A TEN YEAR HISTORY
2003 - 2013
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ABBREVIATIONS

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACCK</td>
<td>Asbestos Co-ordinating Committee of Kgalagadi</td>
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<tr>
<td>AIG</td>
<td>Asbestos Interest Group</td>
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<tr>
<td>ARD 1</td>
<td>Asbestosis/Asbestos related pleural thickening (mild, moderate)</td>
</tr>
<tr>
<td>ARD 2</td>
<td>Asbestosis/Asbestos related pleural thickening system (severe)</td>
</tr>
<tr>
<td>ARD 3</td>
<td>Asbestosis/Asbestos related lung cancer</td>
</tr>
<tr>
<td>ARD 4</td>
<td>Mesothelioma</td>
</tr>
<tr>
<td>ART</td>
<td>Asbestos Relief Trust</td>
</tr>
<tr>
<td>ARTMis</td>
<td>Asbestos Relief Trust Management Information</td>
</tr>
<tr>
<td>CCOD</td>
<td>Compensation Commissioner for Occupational Diseases</td>
</tr>
<tr>
<td>COIDA</td>
<td>Compensation for Occupational Injuries &amp; Diseases Act 1993</td>
</tr>
<tr>
<td>CxR</td>
<td>Chest X-ray</td>
</tr>
<tr>
<td>DMR</td>
<td>Department of Mineral Resources</td>
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<tr>
<td>DoE</td>
<td>Department of Environment</td>
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<tr>
<td>DoH</td>
<td>Department of Health</td>
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<tr>
<td>DoL</td>
<td>Department of Labour</td>
</tr>
<tr>
<td>Gefco</td>
<td>Griqualand Exploration and Finance Company Ltd.</td>
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<tr>
<td>Gencor</td>
<td>Gencor Ltd.</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organisation.</td>
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<td>KRT</td>
<td>Kgalagadi Relief Trust</td>
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<tr>
<td>LFx</td>
<td>Lung Function Test</td>
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<tr>
<td>MBOD</td>
<td>Medical Bureau for Occupational Diseases</td>
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<tr>
<td>MDA</td>
<td>Mineworkers Development Agency</td>
</tr>
<tr>
<td>MEC</td>
<td>Member of Executive Committee</td>
</tr>
<tr>
<td>Msauli</td>
<td>Msauli Asbestos Beperk</td>
</tr>
<tr>
<td>NIOH</td>
<td>National Institute of Occupational Health</td>
</tr>
<tr>
<td>NUM</td>
<td>National Union of Mine Workers</td>
</tr>
<tr>
<td>ODMWA</td>
<td>Occupational Diseases in Mines and Works Act 1973</td>
</tr>
<tr>
<td>SOMP</td>
<td>Specialist Occupational Medical Panel</td>
</tr>
<tr>
<td>UCT</td>
<td>University of Cape Town</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
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BACKGROUND

The mining of minerals and metals represents an important part of the South African economy and is to a large extent labour-intensive.

Mining is by nature a high risk, a labour intensive and dusty industry in which miners’ lung disease is prevalent. One of the minerals occurring in abundance in this country is asbestos, and was exploited from as early as 1893.

During the early years of gold mining in South Africa no dust control measures existed. Mineworkers who contracted lung disease were simply discharged without any compensation. During 1912, the Miners’ Phthisis Act was promulgated and mines were obliged to contribute towards a central Government-run fund from which affected persons were compensated. This Act covered mainly gold mines. From 1946 the term phthisis was replaced with silicosis but it was only in 1956 when the Pneumoconiosis Act was promulgated that other mines were also included. During 1973 the Occupational Diseases in Mines and Works Act (ODMWA) replaced the earlier Acts, and the terminology changed to occupational lung diseases. The statutory fund created in terms of this Act currently compensates affected workers of all controlled mines, (if they are certified), as suffering from any of the designated occupational lung diseases. This fund does however not cover environmentally exposed members of the general public. Individual operators always had to take out private insurance for such claims.

WHAT IS ASBESTOS?

ITS MINING AND USE

Asbestos is a fibrous mineral found in many countries in the crust of the earth. It’s main advantages in commercial use was that it is fire and acid resistant. It was mainly used in building materials and for insulation purposes. More than 300 applications have been documented over the years. In South Africa the main deposits are found in the Northern Cape and North West provinces (Cape Blue or Crocidolite asbestos), Limpopo province (amosite, also known as brown asbestos, together with Transvaal Blue asbestos) and Mpumalanga province (chrysotile or white asbestos). Asbestos seams are mined together with attaching host rock. In earlier times any host rock attaching to the fibre was chiselled off manually to produce a clean ‘cob’. Crushing and milling plants were later introduced which facilitated automatic separation of rock and dust to produce clean basic fibre. The fibre, being lighter than grit, was airlifted by a suction process and then cleaned, graded and bagged.

At all times about 95% of the fibre produced in South Africa was exported.
Medical evidence has it that lung diseases caused by asbestos are more severe than those caused by most other minerals. This is particularly true in the case of asbestos-related lung cancer and mesothelioma, the latter being a rare form of cancer which develops mainly in the lung lining or peritoneum. When this disease was recognised as being caused predominantly by asbestos, there were worldwide calls for the discontinuance of the use of this mineral. However, for various reasons, including there being no viable substitutes available, mining and use of the mineral continued. Some developed countries however restricted the import and use of certain types of asbestos from as early as 1961. In common with conditions caused by dust from most other minerals, there is a fairly long latency period between exposure to the harmful substance and the eventual manifestation of a disease. This is particularly true in the case of asbestos where the latency period is normally between 15 and 20 years and sometimes longer.

The United States of America (USA) was a large consumer of asbestos. This was particularly true during World War II when liberty ships were built and sprayed with asbestos as a fire retardant. Asbestos was classified as a strategic material and large quantities were acquired and stocked by the US Government.

Some years after World War II exposed workers in the USA started developing asbestos-related diseases from occupational exposure and claimed from the existing statutory compensation funds as ex-workers. However, affected individuals could also claim against producers and manufacturers who “introduced harmful products into the commercial stream”. This led to large-scale class actions by thousands of exposed individuals against suppliers of asbestos materials and manufacturers of products containing asbestos. These actions virtually bankrupted the American insurance industry. From 1984 insurance for asbestos diseases was no longer available.

More and more substitutes were meanwhile developed replacing asbestos in many applications. This resulted in a contraction of the world market for the mineral. Mining companies were forced to scale down and eventually the South African mines had to close.

THE LITIGATION THAT LEAD TO THE ESTABLISHMENT OF THE TRUST

In South Africa, although many companies and individuals were involved in the mining of asbestos over the years, only Gencor Limited (Gencor), The Griqualand Exploration & Finance Company Limited (Gefco) and Msauli Asbes Beperk (Msauli) were still in existence during 2002/03 (jointly referred to as the Founders) when litigation was initiated.

