December 2025

Report on All-Party Parliamentary Group Meeting of 3 November 2025 on Silicosis

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In partnership with Thompsons Solicitors and the TUC

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- Tina Conroy of Pragma Associates
- Dr Jennifer Hoyle - Consultant Physician, Manchester University NHS Trust
- Jason Poulter - Unite National Officer for Construction

Thank you also to all of those who attended the meeting for your invaluable insight and commentary.

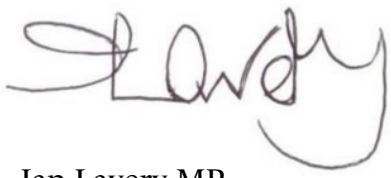
Foreword from Ian Lavery MP

The report you are about to read lays bare a silent, ongoing tragedy within our workplaces: the entirely preventable disease of silicosis.

For too long, the dangers of respirable crystalline silica (RCS) dust have been underestimated or ignored, particularly in the booming engineered stone industry where workers are exposed to astonishingly high levels of silica.

The harrowing accounts of young workers diagnosed with an irreversible, progressive, and potentially fatal lung disease underscore an urgent need for systemic change.

This is a call to action for industry, regulators, and government to prioritize human life over production, enforce stringent safety protocols, and ensure no more lives are senselessly cut short by a dust we have known how to control for centuries.



Ian Lavery MP

December 2025

Executive Summary

Silicosis is Britain's oldest known occupational disease, yet it continues to claim hundreds of lives each year. Despite clear medical evidence, robust legislation, and decades of awareness, enforcement failures and underreporting have allowed this preventable disease to persist—now with alarming new cases linked to high-silica engineered stone.

The All-Party Parliamentary Group on Occupational Safety and Health convened experts, unions, lawyers, and clinicians to assess the scale of the crisis. Key findings include:

Medical evidence

Accelerated silicosis is increasingly diagnosed in young workers, with cases requiring lung transplants as early as age 23. The disease doubles the risk of lung cancer and is linked to COPD, TB, and autoimmune conditions.

Legal and regulatory gaps

Current UK workplace exposure limits are twice as high as those in many jurisdictions. Compensation and reporting mechanisms remain inadequate, leaving workers and families without justice.

Worker impact

Testimonies reveal devastating personal consequences—loss of livelihood, family strain, and premature death—underscoring the human cost of regulatory inaction.

International comparisons

Australia has banned engineered stone; California has enacted emergency regulations. The UK lags behind, despite mounting evidence of similar risks.

Policy priorities:

- Ban high-silica engineered stone to prevent further cases.
- Reduce workplace exposure limits in line with international standards.
- Reinstate silicosis as a reportable disease under RIDDOR and establish a national register.
- Strengthen enforcement capacity of the Health and Safety Executive.
- Expand health surveillance, including CT scans, and ensure access for precarious and migrant workers.
- Launch multilingual education campaigns to raise awareness among employers and workers.

The APPG concludes that silicosis is not only a medical emergency but a matter of social justice. Without decisive government action, the UK risks repeating the failures of the asbestos crisis. Urgent collaboration between policymakers, unions, medical professionals, and legal advocates is essential to protect workers, enforce accountability, and prevent thousands of avoidable deaths.

Background

Hundreds of workers are dying every year in Britain from silica exposure, yet official reporting remains extremely low. Affected industries include construction, stone working - including engineered stone, quarrying, brick making, foundries and potteries, amongst many others.[1]

Against this backdrop, Thompsons Solicitors with the TUC hosted a joint meeting of the All-Party Parliamentary Group (APPG) on Occupational Safety and Health (OSH) to call for urgent action on the issue.

The event took place on Monday 3rd November in the Palace of Westminster.

The meeting brought together leading experts, trade union representatives, and legal specialists to highlight the growing health crisis linked to silica dust — particularly the rising number of cases of artificial stone silicosis, a deadly lung disease increasingly diagnosed in young workers.

Dr Johanna Feary, consultant in occupational lung disease at the Royal Brompton Hospital and lead author of the first UK paper on artificial stone silicosis, told the APPG that since the publication of her 2024 paper, which studied eight confirmed UK cases where the average age of sufferers was 34, that number has now increased to 45, with an average age of just 31.

