Q(h)ubeka Trust
2016 to 2023

Moving forward over seven years to distribute compensation funds for silicosis

September 2023

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Contents:

Abbreviations and acronyms

AASA	Anglo American South Africa Limited [now (Pty) Ltd]
AGA	AngloGold Ashanti Limited
CCOD	Compensation Commissioner for Occupational Diseases in Mines and Works, appointed under section 54(a) of ODMWA
CIMS	The QT claimant information management system - a digital database storing all the medical records, bank and claim information for claimants
COIDA	Compensation for Occupational Injuries and Diseases Act, Act 130 of 1993
COMP	Consultative Occupational Medical Panel - the independent panels of occupational health specialists and radiologists that assessed the medical records and arrived at a medical outcome for QT, in terms of the Trust Deed.
FICA	Financial Intelligence Centre Act
HURIS	AngloGold's Human Resources Information System
ILO	International Labour Organisation
MBOD	Medical Bureau for Occupational Diseases established under S.2 of ODMWA
MHSA	Mine Health and Safety Act, No 29 of 1996
MDA	Mineworkers' Development Agency
MN	Mbuyisa Neale
NIOH	National Institute for Occupational Health
NIOSH	US National Institute of Occupational Safety and Health
ODMWA	Occupational Diseases in Mines and Works Act, Act 78 of 1973
OLD	occupational lung disease
OTP	Office of the Premier, Eastern Cape
PMF	Pulmonary Massive Fibrosis (scars inside the lungs from silicosis)
QT	Q(h)ubeka Trust (the Trust)
SAMA	Southern African Miners Association
Settlors	Anglo American and AngloGold, the founders of QT
SIMRAC	Safety in Mines Tripartite Research Advisory Committee under the Mine Health and Safety Act, No. 29 of 1996
SOMP	Specialist Occupational Medicine Panel
SMMA	Swaziland Migrant Mineworkers Association
SRD	Silica Related Disease (Silicosis and Silica-tuberculosis)
TB	tuberculosis
TEBA	The Employment Bureau of Africa
UCT	University of Cape Town
WNLA	Previous name for TEBA - Witwatersrand Native Labour Association/WENELA

Foreword

In southern Africa the story of silicosis and tuberculosis is deeply embedded in the context of the century's old history of colonialism, of mining, of dispossession, of migrant labour, of poverty, of apartheid-era violation of human rights and of inequality. The story is also embedded in the organisations and the resistance of our people. It lives in beautiful and moving songs, in dances both traditional and modern, in motivating and reflective poetry in many languages, in numerous works of art, in photographs, in descriptive historic movies, in history books and in the oral history of families and countries.

The brief story of the Q(h)ubeka Trust is but one contribution to this historic journey of men, women, families, and societies collectively finding ways towards a measure of redress and hopefully some measure of social justice. This story is told mainly through interviews by Peter Lewis with staff members, service providers, trustees, the lead attorney and researchers. Throughout this story there are the ever-present echoes of the voices and the experience of the claimants.

We are indebted to all who have made this settlement trust and others possible but primarily we are indebted to the claimants.

Acknowledgements

We wish to acknowledge the following people for their contribution to this history:
Peter Lewis for conducting the interviews and transcribing those as part of the original draft.
Martin Nicol and Judith Cornell for editing and so much more.

The trustees acknowledge the valuable contribution made by the different managers of the Trust, COMP members, medical consultants, medical practitioners, radiologists, radiographers, occupational health nurses, technicians, laboratory staff, lawyers and advocates, researchers, epidemiologists, biostatisticians, actuaries, IT teams, taxi-drivers, food providers and auditors. Some operated centrally in cities and others in the field. A special "Thank You" to the Outreach Teams who were with us to the very end. Your direct interaction with our claimants and your dedication and diligence have enriched our work and given much needed direct support to claimants at the local level.

Q(h)ubeka Trust
2016 to 2023

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Introduction

Since the earliest years of industrial gold mining, workers – black and white – have been victims of silicosis, a lung disease caused by silica dust that makes it hard to breathe, resulting in a poor quality of life, inability to work and earn a living and at times causes early death. Silica dust in the lungs predisposes to Tuberculosis (TB) and a worker with silicosis often has repeated episodes of TB with resultant further scarring of the lungs.

The mining companies have known this, and so have the government authorities, for over 100 years. Despite this knowledge, mine owners failed to control dust and prevent disease. And government failed to police occupational health risks adequately or to put in place fair and preventive compensation for mineworkers who contracted silicosis from their underground work.

This combined failure of care by business and successive governments led to the creation of the Q(h)ubeka Trust in 2016.

The task of the Trustees was to deal with this injustice by paying out the compensation award which had been set aside after the settlement between Anglo American and AngloGold Ashanti, and 4,365 of their former employees.

The Q(h)ubeka Trust came to the end of its planned life on 21 April 2023.

This history tells what the Trust did over its seven years, through accounts of individual experiences, statistics and interviews with those involved.

The history needs to be read alongside the Trust Deed – which specified what the Trustees had to do, and who could be paid – and the annual reports and audited financial statements published by the Trustees from 2017 to 2023. All of these are available on the Q(h)ubeka website. The history should also be read within the context of the mammoth efforts of workers, medical experts and lawyers for justice in wider struggles that are still being waged.

…But let's begin with the life histories of three qualifying claimants.

