



Victorian Lead Risk Work Notification Compliance and Workers Compensation Case Study

Worker health is the first casualty when “she’ll be right mate” is baked in to the system

Case Details from the Worker, Questions and WebSearch Result inputs by Elizabeth O'Brien, BSc, GradDipHealthEd; Case Study and Answers collated by Claude AI for LEAD Action News, published by The LEAD Group Inc. May 2026 [LID 29394]

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The case: known facts and timeline

This Q&A addresses notification obligations arising from the following known facts and the adequacy of the Victorian Workers Compensation system in dealing with a lead exposure case:



- **13 November 2025:** A female worker of reproductive age commences new role removing obsolete telecommunications cable for a telecommunications subcontractor in Melbourne, Victoria. The telecommunications cables were encased in lead metal or plastic sheathing, then buried in conduit. After decades underground, the lead sheathing undergoes oxidation, forming **powdery lead oxide dust on the surface of the cable**. Hauling the cables out of the manhole, by hand or using heavy machinery, cutting the lead-sheathed cables into 1.5 metre long pieces on the public thoroughfare, and loading them by hand into a bin on a flatbed truck for transport to the scrap metal recycling facility disperses lead oxide dust further. Lead dust contaminates workers' overalls, gloves and boots, is tracked into the truck cabin during transit to job sites, the recycler, and back to base, and spreads by secondary contact throughout the work environment.

- **Before 13 November 2025:** This work is a defined **lead process** under Regulation 178(a) of the Victorian OHS Regulations — *"work that exposes a person to lead dust or lead fumes arising from the manufacture or handling of dry lead compounds"* — and constitutes *"lead-risk work"* (meaning work performed in a lead process that is reasonably likely to cause the blood lead level of the employee to exceed, for a woman of reproductive capacity, 0.24 $\mu\text{mol/L}$ (5 $\mu\text{g/dL}$)) under Reg 193(2)(a). The employer was required to arrange health

monitoring — including a baseline medical examination and biological monitoring (blood lead testing) — **before the worker started lead-risk work** (Reg 196(1)). The employer's



arrangement of a blood test on 18 November 2025 demonstrates it was aware of this obligation – yet it failed to act before commencement. Biological monitoring was not explained as required by Lead Compliance Code, and the employer did not explain the likely rise in blood lead levels to the employee. — **Pre-commencement monitoring: not done**

- **18 November 2025:** Blood collected — four work days after commencement — for the worker's baseline biological monitoring. The employer's arrangement of this test confirms awareness of its monitoring obligation. The blood lead level (BLL) result: **2.3 µg/dL (0.11 µmol/L)** — below the 5 µg/dL lead-risk work threshold but confirming lead absorption had already begun after only four days of work. The Victorian Code of Compliance for Lead states:

*Employers **must** arrange health monitoring for employees who will be engaged in the work, before they start. They **must** also arrange follow up biological monitoring for employees **within a month** of the work starting, and ongoing. Medical examinations must be done by a registered medical practitioner (preferably trained in occupational medicine), and biological monitoring must be done under the supervision of a registered medical practitioner. An employer must provide the medical practitioner who is to conduct a medical examination with details of:*

- *the name and address of the employer*
- *the name and date of birth of the person to be examined*
- *the lead process the person is engaged in, and*
- *the period the person has been engaged in that process.*

Employers must also ensure that the medical practitioner provides a report setting out:

- *the dates of medical examinations and blood sampling*
- *the results of biological monitoring and any other tests undertaken*
- *the name of any pathology service used*
- *the details of any opinion formed by the medical practitioner after the medical examination.*

At the start of employment, the employer required the employee to book and pay for a pathology test, and the employee underwent a walk-in blood test at a pathology clinic on 18 Nov 2025. The only information the employee provided in the pathology suite was her name and DOB, no examination occurred, and no report was issued.

The 18 Nov 2025 blood lead test, for which the BLL result was **2.3 µg/dL**, was meant to be done before the worker engaged in lead risk work and was meant to be followed by repeat blood lead testing **one month after starting lead risk work** (Table 1A, Reg 198(1A)) — next test due approximately 13 Dec 2025. This was the **only health monitoring action the employer took in the entire course of the worker's employment**. The result of the

later blood lead result, just over one month after commencing lead-risk work, indicates that the OHS Regulations' requirement to monitor blood lead for the second time one month after lead risk work commences is **inadequate** for the purpose of protecting workers from lead exposure. The LEAD Group always advises lead workers to obtain a blood lead result one to two weeks into the job, or sooner, depending on their sense of whether any lead could possibly be getting into them at work. The LEAD Group recommends each Australian state and territory amend their OHS Regulations to ensure lead-risk workers are blood lead tested for the second time one to two weeks into the lead-risk work. Had this amendment already been in force, this case may have been entirely prevented.



Early December 2025. The worker's symptoms, starting in early Dec 2025, and increasing in frequency and severity throughout the New Year and into 2026 were:

- Extreme fatigue, lethargy and decreased muscular endurance
- Erratic sleep patterns and insomnia
- Frequent, very intense headaches that last the whole day
- Frequent vertigo and headspins, while moving, getting up, and sitting still
- Brain fog and difficulty concentrating
- Stuttering and losing the “thread” of conversations
- Frequent intense nausea, coupled with frequent diarrhoea
- Noticeable weight loss - approximately 10% of total body mass
- Marked increase in debilitation during hot weather
- Marked, constant tremors in hands that become very intense when fatigued

- **18 December 2025:** The worker, feeling very unwell with wide ranging and recurring symptoms, attended her GP and was referred for an extensive clinical workup — iron studies, gluten antibodies, thyroid and liver function, varying disease and

other blood markers — to investigate the cause of her symptoms, including a repeat blood lead test. This test was initiated by the worker for clinical reasons; **it was not arranged by the employer**. The elevated blood lead level was the only significant change found across all tests compared with earlier blood marker results (worker's email to The LEAD Group, 2 April 2026). BLL result: **18.6 µg/dL (approximately 0.90 µmol/L)** — an EBLL nearly four times the lead-risk work threshold and nearly twice the removal threshold for a woman of reproductive capacity. The rise of 16.3 µg/dL in approximately 30 days reflects very heavy ongoing lead absorption throughout the month of mid-November to mid-December 2025.

- **22 December 2025:** Pathology laboratory notified the worker's GP of the 18.6 µg/dL result. The pathology report included: Workplace exposure: The laboratory was required to notify the Department of Health within 5 days — i.e., by **27 December 2025**. There is no reason to suspect that the lab did not notify Vic Health on the same day they notified the GP — 22 December 2025.