In addition, research suggests that at least around 500 construction workers die each year from silica exposure, and that indeed the real figure is likely to be higher due to under-reporting.

Silica exposure is now taken so seriously that Australia and California [2] have passed legislation to ban the use of high-silica engineered stone. Earlier this year, the TUC joined other organisations, including UNITE, in calling for a similar ban in Britain, alongside a lower workplace exposure limit.

Among the speakers were Dr Jennifer Hoyle, Consultant Respiratory Physician at North Manchester General Hospital, Jason Poulter, National Officer for the Construction Sector at Unite the Union and Tina Conroy, Chartered Occupational Hygienist of Pragma. The meeting also heard from expert disease solicitors, Daniel Poet of Thompsons Solicitors and Claire Campbell from Thompsons Solicitors Scotland.

The meeting heard shocking evidence that stonemasons as young as 23 are now requiring lung transplants after developing the deadly respiratory disease, which has been linked to the cutting of high-silica kitchen worktops.

Background

Daniel Poet, Partner at Thompsons Solicitors, said concerns were also heard that the lower numbers currently recorded in Britain, compared with countries such as Australia, may simply reflect underreporting and delayed symptoms.

He said: “This is a disease that can take years to show itself. Like other industrial illnesses, we may not yet know the full extent of the damage that has already been done.

“In many of our cases, clients have been exposed to silica dust for only a few years, yet the damage is already severe. We’re also deeply concerned about the long-term impact on their ability to work and support their families as their conditions worsen.

“Silicosis is entirely preventable - there is no excuse for inaction.”

He added that protection for workers - both financial and health-related - remains “woefully inadequate.”

The APPG also heard testimony from a stonemason represented by Thompsons Solicitors, who was diagnosed with silicosis at just 37 after years of exposure to heavy dust at work. He described the impact of his illness as “life-changing.” His wife is now his full-time carer and he made the very difficult decision to have a vasectomy, as he no longer felt capable of caring for another child.

Paul Nowak, General Secretary of the TUC, said: “Without action there will be thousands more deaths from silicosis. The unsafe cutting of high silica stone must be banned – and backed by firm enforcement. Other countries are acting, and Britain must not be left behind. That can only be done with greater funding for the Health and Safety Executive, so it has the capacity to crack down on rogue employers who subject their staff to lethal hazards.”

Jason Poulter of Unite the Union said: “Unite members continue to be exposed to deadly silica dust leading to premature deaths as employers fail to protect their workforce. We are proud to join the call for a ban on engineered stone and strict dust limits but we are also clear on the need for government legislation to extend the role and influence of union safety reps in defending workers across our industries.”

Dr Jennifer Hoyle, Consultant Respiratory Physician at North Manchester General Hospital, told attendees that the risk of developing lung cancer doubles for people living with silicosis.

The meeting concluded with a united call for the Government to ban high-silica engineered stone and to strengthen enforcement and reporting mechanisms. Speakers warned that current reporting of cases is failing to keep pace with this new, rapidly progressive form of the disease.

Background

The Westminster event marks a key step in building momentum behind a national campaign to ban engineered stone and strengthen workplace safety law — with Thompsons Solicitors and the TUC leading the charge.

This summary paper looks to bring together the information shared at the meeting and assess likely future action points.

What is Silica?

Silica is a naturally occurring material in most rocks, sand, clay, concrete and in bricks. It makes up approximately 25% of the earth's crust, usually in complexes with oxygen (SiO_2).[3]

Cutting, grinding, sanding or polishing stone releases tiny particles into the air which can then be breathed in - the particles are then 'respirable'. The respirable particles can have a more serious impact if fresh and are crystalline, called respirable crystalline silica (RCS). The particles cannot be seen by the naked eye but pose a significant risk to lung health and may cause a number of other health conditions.[4]

The degree of risk will depend, to some degree, upon what substance is being worked upon as different substances contain differing percentages of silica. This is illustrated in the table below.[5]

Often, however, workers will not know exactly what they are working with. The risk will also vary depending upon the particle size and the length of time exposed.