Life histories of three claimants

Names and places have been changed to protect claimants' confidentiality, but the details come from the lives of real people. Data have been anonymised.

QT01 – Paying a claimant based on a medical examination

Vuyo Mpiti was born in the Transkei, in Apartheid South Africa on 20 March 1950. He died, close to his birthplace, at the age of 68 in 2018. He died in the Eastern Cape in democratic South Africa of "natural causes", just four months after receiving R162,805 from the Q(h)ubeka Trust.

Mr Mpiti had been a mineworker from the age of 25 years. The money was the first part of a R345,172 compensation payment awarded to Mr Mpiti by the Trustees because his workplace had made him ill. He had silicosis, a disease that is caused by breathing in the dust that hangs in the air in underground gold mines – when it is not properly controlled.

Mr Mpiti started off working at Grootvlei (managed by Gencor) in 1975. His next contract was at Libanon (managed by Gold Fields). While he was working there, his home area was incorporated into the "Republic of Transkei". In 1984 he got a job as a machine driller at Western Deep Levels (managed by Anglo American/AngloGold). In 1987, General Bantu Holomisa [today a Member of Parliament] became the ruler of Transkei after a bloodless *coup d'état*.

In 1994, Mr Mpiti was issued a green ID book as a SA citizen, in preparation for the democratic elections. The next year he attended a routine medical examination by the government Medical Bureau for Occupational Diseases (MBOD). His weight was recorded as 65 kg. The MBOD diagnosed him with Tuberculosis. He received treatment for the TB, but the TB "reactivated" seven years later, in 2001, the year he ended his mine employment at the same AngloGold mine, now renamed "TauTona". He was 52 years old and had worked underground in gold mines for 27 years.

The Anglogold Health Service, West Rand indicated that Mr Mpiti had completed his TB treatment, but also that he had extensive fibrosis in one lung. The doctor submitted him to MBOD for compensation. [We don't know whether he received compensation.]

In 2009, Anglo American plc (which had moved to London as an international mining company) waved "A golden goodbye" to South Africa. "After steadily reducing our stake in AngloGold Ashanti over the past decade, we finally part company by selling our remaining shares, closing our chapter on investing in gold." (Anglo American website)

In 2011, the Constitutional Court ruled - after some five years of court battles - that mineworkers could sue their employers for compensation if they suffer from occupational diseases. The same year, on the basis of the court judgment, international human rights lawyers Leigh Day & Co joined up with Mbuyisa Neale Attorneys to launch a court case for compensation for silicosis from the mining companies, Anglo American South Africa Limited and AngloGold Ashanti Limited. The lawyers travelled all around the Eastern Cape looking for ex-mineworkers to join the case.

The Qubeka court case and the settlement

Mr Mpiti was one of 4,365 claimants who signed up to ask for justice against their former employers.

The case was called Qubeka v Anglogold Ashanti Limited. Biyana Benson Qubeka is a former mineworker from another Anglo mine: Vaal Reefs. He also had severe silicosis and his example was used as a 'test case'. The mine owners used all sorts of legal arguments to defend themselves. They said they never broke any law, they respected health and safety rules and they were not negligent. In 2015, while the court case was still going on, Mr Mpiti's health further deteriorated.

In March 2016, the mines agreed to stop the legal fight and settled the case 'out of court'. A trust fund was set up to pay compensation. The name of Mr Qubeka (who is still alive in 2023) was the inspiration for using the isiXhosa word 'qhubeka' – forward – as the name for the Trust.

The Q(h)ubeka Trust Deed, the legal document establishing the Trust and naming the first four trustees was soon signed. The settlement was 'closed' and included only the 4,365 named claimants (including Mr Mpiti and Mr Qubeka). It did not apply to any others of the hundreds of thousands of mineworkers who were victims of occupational diseases. The Trust Deed also limited compensation to silicosis only - it did not provide for tuberculosis on its own.

On 22 April 2016, The Q(h)ubeka Trust was registered with the Master of the High Court, Gauteng. The Trustees began work to identify which of the claimants had silicosis. Only those diagnosed with silicosis by the Trust's medical assessment panel (COMP) were eligible for compensation. And among those who had silicosis, claims could only be paid if claimants had two years of qualifying service on a specific list of mines. Mr Mpiti had worked on one of these mines for ten years – the next question was whether he had silicosis.

Mr Mpiti attended the Q(h)ubeka Trust medical examination by Dr Sonxaba in Lusikisiki in January 2017. He signed all the Trust claim documents—with an 'X', because he could not write. Here he renounced any further claims against "Anglo American South Africa Limited and AngloGold Ashanti Limited and all of their former or present direct or indirect holding companies, subsidiaries and/or associated companies and their former or present or future directors and/or officers and/or employees and/or shareholders anywhere in the world." His age was 67 years and his weight had dropped to 43kg.

The Trust's independent panel of medical experts (COMP) diagnosed Mr Mpiti with the worst form of disease: "Category 4: Silicosis with SEVERE lung function loss."

On 22 January 2018, the Q(h)ubeka Trust submitted all the medical and other documentation to MBOD to support a claim by Vuyo Mpiti for government statutory compensation for silicosis. [According to information provided to the Trustees by the Compensation Commissioner for Occupational Diseases (CCOD), the government's CCOD had still not paid this claim five years later in January 2023.]