Soon after closure of the South African mines, the last in 2001, some ex-workers and environmentally exposed individuals organised themselves
into Interest Groups with the object of taking legal action against their erstwhile employers or operators of mines. One such group, The Asbestos Interest Group (AIG) under the guidance of a South African personal injury attorney, Richard Spoor, obtained the services of Thompsons, a United Kingdom firm of attorneys, to represent them in a court action in South Africa against the three remaining mining companies on a contingency fee basis. Similar actions were also launched in England by other groups against Cape Asbestos who was involved in asbestos mining in South Africa from 1893 to 1978.

It was generally acknowledged that the statutory compensation was inadequate and that environmental claimants should also be compensated.

The case against the Founders proceeded in the South African High Court but prior to judgement an out-of-court settlement, without admission of liability, was reached which saw the creation of the Asbestos Relief Trust.

The out of court settlement giving rise to the Trust was a historical agreement. It was the first time that compensation was being considered beyond the constraints of ODMWA and COIDA. It was also the first time that a minority shareholder had agreed to pay compensation on behalf of the operating companies. In terms of the settlement agreement, Gencor, Gefco and Msauli agreed to settle approximately R380 million in trust to be used as additional compensation for former mineworkers who were employees on specific sites and during specific periods. There was no mention of the number of miners or of how much each one was to receive. That was left to the trustees to determine.

**CREATION OF THE TRUST**

The Settlement Agreement to create the Trust together with the Deed of Trust was signed on 12 March 2003 by the parties involved.

The object of the Trust is to compensate as fully, fairly and effectively as its means allows, all qualifying individuals who are diagnosed as suffering from an asbestos-related disease as defined in the Trust Deed. A claimant must satisfy the Trustees that the condition is in full or in part attributable to mining operations previously carried on by the Founders.

In order for the Trust to establish the necessary infrastructure and administrative facilities to receive and deal with claims, a six-month inception period was allowed before claims could be processed. An exception was made in the case of mesothelioma and asbestos-related lung cancer claimants, to whom interim payments could be effected. Up to February 2004 an amount of R900 000 was paid out to nine claimants in terms of this transitional arrangement.
REFLECTIONS OF THE EARLY YEARS OF THE ART

Outreach and activism work with former asbestos miners and communities.

For more than a decade preceding the registration of the Trust Deed of the Asbestos Relief Trust (ART) on 21 July 2003, there was an increasing public focus on the multitude of problems related to the use of asbestos. Many different individuals, interest groups, trade unions, health professionals, national and international human rights lawyers and seasoned researchers contributed to healthy debates and discussions on asbestos. This was more so given that South Africa mined, milled and exported, at different times, all 3 types of "commercial" asbestos for nearly a hundred years.

Given the increasing burden of asbestos related diseases, there was growing unease and pressure for greater protection, but also for accurate diagnoses and compensation those who were exposed to asbestos. Workers in the mining and asbestos-cement industries were keen on finding solutions. Many health professionals, especially in the occupational health field, assisted in different ways. It became possible to review, as negotiated by trade unions, the medical records, chest X-rays, and where available, the lung function tests of more than 10,000 workers, in different asbestos industries. The outcome of these medical reviews helped to inform the negotiations for greater protection, for speedier compensation, for on-going training on the health effects of asbestos and for the replacement of asbestos by safe alternatives.

The spirit of hope, of consultation and reconciliation, of respect and of endless positive possibilities that characterised the pre- and post-94 period in our history, had a remarkable positive influence on the asbestos deliberations. A major outcome of these national and international developments was the Parliamentary Asbestos Summit which took place from 24 to 26 May 1998 in Johannesburg. The Declaration of the National Asbestos Summit includes the summaries of the four commissions: Community Development and Rehabilitation; Health, Remediation and Compensation; Regulatory Systems; Industry - Future Applications. Amongst many others, the summit recommendations include: compensation for diseases related to environmental asbestos exposure; intensification of inclusive processes for rehabilitation and sustainable development with community participation; review and overhaul of the compensation system and the need to motivate for inclusion of pain and suffering in the compensation calculations; the inclusion of training on ARD's in the curricula of health professionals and the need for interdepartmental co-operation to address the many asbestos related challenges.

Amongst the important outcomes of the Parliamentary Asbestos Summit was a need for rehabilitation and of a greater understanding of what communities were trying to do with regards to asbestos. It was therefore most timely, when we were approached in 1999 - 2000 by Professors Nancy Jacobs and Lundy Braun from Brown University. They asked us to join them and a group of students from the USA on an asbestos research project with community participation in the Northern Cape. The research would in fact be a follow-up to aspects of the Parliamentary Asbestos Summit. Simphiwe Mbuli, an industrial hygienist who taught at the Cape Peninsula University of Technology joined the research team with a group of his students. The participatory research that was conducted in several villages in the Northern Cape was presented as a report to Parliament in October 2001. The translators and some of the interviewees of this research constituted the Asbestos Interest Group (AIG) who were an integral part of the group who reported back to Parliament. They initially received support from the Moffat Mission and played an important role in community awareness as well as in the outreach to villages during the run-up to the asbestos court cases.

This brief reference to the Parliamentary Asbestos Summit helps to indicate that the South African asbestos litigation, nationally and internationally, in part grew out of a much broader quest to find common and definitive solutions towards addressing and redressing some of the asbestos related challenges. Many different groups and individuals therefore contributed to the outcome which eventually made the registration of the Trust Deed possible.

The ART symbolises in many ways the positive spirit of seeking and finding common solutions to very complex situations and can stand as an inspiration to similar problems nationally and internationally. We believe the Trustees will continue to steer the ART in a manner that will leave a lasting legacy of community engagement and the support of structures that will benefit communities most affected by asbestos.

Sophie Kisting
THE TRUSTEES

The first trustee nominated by both the Founders and the litigating attorneys on behalf of claimants was Mr John Doidge of Sentinel Trust.

Four additional Trustees were thereafter appointed. They were

Mr. Jan De Bruyn -- nominated by Gencor
Mr. Piet van Zyl -- nominated by Gefco and Msauli
Dr. Sophie Kisting -- nominated by claimants’ representatives
Mr. Crosby Moni -- nominated by claimants’ representatives

Dr Kisting resigned during 2005 to take up a position with the World Health Organisation and was replaced by Mr Phiroshaw Camay.

Mr Moni resigned during 2011 to become an MP and was replaced by Dr. Lady Jood.

TRUSTEE PROFILES

John Richard Parker Doidge

B.Proc (UCT).

Managing Director of GMG Trust Company (SA) (Pty) Limited.

Attorney of the High Court of South Africa. Admitted in December 1980.


Former chairman and honorary life member of the Association of Trust Companies in South Africa (now Fiduciary Institute of South Africa) and founder and former chairman of the South African Securitisation Forum.

Director of a number of companies, including chairman of Alexander Forbes Preference Share Investment Company Limited, listed on the JSE.
Jan J de Bruyn

BSc, BEng (Civil) Stel, MBL (Unisa), AMP Diploma (Harvard).

After a 32-year career retired from the Industrial Development Corporation of South African (IDC) as Deputy Managing Director.