Stone	Silica content
engineered stone	up to 95%
sandstone, gritstone, quartzite	>70%
concrete, mortar	25 to 70%
shale	40 to 60%
china stone	up to 50%
slate	up to 40%
granite, brick	30%
ironstone	up to 15%
Basalt, dolerite	<5%
Limestone, chalk, marble	<2%

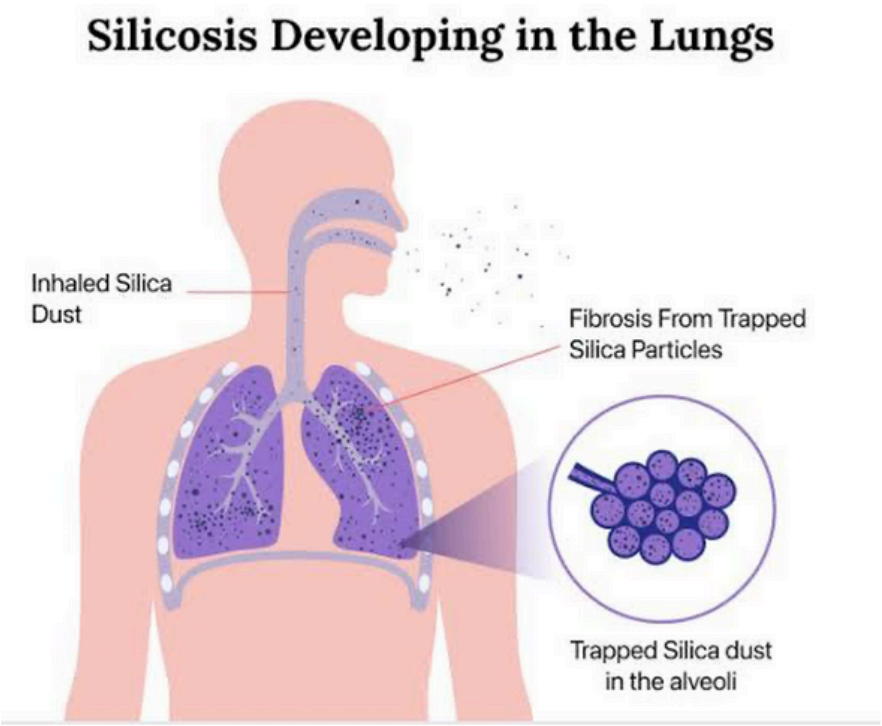
What is Silicosis?

Silicosis is a long-term lung disease caused by inhaling large amounts of crystalline silica dust, usually over many years.[6]

Once inside the lungs, it causes swelling (inflammation) and gradually leads to areas of hardened and scarred lung tissue (fibrosis). Lung tissue that's scarred in this way doesn't function properly.

Silicosis is a progressive and irreversible disease and symptoms can continue to develop and worsen even after exposure to silica dust has stopped. The progression can vary significantly between individuals depending on factors like the amount of dust inhaled and smoking history.

Unfortunately, there is currently no cure for silicosis, making prevention the most essential step.



Other health effects of silica[7]

Whilst there is understandably considerable focus upon silicosis and in particular accelerated silicosis, the meeting heard from Dr Hoyle that RCS is also linked to a number of other serious conditions, including:

- Lung Cancer
- COPD
- TB – increased risk of infection and relapse
- Serious Rheumatological conditions such as Erasmus Syndrome, Lupus and Rheumatoid Arthritis.

Who is affected?

A number of industries come with well established risks associated with RCS, such as:-

- stone masonry and stone cutting–especially with sandstone
- construction and demolition – as a result of exposure to concrete and paving materials
- worktop manufacturing and fitting
- pottery, ceramics and glass manufacturing
- mining and quarrying
- sand blasting
- glass manufacturing.

However, the meeting heard from Dr Hoyle that less obvious industries also come with risks associated with RCS.

Dentistry[8]

RCS presents a risk within dental laboratories because procedures like grinding and polishing dental materials generate fine, airborne crystalline silica dust[9].

Fashion Industry[10]

The fashion industry can also involve high risk processes:

- Denim Sandblasting: To achieve a "distressed" or faded look for jeans, workers in some factories use high-pressure air guns to blast sand (containing high levels of silica) onto the fabric. This practice has led to an epidemic of silicosis, particularly in countries like Turkey, where the practice was banned in 2009, though it has since migrated to other nations[11].