- **6 January 2026:** The worker and, later that day, the employer became aware of the 18.6 µg/dL result. The worker informed the employer directly of it, in writing. The employer was immediately required to: (a) remove the worker from lead-risk work; (b) notify WorkSafe Victoria; and (c) arrange a medical examination within 7 days and follow-up blood lead testing in 6 weeks.
- **6 January 2026 (evening):** Employer told the worker there was no more work for her the next day, and promised updates on the situation after talking to management. The employer did not formally remove her from lead-risk work, did not arrange a medical examination or repeat blood lead testing at the required frequency of 6 weeks (ie by 29 Jan 2026), and did not (to the worker's knowledge) notify WorkSafe Victoria that the worker, in response to her Dec 2025 pathology report stating that removal from lead risk work was mandatory, had been removed from lead risk work by the employer. **This was the last contact between the employer and the worker.**
- **13 January 2026:** The worker submitted a Workers Compensation Claim.
- **9 February 2026:** The insurer sent a letter requesting an assessment of the worker, to an Independent Medical Examiner (IME), attaching the 18 December 2025 high blood lead level pathology report but nevertheless stating that: “[the worker] reports noticing physical symptoms for some time, nausea, vertigo, brain fog and fatigue and proceeded to have full blood work where she **alleges** it was identified **high lead levels** were found.” The insurer's letter did not state that the employer alleged anything, but did state: “Employer has concerns with liability as none of her symptoms were reported [to him] or witnessed [by him].” Could such framing by the insurer have persuaded the IME to disbelieve the worker?
- **19 February 2026:** The worker was assessed in the consulting rooms of an Independent Medical Examiner (IME), organised and paid for by the insurer.
- **20 February 2026:** Blood was collected for third BLL result: **7.7 µg/dL (approximately 0.37 µmol/L)** — arranged by the worker, **not the employer**, with whom the worker had no contact since 6 January 2026. The BLL is still above the 5 µg/dL return-to-work threshold. Monitoring interval of 9+ weeks exceeded the required 6-weekly frequency. It is not known on what date the result was given by the GP to the worker but a standard timeframe is the Department of Health would have been notified and the GP would have received this result three business days after blood collection and since the result was still too high for the worker to return to lead risk work, hopefully the GP would have advised the worker on the day the result was received, or shortly thereafter, and the Victorian Department of Health would have notified WorkSafe Victoria that this worker's BLL was still above the return to lead risk work level.
- **23 February 2026:** The IME submitted his report on the worker to the insurer.
- **26 February 2026:** The insurer rejected the Workers Compensation Claim citing the IME's statement that the worker had lead exposure at work but not lead poisoning, and concluding that this was not a compensable injury under the relevant Act.

Sources: OHS Regulations 2017 Version 016 (effective 26 November 2024); WorkSafe Victoria Lead Compliance Code (April 2022, Edition 1); WorkSafe Victoria Notification of Lead-Risk Work form FOR569 (August 2024); WorkSafe Victoria Safety Alert: Lead-based Paint Removal (20 January 2025); WorkSafe Victoria 'Are you performing lead-risk work?' (reviewed 4 May 2023); WorkSafe



Victoria 'Lead at work: Legal duties' (reviewed 31 July 2022); WorkSafe Victoria 'Blood lead testing schedule' (April 2024); WorkSafe Victoria 'New silica-related diseases now proclaimed' (reviewed 29 July 2022); WorkSafe Victoria Lead hub page (last reviewed 23 April 2024); health.vic.gov.au/environmental-health/lead-and-human-health (3 October 2025); worker's emails to The LEAD Group, 20 Feb 2026, 2 Apr 2026 and 4 May 2026 which included the BLL reports, IME's 26 Feb 2026 report, the insurer's 9 Feb 2026 letter to the IME, etc.

Q1. Is lead-sheathed cable removal a lead process and lead-risk work under the OHS Regulations?

Yes, on both counts.



Regulation 178 of the OHS Regulations defines **lead processes**. The applicable categories include: "work that exposes a person to lead dust or lead fumes arising from the manufacture or handling of dry lead compounds" (Reg 178(a)) and "dry machine grinding, discing, buffing or cutting by power tools of lead or alloys containing greater than 5% by weight of lead metal". Lead-sheathed telecommunications cables are structural lead metal. After decades underground, the lead sheathing oxidises to form powdery lead oxide dust — a dry lead compound — on its surface. Cutting, hauling, loading, and transporting these cables disperses that dust. The work falls within both Reg 178 categories, and WorkSafe also has the power to determine any process to be a lead process (Reg 178, final item).

The contamination pathway is particularly insidious. Lead oxide dust forms passively on aged sheathing before cutting begins. Cutting and handling release further dust, which contaminates workers' overalls, gloves, and boots and spreads into the truck cabin during transport. The



Compliance Code (April 2022, para. 101) specifically requires employers to ensure employees **do not carry lead outside the workplace on their bodies or clothing.**

A lead process is lead-risk work for a female worker of reproductive capacity if it is reasonably likely to cause her BLL to exceed 5 µg/dL (Reg 193(2)(a)). The worker's BLL of 18.6 µg/dL after only 35 days (24 workdays) proves this conclusively. Under Reg 194(4), if an employer cannot determine whether a lead process is lead-risk work, **it must be treated as lead-risk work** until the employer establishes otherwise.

On 20 January 2025, WorkSafe issued a Safety Alert (worksafe.vic.gov.au/safety-alerts/lead-based-paint-removal) identifying employers who had committed every breach that occurred in this case. The Safety Alert was publicly available nearly a year before this worker started.

Q2. What health monitoring obligations applied, and how were the tests arranged?

The employer arranged only **one** of the three blood tests — and that test was four days late. This selective compliance is more serious than total ignorance: the employer knew its obligations yet failed to act before commencement, notify WorkSafe of the lead-risk work (as far as was able to be determined by the worker asking the employer for a copy of the notification to WorkSafe Victoria and being refused), implement controls, or arrange any further monitoring after November 2025.

- **Reg 196(1) — pre-commencement monitoring:** Must be arranged **before the employee starts lead-risk work**. Blood test arranged on 18 November 2025 — four days after commencement. — **Breach: done 4 days late**
- **Reg 196(2) — follow-up within one month:** Must be arranged within one month of commencement (deadline: 13 December 2025). The 18 December 2025 test was arranged by the worker/GP for clinical reasons — 5 days overdue and not employer-initiated. — **Not done by employer**
- **Reg 198(1A) Table 1A — 6-weekly monitoring once BLL ≥ 5 µg/dL:** Required every six weeks after the 18.6 µg/dL result. No further employer contact after 6 January 2026. The 20 February 2026 test was arranged independently, 9+ weeks later. — **Not done by employer**
- **Reg 200 — medical examination within 7 days of removal:** Employment was ended rather than formal removal; no further employer contact. — **Not done**

Had the employer arranged the Reg 196(2) one-month follow-up test by 13 December 2025, the rapidly rising BLL would have been detected as soon as that result was reported to the worker and notified to the Department of Health Victoria.

Q3. What were the key blood lead thresholds applicable to this worker?

The following thresholds have applied to female workers of reproductive capacity working in lead risk



work in Victoria since 5 June 2020:

- **5 µg/dL (0.24 µmol/L) – Lead-risk work definition threshold** (Reg 193(2)(a)) and monitoring frequency trigger: BLL ≥ 5 µg/dL requires 6-weekly monitoring (Table 1A).
- **10 µg/dL (0.48 µmol/L) – Removal threshold** (Reg 199(1A), Table 2): employer must **immediately** remove the worker from lead-risk work.
- **5 µg/dL (0.24 µmol/L) – Return-to-work threshold** (Reg 201(3A), Table 3): BLL must be below this level AND a medical practitioner must certify fitness. At 7.7 µg/dL on 20 February 2026, the worker remained above this threshold.