On 27 March 2018, the Trustees paid the first part (tranche) of the Q(h)ubeka Trust compensation award for category C4 silicosis into Mr Mpiti's personal bank account. It was R162,805. Shortly afterwards, Mr Mpiti passed away at his home. He was 68 years.

Paying the bereaved family

2018 was the year when AngloGold Ashanti put the TauTona mine “into orderly closure”. In 2020 it sold the last of its remaining mines in South Africa.

During 2019 and 2020 the Q(h)ubeka Trust staff and field workers struggled without success to reach the family of Mr Mpiti to inform them of the outstanding claim for statutory compensation from CCOD.

In April 2022, the second tranche of the compensation award (delayed by Covid and prescriptions related to payment of the 2nd tranche) became available for Mr Mpiti’s family to claim. Q(h)ubeka Trust wrote to the local office of the Department of Justice to ask for the details of "the individual who has been appointed Executor of the deceased’s Estate". No reply was ever received from the government to this letter.

In November, three members of the Q(h)ubeka Trust field team travelled on a "bad road" to visit Mr Mpiti’s sister. "We calmed down the family, as they are very cross with anything to do with companies working with ex miners. So we explained about Q(h)ubeka Trust and they are now ok." The family agreed to ask the court in Mthatha to appoint an executor. This was required because Mr Mpiti had not signed a will. [See the interviews below with Sr Nodu Nolokwe and Mzamo Dlamini. They were part of the field team that convinced the family that this was not a scam, and they should claim.]

The Master of the High Court in Mthatha (who was very helpful to the Trustees) quickly issued a formal "Letter of Authority" (LOA) naming a family member to take charge of the estate. Now things moved with speed. The Q(h)ubeka staff in Mthatha WhatsApped photos of the LOA and the bank account details to the head office in Johannesburg, where they were immediately uploaded onto the Trust “CIMS” computer system. The staff in Cape Town verified all the documents and made sure all the signatures and IDs and bank numbers were in order. The claim was marked "released for payment" on CIMS. The Q(h)ubeka accountant confirmed the bank account was open and asked the Q(h)ubeka Manager in Cape Town to log onto the bank website to pay the money. On the same day, 23 November 2022, Q(h)ubeka Trust paid the second and final tranche of the compensation award for category C4 silicosis of R182,637 into the "estate late" bank account controlled by the family of Mr Vuyo Mpiti.

Approximately R105,000 remains due to the family from CCOD, in full settlement of the claim for compensation from the government. The MBOD claim of Mr Mpiti was submitted to the MBOD in January 2018. Five years later, in January 2023, CCOD reported to the Q(h)ubeka Trustees that his estate was awaiting payment for ‘second degree compensation’. The MBOD had 'finalised' the claim, but CCOD had not yet been able to pay the money.

The Q(h)ubeka compensation, fully paid, came to a total of R345,172.

The Q(h)ubeka Trust came to the planned end of its life on 21 April 2023, after the Trustees had done their job - distributing over R420-million to qualifying claimants from the original list of 4,365 who were diagnosed with silicosis - or to their families. 98.8% of claims had been paid by this time. The 37 unpaid claims (of whom 16 have received the first tranche) were transferred to Fairheads Umbrella Trust who will pay when the heirs to the claimants can be confirmed.

QT02 - Paying a dependant beneficiary where there was evidence the deceased claimant had contracted silicosis

Petros Mapatane was born in Willowvale, in the Transkei, on 9 April 1954. He went to work on the gold mines at age 19—at Kinross and Blyvoor first, switching to the Free State gold fields managed by Anglo American/AngloGold from 1976. He was at President Brand and then at Western Holdings. Several 'performance complaints' appear in his work record:

- Warning "Refused to work, likes to sit and watch"
- Final warning - no details
- Warning "Loafing"
- Final warning "Left workplace at 11am"

At Free State Geduld, Mr Mapatane's job was: mining hand, mining helper, mining team.

In 1986 he received a green ID book as a SA citizen. (Remember this point – it is more than a detail.)

From 1988 to 1996, the work record included these hints of his work experience:

- Conduct complaint: Not performing duties "left clocking badge underground"
- Literacy Course Xhosa PASS (age 35)
- Prof Tusinius Industrial Relations course PASS [Prof Robert Tusinius, founder of Organisational Interface Management (OIM), facilitated "conflict resolution and management-union relationships for major organisations such as Anglo Gold"]
- Absent without permission (AWOP) - "arrested, proof brought forward, condoned"
- Scraper winch driver course PASS – age 40
- Double Drum Winch Operator PASS

In 1996 Mr Mapatane left the mining industry after 22 years – aged 42. He returned home and married 25-year old Nomsa, in a civil marriage in Willowvale. The Home Affairs marriage certificate showed the same ID number as on the mine work records.

In 2010, for unknown reasons, Mr Mapatane obtained a second ID document - in his same name, but with a different ID number and different birth-date : 12 June 1947

Mr Mapatane signed up with lawyers Leigh Day & Co and Mbuyisa Neale Attorneys, as one of the 4,365 claimants in the court case to demand compensation for silicosis from Anglo Gold. He used his old 'mine and marriage' ID document, not the new ID, when he signed.

The Qubeka court case began and continued for another four years. But Mr Mapatane died in 2013 in Willowvale before the settlement agreement. The Home Affairs Death Certificate was issued with his '*new*' ID number. This created a major problem - as his marriage was under his 'old' ID number. Was his age 59, or rather 66 years?