- Rhinestone Manufacturing: Workers in facilities that cut, grind, and polish artificial gems (rhinestones), which are made using quartz sand, are also at high risk of exposure to silica dust[12].

- Contaminated Clothing: Silica dust can settle on workers' clothing and become airborne again when disturbed by movement, causing prolonged exposure and the potential for contamination of other areas.[13]

As such, the risks associated with RCS are not limited to “traditional” stone cutting industries and this trend is likely to continue, as we develop new ways to use silica. Future work targeting “at risk” industries therefore needs to be wide ranging.

The extent of the problem

The Health & Safety Executive (HSE) have said that silica is the biggest known risk to construction workers after asbestos.[14]

An estimated 600,000 workers in the UK are exposed to silica. The HSE estimates that approximately 600 deaths per year are caused by lung cancer associated with exposure to RCS with around 450 of these occurring from exposures within the construction sector.[15][16]

When other diseases attributable to silica are considered, the number of deaths has been estimated to be potentially as high as 1000 a year.

Silicosis is NOT a new problem

The meeting heard compelling evidence from Tina Conroy, Occupational Hygienist, outlining the history of silicosis and the long-standing knowledge of the risks.

There is evidence that silicosis was prevalent in neolithic flint miners, as early as 3000BC. In fact, the condition, now known as silicosis, is considered the world's oldest known occupational disease. The problem gained significant attention in the early 1900s, especially following the increased use of power tools which generated more dust. A major U.S. federal campaign, "Stop Silicosis," was launched in 1938 after the tragic Hawks Nest Tunnel disaster, which caused hundreds of deaths in the 1930s.

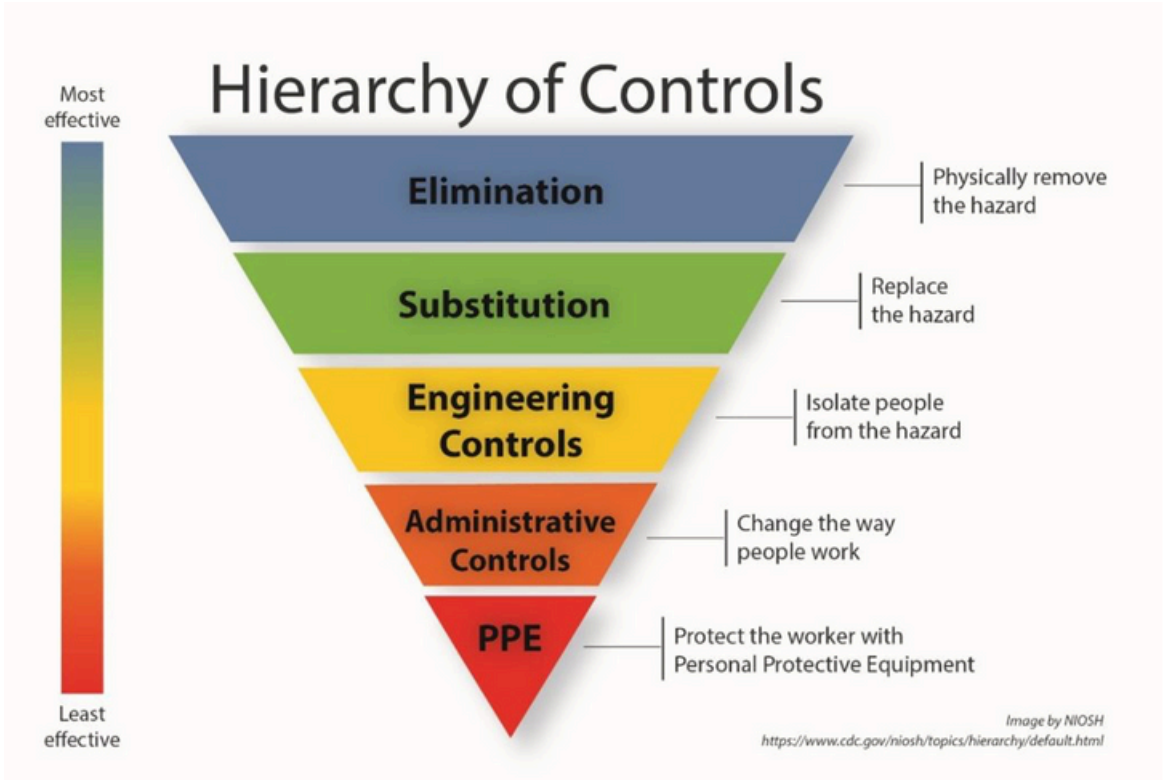
In 1997, the International Agency for Research on Cancer (IARC) officially classified occupational exposure to crystalline silica as carcinogenic to humans.[17]

