..."

75 And a very recent Finnish study [DRUID - Driving under the Influence of Drugs, Alcohol and Medicines. Analytical evaluation of oral fluid screening devices and preceding selection procedures (Eds) T Blencowe, Anna Pehrsson, Pirjo Lillsunde. Project No. TREN-05-FP6TR-S07. 61320-518404-DRUID Finland, March 2010] records that for saliva screening devices:

> "....it is disturbing that the sensitivity of the cannabis and cocaine tests were quite low... None of the evaluated devices is on a desirable level (80% for sensitivity, specificity and accuracy) for all of the separate tests that they comprised..."

Of course, oral testing is all that is practicable for roadside testing of drivers. But workplaces obviously have proper facilities, ie toilets, available to obtain urine samples, albeit the procedure for testing may be more involved than oral testing and take longer to carry out.

76 A false positive reading from a urine test (or an oral test) is, of course, less of a concern for it would be subject to confirmation in subsequent laboratory testing which would establish that the initial reading was not correct. But a false negative for a urine test (or an oral test) would naturally go no further. Dr Perl adds in her report:

> "....While it is desirable that a screening device does not have too many false positives or false negatives, any result obtained on a positive *must* be confirmed and the confirmation procedures for either urine fluid is carried out in a laboratory by gas chromatography and *only* this confirmation be used to imply a positive finding..."

Therefore a driver actually under the influence of drugs who nevertheless produces a false negative reading from his test - urine or oral - may go undetected - except for what an observer may actually see from his conduct, behaviour and attitude at work. It is for that reason that I believe it is important to ensure the most accurate initial assessment as possible.

77 There are presently eleven laboratories in Australia accredited to conduct both screening and confirmatory testing of urine - under AS/NZS 4308. By comparison, Dr Lewis asserts that the use of oral fluids for drug testing is of more recent application and it has bypassed the laboratory-based screening with total reliance on the device provided to detect drug use. According to Dr Lewis there is only one laboratory in Australia that is fully accredited to undertake both screening and confirmatory testing using oral fluids. In that respect Ms Fullarton had this to say in her evidence:

> Ms Fullarton: The accreditation of a device in particular is a lengthy process. Saliva is relatively new in comparison to urine testing and the cost associated with that as well you would certainly

want to make sure that the device that you were getting accredited was the one that you were going to stay with. And with all the development still ongoing with saliva testing, I would suggest that's the reason why no one has done it as yet.

Mr Metcalfe: Is there also an economies of scale issue there, that the more potential donors you have, the more cost effective it becomes to get accreditation?

Ms Fullarton: Absolutely.

Mr Metcalfe: And in your experience, is this an expanding area of workplace testing?

Ms Fullarton: Certainly. I mean, the number of companies that are coming online with us that have not done testing before is increasing.

Mr Metcalfe: And will that therefore, in your view, lead to a commercial decision being made to pursue accreditation in the not too distant future?

Ms Fullarton: That is certainly our goal, yes.

78 Clearly, saliva swabs and other oral testing devices are less intrusive than obtaining a urine sample. Dr Lewis also acknowledges certain benefits from oral testing, ie (i) that there is no requirement for a toilet or other private area for collection of the sample and (ii) that there is a more rapid confirmation of a test result of any drug ingested within hours of analysis. Dr Perl also asserted that oral testing is less likely to produce a compromised sample since the urine sample is provided in private and therefore any conduct by the person aimed at producing a false urine sample would be less likely to be detected.

79 Firstly, therefore, there is arguably the greater potential of adulteration of the urine sample provided by the individual in the privacy of a toilet cubicle. There is always the possibility that in such circumstances the sample may be tampered with in a manner which would not arise with saliva samples given by the person being tested in the presence of the person actually giving the test. Dr Lewis conceded in his evidence that it was always possible for the person giving the urine sample to adulterate his urine by way of chemicals under the fingernails, affecting the screening tests, by drinking copious volumes of water prior to the test, thereby diluting the urine to make detection of drugs more difficult, or substituting another person's urine for the person being tested. Dr Lewis claimed, however, that there are laboratory tests that can detect adulterants and the creatine test, performed by competent laboratories, easily identifies urine dilution.

80 The temperature of the urine sample also provides a key to it being a replacement. A recent example of an occasion where an employee had tampered with a urine sample in a random drug test in that respect was referred to by Macdonald C of Fair Work Australia in his decision of Friday, 12 November, 2010 in Ruddell v. Camberwell Coal Pty Limited [2010] FWA 8436. In that case a cold urine sample was not accepted by the person taking the random drug test and the employee was dismissed for serious misconduct. Macdonald C upheld that decision. I would expect that Fit 4 Duty has a fairly sophisticated system in place to eliminate that prospect. Indeed, Mr Nicholson has given evidence of an example where a nurse rejected a urine sample provided to her because it was not at body temperature.