Thresholds for women of reproductive capacity are significantly lower than for other workers (removal: 10 µg/dL vs 30 µg/dL; return: 5 µg/dL vs 20 µg/dL), reflecting the particular risk that lead poses to reproductive health and foetal development.

Q4. What notifications to WorkSafe Victoria were required, and by whom?

(a) Regulation 195 – notification of lead-risk work (within 7 days):

The employer must notify WorkSafe in writing within 7 days of identifying lead-risk work, using form FOR569 (August 2024). The employer's arrangement of the 18 November 2025 blood test demonstrates it had identified the work as lead-risk work – yet, to the knowledge of the worker, he never submitted FOR569. The notification deadline was **20 November 2025** at the latest. There is no evidence the notification was ever made.

The most applicable checkboxes on FOR569 are: *"Any work which exposes a person to lead dust in air or lead fumes arising from the manufacture or handling of dry lead compounds"* and/or *"Dry machine grinding, discing, buffing or cutting by power tools of lead or alloys containing greater than 5% by weight of lead metal."*

(b) Regulation 203 – biological monitoring results to WorkSafe after removal:

Once an employer removes a worker from lead-risk work under Reg 199, it must send the biological monitoring results to WorkSafe as soon as reasonably possible (Reg 203(2)). The employer did not formally remove the worker, he just told her there was no work for her tomorrow then never contacted her again, so Reg 203 was not technically triggered – but failing to remove a worker whose BLL far exceeds the removal threshold is itself a breach of Reg 199. The employer may never have sent any blood lead results to WorkSafe under any provision.

Q5. What notification to the Department of Health was required, and by whom?

Under the **Public Health and Wellbeing Amendment Act 2022 (Vic)** and the **Public Health**



and Wellbeing Regulations 2019 (Vic) (as amended 1 April 2025), pathology laboratories are required to notify the Department of Health of any BLL greater than 5 µg/dL within **5 days of initial diagnosis**. Since 1 September 2018 GPs are no longer required to notify. The laboratory notified the GP and the Victorian Department of Health on 22 December 2025; though the notification deadline to the Department was on or before **27 December 2025**.

Note: The Public Health and Wellbeing Regulations 2009 (Vic) were replaced by the Public Health and Wellbeing Regulations 2019 (Vic), which are the current operative regulations as at December 2025. The Victorian Department of Health webpage 'Lead and human health' (3 October 2025) – the source for the substance of the notification obligation summarised above – references the 2009 Regulations and the 1 September 2018 amendments without naming a specific regulation number; readers seeking the precise regulation citation should consult the consolidated PHWR 2019 directly at legislation.vic.gov.au.

Q6. What is the Department of Health required to do once notified?

Once notified by a laboratory of a BLL above 5 µg/dL, the Victorian Department of Health may contact the individual or their GP to help identify the source of exposure, provide guidance to prevent further exposure, and track notified cases to identify broader trends. (health.vic.gov.au/environmental-health/lead-and-human-health, 3 October 2025). These response actions appear discretionary rather than hard statutory duties.

Note: The Department's powers in respect of notified conditions of public health significance are set out in Part 8 of the Public Health and Wellbeing Act 2008 (Vic), which includes powers of investigation, examination, and exposure-prevention direction. Whether the Department has a statutory obligation – as distinct from a discretionary power – to refer workplace lead poisoning cases to WorkSafe Victoria is not addressed on the Victorian Department of Health 'Lead and human health' webpage (3 October 2025) and may require direct enquiry to the Department's environmental health unit.

Q7. What workplace hygiene controls were required, and were they provided?

Given the nature of lead-sheathed cable removal – lead oxide dust forming passively on aged lead sheathing inside plastic conduit, spreading through being dragged out of its tight-fitting plastic conduit by a skid steer - a little digger - on maximum revolutions, thus creating a lot of friction, then cutting and handling the lead-sheathed cabling and throwing each 1.5m length of lead-sheathed cabling into a bin on a truck, driving in the dusty truck cabin which was the only place to store drink bottles and food, then unloading each piece of cabling at the scrap metal recyclers, with lead constantly contaminating clothing, gloves, boots, machinery, tools and equipment and the truck cabin – the hygiene controls required by Part 4.3 of the OHS Regulations and the WorkSafe Lead Compliance Code (April 2022) were of critical importance. Based on available information, only the hand-washing station and appropriate soap, not the showering or changing facilities required in the first of the following and belated laundering of contaminated work clothing (after it had been reworn a



few days) appear to have been provided.

- **Hand and face washing facilities:** Employers must provide and maintain washing and changing facilities (Reg 191; Compliance Code para. 113). Workers must wash hands and face after leaving a lead process area and before eating, drinking, or smoking (Reg 205(3)). Appropriate soap capable of removing lead from skin is required. The workers had hand washing stations on the trucks with D Lead soap.
- **Separate eating and drinking area:** Employers must provide an eating and drinking area that cannot be contaminated with lead from any lead process (Reg 190(2); Compliance Code para. 110). Eating, drinking, chewing gum, or smoking in any lead process area is prohibited (Reg 190(1); Reg 205(1)). Instead of these provisions, the workers' food and drink were carried inside the cabin of the lead process vehicles where workers wore contaminated overalls and boots, and placed tools that had been used in lead processes.
- **Meal breaks away from the lead work area:** The prohibition on eating in a lead process area combined with the requirement to provide a separate eating area necessarily implies that workers must be given meal breaks during which they can leave the lead work environment, wash, and eat in an uncontaminated area. A continuous shift of 7:00 to 15:30 (8.5 hours) with no meal break would deny the worker these legal entitlements and is inconsistent with the employer's duties under Regs 190 and 191 and OHS Act s21.
- **Eating before commencing lead work:** WorkSafe Victoria does not explicitly state that workers should be advised by their employer to eat a meal before commencing their daily lead work shift. However, The LEAD Group contends that this is an oversight in the lead Compliance Code because standard occupational health guidance for lead workers recommends eating before starting work, (and at standard meal-times that occur during the shift) as food in the stomach raises gastric pH and substantially reduces the absorption of ingested lead through the gastrointestinal tract. A worker arriving fasting at 7:00 am and working through to 15:30 without a designated lead-dust-free meal break would be particularly vulnerable to gastrointestinal lead absorption throughout the shift, especially if she had not been explicitly advised to eat before starting work each day.
- **Laundering of contaminated work clothing:** Employers must arrange laundering or disposal of protective clothing contaminated with lead dust (Reg 192(1); Compliance Code paras. 117–122). Contaminated clothing must not be taken home (Reg 192(2)).
- **Containment of lead contamination in the truck cabin:** The Compliance Code (para. 101) requires employers to ensure that employees do not carry lead outside the workplace on their bodies or clothing. Where workers travel to and from job sites in contaminated clothing in the same vehicle, this requires at minimum that workers change before entering the cab, and that the cab is regularly cleaned by wet methods or Class M/H vacuum. The workers were not informed of this requirement and only removed plastic outer gloves before driving the trucks, wearing the contaminated overalls, inner gloves and gumboots while driving. The worker was not informed of the necessity of decontaminating the lead process truck, was not provided or shown any lead cleaning equipment, and never cleaned any part of the truck in any way during the entire employment.
- **Employers must ensure that any lead contamination is confined, so far as is reasonably practicable, to the area where the lead process is carried out:** Workers walked straight into the site office after shift in contaminated overalls and gumboots before changing. The 'clean' clothes and shoes the workers arrived at site in were stored in the same



site office during shift. No containers were provided for the clean clothes and shoes, clothes were hung from the same window frames the lead contaminated overalls were hung from. Shoes were stored on the floor which workers walked over with lead contaminated gumboots. The employer never mentioned the risk of cross contamination, or made any effort to keep the contaminated PPE separate from the everyday clothes. Contaminated overalls and gloves were stored in open laundry baskets waiting for laundering for days running in the site office, next to the open laundry baskets which held laundered PPE. No sealed containers were provided for respiratory equipment, as required by the Lead Compliance Code. The respirators were never cleaned, nor was any maintenance schedule explained.