In March 2016, Anglo American South Africa and AngloGold Ashanti reached a negotiated settlement "out of court" with the lawyers on behalf of the 4,365 named claimants, which still included the name of the late Mr Mapatane. The settlement created the Q(h)ubeka Trust. All claimants diagnosed with silicosis by the Trust's medical assessment panel (COMP) were eligible for compensation, provided they had two years of qualifying service on a specific list of mines. The list includes the "FreeGold" mines where Mr Mapatane worked underground for 20 years.

The main question now was – did he have silicosis? If he did, his family could be paid by the Trust.

Tracing agents appointed by the Q(h)ubeka Trust, located the family of Mr Mapatane in Willowvale. They confirmed that Nomsa was the widow, so she signed all the Trust claim documents. But there were two problems. First the family did not have any medical records for Mr Mapatane. Second, Mrs Mapatane made the claim using the ID number printed on her husband's death certificate. This is totally understandable - but the ID from mine employment and from Mr Mapatane's initial claim for compensation was the 'old' ID.

Because Mr Mapatane passed away before the Trust was established, the Trustees needed to find mine records of his medical history. A note on the CIMS computer system said: "Need more medical information to support claim (XDS)". But AngloGold Ashanti said they could not find any medical records. There was no medical information to back up Mr Mapatane's claim for silicosis compensation.

Development of the predictive model

There were many claimants who shared the problem of missing mine medical records with the Mapatane family. At the end of 2019, all the living claimants had been medically assessed, and most had been paid the first tranche (about half) of their compensation.

The Trust Deed allowed for the compensation for the families of claimants who had died before they could be medically examined either by the MBOD or by the Q(h)ubeka Trust, *provided the Trustees had 'sufficient evidence' to believe they had silicosis*.

The Trustees got medical experts to develop a "predictive model", based on statistics, to allow medical certification for compensation in cases where there were insufficient medical records available for deceased claimants. The QT predictive model is an entirely novel development in the field of certification for occupational lung disease compensation. The Trustees were able to pay awards for people who do not qualify for government compensation. [See the interviews below for details of the predictive model.]

Sr Xavier da Silver (XDS) of Q(h)ubeka Trust, applied the Predictive Model to classify Mr Mapatane as a "qualifying claimant" with "C1(s) - Silicosis with sufficient evidence". [See the interview with Sr Xavier below]

In September 2020, the Trustees paid the first claim for a deceased claimant who they found to have silicosis based on the predictive model. Soon after that, the second tranche payments began. But Mrs Mapatane's claim could not be processed because of the problem with ID numbers.

The Trust outreach team grappled with the problems of "the deceased claimant with 2 IDs". The payment rules required the death certificate of the claimant must be on the CIMS computer database - but the ID number on the death certificate differed from the ID number

of the husband on the widow's marriage certificate - and on all the mine documentation for the claimant!

Mrs Mapatane signed an affidavit for the Trust at the Willowvale police station, to state that her husband, Petros, was using 2 IDs - "but he was the same person".

QT head office staff then submitted the claim for internal verification, so the 2 tranches could be paid to Nomsa, as the widow of Petros. The verification team referred the claim for consideration by the Trustees. They had combed through the documentation saved on CIMS and found one overlap connecting both ID numbers to one mine industry number. They asked the Trustees to approve payment to Mrs Mapatane: "This is the widow of the claimant. She may struggle to get an LOA because of the undocumented identity change."

The Trustees agreed to approve the claim, provided that the widow signed "an affidavit that she is the sole dependant of her late husband, Mr Petros Mapatane, [ID 'new number'] who died on 21-Oct-2013. Once this is submitted, along with a clear, stamped copy of the widow's bank statement (less than 3 months old), the claim will be approved for payment into that personal account."

In October 2022, Mrs Mapatane signed a standard Next of Kin affidavit (Department of Justice form J192) - but this was not what the Trustees requested. The field team was asked to get the exact wording correct - but they were then chasing 100 unpaid claims as the Trust office moved towards closure. Communications were delayed by the loadshedding as the batteries in cell towers failed. And the roads were bad and slow.

The employment contracts of the QT field workers ended on 30 November 2022. But one of them, knowing Mrs Mapatane had not been paid, travelled to see the widow in January 2023. He helped her with the documents and assisted her to open a bank account. [See the interview with Pasika Nontshiza, below.] Mrs Mapatane signed an affidavit in mid-January 2023, with the proper words, at the police station in Willowvale. The verification team could at last pass the claim for payment.

On 24 and 25 January 2023, Q(h)ubeka Trust paid the two tranches of Petros Mapatane's compensation award for category C1(s) silicosis into his widow's personal bank account.

The total compensation payment of R68,974 was made to the widow of a claimant, with 22 years as an underground gold miner, who had no medical records from the mines to prove he had silicosis - and who had died, aged 59 years, before attending the medical examination.

453 C1(s) claimants have been awarded R32-million by the Q(h)ubeka Trust, based on its Predictive Model. By 21 April 2023 all but 17 claims had been fully paid to the families. The money for the few unpaid claims is now held in trust in the hope that the families will come forward. They each need a Letter of Authority (LOA) from the court to claim.