81 Dr Perl gave a number of illustrations of incidences where an individual had

substituted urine to avoid detection of the presence of drugs in the individual being tested and still retaining an appropriate body temperature for the sample to avoid detection of tampering, eg secreting a replacement bag or bottle of urine on the body, in the underpants, in body cavities, to use in the privacy of a toilet. As I understand Dr Perl's evidence, those examples arise predominantly from the use of substances to improve sporting performance. An athlete taking a substance to improve performance would be aware that if he or she subsequently won the competition - the purpose of taking the substance in the first place - the athlete would automatically be subject to urine testing: in that sense therefore, the testing would not actually be *random* and unexpected. To my mind, it is less likely that an employee or contract driver would be prepared, for instance, to regularly carry around a sample of somebody else's urine in his underpants on the off-chance that he would be subject to a random test on a particular day.

82 Dr Lewis gave the following evidence on the basis of oral fluid testing for cannabis:

> Mr Miles: How does the cannabis, the THC enter into the oral fluid?
>
> Dr Lewis: The presence of THC in oral fluid is predominantly as debris. If one smokes a cigarette, you have particulate matter in the mouth and the THC is present in that debris. Basically, what's in the mouth, what's in the teeth, what's behind the gums, it sits there as a result of the rubbish, basically, the solid particulate matter. Unlike other drugs, THC does not pass from the bloodstream into the saliva. Even though there is a parallel in the decay of those drugs over time, there is no correlation. So THC in the oral cavity is a result of what is left over from the smoking process.
>
> Mr Miles: So if that THC is removed, is it replenished?
>
> Dr Lewis: It's not replenished. You may find a very, very miniscule amount that may have been sequestered into the gum tissue, but that hasn't been well documented. Experts in the field and the researchers and the publications point out that predominantly, to all intents and purposes, THC is as debris in the mouth and once it's gone, it's essentially gone.

83 And Dr Lewis also indicated in his report that he believes there are certain defects with oral testing, viz:

> "...Proponents of saliva testing often claim that unlike urine, saliva cannot be adulterated. However, there is published scientific data to suggest that levels of THC in the mouth can be significantly reduced by drinking alcoholic beverages or by using adulterants or mouthwashes. It would be reasonable to assume that brushing teeth and using dental floss could further diminish THC contaminated debris from the mouth. Although saliva is technically immune from the types of adulterants used to mask a urine test, it is very easy for a user of cannabis to perform simple oral hygiene after smoking. Whereas this does not guarantee a person 'passing' a

drug test, there remains a high probability that low levels of THC may be undetected..."

84 As I see the position, it appears that within a fairly short space of time - and certainly when a person may still arguably be impaired by the drug - it may no longer be detectable in the mouth. Dr Lewis indicated under cross-examination:

> Mr Metcalfe: ....I think your evidence is that unless it was tested within three hours of ingestion, the oral fluid method would not pick up levels of THC. That is, after three hours, it's increasingly unlikely, perhaps even improbable that the oral testing would pick up use of cannabis, is that right?
>
> Dr Lewis: There is evidence with some devices and some screening techniques, that it's not detectible after one hour. It's highly dependent on the method, probably the method of smoking...and the method of screening and the method of collection all have very serious impact on how much THC is actually collected.

85 Conversely, the main disadvantage for urine samples appears to me to be the delay for the body to process recently ingested cannabis. According to Dr Perl, a person who has just consumed cannabis orally, ie smoking a joint or using a bong of marijuana, may take up to three hours before THC is detected as waste product in the urine. It would appear to follow that a person may produce a negative result from a urine sample at the very time that he is most impaired by the drug.

86 Dr Lewis conceded that position in cross-examination, viz:

> Mr Metcalfe: ...Urine testing is not particularly useful in picking up the initial part of, or the initial period after use, is it? That is, the metabolite will not collect in urine until it's passed through the kidneys after use and that may not be for one or two hours after use, is that right?
>
> Dr Lewis: If a person has not used cannabis recently, then it would take maybe two or three hours for it to pass into the urine, that is true.
>
> Mr Metcalfe: So assuming that at the time the person was smoking or otherwise inhaling or ingesting cannabis, for the first time, I would suggest to you, up to three hours, oral screening has a better chance of picking up that use, and after three hours, it would then switch to urine testing, because by that stage it's starting to go through the kidneys and into the urine?
>
> Dr Lewis: That depends first of all on the method that's being used and whether the person has taken steps to eliminate or reduce the amount of THC in their mouth, which is highly possible. So I'm sorry, I cannot answer that as a simple yes or no.
>
> Mr Metcalfe: When you say it's highly possible, are you seriously suggesting that somebody having a bong immediately whilst in the euphoric stage is

going to floss their teeth, thinking about detection issues? I mean, I suggest to you it's more likely that...people using cannabis have very poor oral hygiene habits. So when you say it's highly possible, I suggest to you, in fact, it's remotely possible. Do you agree with that?