- **Employers shall: provide and maintain, so far as is reasonably practicable, changing and washing facilities for employees.** No changing or washing facilities other than the single site toilet were made available. Therefore the female worker changed inside the sole toilet cubicle at start and end of shift. Washing of hands with D Lead soap was performed at the cubicle sink. The only other sink was inside the site kitchen. The worker was never instructed to decontaminate the toilet cubicle in any way after changing lead contaminated clothing there.

Q8. What is the significance of the worker's symptoms and the clinical findings?

WorkSafe Victoria's guidance lists two tiers of health effects from lead absorption.

The **early signs and symptoms of high lead levels**, as listed in the WorkSafe Victoria Lead hub page (last reviewed 23 April 2024), *can include*: headaches; tiredness; irritability; nausea; stomach pains; anaemia (a condition where there are not enough red blood cells or oxygen-carrying haemoglobin in the blood, resulting in paleness and weariness); and weight loss. The WorkSafe Lead Compliance Code (April 2022, para. 12) lists the same early signs and symptoms with the exception of weight loss.

The **more serious conditions caused by continued lead exposure**, as listed in both sources, can include: kidney damage; nerve and brain damage; lead palsy (a type of paralysis of the extensor muscles of the forearm); and death. The WorkSafe Lead hub page also specifically states: "A developing unborn child is particularly at risk from exposure to lead, especially in the early weeks of pregnancy. Lead can pass from a mother to her unborn child. Lead can damage a developing baby's nervous system as well as affect behaviour and intelligence."

The worker's own description of her symptoms, in a timeline she sent to The LEAD Group (worker's emails to The LEAD Group, 7 January 2026, 2 April 2026 and 24 May 2026), is that her symptoms began in early December 2025 and increased in frequency and severity through the New Year and into 2026. The worker first attended her GP on 16 December 2025 not knowing what could be making her so unwell and went for extensive blood testing on 18 December 2025 because she was feeling very unwell. Her ten reported symptoms, in her own words, are listed below, followed by a comment identifying which of the cited sources record each as a recognised effect of lead absorption.

The two principal Australian regulatory sources cited throughout this Case Study — the WorkSafe Victoria Lead Compliance Code (April 2022, para. 12) and the WorkSafe Victoria Lead hub page (last reviewed by WorkSafe Vic on 23 April 2024) — together list only seven early signs and symptoms of



high lead levels. The LEAD Group's own Fact Sheet, Health Impacts of Lead Poisoning (Vella et al 2020), draws on 64 peer-reviewed sources and lists many additional adult symptoms not captured in the WorkSafe lists. Where a worker's symptom is not in WorkSafe but is in Vella et al 2020, the Vella et al sub-section is identified below.

1. "Extreme fatigue, lethargy and decreased muscular endurance." Fatigue ("tiredness") is one of the seven early signs and symptoms listed in both WorkSafe sources. Vella et al 2020 specifically lists "Fatigue, muscular exhaustion" (Adults / Behaviour, citing six sources), "Muscular weakness" (Adults / Bone, muscle and joint), and (in the Children section) "Impaired muscular strength and endurance" — all of which directly correspond to the worker's description. The combination of fatigue with decreased muscular endurance is the textbook adult occupational lead presentation.
2. "Erratic sleep patterns and insomnia." Sleep disturbance is not listed in either WorkSafe source. Vella et al 2020 lists "Sleep disturbance, insomnia" (Adults / Behaviour). The worker's symptom corresponds to a recognised adult lead effect outside the limited WorkSafe lists.
3. "Frequent, very intense headaches that last the whole day." Headaches are listed in both WorkSafe sources as an early sign of high lead levels, and in Vella et al 2020 (Adults / Other). The severity and duration the worker reports — whole-day headaches — is consistent with progression beyond "early signs" toward the neurological effects listed in the more serious conditions lists of both WorkSafe sources.
4. "Frequent vertigo and head spins, while moving, getting up, and sitting still." Vertigo and dizziness are not listed in either WorkSafe early signs list. Vella et al 2020 lists "Dizziness" in the Children's section (Peripheral nervous system) — a symptom that, in adults, also fits within the Adults / Nervous system effects of "Encephalopathy", "Psychomotor impairment" and "Cerebrovascular diseases" listed by Vella et al 2020. The IME himself recorded the worker's continuing complaint of vertigo, including "a spinning sensation even when she is sitting without any movement" (see Q9 below), confirming she did report this symptom to the IME during the consultation on 19 Feb 2026.
5. "Brain fog and difficulty concentrating." Cognitive impairment is not listed as an early sign in either WorkSafe source, although "nerve and brain damage" appears in both serious conditions lists. Vella et al 2020 specifically lists "Impaired concentration", "Deficits in short term memory" and "Cognitive function deficit" (Adults / Intellectual and mental). The worker's symptom is a recognised adult occupational lead effect.
6. "Stuttering and losing the 'thread' of conversations." These verbal-cognitive symptoms are not listed in either WorkSafe source. Vella et al 2020 lists "Personality changes" (Adults / Intellectual and mental) and, in the Children section, "Verbal function / linguistic deficits" — symptoms that in an adult most closely correspond to the cognitive function deficits already noted at item 5. Lead-induced disruption of verbal fluency in adults is recognised in the lead occupational health literature but is not specifically itemised by either WorkSafe source.
7. "Frequent intense nausea, coupled with frequent diarrhoea." Nausea is listed in both WorkSafe sources as an early sign of high lead levels. Vella et al 2020 (Adults / Gastrointestinal) specifically lists "Nausea" and "Constipation, diarrhoea" as adult lead poisoning symptoms. The combination of nausea with diarrhoea — rather than constipation — is consistent with the more acute end of



gastrointestinal lead toxicity in adults.

8. "Noticeable weight loss — approximately 10% of total body mass." Weight loss is listed in the WorkSafe Lead hub page (but is NOT in the WorkSafe Compliance Code's seven early symptoms — an inconsistency between the two WorkSafe sources). Vella et al 2020 (Adults / Gastrointestinal) lists "Weight loss, anorexia" as an adult lead symptom. A weight loss of approximately 10% of total body mass over a few months is clinically significant by any measure and is consistent with documented adult lead toxicity.