None of the claims of C1(s) claimants has been forwarded to the MBOD because the law (ODMWA) does not recognise claims by the families of deceased mineworkers unless they have been proved to have silicosis by an MBOD medical examination or an autopsy. There is no sign that the government is planning to change the law, and to confront this injustice.

QT03 – Paying the family of a claimant with silicosis, who died before medical examination.

The Driller from Lesotho

Lebohang Molise was born on 3 March 1949, in the British Crown colony of Basutoland, high in the mountains in Quthing district.

Just before he turned 18, in 1966, Basutoland gained its independence from the United Kingdom and was renamed the Kingdom of Lesotho.

He began his first 12 month TEBA contract in his twentieth year at Libanon Gold Mine (part of the Gold Fields group, near Carletonville). After six months back home, he switched to a new employer, Anglo American, and was sent to their Free State Saaiplaas gold mine near Welkom. He was to complete 23 year-long contracts at this one mine, working underground as a driller, over the next 31 years. During this time, the mine changed its name twice, first to FreeGold, then Masimong gold mine, after Anglo sold it to Harmony in 1997.

To start with, he took quite long breaks between contracts, sometimes more than a year. He worked 8 year-long contracts in the 14 years from 1970 to 1984. *(See the table below–page 18)*

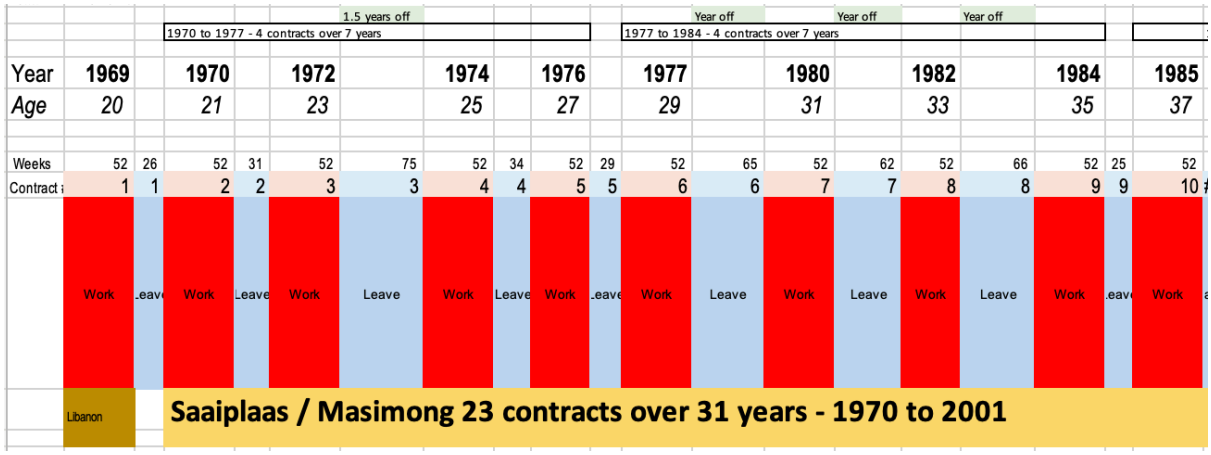
In 1981 he got married. The "bachelor peasant" of 32 years was married to a "spinster peasant" (Lerato Emily, 23 years old) in Quthing after publication of the banns, consent being given by themselves and their parents.

In 1982, at the start of his 8th contract, the medical examiner at Free State Saaiplaas stated:

> "This worker has been clinically and radiologically examined and found free from Pneumoconiosis and Tuberculosis and fit for work in a dusty atmosphere."

The pace of work now picked up—he worked eight, year-long contracts in just nine years to 1994!

This strip below illustrates the pattern of work and home stays [Red = work; blue = leave]



Mr Molise had a wife and three children, but he had *seven years of bad luck* between 1989 and 1996.

Silicosis I

At the start of his 13th contract in 1989 he was diagnosed with silicosis. This was confirmed by a benefit examination for the Medical Bureau for Occupational Diseases in mines and works (MBOD) at Ernest Oppenheimer Hospital, Welkom (Dr Truter). 40 years old, his Bureau No. was XXXyyy. The MBOD stamped Mr Molise's CCOD Application to the associated government entity, the Compensation Commissioner for Occupational Diseases in mines and works (CCOD) for a Benefit by a Black Person in terms of ODMWA – the Occupational Diseases in Mines and Works Act of 1973. On 2 February 1989, the Chair of the MBOD's Medical Certification Committee for Occupational Diseases (MCCOD) signed the finding:

"TB - **No**; other compensatable diseases - **Yes Pneumoconiosis**".