Industrial disease lawyers are well used to describing Silicosis as the “new asbestos”; however, in the 1960s, asbestos was being described as the “new Silicosis”.

This history places the current crisis in stark terms and is a poor reflection on the relative inaction that has taken place to date to arrest this problem.

Current Legislation and Controls

Under the Control of Substances Hazardous to Health Regulations (2002) as amended, there exists a strict hierarchy of controls as set out below.



Workplace Exposure Limit

Currently, in the UK, there is a workplace exposure limit (WEL) of 0.1mg/m³ (as an average over 8 hours). However, this is not identified as a 'safe limit' and the employer has a duty to reduce exposure as far as reasonably practicable.[18]

How does the UK WEL compare to other jurisdictions?

- Australia: The national WEL for RCS is 0.05 mg/m³ (50 µg/m³), although the State of Victoria has a recommended limit of 0.02 mg/m³.[19]
- United States: The Occupational Safety and Health Administration (OSHA) enforces a Permissible Exposure Limit (PEL) of 0.05 mg/m³ (50 µg/m³)[20]
- Canada: The national standard is 0.05 mg/m³. However, some provinces, such as British Columbia and Quebec, have adopted a lower standard of 0.025 mg/m³.
- Europe: The European Union has a framework for worker health protection through "Good Practices". Many other jurisdictions in Europe enforce the 0.05 mg/m³ limit, and Portugal has an even stricter limit of 0.025 mg/m³.

Current Legislation and Controls

As such, the WEL in the UK is at least double that of many other jurisdictions.

As set out in the hierarchy, employers should first assess whether they can eliminate the material in question and, if not, whether they can substitute it for a substance containing a lower concentration of silica.

Thereafter, engineering controls will play a crucial role. Controls are needed, not just during the task but also during clean up, tool cleaning and disposal.

Water Suppression[21]

Can reduce concentrations of RCS dust at source by up to 95% and can be performed in both small or large-scale activities.

Dust Extraction[22]

The use of local exhaust ventilation can reduce concentration of RCS dust at source in excess of 90% or more where attachments such as dust cowls are provided.

Respiratory Protective Equipment (RPS)

RPE is also encouraged to reduce workers' exposure to RCS. However, it is important that the correct type of respirators are used; many facemasks look similar but have completely different uses. Only certain RPE will protect against RCS and it is vital that employers know which types to provide.

Conclusions

Whilst there is an argument to reduce the UK WEL in line with some other jurisdictions, the HSE believe that the current legislation is robust and that the prescribed controls, if implemented effectively, would result in reducing exposure to below the WEL.

The challenge is more one of information, training, surveillance and enforcement, as many employers, particularly those working with engineered stone, have no effective controls in place at the moment.

Engineered Stone

Much of the meeting, perhaps understandably, focused on the high-profile issue of Engineered Stone.

Engineered stone containing silica, also known as quartz or agglomerate stone, is a composite material made by mixing crushed stone with a resin binder. This product can be manufactured to suit the customised specifications of any project.[23]

In recent years it has become increasingly popular due to the perceived resilience to heat and scratches and the variety of colour options available. A report by the Verified Market Research group in November 2024 indicated that the current global market for engineered stone is worth USD 29.15 billion. This is projected to increase to USD 43.01 billion by 2031.

However, working with engineered stone poses an exceptionally high risk of injury in that it is typically made up of 90% to 95% silica. This results in a much greater risk of rapid onset or "accelerated" silicosis.

Engineered Stone

What is accelerated Silicosis?

Accelerated silicosis can be distinguished from chronic silicosis, which has a typical latency of 10 to 30 years.[24]

In accelerated cases, now linked to engineered stone, symptoms typically develop within 3 to 10 years of exposure to RCS, but often even sooner. In addition, the higher doses mean that the patient develops massive fibrosis and respiratory failure within a short period of time.