9. "Marked increase in debilitation during hot weather." This symptom is not specifically itemised in either WorkSafe source or in Vella et al 2020, but it is described in detail in O'Brien and Roberts (2009), an article in *LEAD Action News* titled "Heat and Dust: why lead poisoning is called the 'Summer Disease'". Freeman (1970), as quoted in O'Brien and Roberts (2009), observed that lead-poisoned children with moderately severe poisoning "may seem well during the winter months, but tend to develop symptoms during the hot summer period" and that "factors causing dehydration or acidosis, which like infections mobilize lead from the bones, may be more common in the hot weather". O'Brien and Roberts (2009) also record the direct first-person account of a 70-year-old lead-poisoned woman, a member of The LEAD Group's Lead Poisoned Adults e-group, who reported on 21 April 2009: "I have chelated for lead off and on for three years. When the levels go down, I tolerate heat. The first sign of lead levels rising, is the burning in my feet and ankles, the intolerance to heat and no endurance in any sport." That account precisely matches the worker's description of "marked increase in debilitation during hot weather". O'Brien and Roberts (2009) similarly record the account of a firearms instructor (Case G) who, while occupationally lead-exposed at a BLL of 1.68 $\mu\text{mol/L}$ (35 $\mu\text{g/dL}$), reported: "When I go out into the sun, if I get a lot of UV, I know I'm going to get a lead dump. I get hot flushes — it feels like I'm spontaneously combusting from inside — my entire body heats up and breaks out into a sweat." The pattern is consistent: in lead-poisoned adults, heat exposure mobilises bone-stored lead into the bloodstream, which then exacerbates the underlying multi-system toxicity — including the autonomic, anaemic, renal and muscular sub-systems individually listed in Vella et al 2020 — producing the heat intolerance the worker describes.

10. "Marked, constant tremors in hands that become very intense when fatigued." Tremor is not listed in either WorkSafe source. Vella et al 2020 (Adults / Nervous system) specifically lists "Tremor" with six cited supporting sources — including a dedicated 2003 study by Louis et al on the association between essential tremor and blood lead concentration. The worker's symptom is a recognised adult occupational lead effect with a specific peer-reviewed evidence base.

The worker's own account confirms that she sought medical investigation because of the rapid onset and increasing severity of these symptoms. She booked the 18 December 2025 blood tests herself because of consistent nausea and intense fatigue (worker's email to The LEAD Group, 2 April 2026). The elevated blood lead level was the only significant change found across all of those blood tests compared with earlier blood marker results, making occupational lead absorption the most clinically plausible single explanation for the multi-system symptom picture she describes.

The absence of a meal break during 8.5-hour shifts, and the likelihood that the worker was fasting from before 7:00 am, would have increased gastrointestinal lead absorption throughout her employment, compounding inhalation and dermal exposure pathways and contributing to the rapid



rise in BLL from 2.3 to 18.6 µg/dL in approximately 30 days (20 workdays). The LEAD Group always advises anyone potentially being exposed to lead to eat a hearty breakfast before work or play outside and this advice should be part of each state's Compliance Code for Lead and induction for lead risk work.

Q9. What is the workers compensation claim rejection based on, and is it legally sound?

The workers compensation insurer rejected the worker's claim under the **Workplace Injury Rehabilitation and Compensation Act 2013 (Vic)** (WIRC Act, as amended 6 August 2025) on two grounds: first, that 'lead exposure' is not a compensable 'injury' under the Act's definition; and second, that the insurer's Independent Medical Examiner (IME) found the worker's symptoms were not the symptoms of 'lead poisoning'. This rejection appears to be fundamentally misconceived on multiple grounds.

The pathology report provided to the IME before the worker's consultation included the following printed guidelines for blood lead interpretation:

Guidelines for blood lead interpretation

...Workplace exposure:

Immediate removal from exposure is necessary if blood lead:

> 9.9 µg/dL (0.47 µmol/L): Females of reproductive age

...A worker must not return to at risk work until blood lead:

< 5 µg/dL (0.24 µmol/L): Females of reproductive age

The worker's result of 18.6 µg/dL was printed in red text followed by 'H' (for High). The IME therefore had the applicable removal and return-to-work thresholds in front of him before the consultation.

The IME's report contained the following direct quotes (the IME's report named the worker, but her name has been replaced throughout by "[the worker]"; his blood lead units "mmol/L" — which are wrong by a factor of 1,000 and should have been written as µmol/L — are quoted verbatim as he wrote them):

Current Symptoms (from the IME's report)

"[The worker] is still complaining of all these symptoms with significant ongoing vertigo and a spinning sensation even when she is sitting without any movement."

Summary (from the IME's report)



"It is possible that [the worker] has been exposed to lead. Her whole blood level is 0.9 mmol/L. Adults with BLL less than 1.93 mmol/L are usually asymptomatic and [the worker] most likely has another alternative explanation for her symptoms. She has been exposed to lead but this would not account as lead poisoning and her symptoms are not from acute lead toxicity. She has been removed from the exposure to the lead site immediately and repeat blood tests can be done in three to six months' time to see if the blood levels are improving."

"According to the literature, BLLs of 0.48 to 2.21 mmol/L from previous exposures can be encountered without ongoing exposure. Hence, it is also possible that this was a lead exposure prior to her employment which has just showed up in the blood results, although given that her work involved exposure to lead, it is possible that her lead levels are from the work-related exposure, although her symptoms are highly unlikely to be from the lead exposure. There should be a repeat of the blood test beforehand because skin contamination is possible showing an increased lead level and one-off blood test can be a possible contamination as well. In [the worker]'s case, she has had lead exposure and not lead poisoning. If she has a repeat blood test with similar elevated BLLs, she has most likely had previous exposure."

Later in the IME's report

"Nothing further is required to achieve a full return to work."

"[The worker] has non-specific symptoms along with elevated blood lead levels accounting for lead exposure, but her current symptoms are most likely not from the lead exposure. As far as the work-related lead exposure is concerned, [the worker] has a full capacity for pre-injury employment. No further treatment is required, although her ongoing non-specific symptoms of diarrhoea, nausea, headaches and vertigo are most likely not related to lead exposure and are possible psychosomatic manifestations of underlying poor mental health."

Elizabeth O'Brien, Lead Scientist and Lead Advisor for The LEAD Group charity since 1990, has analysed the IME's report and identified the following serious deficiencies:

- an implication that, in his medical opinion, lead exposure resulting in a BLL of 18.6 µg/dL after one month of doing lead-risk work, in a female worker of reproductive capacity, does not meet the definition of lead poisoning, a compensable injury under the Workplace Injury Rehabilitation and Compensation Act 2013 (Vic);
- no acknowledgment of the mandatory guideline in the pathology report he was provided by the insurer: "A worker must not return to at risk work until blood lead: < 5 µg/dL (0.24 µmol/L): Females of reproductive age." Declaring the worker has "full capacity for pre-injury employment" as at 19 February 2026 is, frankly, negligence (both on the part of the IME and on the part of the insurer's case manager who accepted this negligent statement in the IME's report);
- no referencing for important lead information he relied on to come to his conclusions;