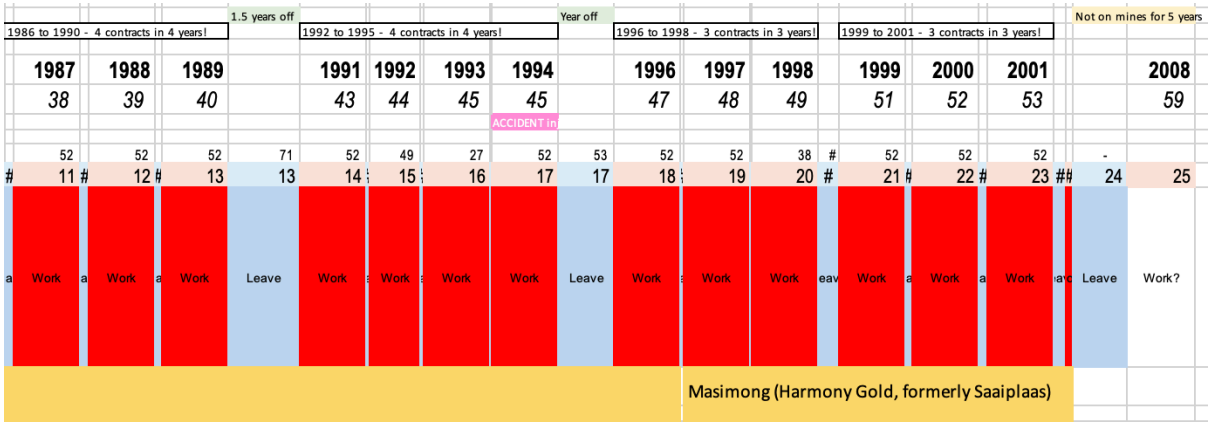
TEBA service documents do not show any change of job after this diagnosis. The medical record of XXXyyy was not mentioned again until 1999. In 2000, a Hospital Medical record card indicated that drugs were dispensed to Mr Molise – the spindly scrawls did not show a reason. Notes here said that he had failed acclimatisation twice..."chest pains, coughing, blood-stained sputum 1/52 ago. Known silicosis has never been compensated."

The TEBA records show, despite the silicosis diagnosis in 1989, Mr Molise worked on as a driller for the next 14 years, in a hazardous environment with heat, noise and dust until 2003. By this time he was suffering from silicosis and tuberculosis "an occupational disease in the SECOND DEGREE...".

But before then, there were two accidents underground.

Leg

The first, on 28 August 1993, was very serious indeed. It occurred when part of the sidewall fell as he was drilling, trapping his right leg and tearing away the muscles. Over 300 pages of medical charts detailed ten days in the ICU, multiple blood transfusions, operations and several skin grafts as the skilled staff tried to save his leg. It was touch and go, he was often confused from the drugs and in pain, but he was discharged from hospital - on sick leave - after seven weeks. He returned to work, still drilling, on 23 February 1994 after 181 days off work.



Doctors reduced his permanent disablement percentage to 1% from a previous 15%, because the wounds had healed. He attended a disability assessment for compensation in terms of the Compensation for Occupational Injuries and Diseases Act (COIDA): “massive crush and avulsion muscles R thigh….20 cm scar healed”. On 8 October 1996, the Rand Mutual Assurance (RMA) rejected the claim for compensation for disablement, because of the lack of clinical information. [RMA was founded in in 1894 to administer Workman's Compensation Insurance benefits to injured miners. RMA operates under license from the Department of Labour, and provides benefits in accordance with COIDA.]

Foot

Two months later, on 16 December 1996, Mr Molise was injured again in an underground accident when rock from hanging wall penetrated his boot and crushed a bone in his right foot. He continued drilling until a stretcher was found for him. He was in hospital for 6 days and in plaster of Paris (POP) for 3 weeks. He attended physiotherapy sessions at the Ernest Oppenheimer Hospital (EOH) and resumed work after 25 days off.

In June 1997, he attended a disability assessment for COIDA compensation: compound committed fracture right foot first metatarsal. Rand Mutual issued a cheque in his favour for R1009 - lump sum compensation under COIDA for 1% disablement from a fractured right foot.

Mr Molise worked almost continuously from now on, completing six, year-long contracts in under seven years.

In June 1998, beginning his 20th contract as a 'Driller - development" at FSS Saaiplaas 5, he went to AngloGold Health Service Free State Region for a 3 yearly medical examination at the Occupational Health Center. Age 49, Height 178; weight 69.

Harmony Hospital - Occupational Health issued an initial certificate of fitness in 1999, as Mr Molise began his 21st contract at the mine - recently absorbed by Harmony and renamed Masimong 5. Mr Molise said on the form he had never had treatment for tuberculosis and never had any operations or serious injuries or accidents. He had consulted a doctor in the previous 5 years—for a flu-like illness Height 177; weight 71kg. A note on the form referred to his Bureau No XXXyyy. The mine knew of his previous silicosis diagnosis.

An undated mine history for Mr Molise shows he did high dust work at Saaiplaas for 12 years, at Masimong (the same mine) 3 years up till 21-Jul-2000; and that he was still employed in high dust work at Masimong from 16-Aug-2000.

TB

In January 2001, an MBOD form “Particulars of a person Buro No AAAbbb” shows Mr Molise was still working as a driller. The form said he had not previously been compensated for a compensable disease. Lerato Molise was identified as his dependent. Mr Molise attended a MBOD benefit examination at Harmony Mine Hospital. He was diagnosed with Pulmonary Tuberculosis based on an Xray and a positive sputa result from a test on 7/1/2001. TB treatment started on 12/01/2001.

Mr Molise was notified on 17 January that he tested positive for TB. He was issued with a Harmony Hospital Tuberculosis Card. The card says that he had not previously had TB. Bureau No AAAbbb

Silicosis II

On 27 July 2001, relying on the examination at Harmony earlier in the year, the MCCOD issued a certificate that Mr Molise was suffering from silicosis and tuberculosis "an occupational disease in the SECOND DEGREE. Maximum certification - you therefore no longer qualify for examinations. Concerning possible compensation the CCOD will send you forms to complete." The old 1989 Bureau Number XXXyyy was printed on certificate, with AAAbbb in handwriting.