Served on the boards of Gencor (until its unbundling), Saldanha Steel (Chair), Algorax (Chair), Hulet Aluminium, Small Business Development Corp (now Business Partners), Methold (later changed to Nail), Technikon Witwatersrand (now part of the University of Johannesburg), National Sorghum Beer Breweries and various other IDC property development companies.

Presently Chair of the Manufacturing Development Board of the dti and a board member of the Coega Development Corporation including a member of its HR&R and AFC committees. Served for many years on the Executive of the Afrikaanse Handelsinstituut (AHI).

Phirosaw Camay

BA(Unisa), DPM(Wits),

First employed at the Non-European Library Services, City of Johannesburg.

General Secretary of the Council of Unions of South Africa which established the National Union of Mineworkers and later the General Secretary of the Council of Unions of South Africa. Founding Director of the Co-operative for Research and Education, an information, capacity building, research and evaluation institution. Past Chairperson of Rand Water Board, Current Chairperson of Scibono. Author of several published articles, research papers and books on elections and civil society.

Dr. Lady Jood

Qualified as Medical Practitioner( MEDUNSA) and Occupational Medical Practitioner( WITS)

Independent General Medical Practice for a number of years; Currently employed full time at KUMBA Iron Ore Sishen mine as an Occupational Medical Practitioner

Chairperson of Kwa-Thema Community Health Forum and later ANCRA.
Pieter Andries van Zyl

Chartered Institute of Secretaries and Administrators, South Africa.

Last position held: Financial Director Gefco & Msauli.

Started as Junior Clerk with Gefco in Kuruman in 1956. Promoted through to Senior Clerk by 1963. Transferred to Gefco’s Sterkspruit Mine near Badplaas during 1963 as Mine Secretary. Appointed Mine Secretary to Gencor’s Msauli mine April 1966 and transferred to Gencor Head Office in Johannesburg 1971, and promoted to Financial Director in 1976.

Member of the consortium effecting the management buyout of Gencor’s interests in Gefco and Msauli 1988.

Continued as director until all the mines closed.

ORIENTATION AND GETTING STARTED

As most of the Trustees were initially not informed about the localities and conditions pertaining to the regions where mining operations were conducted, a special visit was undertaken to Kuruman where Stephen Kotoloane, founding member and co-ordinator of the AIG, and the late Itumeleng Sithole accompanied Trustees on a visit to old mining sites and pointed out how environmental contamination was part of everyday life in these areas. Trustees were, inter alia, taken to the Ncweng School where asbestos could be seen in the walls and floors of the building, as well as on the playing fields around the school.

The Trust Deed was registered in the Master’s Office on 14 March 2003 and became operative during July 2003, after all the pre-conditions embodied in the Settlement Agreement were fulfilled.

The Trustees met for the first time on 15 July 2003 together with the legal representatives of both claimants and Founders. During the meeting a number of issues which were not clearly defined in the Trust Deed, were addressed. On 4 September 2003 an interview with Mr Jan de Bruyn was broadcast over national television and radio, announcing the formation of the Trust and inviting potential claimants to come forward. The second Trustee meeting was held on 25 September 2003. It was deemed prudent to be as visible as possible to potential claimants in the areas where claims were expected to originate from, and for this purpose it was considered essential for the Trustees to visit these areas and meet with interested parties.

During October 2003 a further visit to Kuruman was undertaken and the monthly Trustee meeting also held at a local venue. This was followed by a visit on 19 February 2004 to the Komati valley near the Msauli mine where
a meeting was convened at the Community Hall, in Ekulindeni. This coincided with a feedback meeting with Mr. Richard Spoor. A Trustee meeting was held at a nearby Badplaas hotel on 20 February 2004.

As Kuruman was by far the area from where most claims were expected, a workshop was held at The Moffat Mission from 4 to 6 June 2004. The purpose was to inform the local community and other interested parties of the policies and procedures adopted by the Trust, as well as to clarify grey areas regarding compensation payable.

The next area visited on 27 August 2004 was Penge mine near Burgersfort, where contact was established with local role-players. A Trustee meeting was also held at a local venue on 28 August 2004.

FUNDING

The Trust initially received an amount of R393 077 273 from the Founders. Of this amount R12 245 000 was paid over to the litigating attorneys as a contribution to their costs. The remaining R380 832 273 was later supplemented as per the table below.

<table>
<thead>
<tr>
<th></th>
<th>Gencor R</th>
<th>Gefco R</th>
<th>Msauli R</th>
<th>Total R</th>
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<tr>
<td>Initial contribution</td>
<td>378 000 000</td>
<td>10 045 337</td>
<td>5 031 936</td>
<td>393 077 273</td>
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<tr>
<td>Less: Paid to litigating attorneys</td>
<td>(11 495 000)</td>
<td>(500 000)</td>
<td>(250 000)</td>
<td>(12 245 000)</td>
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<tr>
<td>Sub Total</td>
<td>366 505 000</td>
<td>9 545 337</td>
<td>4 781 936</td>
<td>380 832 273</td>
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<tr>
<td>Supplementary amount: *</td>
<td>9 397 912</td>
<td></td>
<td></td>
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<td>Additional payments in terms of the Trust Deed</td>
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<td>1 935 600</td>
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<tr>
<td>31 December 2004</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 May 2006</td>
<td></td>
<td>1 643 000</td>
<td></td>
<td>1 643 000</td>
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<td>11 May 2007</td>
<td></td>
<td>1 643 000</td>
<td>903 168</td>
<td>2 546 168</td>
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<tr>
<td>3 June 2011</td>
<td></td>
<td></td>
<td>580 608</td>
<td>580 608</td>
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<tr>
<td>4 June 2011</td>
<td></td>
<td>1 461 140</td>
<td></td>
<td>1 461 140</td>
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<td>9 November 2012</td>
<td></td>
<td>2 739 637</td>
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<td>Totals to date</td>
<td>375 902 912</td>
<td>17 032 114</td>
<td>8 201 312</td>
<td>401 136 338</td>
</tr>
</tbody>
</table>

* Residue R40 million after settlement of R35 million Rands with the State for rehabilitation inclusive of interest
Establishing the medical cleaning structures for the ART and training accredited doctors about asbestos related diseases.

Initially it was thought that it would be possible to work mainly with Public Hospitals to do the required medical examinations as well as the X-rays and lung function tests. It soon became clear that in order to accommodate the large number of claimants in need of examinations, as well as addressing the great sense of urgency and expectation amongst claimants and their families, that a new way to get medical examinations done as fast as possible was needed. The earliest training sessions in 2004 for doctors, nurses and lung function technicians therefore took place in several Mpumalanga and Northern Cape Provincial hospitals. Colleagues in private practice were also invited. These training sessions were extremely enriching to the medical office of the ART based in Cape Town and helped to share with and learn from a large number of health professionals who worked amongst the claimants of the ART.

A group of doctors in private practice in the Northern Cape readily accommodated the ART by taking on a large number of the medical assessments of claimants. They made an invaluable contribution to the compensation process as the public health services were overloaded with many other problems.