Dr Lewis: I would suggest that the evidence appears to be that people who use drugs, in particular cannabis and those who smoke, get a very dry mouth and they do drink: they drink fluid and that, in itself, is going to have diluent effect. They may not floss their teeth. I would agree with that. It is available to them. They may not, but they would certainly drink.

87 Dr Lewis also conceded a greater mathematical correlation between saliva and blood (plasma) with methamphetamine and other drugs and between breath tests for alcohol and subsequent blood testing for it - none for THC, however. The evidence of Dr Lewis in that respect was as follows:

Mr Miles: ...In relation to blood alcohol and breath alcohol, is there a relationship between those?

Dr Lewis: There is a relationship which is why mathematically they can draw a conclusion that a breath alcohol equates to a certain blood alcohol.

Mr Miles: Right. Is there a relationship between the level of drugs in blood and the level of drugs in urine?

Dr Lewis: None whatsoever.

Mr Miles: And you've given some evidence...whether a relationship exists between oral fluid and blood may vary according to the drug?

Dr Lewis: That is correct.

Mr Miles: So some drugs have a strong relationship and others, it's quite variable...?

Dr Lewis: That is correct.

Mr Miles: And you have given evidence about the manner in which THC occurs in oral fluid. Is there a relationship between the level in oral fluid and the level in blood for THC?

Dr Lewis: For THC there is no relationship. There is a parallel in the way it decays, which we put down to coincidental, but there is no direct correlation.

88 Dr Lewis adds in his report that:

"....urine testing requires a few millilitres of specimen and there is virtually always ample for

> testing. With saliva testing, specimens are collected by either wiping the inside of the mouth or by a collection pad inserted into a donor's mouth. A person with a dry mouth will have difficulty producing enough saliva and this will occur if a person is anxious or if they are taking a decongestant medication such as pseudoephedrine..."

89 Ms Fullarton also recognised the risk of adulteration with oral swabs, as distinct from the method used by Mediscreen. She was confident that the device used by Mediscene, with the saliva being provided externally, was not open to the same risk of adulteration of the sample as saliva swabs. But Dr Lewis still sees problems in the method demonstrated, indicating in his evidence:

> "...When you smoke marijuana, your mouth is very dry. When you're nervous and anxious, your mouth is very dry. If you take nasal decongestants, it's very dry. And, in fact, just to complicate the matter, the Standard says that one should examine a person's mouth before collecting a sample to ensure there is no food. And there was no mention of that. So there are a lot of issues and processes that need to be considered to make sure you have an adequate sample...."

90 What concerns me most with oral testing is the range of devises on the market at present for oral testing for drugs with what Dr Lewis and Dr Perl both agree have varying degrees of sensitivity to THC (and other drugs). The ROSITA study of different oral fluid testing devices indicated that overall on-site assays with oral fluid devices detected only 46% of the THC-containing oral fluid samples (at or above 2ng/mL) when compared with blood (at or above 1ng/mL). ROSITA summarised the position as follows:

> "....* The analytical evaluation of the amphetamine and methamphetamine tests (in comparison to the reference method in oral fluid) showed a sensitivity (percentage of the true positive samples that tested positive with the on-site assay) varying between 40% and 83% and a specificity (percentage of the negative samples that tested negative with the on-site assay) between 80% and 100%.
>
> * The analytical evaluation of the benzodiazepine tests (in comparison to the reference method in oral fluid) showed a sensitivity varying between 33% and 69% and a specificity between 85% and 94%.
>
> * The analytical evaluation of the cannabis tests (in comparison to the reference method in oral fluid) showed a sensitivity varying between 0% and 74% and a specificity between 70% and 100%. Detailed anaysis of the data for cannabis showed that some devices (eg Drugwipe) gave a negative result even when very high concentrations of THC were found with the Intercept. The reason is unknown, but one hypothesis is that with improved (more thorough) sampling techniques more THC could be captured, resulting in a more positive results.

* The analytical evaluation of the cocaine tests (in comparison to the reference method in oral fluid) showed a sensitivity varying between 0% and 97% and a specificity between 91% and 100%.

* The analytical evaluation of the opiate test (in comparison to the reference method in oral fluid) showed a sensitivity varying between 51% and 100% and a specificity between 86% and 100%.

* No device met the criteria proposed during the ROSITA - 1 project (sensitivity and specificity 90%, accuracy 95%) for the amphetamines, benzodiazepines and cannabis. The Varian Oralab met these criteria for cocaine and opiates, but it gave 26% failures, so it cannot be recommended.

* The operational evaluation of the Drugwipe showed that the sampling technique was well accepted by the police and the subjects, but the results, particularly for cannabis, were difficult to read. There were also problems when using it in cold weather.

* The operational evaluation of the Drager Drug Test/Orasure Uplink showed that sample collection was easy and hygienic, but the procedure was long and complicated. The test must be read by an instrument, so it cannot be used in remote areas or when no instrument is available.

* The operational evaluation of the American Biomedica Oralstat showed that the collection stick lost one of its collection sponges in some cases. This test could also be read with or without the reading unit, but the scanning of the test strip by the electronic reader was sometimes difficult.