TEBA recorded another annual contract at Masimong from 28 October 2001 to 28 October 2002. After a two month break, Mr Molise returned for a new contract on 8 January 2003. But he was immediately "booked off 'SICK' as of today's date. He had Silicosis and PTB - second degree – a mine-related disease.

On 13 January 2003, Harmony issued an **exit medical certificate** for Mr Molise, Bureau no AAAbbb. This says he worked in hazard/risk environments with dust, noise and heat exposure from 1982 to 07-Jan-2003. His chest Xray result at this date was “Fibrosis and Silicosis”. Occupational disease was present: TB + Silicosis & ?NIHL. A compensation submission for lungs had been made on 07-Jan-2001 and that for noise induced hearing loss (NIHL) was to be made to RMA on 29/01/2003.

Noise induced hearing loss

EOH diagnosed Mr Molise as suffering from noise-induced deafness and noted "Consider for compensation". But RMA said the mild degree of hearing impairment shown in the tests was not compensable in terms of COIDA 130/193.

05 February 2003 - TEBA record: **Discharged**

Mr Molise returned home to Quthing. We do not know if or when he received the statutory compensation from CCOD for 2nd degree occupational disease. (He probably did.) Five years later TEBA records reported that he signed a final contract with "Anglo Mining Services". Before beginning work, Mr Molise attended a fitness exam at the AngloGold Ashanti Occupational Health Centre in June 2008. His occupation was listed as "driller", but he was found unfit for underground work on examination. It is not known when his contract ended.

After the mine

In 2011, aged 62, Mr Molise signed up with lawyers Leigh Day & Co and Mbuyisa Neale Attorneys, as one of 4,365 claimants in the "Qubeka" court case to demand compensation for silicosis from Anglo Gold.

The "Qubeka" court case began in 2012 and continued for another four years until March 2016 when the Q(h)ubeka Trust Deed was signed. This followed a negotiated settlement between the lawyers of the 4,365 mine-workers and their former employers: Anglo American South Africa and AngloGold Ashanti. The legal document established the Trust and named the first trustees. The Trust was duly registered with the Master of the High Court, Gauteng. The trustees began their work to identify which of the claimants have silicosis. Only those diagnosed with silicosis by the Trust's medical assessment panel (COMP) were eligible for compensation. And within those who

have silicosis, claims could only be paid if claimants had two years of qualifying service on a specific list of mines.

On 2 September 2017, Lebohang Molise died at Quthing, Lesotho of Undetermined Causes, before attending the Q(h)ubeka Trust (QT) medical examination. His occupation was given as "farmer". He was 69 years old and died in the same village in which he had been born in 1949.

The Q(h)ubeka Process

In 2018, QT staff requested, and received, extensive employment and medical records for Mr Molise from the mining companies. These amounted to over 350 pages, all of which are saved on the CIMS computer system.

In March 2019, the District Administrator Quthing declared Lerato Emily Molise, wife of the deceased, to be the beneficiary of the estates of the late Lebohang Molise. In the same month, the TEBA office at Quthing provided a printed Record of Service that showed Mr Molise worked on the gold mines from 19-Jan-1969 to 2003, including 21 years of service on qualifying mines.

TEBA Contract Analysis				*Anonymised*			
1	2	3	4	5	6	7	8
Contract	Worked	Weeks		Mine	Home	Weeks	
1	19-Jan-69	52.0	18-Jan-70	Libanon Gold Mine	19-Jan-70	25.9	19-Jul-70
2	20-Jul-70	52.0	19-Jul-71	Free State Saaiplaas	20-Jul-71	30.6	19-Feb-72
3	21-Feb-72	52.0	19-Feb-73	Free State Saaiplaas	20-Feb-73	74.9	29-Jul-74
4	01-Aug-74	52.0	31-Jul-75	Free State Saaiplaas	01-Aug-75	34.0	26-Mar-76
5	26-Mar-76	52.0	25-Mar-77	Free State Saaiplaas	26-Mar-77	28.7	13-Oct-77
6	13-Oct-77	52.0	12-Oct-78	Free State Saaiplaas	13-Oct-78	65.0	11-Jan-80
7	11-Jan-80	52.0	09-Jan-81	Free State Saaiplaas	10-Jan-81	62.3	22-Mar-82
8	23-Mar-82	52.0	22-Mar-83	Free State Saaiplaas	23-Mar-83	65.9	26-Jun-84
9	28-Jun-84	52.0	27-Jun-85	Free State Saaiplaas	28-Jun-85	24.6	17-Dec-85
10	18-Dec-85	52.0	17-Dec-86	Free State Saaiplaas	18-Dec-86	8.6	16-Feb-87
11	18-Feb-87	52.0	17-Feb-88	Free State Saaiplaas	18-Feb-88	8.1	15-Apr-88
12	15-Apr-88	52.0	14-Apr-89	Free State Saaiplaas	15-Apr-89	5.6	24-May-89
13	24-May-89	52.0	23-May-90	Free State Saaiplaas	24-May-90	70.9	02-Oct-91
14	03-Oct-91	52.0	01-Oct-92	Free State Saaiplaas	02-Oct-92	3.3	25-Oct-92
15	27-Oct-92	48.6	02-Oct-93	Free State Saaiplaas	03-Oct-93	1.9	16-Oct-93
16	19-Oct-93	27.0	26-Apr-94	Free State Saaiplaas	27-Apr-94	-	27-Apr-94
17	27-Apr-94	52.0	26-Apr-95	Free State Saaiplaas	27-Apr-95	52.7	30-Apr-96
18	29-Apr-96	52.0	28-Apr-97	Free State Saaiplaas	29-Apr-97	1.9	12-May-97
19	12-May-97	52.0	11-May-98	Masimong	12-May-98	3.1	03-Jun-98
20	04-Jun-98	38.4	28-Feb-99	Masimong	01-Mar-99	20.3	21-Jul-99
21	24-Jul-99	51.9	21-Jul-00	Masimong	22-Jul-00	4.7	24-Aug-00
22	24-Aug-00	52.0	23-Aug-01	Masimong	24-Aug-01	9.3	28-Oct-01
23	28-Oct-01	52.0	27-Oct-02	Masimong	28-Oct-02	9.9	05-Jan-03
24	08-Jan-03	4.0	05-Feb-03	Masimong	06-Feb-03	**Medical termination**	
[25]	08-Jun-08	Not begun - medically unfit		Anglo Mining Services			
		22.3	Years at work			11.8	Years at home