The work of Dr Mike Lewis and his team from Embhuleni Hospital in Mpumalanga needs to be acknowledged. They tirelessly supported claimants to obtain the required medical examinations for compensation. Dr Lewis provided the first set of medical records which were examined by the medical team in Cape Town.

The knowledge sharing sessions of health professionals were repeated after a few months and this helped again to share and consolidate information about the medical requirements of the Trust Deed. It also highlighted the great need for good quality X-rays, lung function tests and medical examinations. A lot was learnt about conditions on the ground, and the tremendous amount of work that was required to make the claims process succeed. During these sessions we also explored the possibilities of the ART contributing towards lung function machines for some rural hospitals as well as an X-ray machine at a distant primary care centre that provided medical services to a large number of ART claimants.

At Kimberley hospital the ART engaged in discussions with the physicians and oncologist about contributing towards the cost of a CT Scanner that may have assisted with the earlier diagnosis of asbestos related cancers. At this early stage the ART was already providing regular transport and other support for ART claimants in need of biopsies and other special investigations. The sensitive issue of post-mortem examinations was at times difficult to discuss but we persevered and with the support of local health professionals and hospitals we managed to include it systematically in all our advocacy work. In those early days we dreamt about the possibility of establishing a "Centre of Excellence" in Kuruman to diagnose and effectively manage and provided ongoing training on the many asbestos related health problems encountered. The hope was that academic and health centres nationally and internationally would contribute especially by the rotation of experts in various related fields through the centre.

Sophie Kisting
ADMINISTRATIVE PREPARATIONS

As stated before, the Trustees were allowed a six-month period to set up the necessary infrastructure and administrative facilities to receive and process claims. Maitland Trust, an established firm of trust administrators, was appointed to administer the affairs of the Trust.

The first task the trustees were faced with was to try to establish a fair compensation system that would deal with the varying degrees of disability caused by exposure to asbestos while ensuring that there would always be enough funds to achieve this noble objective. The trustees contacted a prominent actuary, Gary Scott with a brief to assist in developing a system for compensation. At that stage there was very little data to assist in estimating the number of potential claimants so they had to search for the most reliable information.

After researching international trends and guided by the Trust’s actuaries, the trustees established a schedule of compensation. The compensation is a combination of future medical costs, future loss of earnings and pain and suffering taking into account the funds available. The schedule of compensation also takes into account the degree of disability, the age of the claimant, length of service and the level of employment of the claimant when he or she last worked at the mine. Only after settling the schedule of payments could the trustees start dealing with claims.

CLAIMS PROCESSING

Occupational claims

In order to lodge a claim with the Trust the potential claimant must prove that he or she was exposed to asbestos from a qualifying operation. Some of the mines that the Trust covers were closed more than 10 years prior to the creation of the Trust.

However, the Trust was fortunate to have access to all available personnel files of former Gefco and Msauli employees to confirm occupational exposure.
Converting hard copy files (Employment Files) into a database (File Director)

The personnel records were previously stored in a storeroom in the Trust’s Kuruman office. Due to the inherent risks in storing paper records and to the need to make the searching process quicker and more efficient, the Trust embarked upon a project to digitise the records.

The project started in November 2007. During the course of eight months more than 810 000 records were scanned and saved into a database. This also included personnel records for the Kgalagadi Relief Trust (KRT).
Work records in the Kuruman office

Through a specialised programme, File Director, searches can be carried out on the digitised data. Search criteria include full name, surname and identity/passport number. This programme enabled the Trust to move away from the previously laborious process of searching through envelopes and boxes to locate files at the same time affording a dust free search facility. This digitised information has also been made available to the MBOD to assist them in dealing with their outstanding asbestos cases.

**Missing Personnel Records**

The Trust Deed allows for potential claimants to produce their own proof of service, which normally is a copy of their ID document or any other document which indicates that they worked at a qualifying operation. If none can be produced, the Trustees accept affidavits, provided the information so disclosed can be verified beyond reasonable doubt.
Setting up the SOMP – mandate and objectives

As indicated earlier, the Trust Deed for the Asbestos Relief Trust (ART) was registered on 21 July 2003. The appointed Trustees had about 6 months to set up the local, provincial and national structures to start the claims process. The medical office of ART at the outset was located within the School of Public Health and Family Medicine at the University of Cape Town in the Centre for Occupational and Environmental Health Research. Much consideration and reflection went into this decision as the Trustees were keen to ensure the medical work of ART met the required scientific rigour, there would be adequate and on-going support from experienced health professionals, the on-going and collective research the ART envisaged could readily be accommodated amongst the many colleagues and students including those from asbestos exposed or asbestos affected communities.

Several colleagues at UCT medical school and beyond were approached to consider becoming part of the specialist medical panel. The ART had to ensure they fully understood the medico-legal aspects of the Trust Deed, they familiarised themselves fully with the lung function criteria for compensation as set out in the Trust Deed and could interpret the X-rays of clients using the ILO Standard X-rays for Pneumoconiosis. The colleagues who came to constitute the Specialist Occupational Medical Panel included the late Professor Neil White, Professors’ Hillel Goodman, Mohammed Jeebhay, Rodney Ehrlrich and Drs’ George Pillay, Shahieda Adams, Shuiab Manjra, Jim Te Water Naude, Vasantra Reddy and Sophia Kisting. These highly experienced and dedicated Occupational Health Nurses, Sr Nodu Nolokwe and Sr Faiza Omar joined the team. Thandikaya Mgoqi and Sandy Tolosano provided invaluable support at a multitude of levels in the day to day running of the medical office. There was a wonderful sense of excitement, of collective will and of contributing to the common good amongst colleagues who worked in the medical office of the ART.

Prof H Goodman, as a Radiologist at Groote Schuur Hospital, brought with him not only a wealth of experience but a humanitarian spirit and broad range of up-to-date radiological knowledge that helped us make sense of some of the most difficult and at times poor quality X-rays. Some of the X-rays were from deceased claimants or claimants who were too ill to get another X-ray or those who had repeated episodes of pulmonary TB. Prof Goodman provided the professional and accurate input which gave us a radiological foundation of excellence on which we could build with confidence the sound quality of our work. We are all greatly indebted to him.

On 25 March 2004, Dr. Sophie Kisting met with Prof Neil White to review the X-rays of a few claimants who were diagnosed with lung cancer or mesothelioma following the ART settlement. Most of them were very unwell. It was an important day as they have managed to acquire a comfortable reading room, and correctly installed the newly acquired viewing boxes. The ILO Standard Radiographs for Pneumoconiosis ordered from Geneva and proudly displayed on the viewing boxes. Thandikaya Mgoqi carried the X-rays and the files from the offices on the 4th floor to the first floor in the same way he continued, for many months later, to carry X-rays (up to 50 at a time. Prof Neil White indeed joined many of those early reading sessions. We gratefully acknowledge his most important contribution and record the great void his untimely death has left.

Sophie Kisting
The role of claims handlers

In an effort to reach as many potential claimants as possible the Trustees agreed that claims handlers would locate and assist potential claimants to lodge applications with the Trust. Most claims handlers were firms of attorneys.