* The operational evaluation of the Branan Medical Oratect showed that the test was liked by the police officers because it is very small and portable and no additional equipment is needed, but the sample collection was too complicated, it could be outsmarted by the tested person and took too much time. The number of failures was too high.

* The operating procedure of the RapiScan was fairly direct, but was found to intimidate officers if they were not able to use it soon after training. Many officers were uncomfortable using the instrument, stating that it was difficult to remember the procedure.

* The operational evaluation of the Lifepoint Impact showed that in many cases the collected sample volume was not sufficient because the instrument stopped the sampling automatically after a preset time.

> * The test procedure of the Sun Biomedical Oraline was simple with few steps but a rather large sample volume was needed and it took too much time. There were problems to use it in cold and rainy weather. The lines indicating positive or negative results were too pale.
>
> * The operational evaluation of the Ultimed Salivascreen showed that the device gave more invalid than valid tests. Officers reported smearing of the result bands or not enough saliva collected by the device to give a reading.
>
> * The operational evaluation of the Varian OralLab showed that subjects were often unable to provide sufficient oral fluid during specimen collection, resulting in many invalid tests. Officers also experienced difficulty observing the presence or absence of the test lines, making interpretation of results inconsistent..."

91 DRUID also reported on oral testing device failures, viz:

> "....A number of device failures were observed in the study. The reasons for the device failure may vary, for example, the device is used incorrectly or only part of the integrated device is successful (ie there is no control line, indicating a successful negative or positive screening, for one of the test strips). Therefore, for at least some of the tested devices, only some of the individual drug tests failed. 15 OrAlert devices were observed to fail in the Belgium study, a smaller number of Rapid STAT, Drug Test 5000 and OralLab 6 devices also completely failed (5, 2 and 1 respectively). In the Finnish study one DrugWipe 5 device failed, except for the amphetamines tests were for the BIOSENS cocaine test (15 failed tests on the second analysis) and one DrugTest 5000 methamphetamine test. The roadside analysis of the Oratect III was also aborted due to the failure of a number of tests, however in the coffee shop all tests with the Oratect III were successful..."

92 Dr Lewis indicated in his report that, to his knowledge, there are no Australian quality assurance programmes specifically for workplace oral drug testing and, whilst he concedes that there are new screening devices currently entering the market, he believes that no existing screening devices have adequate sensitivity to THC at the present time. He writes in his report:

> "....On-site urine devices are preferred to oral fluid devices as they provide a more consistent approach to testing with defined cut-off values. Devices that have been independently verified according to Appendix B of AS/NZS 4308 are suitable for workplace screening. Urine devices have adequate sensitivity to all the defined drug groups, whereas on-site devices do not..."

93 Dr Perl emphasises in her written report and in her subsequent evidence in this hearing that the police have their own procedures to confirm impairment in all drivers in New South Wales and that suggests to me that the additional testing of the Holcim contract drivers, either urine sampling or saliva swabs, may represent a case of double counting. She comments in her report that, whilst she believes that all forms of random testing do act as a deterrent to illicit substance use, punitive actions should be based on the sound knowledge that a person is in fact impaired and unfit to perform his duties. She writes in her report that:

> "....in New South Wales, police have a stringent procedure to identify impairment in a driver of a motor vehicle and some other road users (eg pedestrians). This includes an assessment process by the police, a breath test to exclude alcohol as being the intoxicant, followed by blood and urine sampling to identify the cause of the symptoms of impairment identified by the assessment process. Some countries (eg the United States of America) use a drug recognition expert [DRE] who is a highly trained person (eg police, doctors, nurses, corrective service officers, etc) to carry out the assessment, although there may be a much simpler preliminary field sobriety test [FST] carried out by the police officer stopping the driver. In Victoria the processes used by the DRE's are used in a clinical assessment by a medical person to assess the drivers who have been detained by police on suspicion of impaired driving.
>
> All drivers of vehicles who would provide services to Holcim and all workers of Holcim who drive to their place of employment are already subject to the drug and alcohol detection programmes carried out by police including random breath testing, targeted testing of drivers stopped on suspicion of being impaired and random oral fluid testing..."

However, she believes - and so do I - that it is inappropriate for random drug testing to be regarded, at least at the outset, as part of any punitive disciplinary measure, rather to be considered entirely as an occupational health and safety issue and for further investigation and, if necessary counselling of the individual drug user.

94 As I see it, the evidence before me in this hearing is that Holcim's drug and alcohol policy does not principally represent disciplinary action against the driver who has a non-negative result from a random drug test but is rather treated quite properly as an issue of road safety and an occupational health and safety concern. Any disciplinary action arises only when the Holcim driver continues to have a non-negative result to successive tests, a failure to accept counselling services or a refusal to take a future test.