The risk of working with engineered stone applies at both production and installation phases.

- Fabrication workers: Those who work in workshops that perform cutting, grinding, and polishing are at high risk because they often engage in these activities for most of their shift.
- Installation workers: On-site installers are also at risk, particularly when they need to do minor processing, such as cutting or drilling, to fit materials in place.
- Workers using dry processing: Any activity that involves dry cutting, grinding, or polishing, whether in a shop or on-site, generates high levels of dust and is a significant risk.

Worldwide knowledge of engineered stone

- United States: Hundreds of cases have emerged across the US, particularly in California, which has implemented emergency regulations. As of late 2025, California has documented 336 confirmed cases of silicosis among engineered stone workers, resulting in 19 deaths and 41 lung transplants. The cases are predominantly among Latino immigrant men, who were often diagnosed with advanced disease, with a median age of 45 at diagnosis and a median work history of 14 years.[25]
- Spain: Cases were first described in Spain (and Israel) in the early 2010s. Studies there revealed that around 50% of workers in some factories were affected.
- Israel: Along with Spain, Israel was one of the first countries to report cases of engineered stone-related silicosis. 82 cases found 1997-2012. 40 workers were documented on the lung transplant assessment list.
- China/India: Hundreds of cases have emerged in China. Globally, the highest number of incidents of silicosis in general were in China and India where most production takes place.

Engineered Stone

Australian Ban

Australia became the first country to ban the use, supply, and manufacture of engineered stone with effect from July 2024.[26]

Around 10,390 Australians are predicted to develop lung cancer in their lifetime as a direct result of being exposed to the dust. This translates to 1.02% of projected lung cancer cases.

Within the meeting there was a strongly held view that the UK should also now move to a position of a total ban.

Position in the UK

The trend of cases of silicosis associated with engineered stone in the UK has lagged somewhat behind those of other countries, primarily because it was not introduced into the UK until some years later.

However, the evidence from other countries has meant that many physicians had been anticipating a comparable spike in UK cases. Unfortunately, this now seems to be coming to fruition.

The first cases of workers who developed silicosis after cutting and finishing artificial stone worktops were reported in 2023 in Thorax. At that stage there were 8 reported cases, but the meeting heard from Dr Johanna Feary, who is leading on analysis of the cohort, who explained that the number has now risen to 45 and is expected to keep growing. [27]

All eight patients highlighted in the initial paper were seen by experts in occupational lung disease at Royal Brompton Hospital, a specialist centre for respiratory diseases and part of Guy's and St Thomas' NHS Foundation Trust. All were men, with an average age of 34 years old, and at least one had only four years' exposure before developing the disease after inhaling the dust from cutting artificial stone worktops.

All the men were involved in dry-cutting and polishing engineered stone worktops and reported having no effective respiratory protection. As a result they were exposed to huge doses of respirable silica.

While cases of silicosis among worktop manufacturers have been reported from countries around the world since 2010, this is the first time the UK has seen worktop tradespeople with the condition. Dr Feary warns there are likely to be many more similar cases as yet unreported.

Dr Feary stated that "Silicosis is a devastating and deadly disease for which we have no cure. The first cases of it resulting from artificial stone manufacturing we have seen at Royal Brompton have all been in young, otherwise fit men who became very ill, very quickly.

Engineered Stone

"We anticipate there are many more people out there with this type of silicosis and we would urgently call for greater awareness of this disease, further research to determine the scale of the problem and for enforcement of regulations to try and prevent a large number of cases occurring in the UK as seen elsewhere in the world."

Jason Poulter of Unite the Union said: "Unite members continue to be exposed to deadly silica dust leading to premature deaths as employers fail to protect their workforce. We are proud to join the call for a ban on engineered stone and strict dust limits but we are also clear on the need for government legislation to extend the role and influence of union safety reps in defending workers across our industries."

The HSE have advised us [if correct to say that] is looking closely at this issue. If a ban were to be considered, they say that there are a number of complex logistical issues to consider.