Their services were regulated by a Service Level Agreement (SLA) which, more importantly, also regulated the fees that claims handlers could charge for their work. The Trust paid these fees in order to ensure that the claimant did not have to pay for services from the compensation that they received. Claims handlers were trained by the Trusts and provided an essential service to potential claimants who did not live close enough to Trust offices in Kuruman, Danielskuil, Burgersfort and Msauli.

The criteria for appointment of claims handlers agreed were:

1. Be an existing legal entity registered in the country of origin.
2. Be open to scrutiny from a professional body.
3. Be open to independent audit.
4. Have no conflict of interest between the Trusts, the applicant body or its staff, or between an accredited claims handler and the applicant body.
5. Have a functioning office, including the use of a computer and email and internet facilities, in the relevant and defined geographical area.
6. Undertake to provide training on the Trust Deed.
7. Ensure quality control in terms of the agreed standards.
8. Relate positively and in a non-conflictual manner with the Trust and other service providers.

In 2010 the Trust cancelled the SLAs after a sharp decline in new cases being lodged. The Trust does however when presented with new claims still pay claims handlers set fees so that claimants do not have to pay for these services.

Lesotho Recruitment Programme

Due to the labour recruitment practices of South African mines, many workers from neighbouring states, including Lesotho, were recruited to work on the asbestos mines.

The Mineworkers Development Agency (MDA) was appointed claims handlers representing the ART and the KRT, in Lesotho and were chiefly responsible for the claimant identification programme in that country.

Following several meetings with the Lesotho Ministry of Health, the trusts developed a mobile medical assessment model in order to determine whether potential claimants had a compensable asbestos related disease.
The model featured the use of a mobile chest X-ray (CXR) Unit as well as a mobile unit run by the trusts’ medical staff to conduct the medical examination and spirometry. A mobile administration team helped complete claim forms after Lung Function Tests (LFX) confirmed that the claimant had a compensable ARD.

Registering claimants in Lesotho

The Lesotho programme reached out to former asbestos miners in very rural areas of Lesotho. Through the programme the Trust was able to create awareness of ODMWA and to get permission from the MBOD for the trusts to submit claims to them on claimants’ behalf, as well as the services provided by the National Institute for Occupational Health.

Swaziland

Many ex-workers also hailed from this country and qualify for compensation in terms of the Trust Deed.

However, after having located a number of potential claimants and having conducted medical screening, the Swaziland Government refused to allow the Trust to proceed with the project.
Local Offices

Initially, local offices were established in Kuruman, Danielskuil, Msauli and Burgersfort, with a head office in Johannesburg and a Medical office in Cape Town. The local offices were closed by 2010 as the levels of claims no longer justified maintaining them.

Finding Beneficiaries

The next challenge facing the trustees was to try to reach as many potential beneficiaries as possible. The trustees unanimously decided that no stone should stand in the way of a potential beneficiary so it was decided to search for former employees and to provide them all with free medical examinations to determine whether they had a compensable asbestos-related disease.

Whilst it may have been the intention of the Founders that the claimants would make use of the initial and biennial free medical examinations provided for by ODMWA, it was soon realised that this approach would unduly delay payments from the Trust to the detriment of claimants. Typically MBOD payments lag by three years as is evidenced from comments provided by claimants. The main areas to be serviced were Kuruman, Msauli and the Penge mine area. As contract labour formed a substantial portion of any mine’s labour force, arrangements were also put in place to register claims from Lesotho and Swaziland.

Having regard to the poverty levels in these areas, it was decided that the Trust will also pay reasonable travelling expenses incurred by claimants to attend the medical consultations.

Registering claimants in Lesotho
**Medical Surveillance**

Medical doctors with the necessary expertise in the field of occupational diseases, particularly asbestos-related diseases, were identified in the main feeding areas and appointed to conduct the initial clinical, radiological and spirometry tests.

In order to ensure the most accurate diagnosis in each case, a Specialist Occupational Medical Panel (SOMP) was appointed. This panel consisted of specialists from the Lung Institute of the University of Cape Town.

As medical evaluations involve substantial administrative work, it became necessary to also open a Medical Office in Cape Town. This office also involves itself with international and other scientific research regarding asbestos-related diseases.

**Developing ARTMIs**

Initially, claimant information was stored in Excel spread sheets. There were a number of inherent risks in using Excel spread sheets both to capture information and use as a database. It was difficult if not impossible to draw any meaningful reports.
In 2005 the ART with the assistance of IT specialists, developed a unique and specialised management information system, the Asbestos Relief Trust Management Information System (ARTMis). The key objectives were to create a database in which claimant information could be stored; to ensure a process of capturing and accessing information by the Cape Town and Johannesburg Offices that was seamless, and to enable the generation of statistical reports for the use of Trustees, research and management oversight.

In 2008 further refinements took place to improve ARTMis in line with changes in the claims process.

ARTMis is a unique system which can be adapted to cater for other similar trusts or compensation schemes.

**Investment of Funds**

The Trustees recognised that, having been entrusted with a substantial amount of money with which they were expected to meet claims for at least 25 years, a very conservative approach should be adopted when considering investment alternatives.

A closed tender process was put in place and after due consultation with various investment advisers, it was decided to appoint two specialist firms to manage the investments in accordance with specific mandates.

This strategy has stood the Trust in good stead as no capital losses were suffered during the turmoils in the financial markets over the past 5 years, whilst reasonable returns were still realised. At the end of 2012/2013 financial year of the Trust, the reserves were R305m against total payments of R257m.

**Office Building**

As stated the Trust’s affairs were initially managed by Maitland Trust, but due to their own increased requirements as far as staff and office space were concerned, it eventually became problematic for them to perform this function.

This prompted the Trust to appoint its own staff. Initially the Trust rented the requisite office space from Maitland but this was soon rendered impossible.

The Trust then considered acquiring its own offices and during 2008 a unit in the Eton Building Sectional Title development Sherborne Square, 5 Sherborne Road, Parktown was acquired at a cost of R5,5 million.

The Trustees are of the opinion that this investment can be justified on the basis that it provides permanence of tenure together with capital appreciation.
Since the introduction of the rationalisation program from 2010 onwards, some space became available and is currently rented out at market related rates to third parties.

SETTLING ENVIRONMENTAL CLAIMS

The Trustees continue to wrestle with the implications of the trust deed that requires them to identify legitimate environmental claimants who would have experienced “significant” exposure “at or near” a qualifying mine.

Based on the guidance of environmental practitioners and lawyers and having regard to International practices, the trustees developed assessment criteria. One of the key considerations is how far the claimants reside from the source of pollution. It was determined that a qualifying claimant must have resided within 10 kilometres of a Qualifying Operation, beyond which environmental exposure can no longer be attributed to a single source. Alternatively, the claimant must be able to show that they were exposed at home, for example through a family member who worked at a Qualifying Operation and brought asbestos pollution into the home.

The trustees continue to assess the situation and are taking into account the work of commentators such as Dr Rob Jones who has conducted secondary asbestos pollution research in communities throughout the
Northern Cape and North West Provinces\(^1\) on behalf of the Department of Environmental Affairs.