95 Dr Perl summarised the essential issues before me when she comments in her report:

> "....The use of urine is certainly much more invasive and more likely to be subject to substitution or adulteration (unless the sample is witnessed) than oral fluid. Oral fluid on the other hand is more likely to be indicative of very recent use and thus it is much more likely to indicate a real risk of impairment but I agree with Dr Lewis that oral fluid

> may not always be accurate for cannabis use. Obtaining oral fluid is, however, less invasive and less likely to be adulterated or substituted. There is an Australian Standard for oral fluid, like that for urine, already in place and some workplace requirements (eg CASA) have opted for oral fluid testing..."

She concludes her written report that:

> "....neither urine or oral fluid are satisfactory if they are used to satisfy legislative and common law 'duty of care' requirements to ensure that the risk of performing work whilst impaired is addressed. None of these screening processes addresses the issue of 'risk of impairment'..."

And she adds:

> "...A much better option would be random screening with the least invasive method (being oral fluid) and an initial assessment of the worker by trained persons to determine if there are any signs of impairment and if there are then a clinical assessment of impairment in combination with a urine sample (for confirmation of the substance/s) would be more appropriate..."

Conclusion

96 Any drug and alcohol policy to some extent represents an intrusion into the privacy of individual employees. But I note what was said by the Full Bench of the Western Australian Industrial Relations Commission (Fielding SC, Cawley and Beech CC) in BHP Iron Ore Pty Limited v. Construction, Mining, Energy, Timberyards, Sawmills and Woodworkers Union of Australia (1998) 82 IR 162. In that case there had been objection on behalf of the employees that the requirement that they provide a body sample for testing on demand constituted an unreasonable intrusion into the privacy of those employees since there was no evidence of prevalence of drug use by employees either in the workforce or immediately before commencing work. There was also argument (at p.163), consistent with the argument between Holcim and the TWU in this hearing, that urine testing for drugs was not, in fact, a particularly reliable indicator of actual impairment.

97 The Full Bench commented (at p.167):

> "...It is trite to say that the company has a duty to ensure, so far as is reasonably possible, that it maintains a safe working environment. Essentially the extent and manner to which drugs are likely to cause action and reaction in those who ingest the drugs is a pharmacological question... We consider it reasonable for the company to take steps to put in place a scheme designed to detect, so far, as is possible, the level of consumption of drugs by employees and to implement procedures designed to deter the use of drugs in the workplace. Not only is the presence of drugs in the workplace prohibited by law, but credible evidence before the Commission suggests that the use of certain drugs has the potential to impact on safety in the

workplace..."

And the Full Bench concluded (at p.168):

> "...As...the union so ably argued, there can be no doubt that the programme (of drug and alcohol testing) involves an intrusion into the privacy of individual employees. However, the current standards and expectations of the community concerning health and safety in the workplace, as evidenced by legislative prescriptions and judgments of courts and industrial tribunals, are such that there will, of necessity be some constraints on the civil liberties at times and, in particular, an intrusion into the privacy of employees... "

98 The TWU argues in its written statement in response to the claim before me in this hearing that those occupational health and safety concerns:

> "...must be balanced against the fact that Holcim cannot dictate what drugs or alcohol its employees take in their own time and which the workers do not come to work impaired by these drugs or alcohol..."

But, in my opinion, what a person does in his own time may still have an affect on his work performance.

99 It is now difficult to argue questions of unfairness for drug testing some twelve years after the decision in the BHP Iron Ore Case in the light of the many programmes for testing that have been introduced across various industries in this country and internationally - include those relying on urine testing - and the TWU does not argue it in this hearing. It simply supports what it believes is the less intrusive option - oral testing.

100 I believe that the issue of random drug testing has certainly now been resolved throughout the industrial community generally, and the transport industry in particular. As I noted earlier in this decision, for instance, in the Mutual Responsibility for Road Safety Case the Full Bench indicated (at p.75) that a drug and alcohol policy for the transport industry should specifically allow for random testing. And as Mr Miles asserted, and as I see the position, it is now no more than a legitimate prerogative of Holcim management to implement such a drug and alcohol policy.

101 Any questions concerning the privacy of the individual employee (or, in this case, contract driver) or fairness, whilst obviously still important, must be considered in the context of the wider issue of occupational health and safety and, in the case of the drivers of any heavy vehicles, the interests of the general community which, of course, also uses public roads. Those safety concerns remain paramount, in my opinion. Whilst the genuine concerns raised by the TWU on behalf of its member contract drivers in this hearing should be borne in mind, my task essentially remains to determine the most appropriate and reliable method to adopt - an evaluation based entirely on the scientific information available and provided to me.