- clear disbelief that the worker was suffering from vertigo and a spinning sensation even when sitting. If he believed she had this symptom he could not have written: "[The worker] is **still complaining** of all these symptoms with significant ongoing vertigo and a spinning sensation even when she is sitting without any movement" in the same report as he wrote: "Nothing further is required to achieve a full return to work." What work do you know of, that can be done while suffering from vertigo and a spinning sensation even when sitting? If he believed the worker, he would have done his due diligence and at the very least referred her back to her GP for a referral to a vertigo/balance/dizzy clinic. By disbelieving the worker, the IME is effectively encouraging the GP, the insurer and anyone else who reads his report to discredit this and other things the worker says;
- zero knowledge of blood lead testing units. His 0.9 mmol/L (millimoles per litre) is equal to 900 $\mu\text{mol/L}$ (micromoles per litre) — a person would be long dead from lead poisoning before they could ever absorb that much lead into their bloodstream;
- probable inability to type numbers accurately from a reference, and to include important context for what he located in his web-searching. Whereas the IME wrote: "According to the literature, BLLs of 0.48 to 2.21 mmol/L from previous exposures can be encountered without ongoing exposure," that range — with the units corrected — of 0.48 to 2.21 $\mu\text{mol/L}$ converts to 10 to approximately 45.8 $\mu\text{g/dL}$. The lower end of that range (10 $\mu\text{g/dL}$) appears in hundreds of thousands of lead documents including being the WorkSafe Victoria removal threshold for women of reproductive capacity, whereas I cannot recall from the tens of thousands of documents I have read on lead, anyone specifically citing 45.8 $\mu\text{g/dL}$ as being at the top end of the "concerning but not acutely toxic" blood lead range. Nevertheless, the range of 10 to 45 $\mu\text{g/dL}$ is the kind of range cited when discussing endogenous re-mobilisation of bone lead — i.e. when noting that lead absorbed years earlier can leach back out of bone in to the bloodstream. Mentioning that the source of lead in blood is the worker's own bones in that case, would have been helpful for non-medical people (like the insurer's case manager) reading the IME's report and needing to decide whether to reject the worker's compensation claim;
- zero knowledge of the phlebotomist's protocol for the removal of skin lead contamination prior to venous blood collection — a critical step in ensuring an accurate blood lead result for a worker who has been handling lead-contaminated materials or indeed anyone seeking to know their blood lead level;
- faulty logic. Even if it were true that "Adults with BLL less than 1.93 $\mu\text{mol/L}$ are usually asymptomatic," that does not mean that every adult with a blood lead level of less than 1.93 $\mu\text{mol/L}$ (40 $\mu\text{g/dL}$) MUST be asymptomatic;
- confusion about interpretation of increasing blood lead levels in relation to contemporaneous known lead exposure, as compared to increasing blood lead levels due to lead moving from the bones into the bloodstream when there is no contemporaneous known lead exposure. Whilst it is true that blood lead levels can rise from both exogenous (e.g. occupational) lead and endogenous (bone) lead and that these two reasons for a rising blood lead level can occur at the same time, the IME made no comment on whether the worker might have been suffering from any of the conditions that can cause earlier-in-life bone-stored lead to leach into the blood. In other words, he made no comment as to whether the worker was pregnant, lactating, suffering bone loss, hyperthyroidism, calcium deficiency, immobilisation, early menopause, or any other condition typically associated with lead moving from the bones to the bloodstream. If he really believed that the lead in her blood could have been due to previous lead exposure



(now leaching from her bones), surely his duty of care would involve referring her on for investigation of that hypothesis;

- no evidence of any previous experience or knowledge of lead exposure cases, the signs or symptoms of lead poisoning, lead exposure case management, or the schedule of repeat blood lead monitoring required under Victorian OHS Regulations. By writing "She [the worker] has been removed from the exposure to the lead site immediately and repeat blood tests can be done in three to six months' time to see if the blood levels are improving," the IME demonstrates that he thinks it would be immaterial if a person's blood lead level kept rising for up to six months after the consultation date after she was removed from lead-risk work. In fact, if his hypothesis that her BLL on 18 December 2025 was due to previous (i.e. prior to her 13 November 2025 start of lead-risk work) lead exposure was correct, and the worker's BLL did keep rising for another six months from the consultation date of 19 February 2026, the IME would be liable for medical negligence for not having directed the worker to obtain an earlier blood lead result in order to determine whether the post-removal-from-lead-risk-work blood lead trend was in fact falling or rising. Obtaining a repeat BLL within two weeks following removal from lead-risk work is another LEAD Group recommendation which needs to be incorporated into OHS Regulations and Public Health follow-up of notifiable BLLs. Discovering the BLL trend in as few as three days or at most fourteen days once you think lead exposure has been ended (and also when treatment for lead poisoning has begun) is crucial to secondary lead poisoning prevention (case management after a blood lead threshold has been exceeded);
- stepping outside his area of expertise as a General Physician by making the wild accusation that the worker's ongoing symptoms "are possible psychosomatic manifestations of underlying poor mental health";
- a general shotgun approach to shooting down the worker's claim, which could only work in a broken system. The IME tried everything: ignoring or not reading the mandatory guideline in the pathology report; opining that "lead exposure" is not "lead poisoning"; applying a generalisation as if it were an absolute rule about symptoms; raising doubt about the worker's credibility, the phlebotomist's ability to follow skin-cleaning protocol, and that the lead in the worker's blood a month after starting lead-risk work was not necessarily from her occupational exposure; and suggesting repeat blood lead testing on a timeframe well outside the frequency required at this particular BLL by Victoria's OHS Regulations or even to prove or disprove the IME's poorly elucidated hypothesis as to the source of the lead in the worker's blood.

Detailed rebuttal of two of the IME's claims

The IME's report includes the assertion: "According to the literature, BLLs of 0.48 to 2.21 mmol/L from previous exposures can be encountered without ongoing exposure." (For "mmol/L" read "µmol/L" – the thousand-fold unit error already noted in Elizabeth O'Brien's analysis above.) The IME does not name any literature source for this assertion.

- The leading Australian regulatory source on the topic – Safe Work Australia's Health monitoring guide for lead (inorganic) (March 2020) – does not support the IME's claim. The number 2.21 does not appear anywhere in the document. The phrases "previous exposure", "previous exposures", "without ongoing exposure", "past exposure", "bone lead", "mobilise/mobilize", "endogenous" and "leach" do not appear. The number 0.48 µmol/L does appear, but in the directly opposite context – as the SI equivalent of 10 µg/dL, the mandatory removal threshold for females of reproductive capacity. Safe Work Australia states:

"If it is confirmed that lead blood levels exceed 10 µg/dL (0.48 µmol/L) for female workers



of reproductive capacity ... the worker must be removed from lead risk work and the workplace practices and controls should be immediately reviewed as this indicates current controls are not performing effectively."

"Females of reproductive capacity should be informed about the reproductive health risks where blood lead levels may exceed 10 µg/dL (0.48 µmol/L)."