The trustees continue to regularly review the guideline in the light of new evidence and experience.

**CLAIMS HISTORY OVER THE YEARS**

On 24 May 2004 the actuarial figures were made available and general claims processing commenced.

By February 2005 a total of 3 659 claims were received of which 286 were diagnosed as suffering from an asbestos-related disease and were compensated.

Of these 157 were diagnosed with ARD 1 (lung impairment of between 10 and 40%), 78 with ARD 2 (lung impairment +40%) 10 with ARD 3 (asbestos-related lung cancer) and 30 with mesothelioma.

The total amount paid out during this period was R26 962 496.00 at an average of R98 045 per claim. Total to date (R900 000 + R26 962 496) = R27 862 496.

As the Trust Deed was not specific in all respects, the Trustees had to obtain independent legal advice from time to time regarding a number of issues affecting the acceptance and/or settling of claims.

As at 28 February 2013 the number of claims received by the Trust is as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total claims registered</td>
<td>13 633</td>
</tr>
<tr>
<td>Non-qualifying and non-compensable claims</td>
<td>-1 646</td>
</tr>
<tr>
<td>Still being processed</td>
<td>-1 126</td>
</tr>
<tr>
<td></td>
<td>10 861</td>
</tr>
</tbody>
</table>

Diagnosed having no ARD presently                 | 6 970    |

Of the balance of 3 891 or 81.6% were diagnosed with ARD1, 8% with ARD2 2% with ARD3 and 8% with ARD4. The number of monthly claims reduced from a high of 425 during 2005 to 7 in the 2013 financial year. These statistics includes 251 environmental claims.
Claims Paid

The table below reflects the number of diagnosed claims by ARD category and the total amount paid to 28 February 2013.

<table>
<thead>
<tr>
<th>Period</th>
<th>ARD 1</th>
<th>ARD 2</th>
<th>ARD 3</th>
<th>ARD 4</th>
<th>Total Paid (Number)</th>
<th>Total Amount (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2003 –Feb. 2004</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9</td>
<td>900 000</td>
</tr>
<tr>
<td>2004 - 2005</td>
<td>157</td>
<td>78</td>
<td>10</td>
<td>30</td>
<td>275</td>
<td>26 962 496</td>
</tr>
<tr>
<td>2005 - 2006</td>
<td>522</td>
<td>113</td>
<td>3</td>
<td>27</td>
<td>665</td>
<td>42 988 721</td>
</tr>
<tr>
<td>2006 - 2007</td>
<td>456</td>
<td>44</td>
<td>2</td>
<td>12</td>
<td>514</td>
<td>26 524 114</td>
</tr>
<tr>
<td>2007 - 2008</td>
<td>529</td>
<td>39</td>
<td>4</td>
<td>23</td>
<td>595</td>
<td>30 165 603</td>
</tr>
<tr>
<td>2008 - 2009</td>
<td>476</td>
<td>32</td>
<td>3</td>
<td>29</td>
<td>539</td>
<td>30 823 024</td>
</tr>
<tr>
<td>2009 - 2010</td>
<td>361</td>
<td>15</td>
<td>8</td>
<td>45</td>
<td>429</td>
<td>33 338 478</td>
</tr>
<tr>
<td>2010 - 2011</td>
<td>269</td>
<td>9</td>
<td>13</td>
<td>34</td>
<td>325</td>
<td>25 500 755</td>
</tr>
<tr>
<td>2011 - 2012</td>
<td>198</td>
<td>11</td>
<td>7</td>
<td>28</td>
<td>244</td>
<td>17 458 381</td>
</tr>
<tr>
<td>2012 - 2013</td>
<td>66</td>
<td>2</td>
<td>1</td>
<td>30</td>
<td>99</td>
<td>15 472 716</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td>3 033</td>
<td>250 134 288 *</td>
</tr>
<tr>
<td>%</td>
<td>82,1</td>
<td>9,3</td>
<td>1,4</td>
<td>7,2</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

* Excluding amounts not paid to beneficiaries

During the 2010 financial year it became clear that the number of new claims being lodged per month was reducing significantly. This indicated that the bulk of claims receivable from the main feeding areas were duly dealt with.

This prompted the Trustees to embark on a restructuring exercise, with a view of reducing costs. Following consideration of various options, it was decided to close the Kuruman office during November 2009, discontinuing the use of claims handlers, reducing staff costs in the Johannesburg and Cape Town offices, adopting a more passive form of claims recruiting and generally saving costs in other areas.

This exercise was completed during the 2011/12 financial year.

During this period a special effort was also made to clear most of the administrative pipeline cases, leaving only those where missing information remained unobtainable.
A notable feature of claims currently being received is that most are from sufferers of mesothelioma from both occupational and environmentally exposed claimants. As the quantum of awards for this type of disease is much higher than those for the lesser types of disease, the average amount payable per claim is expected to be much higher in future than the average to date.

**KGALAGADI RELIEF TRUST**

In early 2006 the ART entered into a fee paying administrative agreement with the Kgalagadi Relief Trust ("KRT") which was created to compensate mainly Kuruman Cape Blue and Daniëlskuil Cape Blue Asbestos claimants from the Kuruman/Daniëlskuil areas. This relationship continues and now includes shared funding of research and certain social projects.

**GEFCO AND MSAULI FUNDS**

In terms of the Trust Deed the funds of Gencor, Gefco and Msauli must be kept separately until 20 years have elapsed. Thereafter any funds remaining can be merged.

Claims payable in full or in part from either Gefco and/or Msauli funds can therefore not be met from the Gencor funds.

Since 2006 the Gefco and Msauli funds were depleted and no claims could thereafter be entertained.

**SOCIAL RESPONSIBILITY PROJECTS**

In terms of the Trust Deed, Trustees are allowed to expend up to 10 percent of interest earned on funds invested on projects which will benefit the communities living in areas where asbestos was mined and processed.

A major social project was the hosting of The National Asbestos Conference by the ART and the KRT during October 2008. This was a follow-up of the National Asbestos Summit arranged during 1998 hosted by the Government.

It was also considered appropriate to provide continuous support to patients suffering from the more serious forms of asbestos-related diseases, namely asbestos-related lung cancer and mesothelioma. For this purpose a fulltime palliative care nursing sister was appointed to serve patients in the Kuruman area where the Trust witnessed a prevalence of asbestos related cancer cases. This service is on-going and is much appreciated by all terminally ill patients and their families.
Preparing an oxygen concentrator

The purpose of this conference was to measure progress on the action plan agreed to at the 1998 Summit and to assist communities living in areas where asbestos was previously mined to obtain support for activities such as cleaning up of the environment and improving access to health care in general. Equipment at some hospitals was also upgraded.

Since the formation of the KRT in 2006, most of the projects in the Kuruman area are being jointly funded by both Trusts.