102 I do not share the view expressed by Mr Metcalfe in this hearing that the emphasis of the Holcim drug and alcohol policy is on disciplining the individual drug or alcohol user. From the outset, Holcim does not appear to treat the drug user employee/contract driver as part of any disciplinary programme. In my view, neither the policy nor, according to the evidence of Mr Nicholson and Mr Noakes before me in this hearing, the manner in which it has been applied emphasises punitive measures against the individual drug or alcohol user. Clearly, the point may ultimately be reached where continued occupational health and safety concerns mean that the transport enterprise

may have no other option other than to terminate the engagement of an habitual drug consumer. The obligation on the enterprise under the Occupational, Health and Safety Act may necessitate such a punitive measure. Disciplinary measures of that nature are a feature of all of the drug policy regimes of which I am aware but, of course, such disciplinary measures are not appropriate in the initial phases of management of a driver found to be driving under the influence of drugs. I share Mr Metcalf'e's view in that respect.

103 For instance, Hamberger SDP of Fair Work Australia in his decision of Monday, 19 October, 2009 in Caltex Australia Limited v. Australian Institute of Marine and Power Engineers [2009] FWA 424 supported the introduction of a drug and alcohol policy (including random testing for drugs and alcohol) in the oil and gas industry (the Kurnell oil refinery), subject to certain safeguards, ie confirmation of a positive test result, formal counselling, with repeat positive results from testing receiving progressively more serious sanctions - warnings, a final warning and ultimately dismissal, time off work on sick leave, etc. In particular, with respect to the question of sick leave, Hamberger SDP commented:

> "...[108] The employees also put forward the view that employees who need to spend time off work because of drug or alcohol problems should receive paid sick leave. The ILO code of practice...stipulates that: 'Workers with alcohol or drug related problems should be treated in the same way as workers with other health problems, in terms of benefits such as paid sick leave, paid annual leave, leave without pay and health care insurance coverage in accordance with national laws and regulations or as agreed upon in collective bargaining'.
>
> [109] Employees at Kurnell who need to take time off because of alcohol or drug related problems should have access to the Kurnell sick leave policy...in the same way as employees who are ill or injured for other reasons..."

104 It would be appropriate that the Holcim drug and alcohol policy also emphasise occupational health and safety and road safety concerns and not in the first instance primarily disciplinary measures, that it involve proper laboratory confirmation of all positive test results, offers of counselling services, access to paid sick leave and/or annual leave during any period of stand down. I believe that it does.

105 That having been said, the question still remains whether it would be appropriate that the random testing provided in the Holcim drug and alcohol policy be based on urine samples or oral testing. A false positive urine test or oral sample would be rectified in a subsequent laboratory confirmation of a blood sample - and I understand that it is only the laboratory confirmation on which Holcim management intends to rely to ultimately establish the fitness of the individual for work. But, as I indicated earlier in this decision, a false negative result is another matter entirely, however, since it would go no further for laboratory confirmation as a blood sample. It is for that reason that the reliability of the initial testing - either urine or saliva - is so important.

106 It is common ground in these proceedings by Mr Miles and Mr Metcalfe, and indeed, the views of the witnesses called to provide the scientific evidence in this hearing, that neither urine testing or oral testing produces completely reliable data. I accept that there is no real correlation between a positive reading for THC in the urine and an actual impairment to drive a vehicle. I also note in that respect what was said by way of summary of expert evidence by the Full Bench of the Western Australian

Commission as far back as 1998 in the BHP Iron Ore Case (at p.167), viz:

> "....The expert evidence suggests that as yet there is no reliable test for detecting drug related impairment. Some tests have been developed but as Associate Professor Allsop indicated, while these tests may show some promise they are in their infancy..."

107 Based on my evaluation of the expert evidence before me, it does not appear that the science has really progressed all that much over the twelve years since those comments were made in the BHP Iron Ore Case. But whilst there may be no concrete relationship to establish conclusively impairment with a positive result from a urine test (or an oral test), there is certainly the *risk* of impairment - something on which both Dr Lewis and Dr Perl agreed in their evidence. That *risk* is sufficient, in my opinion, to raise occupational health and safety concerns at work and thereby provide the proper basis for a drug and alcohol testing regime.

108 The decision in the BHP Iron Ore Case goes on to comment further on the expert evidence before the Full Bench (at pp.167 and 168):

> "...Associate Professor Christie also testified that impairment tests have a limited value at present. In his opinion it is impossible to determine whether a person is adversely affected by drugs simply by observation or by impairment tests, except where high doses of drugs are involved. He testified that '...even highly trained observers cannot reliably detect individuals intoxicated by alcohol and other drugs...'. Much the same opinion was advanced by Professor Homel. He testified that '...there is a considerable body of evidence that even trained officers are not particularly good at detecting impairment when an offender comes to notice...' In the opinion of Associate Professor Christie urine testing was a more effective means of detecting the presence of drugs and dealing with the 'problem'. Although not a reliable test of intoxication or impairment, urine testing '...can detect a likelihood of impairment...'. That is particularly so at the cut-off levels proposed under the programme (considered in that case) which, in his opinion, are at such levels as to give rise to a strong possibility that the employees recording a positive test are likely to be impaired in the performance of their work. Again we see no reason why Associate Professor Christie's evidence in relation to these matters should not be accepted. Certainly, it is difficult in view of that evidence to say that the company is acting unreasonably in seeking to instigate a testing regime rather than simply relying on education and observation as a means of satisfying its obligations to provide a safe system of work..."