- In other words, the lower bound of the IME's quoted range — 0.48 µmol/L — is, in Safe Work Australia's own framework, the level at which (a) the worker must be removed from lead-risk work because controls are not performing effectively, and (b) the worker must be informed of reproductive health risks. It is not, as the IME's framing suggests, a "background" level that might be encountered without ongoing exposure.
- On the implications of the worker's BLL of 18.6 µg/dL — well above 10 µg/dL — for a woman of reproductive capacity, Safe Work Australia states:

"Research in non-occupational settings has indicated: increased risk of spontaneous abortion and potential for postnatal developmental delay at maternal blood lead levels greater than or equal to 5 µg/dL; hypertension and kidney dysfunction at blood lead levels greater than or equal to 5 µg/dL; reduced birth weight and potential for subclinical neurocognitive deficits at maternal blood lead levels greater than or equal to 10 µg/dL..."

- At 18.6 µg/dL, the worker was approximately four times the 5 µg/dL threshold for increased risk of spontaneous abortion, postnatal developmental delay, hypertension, and kidney dysfunction, and approximately twice the 10 µg/dL threshold for reduced birth weight and subclinical neurocognitive deficits — even in non-occupational settings, where ambient exposure is generally lower than in lead-risk work.

On the IME's separate claim that "Adults with BLL less than 1.93 mmol/L are usually asymptomatic" (units corrected: less than 1.93 µmol/L or less than 40 µg/dL), no source is cited. Safe Work Australia does mention 40 µg/dL but says something quite different — and in the opposite direction:

"It is possible for people with blood lead levels of 40 µg/dL or more not to exhibit noticeable health effects."

"Blood lead levels where people exhibit symptoms vary greatly between individuals."

Safe Work Australia's point is that the relationship between BLL and symptoms is highly variable between individuals — even at 40 µg/dL or above, some people happen not to exhibit noticeable health effects. The IME has inverted this: he has converted "some people at 40 µg/dL or above may still be asymptomatic" into the categorical claim that "adults with BLL less than 40 µg/dL are usually asymptomatic." These are not the same statement, and Safe Work Australia explicitly cautions against treating BLL-symptom relationships as general rules. Safe Work Australia also lists 30 µg/dL as the threshold for "increased non-specific symptoms" — meaning symptoms are expected to increase as BLLs approach the worker's range, not be absent below 40 µg/dL.

The IME's report cites no source for the "1.93 µmol/L (40 µg/dL) usually asymptomatic" claim. Two Australian regulatory sources have been searched for the claim, and a peer-reviewed review of the lead literature directly contradicts the IME's framing:



(1) Safe Work Australia's Health monitoring guide for lead (inorganic) (March 2020) — 1.93 does not appear; the closest statement is that some people at 40 µg/dL or above may not show noticeable health effects, the inverse of the IME's claim.

(2) Austin Health Toxicology Services Lead Guideline (Version 3, published August 2025) — 1.93 does not appear; "asymptomatic" does not appear; the IME's framing of "BLLs of 0.48 to 2.21 mmol/L from previous exposures ... without ongoing exposure" does not appear. Austin Health's adult action-BLL thresholds are at 0.48, 2.4, 3.4 and 4.5 µmol/L (10, 50, 70 and 100 µg/dL) — and at 0.48 µmol/L the recommendation is "Remove from source; repeat concentration in a month; chelate if symptomatic." In other words, Austin Health, like Safe Work Australia, treats a BLL above 0.48 µmol/L (10 µg/dL) as a level requiring action — not as a "background" level associated with past exposure.

Sanders et al (2009), who reviewed 200 articles on lead, specifically state that neurotoxicity symptoms of lead can begin in adults at blood lead (BPb) levels below 18 µg/dL:

"A remarkable explosion in the literature about the health effects of lead has occurred since the dissemination of U.S. Occupational Safety and Health Administration (OSHA) lead standards in 1993 (OSHA 1993a,b) stating that workers can attain blood lead levels up to 40 µg/dL for their working lifetime. Since then, many longitudinal studies have provided evidence that cumulative lead dose causes cognitive dysfunction or decline (reviewed in Shih et al 2007). The neurotoxic effects of lead in workers can be induced at BPb levels below 18 µg/dL, somewhat higher than the critical level of lead neurotoxicity in children (5 µg/dL) (Murata et al 2009)."

However, the Austin Health Toxicology Services Lead Guideline (August 2025) is itself substantially out of date with respect to Victorian occupational lead-risk work. Although reviewed in August 2025 — five years after the Victorian OHS Regulations 2017 were amended on 5 June 2020 to introduce a 10 µg/dL removal threshold for women of reproductive capacity and a 30 µg/dL removal threshold for all other workers — the Austin Health guideline footnotes that "Occupational exposure guidelines recommend removal from source if conc. > 20 µg/dL (0.96 µmol/L)." This is the pre-2020 Victorian threshold, it does not differentiate workers by gender, and it is therefore inconsistent with the current Victorian OHS Regulations. A treating clinical toxicologist who relies on this guideline for advice about a female worker of reproductive capacity in lead-risk work would risk repeating the same error as the IME — treating BLLs that are above the Victorian removal threshold as if they were below it.



This out-of-date guidance is of immediate concern in this worker's case because she was referred by her GP to Austin Health Toxicology Services. If the consulting toxicologist there relies on this guideline, the advice [the worker] receives (if she attends the service) may be at variance with the Victorian OHS Regulations that should govern her clinical management. The LEAD Group recommends that Austin Health update its Lead Guideline to reflect the current Victorian OHS Regulations (and the corresponding regulations in other Australian jurisdictions).

Where to find a more lead-knowledgeable Independent Medical Examiner

Given the IME's apparent lack of experience with lead exposure cases — evidenced by the unit error, the unsourced quantitative claims, and the absence of any reference to Victorian OHS-specific blood lead action levels for women of reproductive capacity — The LEAD Group recommends that workers compensation insurers, workers and their advocates seeking a medical opinion consult the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) "Find a Consultant" directory, which lists nine Victorian doctors as at May 2026. AFOEM is a faculty of the Royal Australasian College of Physicians and does not publish its own lead guidelines; its members are expected to follow the Safe Work Australia Inorganic Lead Guidance and the NHMRC Managing Individual Exposure to Lead in Australia Guide. An AFOEM-listed consultant is therefore the most likely first port of call for a Victorian workers compensation insurer or worker seeking medical advice that is both occupationally informed and current with Australian regulatory thresholds.

Q10. On what grounds should the workers compensation claim have been accepted

Ground 1: Lead poisoning is a proclaimed disease — the burden of proof is reversed



Most critically, "**lead poisoning or its sequelae**" is a **proclaimed disease** under the WIRC Act. WorkSafe Victoria's own guidance explains the effect: "A worker, or a dependant of a worker, with a proclaimed disease are entitled to compensation **irrespective of whether work is proven to have contributed to the disease**, unless WorkSafe or a self-insurer **proves that the disease was not due to employment.**" (WorkSafe Victoria, 'New silica-related diseases now proclaimed', reviewed 29 July 2022, worksafe.vic.gov.au/new-silica-related-diseases-now-proclaimed)

The current Victorian proclaimed diseases list on that page includes: "**Lead poisoning or its sequelae.**" The workers compensation insurer — not the worker — therefore bears the burden of proving the lead poisoning or its sequelae was not due to her employment. Given that the worker's BLL rose from 2.3 µg/dL (her first-ever blood lead test, shortly after commencing lead-sheathed cable removal) to 18.6 µg/dL in only 35 days, and that the elevated BLL was the only significant change in an extensive clinical workup, this is an extremely high burden to discharge.