As set out above, current legislation is robust when implemented and the HSE is keen to exhaust all options and to fully explore the full effects of more effective information, training, surveillance and enforcement before considering a ban. They are also further assessing whether the methods and timings of health surveillance can materially impact the number of workers affected.

Analogies have been drawn with the approach taken in New Zealand , who have not sought to pursue an outright ban, at this stage at least.

Instead, New Zealand has focused on the establishment of an Accelerated Silicosis Assessment Pathway (ASAP). They have also sought to provide free health assessments for at-risk workers. Furthermore, WorkSafe , the NZ equivalent of the HSE, has conducted numerous inspections and taken enforcement actions against non-compliant businesses since 2019.[28]

That said, a total ban on the importation, use, or supply of all engineered stone is being considered as an option for consultation.

Role of Surveillance

Whilst the HSE has only recently published updated guidance on health surveillance in the context of silica related illness, it is likely that further refinement is required, ideally to address cases of accelerated silicosis.

Indeed, the HSE is currently assessing further changes to the guidance for possible release in 2026.

The current guidance is contained within G404 "Health surveillance for those exposed to respirable crystalline silica (RCS)".[29]

Surveillance is required for

1. Workers who are involved in high-risk occupations, including construction, foundry work, brick and tile work, ceramics, slate, manufacturing, worktop manufacturers and installers, quarries and stonework.

2. Where workers are regularly exposed to RCS dust and there is a reasonable likelihood that silicosis may develop, health surveillance must be provided.

3. Further examples of where health surveillance for silicosis may be appropriate include:

- where there have been previous cases of work-related ill-health in the workplace;
- where there is a reliance on respiratory protective equipment (RPE) as an exposure control measure for RCS; or
- where there is evidence of work-related ill-health in the industry.

Surveillance will typically involve

- an appropriate questionnaire
- lung function testing
- chest x-rays.

Currently, a baseline chest X-ray is recommended for those who are starting work in a role which falls into the above categories. However, early lung disease can be missed on plain X-rays and so the use of low-dose CT scans is being considered by the HSE.

Role of Surveillance

Practical challenges to updated guidance

- Many workers performing high-risk work such as working with engineered stone and within the construction industry do not have contracts of employment and so are not subject to health surveillance.

- More involved procedures such as CT scans are one option. However, the use of CT scans means balancing the benefits of more accurate data, with the additional risks of increased radiation and of possible mental health issues associated with the identification of other latent damage, unrelated to silica.

- Guidance on the timing of surveillance interventions is likely to prove challenging. Whilst a base line scan could be undertaken at the start of relevant employment, thereafter, follow-up action will need to be reactive. Results will dictate the next steps and will require tailored advice from a chest physician. This may mean that a “one size fits all” approach to surveillance is difficult to achieve.

- Subject to any new guidance, there are likely to be resourcing issues in administering a more onerous surveillance regime.

Riddor

In 2013, Silicosis was removed from the list of reportable diseases under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, following a review of the Regulations.[30]

As such, the current Regulations do not require employers to report silicosis. This absence of mandatory reporting means that recorded numbers almost certainly underestimate the true number of workers affected by silica-related diseases as a result of a combination of under-reporting and under-diagnosis

It also means that in many cases, the HSE are not privy to the employers who are likely to be the worst offenders and so are unable to gain access and enforce measures to improve overall compliance.

In recent years there have been consistent calls from MPs for silicosis to be made a reportable condition again and to create a national register to help track and address the issue.

To that end, the HSE is currently considering the inclusion of pneumoconiosis (including silicosis) in the reportable list as part of its ongoing review of the RIDDOR Regulations and is hoping to publish its findings and make them available for public consultation in approximately March 2026.

It is also felt that silicosis should properly be considered as a notifiable disease under the Health Protection (Notification) Regulations 2010. This would provide a more accurate understanding of the incidence and prevalence of silicosis cases across the UK. Doctors and laboratories would be legally required to report new cases to the UK Health Security Agency (UKHSA). This data would form a compulsory national register, helping to quantify the scale of the problem which is currently believed by relevant experts such as Dr Feary to be widely underestimated.

Timely and complete data would allow public health authorities to take prompt action to prevent further cases and control exposure in workplaces. It would enable the identification of high-risk industries, employers who are failing to control dust exposure, and specific geographical areas with higher disease burdens.