109 The TWU indicated in its written statement that it:

> "....believes that the method of oral fluid sample testing is better able to detect if the contract carrier

> is likely to be impaired, compared with the urine sample test, due to detecting active components of drugs, rather than historical metabolic breakdown of drugs like the urine sample. The policy would be better designed to eliminate the risk of workers coming to work impaired by drugs and alcohol if the method of testing is by taking oral fluid samples. Currently, the policy goes further than its objective by seeking to detect workers who are not likely to be impaired by drugs and alcohol at work, but who have an historical use of drugs and alcohol that occurred outside working hours. In some cases the testing regime may detect traces of drugs in the worker's system that relates to use that predates employment with the company. Such draconian and ill adapted testing regimes can be expected to generate avoidance..."

110 And the TWU further states:

> "...Urine samples are inherently easier to avoid than taking of an oral fluid sample. Urine sampling is susceptible to fraud: commonly another person's 'clean' sample can be easily substituted due to the natural reticence in observing the giving of such a sample. An oral sample can be taken in full view and is almost impossible to corrupt. A scenario where a urine sampling regime creates an 'underground' of illegal drug users in a workplace is conceivable and also fundamentally shows the lack of fitness for the purpose of such a testing regime..."

111 The Full Bench had this to say in the Mutual Responsibility for Road Safety Case (at p.72):

> "....[218] As to the method of testing...the evidence...was that no method of testing, ie urine or saliva, could predict impairment. However, Dr Perl's evidence should be preferred in so far as the advantages of urine testing may detect drug use over significant period's of time..."

And the Full Bench went on to say (at pp.72 and 73):

> "...[222] (Counsel for the TWU) referred to the debate...about the preferred method of testing. He emphasised that the application does not seek to prohibit any particular method of testing, but rather where the methods of testing can achieve the intended purpose, the least invasive method should be used. Dr Perl's comprehensive expert evidence demonstrates that saliva testing is more likely to give a result of recent drug use, than urine testing, although both tests cannot determine impairment..."

112 Whilst I have formed the view that oral testing for drugs may in time become increasingly an appropriate and more convenient method (and more accurate one) to adopt than urine testing, I am not convinced that oral testing for drugs has reached a stage where it has effectively made urine testing a redundant technique or replaced it as

the preferred method to adopt in all cases. I accept that oral testing appears to me to be directed more towards establishing actual impairment of the individual from the consumption of drugs rather than whether that individual has been using the drug regularly in the past, as urine testing tends to do.

113 Establishing actual impairment of the individual driver is, of course, the primary concern, having regard to the basis of the random testing in the first place - occupational health and road safety. But an individual who is actually impaired at work by drugs or alcohol is, in my opinion, more likely to be identified by any observer, independent of any testing because of his erratic behaviour and performance at work. However, I note that a contrary view was expressed in the expert evidence before the Full Bench of the Western Australian Commission in the BHP Iron Ore Case (at p.167) to which I referred earlier in this decision, ie that even a highly trained observer would not necessarily be able to reliably detect a person intoxicated by alcohol or drugs. It would always be a question of degree how much of the drug had been consumed and how impaired the individual may appear to be.

114 In any event, to my mind a driver who has a non-negative urine test result, suggesting as it may do, a history of drug taking, would also represent a cause of legitimate concern to an employer as a risk on occupational health and safety grounds. There is the "hangover" effect to which Dr Lewis referred in his evidence in the hearing and his assessment that an irregular or habitual user of cannabis, in his opinion, still presents a safety risk due to a loss of cognitive function and motor skills.

115 I would not presume in this hearing to suggest that those business enterprises who have moved to oral drug testing have done so ahead of the technology actually available but the evidence before me in this hearing suggests to me that, on balance, a more conservative approach is more appropriate, supporting at the present time a regime of urine testing as the safest method to adopt for the Holcim drivers. I am also concerned at the fact that there appears to be such a wide range of oral devices available at the present time, with varying degrees of sensitivity to the drugs, none of which have presently achieved accreditation.

116 As far as the Holcim contract drivers before me are concerned, there are a number of issues which have also influenced me to prefer the continuation of urine testing for them, viz:

* urine testing has already been introduced for the entire Holcim workforce nationally, ie in Queensland and Victoria, and for Holcim employees in New South Wales, and it would not be appropriate, in my opinion, for this discrete group of New South Wales contract drivers to be on an entirely different drug testing regime from the rest of the Holcim workforce: a single standard approach should apply to the entire workforce;
* when the contract drivers are required to work on State Rail projects and other sites on which there is random urine testing, they would be subject to, and have accepted, the regime of random urine testing, mandated in the case of the State Rail projects by State legislation and regulation: Mr Miles also speculated in his submissions, on the desirability for there to be consistency in that respect and that it would be inappropriate should a contract driver received an oral random test at Holcim's depot which proved negative, only to be subsequently tested by giving a urine sample which proved to be positive;