Ground 2: **The IME's own diagnosis falls within the OHS Regulations' category of 'excessive lead absorption' — and is covered by 'sequelae'**

The OHS Regulations draw a precise distinction between outcomes a medical practitioner must assess when examining a worker (Reg 202(2)):

- (b) the worker "**has excessive lead absorption and must not perform lead-risk work**"
- (c) the worker "**shows symptoms or signs of clinical lead poisoning and is unfit to work**"
- (e) the worker "**is fit to continue performing lead-risk work**"

These are **two distinct, separately defined categories**. Category (b) — excessive lead absorption — does not require clinical lead poisoning symptoms. The insurer's IME, by diagnosing 'lead exposure' while finding no 'acute lead toxicity' symptoms, was effectively making a Reg 202(2)(b) finding: **excessive lead absorption** — a defined, regulated, actionable condition under Victorian OHS law, not an absence of injury. A BLL of 18.6 µg/dL — nearly twice the mandatory removal threshold for women of reproductive capacity — is by definition excessive lead absorption.

Furthermore, the proclaimed disease is 'lead poisoning **or its sequelae.**' Excessive lead absorption causing a BLL of 18.6 µg/dL, accompanied by the symptoms the worker reported — **nausea, fatigue, vertigo, brain fog, and upset stomach** — is a sequela of lead poisoning. The IME cannot escape the proclaimed disease framework by characterising the condition as category (b) rather than category (c) when the proclaimed disease expressly covers sequelae.

Ground 3: **WorkSafe Victoria does not define 'lead poisoning' by a specific BLL threshold**

Nowhere in the OHS Regulations, the Compliance Code, or any WorkSafe Victoria guidance do the uploaded documents define 'lead poisoning' as requiring a specific blood lead level. The removal threshold of 10 µg/dL for women of reproductive capacity is not labelled 'lead poisoning' — it is simply the level at which removal is mandatory. WorkSafe's own hub page describes lead as "*a cumulative poison*" that "*can build up in the body over time until symptoms occur*" — language directly



applicable to the worker's trajectory from 2.3 to 18.6 µg/dL over 30 days. The insurer's IME has drawn a definitional line — 'lead exposure' vs 'lead poisoning' — that WorkSafe Victoria itself has not drawn in its legislation or published guidance.

Ground 4: **Additional independent grounds**

- The WIRC Act definition of 'injury' independently includes **disease contracted in the course of employment**. Occupational lead absorption causing a BLL of 18.6 µg/dL and associated symptoms constitutes an occupational disease under this definition, independently of the proclaimed disease provision.
- The insurer's IME confirmed lead exposure occurred — confirming lead was absorbed into the worker's body in the course of her employment.
- The employer's own arrangement of the 18 November 2025 blood test is an implicit acknowledgement that it knew lead-risk work was occurring.
- The WIRC Act was amended on 6 August 2025 — approximately three months before the worker commenced — to improve support for injured workers accessing the WorkCover Scheme.
- The employer's multiple OHS Regulation breaches — no pre-commencement monitoring, inadequate controls, no meal breaks away from lead work, no removal at the 10 µg/dL threshold, (evidently) no WorkSafe notification, and complete abandonment after 6 January 2026 — created the conditions for the worker's harm and are directly relevant to the insurer's ability to prove the disease was not due to employment.

Q11. Is the employer's conduct consistent with a pattern WorkSafe has already identified?

Yes. WorkSafe Victoria publicly identified exactly this pattern of breaches before this worker commenced employment.

On **20 January 2025**, WorkSafe's Safety Alert identified employers who had committed every breach that occurred here. (worksafe.vic.gov.au/safety-alerts/lead-based-paint-removal)

On **24 May 2022**, WorkSafe warned of "potentially deadly risks" after finding unsafe practices at 11 workplaces, including three not providing required biological monitoring. (worksafe.vic.gov.au/news/2022-05/lead-safety-breaches-prompt-warning)

The employer's arrangement of the 18 November 2025 blood test — four days late — demonstrates selective awareness of obligations. Yet it may have failed to notify WorkSafe, and failed to implement any hygiene controls, provide meal breaks, arrange the one-month follow-up test, or take any action upon the 18.6 µg/dL result other than ending the worker's employment and ceasing all contact. This is not ignorance — it is selective compliance followed by abandonment.

Q12. Summary — what notifications and actions were required, by whom, and what happened?



- **Employer → WorkSafe Victoria (Reg 195):** Notify of lead-risk work within 7 days via form FOR569 to hygieneunit@worksafe.vic.gov.au or PO Box 279, Geelong VIC 3220. Deadline: 20 November 2025 at the latest. — **Not done**
- **Employer → Worker (Reg 196(1)):** Pre-commencement health monitoring before 13 November 2025. — **Done 4 days late (18 November 2025)**
- **Employer → Worker (Reg 196(2)):** Follow-up biological monitoring within one month (by 13 December 2025). — **Not done by employer. Test on 18 December 2025 arranged by worker/GP for clinical reasons, 5 days overdue**
- **Employer → Worker (Reg 198(1A)):** 6-weekly monitoring once BLL $\geq 5 \mu\text{g/dL}$. — **Not done. No employer contact after 6 January 2026. Test on 20 February 2026 arranged independently by worker/GP (9+ weeks later)**
- **Employer → Worker (Regs 190, 191, 205):** Provide separate eating area, washing facilities, and meal breaks away from lead work. — **Apparently not done. Worker required to work 7:00–15:30 shifts with no meal break**
- **Employer → Worker (Reg 192):** Arrange laundering of lead-contaminated work clothing; ensure contaminated clothing not taken home. — **Not done. Work clothing was not taken home. Employer stated that contaminated work clothing and PPE would be laundered offsite when “dirty enough” - not at the end of every shift as required by Compliance Code.**
- **Employer → Worker (Reg 199):** Immediately remove from lead-risk work upon $18.6 \mu\text{g/dL}$ result. — **Not done (employment ended instead)**
- **Employer → Medical practitioner (Reg 200):** Arrange medical examination within 7 days of removal. — **Not done. No employer contact after 6 January 2026**
- **Employer → WorkSafe Victoria (Reg 203):** Send biological monitoring results to WorkSafe after removal. — **Presumably not done. No formal removal; notification of removal presumably not sent to WorkSafe**
- **Pathology laboratory → Department of Health:** Notify of BLL $> 5 \mu\text{g/dL}$ within 5 days of diagnosis (deadline: 27 December 2025). [PHWA 2008; PHWR 2009 as amended 1 September 2018] — **Done: 22 December 2025**
- **Pathology laboratory → GP (Reg 181):** Notify supervising registered medical practitioner of result. — **Done: 22 December 2025**
- **GP → Employer (Reg 202(2)):** Provide biological monitoring report to employer. — **Worker informed employer directly on 6 January 2026**
- **Department of Health response:** Any mandatory action or referral to WorkSafe upon receiving laboratory notification — see Q6 — the Department's response actions appear discretionary under PHWA Part 8 rather than mandatory; whether referral to WorkSafe Victoria occurs as a matter of practice is not stated on publicly available Department of Health guidance.



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