Notification would help ensure that patients are not excluded from essential primary care diagnosis and that relevant work history information is shared within referral pathways to specialist care. It would also encourage healthcare professionals, especially GPs, to better recognise symptoms and link them to occupational history, triggering earlier investigation and treatment. It could also lead to the introduction of more effective occupational health services within GP surgeries, mandatory health surveillance for exposed workers, and targeted awareness campaigns within industries like construction and stonemasonry.

Targeted Knowledge and Education

What appears clear is that a significant part of the ongoing problem is a general lack of awareness of the risks associated with RCS.

This would appear to be the case, particularly amongst the workforce and employers. However, it also appears to be the position to some extent within health surveillance and screening systems, as well as the diagnosis pathways.

Whilst the HSE has a crucial role to play in terms of enforcement against key employers, it is vital that the workforce are educated on the significant risks associated with RCS, the employer's obligations and the signs and symptoms to look out for.

This workforce poses a particular challenge in this regard in that workers are typically not unionised, with many of them working outside of traditional employer/employee relationships. It is likely also to be the case that many are migrant workers, who may not speak English fluently. As such, educating migrant workers about the risks of silica dust requires a multi-faceted and culturally sensitive approach that addresses language barriers.

Possible strategies might include:-

Multilingual Training Materials: Providing all health and safety information, including safety manuals, checklists, and operating procedures, in the workers' native languages. The HSE already publishes guidance documents in Polish, Arabic and Punjabi, being the most prevalent foreign languages spoken by respondents in general. However, there is argument for a more tailored consideration of the key industries in the context of RCS, to identify any further languages that should be a priority in this regard.

Visual Communication: Use of photographs, international symbols, infographics, and videos to illustrate hazards and correct safety procedures, as visual cues which could transcend language barriers effectively.

Hands-on Demonstrations and Practical Exercises: Supplementing classroom-style training with practical, on-site demonstrations of safety measures, such as proper use and fitting of respiratory protective equipment (RPE)and dust control systems (e.g. wet cutting, on-tool extraction).

Bilingual Supervisors and Interpreters: Employers might be encouraged to use bilingual supervisors or experienced co-workers as interpreters and dedicated mentors to facilitate clear, two-way communication and provide ongoing guidance.

"Buddy System": Pair new migrant workers with experienced, trusted colleagues who speak the same language and can model and reinforce safe work practices.

Targeted Knowledge and Education

Interactive and Dialogue-Based Sessions: Encourage workers to ask questions and report concerns in an environment that is non-judgmental, using open-ended questions to confirm understanding. This builds trust and fosters an open safety culture.

Accessible Training Formats: Offer online e-learning modules (with video and interactive components) that workers can access at their own pace and convenience, potentially via smartphones.

Clear and Simple Language: When written materials in the native language are unavailable, use simple, plain English, avoiding jargon, acronyms, and slang. Focus on one clear idea or issue at a time.

Regular Reinforcement: Conduct frequent, short "toolbox talks" to regularly review and reinforce safety information. Tailor these messages to current on-site activities and hazards.

Health Surveillance Integration: Incorporate discussions about the health effects of silica exposure (e.g. silicosis, lung cancer, kidney disease) into training, linking safety actions directly to the prevention of severe, irreversible illnesses.

Employer Commitment: Ensure management visibly commits to the program, providing necessary resources like proper RPE and engineering controls, which reinforces the importance of the training.

By implementing these strategies, employers can significantly improve the effectiveness of silica safety education, ensuring all workers understand the risks and necessary preventative measures.

Next steps

The combined evidence of the meeting, distilled within this report, highlights a number of areas where interested parties can potentially affect real change.

Whilst the HSE assesses the position on engineered stone, RIDDOR and improved surveillance, Thompsons Solicitors, along with the TUC and their affiliated unions, aim to focus on targeted education of the risks associated with RCS within all relevant industries, in addition to robustly representing those affected by this terrible disease. In doing so, we are happy to work with all interested parties to work toward a clear, common goal of reducing the prevalence of this terrible disease

It is hoped and anticipated that we can revisit this incredibly important issue with the APPG at an appropriate interval in the future to assess the progress made and to identify next steps.

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