* the system of urine testing presently available to Holcim through Fit 4 Duty appears to me to be a fairly sophisticated system with proper accreditation and back up with laboratory tests;

* notwithstanding Dr Lewis' reservations, I accept that the method of oral testing carried out by Mediscreen, which was demonstrated in the hearing by Ms Fullarton (and which I understand the TWU favours) is impressive: nevertheless it has not yet received appropriate accreditation;

* whilst oral drug testing is no doubt less intrusive than urine sampling and would not invade the privacy of the individual to the same extent, I believe that urine sampling has already been generally accepted throughout the industrial community for several years and has general community acceptance at present as a suitable method to test for drugs;

* whilst urine sampling may be a slower process than oral testing, I am operating on the assurance given by Holcim management that the whole process of testing may be conducted with a limited amount of additional time for the contract drivers to be off the road and that the roster arrangements in place for the contract drivers would accommodate the drivers and eliminate any unnecessary waiting time;

* a non-negative result from urine testing of a contract driver does not immediately mean that Holcim management will automatically assume that a contract driver is working under the influence of drugs but the test will be considered in the context of the policy in place, ie the contract driver will not be immediately subject to any disciplinary measure but will be placed on sick leave whilst the urine sample is tested further in a laboratory, offers of counselling, etc;

* although, as Dr Perl emphasised in her evidence, urine testing may show a *history*of drug taking rather than a current impairment, as I indicated earlier in this decision, it seems to me still of concern that a chronic or habitual drug user may present a safety risk and something of which a transport business may be entitled to be aware, albeit that at the time of the testing the contract driver has not taken the drug so recently as to be actually physically impaired by it at that time: it must be acknowledged that the testing is random and I do not believe that a chronic user of cannabis who just happens to not to have taken the drug on the day he is tested automatically should relieve his employer of any concern on occupational health and safety and road safety grounds that on other days he was driving he may have taken the drug and be impaired by it; and

* it would appear that oral testing is a less effective measure for the testing of methamphetamine than urine samples and, whilst the Holcim contract drivers are not involved in long distance travel where the use of that drug has been of particular concern, it is nevertheless an issue which I believe should be part of the testing for the Holcim drivers.

117 In those circumstances, I direct Holcim management and the TWU into further discussions with a view to extending the urine testing to the Holcim contract drivers engaged in driving agitator vehicles. I am not convinced at this stage that the process actually needs variation to the two contract determinations covering the contract drivers the subject of these proceedings, seeing the matter essentially as an issue for the formation of a policy within the Holcim operations. Drug and alcohol policies in the transport industry have already apparently been introduced in various transport enterprises without being strictly prescribed by a separate State industrial instrument.

118 Moreover, in my opinion, it is important that the Holcim drug and alcohol policy be co-ordinated with the Transport Industry - Mutual Responsibility for Road Safety (State) Contract Determination flowing from the Mutual Responsibility for Road Safety Case. A consistent approach to drug and alcohol policies in the transport industry in this State is to my mind not only desirable but essential. I do not see the Holcim drug and alcohol policy as inconsistent with the principles emerging from the Mutual Responsibility for Road Safety Case but the TWU clearly does. To have a separate contract determination covering the Holcim operations alone would I believe promote different standards on this important issue which would not be appropriate in the circumstances.

119 I prefer instead at this time to leave the matter to be the subject of further discussions between Holcim management and the TWU with a view to the extension of the existing regime of the Holcim drug and alcohol policy, including random urine testing, to the contract drivers the subject of these proceedings. Those discussions should, I believe, seek to clarify that the emphasis of the drug and alcohol policy is not primarily directed not to any disciplinary action but is to be considered as an occupational health and safety and road safety concern - as I believe is really the case.

120 Those suitable guidelines should also ensure that any unnecessary time delays with the testing of the contract drivers should be addressed. That is not a problem for employees who would remain on the payroll whilst they are tested. But I accept that any delays for testing may lead to a financial loss for contract drivers. Mr Miles pointed out in his submissions that Holcim has a similar interest, on financial grounds alone, to ensure that contract drivers were not unnecessarily delayed at the start of their runs. He believes that with the current roster, that will not be a problem. However, if that proves not to be the case, and the contract drivers suffer financially as a result, the parties should consider some compensation to them.

P J CONNOR
Commissioner

LIST OF WITNESSES

Beattie, Robert* concrete improvements manager
Blackmore, Gary owner driver (and TWU delegate)
Brien, Darron managing director of an organisation providing drug and alcohol testing
Buchanan, Scott operations manager
Childs, Ray owner driver (and TWU delegate)
Fullarton, Dezra manager of an organisation providing drug and alcohol testing
Lewis, John (Dr) consultant toxicologist
Nicholson, Bruce operations manager
Noakes, Paul area manager
Olsen, Richard TWU organiser
Perl, Judith (Dr) consultant pharmacologist

**Evidence admitted without the need for cross-examination.*