The total amount spent by the Trust as at 28 February 2013 is R5 020 950.
## List of Social Responsibility Projects

<table>
<thead>
<tr>
<th>Project</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neil White Bursary</td>
<td>Fees, travel and accommodation for participants in the Diploma in Occupational Health.</td>
</tr>
<tr>
<td>Asbestos Interest Group Community Activist and Advocacy Group</td>
<td>Assist in creating awareness in communities about the risks attendant to asbestos in the environment. Also acts as co-ordinators of the Trust in Kuruman.</td>
</tr>
<tr>
<td>Kuruman Palliative Care Nurse Project</td>
<td>To provide palliative care to terminally ill patients suffering from asbestos-related cancers.</td>
</tr>
<tr>
<td>Providing Medical Equipment to Hospitals</td>
<td>Provision of or upgrading of equipment at hospitals in the areas where asbestos was mined, to facilitate diagnosis of asbestos-related diseases.</td>
</tr>
<tr>
<td>Cancer Charity Workers</td>
<td>Support group for cancer sufferers operating in the Kuruman district.</td>
</tr>
<tr>
<td>Supedi Maths Projects</td>
<td>Programme aimed at improving maths education in schools (37) in areas where asbestos was mined earlier. (This was a one-year project).</td>
</tr>
<tr>
<td>Asbestos Co-ordinating Committee of Kuruman</td>
<td>To co-ordinate advocacy efforts on asbestos issues such as cleaning up of the environment.</td>
</tr>
<tr>
<td>Measuring Incidence of Mesothelioma near Kuruman (MINKS)</td>
<td>Developing a model to predict mesothelioma in the Kuruman area.</td>
</tr>
<tr>
<td>Research into the spending patterns of beneficiaries.</td>
<td>Conducted to measure the impact of grants on households</td>
</tr>
<tr>
<td>Spirometery training.</td>
<td>Training fees for Sr. Dorah Mentor at Tswarangano Hospital.</td>
</tr>
<tr>
<td>Research into the suitability of Penge for human settlement.</td>
<td>To inform the Limpopo Housing Development Department on the advisability of developing a township on an old asbestos mining site.</td>
</tr>
<tr>
<td>Publication of book on the History of asbestos mining in South Africa.</td>
<td>To record the history of asbestos mining in South Africa.</td>
</tr>
</tbody>
</table>
PARTNERSHIPS ESTABLISHED BY THE TRUST

Having regard to the fact that the work of the Trust in many respects dovetails with the responsibilities of other organisations with an interest in the welfare of ex-workers or communities living in areas where asbestos was mined previously, it became clear that some working relationship should be established with these organisations.

Media Bureau for Occupational Diseases (MBOD) / Compensation Commissioner for Occupations Diseases (CCOD):

The MBOD acts in terms of the Occupational Diseases in Mines and Works Act (“ODMWA”) and is responsible for diagnosing lung disease amongst mine workers.

Mineworkers diagnosed with a compensable lung disease are compensated by the CCOD from a central fund created for this purpose and to which mines pay levies based on risk levels determined from time to time.

In terms of the Trust Deed, any benefits received or receivable from the CCOD must be deducted from any award made by the Trust.

It has been the Trust’s experience that payments from the CCOD are in general much slower and for this reason the Trust has opted to pay out
awards ahead of payments by the CCOD, deducting however the partner’s payable by the CCOD.

As many ex-workers are not informed about their entitlements under ODMWA, Trust officials render assistance to these individuals by directing them to the accredited medical practitioner nearest to them who then attends to their applications to MBOD.

A healthy relationship with these two entities has been built up over the past ten years.

National Institute of Occupational Health (NIOH)

The NIOH is the entity dealing in general with occupational health issues. The MBOD liaises closely with it as far as miners’ lung disease is concerned. The Trust’s medical office also correlates its work with the standards of the NIOH.

The Trust has worked closely with the NIOH over a number of years to promote awareness around the rights of mineworkers to post-mortem examinations which may lead to the family receiving compensation from the CCOD and, indeed, the Trust where the qualifying criteria are met. Part of the awareness includes the Trust sponsoring a comprehensive leaflet dealing with this very subject. This leaflet was translated into several regional languages and distributed nationwide.

Department of Health (DoH)

The majority of workers previously employed on the asbestos mines are reliant on State health facilities in the areas where they reside.

For this reason the Trust endeavours, as far as possible, to utilise such facilities and expertise to attend to medical examinations and radiological services with a view of upskilling staff in the detection and/or treatment of asbestos-related diseases.

Department of the Environment

Due to the contamination of the general environment over a period of more than a century, many people living in areas next to old workings are regularly exposed to asbestos fibre and dust. Although some action has already been taken by the State, a lot still needs to be done to ensure that no undue risks exist to the general public.

The Trust actively engages with communities to lobby for remedial actions where necessary. The Trust has actively contributed to asbestos awareness campaigns sponsored and promoted by the Department in an attempt to contribute its expertise in addressing the asbestos legacy. The Trust has also attended seminars / workshops organised by the Department.
Department of Mineral Resources (DMR)

As part of the legacy of asbestos mining, DMR is responsible for rehabilitating old abandoned sites. The Trust supports affected communities and other pressure groups in an endeavour to ensure that these government responsibilities are carried out, conscious always of the budgetary constraints in the department.

MEASURING IMPACT, ADVOCACY, ASBESTOS CONFERENCE AND MEDICAL RESEARCH

Impact Study

At the request of the Trustees a survey was conducted during 2006/7 by Paul Stewart from the School of Social Sciences at the University of the Witwatersrand, mainly to determine how awards from the Trust affected the lives of beneficiaries.

The conclusions drawn were that, in the main, beneficiaries welcomed the additional relief.

Some spending went to shelter and housing, whilst monthly living expenses featured high on the priority list.

An unexpected finding resulting from this survey was that it was brought to the attention of the Trust that certain staff members of claims handlers enriched themselves by charging beneficiaries a private “fee” for their services. This resulted in the termination of the Service Level Agreement with certain claims handlers, who then blacklisted.

Advocacy

It is submitted that individuals and interest groups requesting assistance from Departments for matters like remediating the environment or to provide health facilities in rural areas are sometimes frustrated at the responses received. To the extent that the Trust can assist, it supports such requests.

Medical Research

As is the case with most occupational lung diseases, it remains impossible to reverse lung function impairment caused by the inhalation of asbestos fibres and dust over prolonged periods.

Patients with mild impairment can normally continue with everyday life, excepting only the performance of strenuous tasks. Patients with severe impairment are restricted in the performance of most tasks and may eventually be dependent on oxygen supplementation.
Although worldwide research into the possible cure of both asbestos-related lung cancer and mesothelioma has been on-going for many years, no breakthrough has been achieved to date. The Trust supports programs aimed at furthering such research. The current thrust appears to be towards early diagnosis at which time intervention may assist.

The constant search for quicker and more effective mesothelioma diagnosis

The diagnosis of malignant mesothelioma is based on three main sources:

Clinical information
Complete work history, including questions on domestic/familial and environmental exposure is mandatory. The first clinical symptoms of a typical pleural mesothelioma may be thoracic pain, shortness of breath and weight loss in an elderly patient, which may occur 20-40 years after asbestos exposure because of the extremely long latency period. These symptoms however are not exclusive to mesothelioma.

Diagnostic imaging
The conventional chest X-ray may show pleural effusions and sometimes changes in the chest wall suggesting mesothelioma. But they are not specific and a differential diagnosis including TB and other malignancies must be made. CT-scans may demonstrate changes in the thoracic wall better than conventional X-rays.

Histology
A histological tissue examination is the core of the diagnosis of mesothelioma. When mesothelioma was first identified as a primary malignant tumour (around 1960) the diagnosis was generally made on autopsy. Today, we can obtain biopsies from CT-guided needle biopsies. The gold standard, however, is thoracoscopy – a direct inspection of the thoracic cavity with video cameras with minimally invasive instruments under general anaesthesia. This allows large biopsies of suspicious areas. There are three histological subtypes of mesothelioma: epithelioid, sarcomatous, and mixed types. The most frequent is the epithelioid type, which occurs in about 60% of the cases. The histological diagnosis can be very difficult in particular in the epithelioid subtype the differential diagnosis includes adenocarcinoma or benign mesothelial proliferation. In the sarcomatous subtype the diagnosis may be very difficult.

In recent years a variety of immune histological markers have been developed which greatly facilitate the diagnosis in particular of epithelioid mesothelioma. A combination of two negative markers (reactions which do not stain mesothelioma cells but do stain carcinoma cells) and two to three positive markers (which stain mesothelioma but not carcinoma cells), are standard in the histological workup.

A comment on laboratory tests
It should also be noted that although general laboratory tests are not conclusive, they may serve as a prognostic indicator. Over the past 10 years several serological markers have been developed. Two examples are Mesothelin and Osteopontin, which are two proteins found in serum or pleural fluid of patients with mesothelioma. Unfortunately their sensitivity and specificity is not high enough to either be fully reliable for diagnosis or to identify people who are at risk of developing the disease. Mesothelin is useful for follow up in patients treated with surgery or chemotherapy, but it is only produced in the epithelioid subtype and not in the sarcomatous type (see above).

New markers are developed nearly every month. Recently some interesting studies in the field of genetics have identified people with a high risk of developing mesothelioma. Currently, however, it is still too early to implement this technology "from bench to bedside."

Markus Heitz, 2013
COMMUNITY LIAISON

Asbestos Interest Group (AIG)

As mentioned earlier, the AIG was involved in the litigation process and were co-signatories to the Settlement Agreement and the Trust Deed.

Since then a fruitful working relationship was built between the AIG and the Trust, in particular since the closure of the Trust’s Kuruman office.

The AIG assists in making communities in the Kuruman/Daniëlskuil/Vryburg areas aware of the existence of the Trust and directs potential claimants to the Trust’s accredited medical facilities in those areas. They also assist ex-workers to claim from the MBOD by directing them to the local MBOD accredited facilities and help them to obtain work records.

The Trust contributes towards the funding of the AIG’s awareness raising activities.

THE ASBESTOS CO-ORDINATING COMMITTEE OF KGALEGADI

The Asbestos Co-ordinating Committee of Kgalagadi (ACCK) was founded in 2004. It comprised representatives from civil society, community groups, government departments and the Trust in the Kgalagadi and surrounding areas.

The objective was to create a forum for all stakeholders and interested parties affected by the legacy of asbestos mining to come together to debate issues affecting the communities in and around Kuruman.

To ensure coherence and build partnerships it was agreed by the Trustees to support the establishment of the Asbestos Co-ordinating Committee of Kgalagadi (ACCK). After several initial meetings, in 2006 a draft constitution was prepared and submitted to a community meeting. This draft constitution allowed for several categories of membership and provided for an observer capacity for local and provincial government departments and for the ART. At a subsequent meeting a committee was elected in 2007.

The Trusts agreed to provide funding of some R120 000 for the ACCK. The ACCK also made representations to the MEC and DMR.

Through the dedicated guidance of the executive committee in 2008 the ACCK put together a submission to Parliament which contained detailed information of the difficulties facing communities in the region because of the legacy of asbestos mining.
Meetings were convened every quarter in Kuruman. The Trust would use these meetings to provide feedback on operations. Due to a lack of participation by government departments and the failure to respond to issues facing the community, meetings soon became a forum where personal agendas were pursued. The Trust became a target for attacks by individuals who did not qualify to receive compensation in terms of the criteria in the Trust Deed. The Trust withdrew from the ACCK and the organisation collapsed soon after.

At many community meetings, individual and collective claims were being discussed. The history of promises made in the run up to the establishment of the ART, were also continuously raised. Often individual organisations petitioned the local office or politicians locally, provincially or nationally.

Notwithstanding the commitment of many members the organisation once again became a forum for individual agendas. Members began to withdraw and the ACCK once again collapsed once a key administrator passed away leaving in its place a vacuum which has yet to be filled.

THE FUTURE

The Trust Deed provides that the Trust should operate for a minimum of 15 years, with an option to continue for another 5 years.

Given the long latency period between exposure and the potential manifestation of an ARD, it is expected that by this time all those exposed at the operations of the Founders will have been attended to.

As at 28 February 2013 the Trust still had about R305 million available to meet future claims.

This amount is made up as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total amount received from Founders</td>
<td>R401 136 338</td>
</tr>
<tr>
<td>Add: Surplus of investment income over operating costs</td>
<td>R161 623 936</td>
</tr>
<tr>
<td></td>
<td>R562 760 274</td>
</tr>
<tr>
<td>Less: Allocated to beneficiaries</td>
<td>R257 573 326</td>
</tr>
<tr>
<td><strong>Available at 28 February 2013</strong></td>
<td><strong>R305 186 948</strong></td>
</tr>
</tbody>
</table>

It should be mentioned that most Trusts set up in other countries such as the USA, UK or Australia ran out of funds due to under-estimation of the number of claims receivable or paying out excessive grants in the early stages.

The Trustees therefore endeavour to nurture the available funds in such a way that all liabilities will be met during this the remaining years.
THE RECOGNIZED DANGERS OF ASBESTOS

Medical conditions caused by asbestos fibre and/or dust are mainly:

**Scarring of lung tissue** which impairs lung function. If the impairment is between 10 and 40% it is considered mild, and the affected person can continue with less strenuous work but cannot readily do manual labour. If the impairment is more than 40% the affected person will find even light work too strenuous. Breathing becomes more difficult over time which places extra pressure on the heart muscle. Both these conditions can deteriorate over time because of its progressive nature.

Persons suffering from any of these two conditions may develop the latter two diseases at a later stage or it can also manifest in patients not suffering from any of the lesser conditions.

**Asbestos-related lung cancer**, where asbestos exposure together with other factors can cause malignancy.

**Mesothelioma**: This is a rare type of cancer which normally develops in the lung lining or peritoneum and is mainly caused by exposure to asbestos. This condition may be caused by even trivial exposure.

Asbestos-related lung cancer and mesothelioma are terminal diseases and, once contracted, the patient’s life expectancy is usually somewhere between six and 24 months.

All four conditions can also develop from environmental exposure.
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