Source: Trustees of the Q(h)ubeka Trust, from TEBA record sheet – anonymised data

In March and April 2019, Lerato Emily Molise, Mr Molise's 61 year old widow, and his wife for 36 years, signed the QT claim documents at the TEBA office at Quthing.

In September 2019, the Q(h)ubeka expert medical panel, COMP, assessed the exit medical certificate, MBOD certification and other medical records (spirometry) obtained from Harmony. COMP categorised Mr Molise as C4e – the most severe level of impairment, based on previous medical evidence.

On 13 October 2020, QT staff managed to speak to the son of the family to explain the payment process and the need for a bank account. He told them that "his mother will go to the bank on Thursday 15th ". This is noted in the CIMS computer record, but then there is nothing for two years. No further reason for delayed payment is written up in CIMS. The unexplained delays could be due to Covid disruption. Also the 'meeting place' for the claimant had been incorrectly recorded as Qachas Nek, instead of Quthing.

Eventually, QT field staff made contact with the family and on 26 May 2022 the QT head office received details of the Estate Late bank account. The claim was verified by Dr Judith Cornell, the manager of the Trust, and released for immediate payment. Because of the delays, both tranche payments were paid out in the same week: first R162,789, then R180,340. A total of R343,129 was paid into the Estate Late banking account in Maseru for the family of Lebohang Molise.

The life histories above are patchy and partial, drawn in part from coded computer printouts from the mines, where meanings are often obscure. There is no opportunity to reflect the rounded life of a human being from sources like these. But the details we have are important. They reflect lives of hard work and minimal reward.

They also reflect on the particularly cruel and destructive past practices of the system of migrant labour for black workers which developed in Southern Africa. Local mining company needs and government policies intersected with both resistance and compliance from rural societies that became the targets for meeting the demand for workers.

The three lives outlined above are of people who died where they were born. While they worked elsewhere, their wives and families stayed at home.

The burden of care for families, both children and the older generation, fell on the women. When the men returned, sick and broken, from the mines, it was the women at home who cared for them – and had to deal with the problems this fractured work system carried with it. The 'gender aspect' of mining, features only as a shadow in the stories from the mine records. The mines knew black workers had wives and children – they recorded parts of names and asked for numbers. But black wives and families were outside any system of care from the mines — in contrast to the wives and families of white workers, with custom-built communities, schools and health services, as well as recreational facilities such as golf courses and swimming pools, and special events like Christmas shows and gifts. The mines gave generous university bursaries to the children of their white employees. Gender and race are both components of the resulting injustice.

The Q(h)ubeka Trust has made a small but meaningful contribution to the struggle of working people for their rights. The wealthy gold mines never admitted any fault. Governments have never found the mines broke any laws. But the mines paid many millions of rand in a settlement, rather than be exposed by losing a court case against their employees.

This booklet draws on interviews with people who were involved in negotiating the trust deed with the mining companies, setting up and running the trust and assembling the medical and work experience records that were needed to establish compensation claims.

The interviews tell the story – but we need a framework to understand what the Trust accomplished.

This is provided by overall statistics, and by a general historical timeline. Our focus from now on is on what the Trustees – and the teams they set up – actually did.

The Numbers

The notes below give the split between claimants who were paid and those who were not paid; the amounts of compensation paid – and the spread across different provinces and countries.

The 4,365 claimants

4,365 former mineworkers signed up with a team of lawyers in 2011 for a court case against the gold mining companies. The workers were, in the words of the Trust Deed, "claiming damages for silicosis or silico-tuberculosis said to have been contracted by them as a result of their exposure to dust at certain shafts/operations for which Anglo American or AngloGold were alleged to be responsible."

The court case began in 2012, but after four years, before there was a judgment, it was settled "out of court". All the legal proceedings stopped; the mining companies did not have to admit they had been at fault in any way; and a trust was set up with funds from the mining companies to pay compensation to those workers who 'qualified'. The Trust was a 'closed' Trust. Only the named 4,365 claimants could submit claims, and the Trust Deed established basic rules the Trustees had to follow before they could pay a claimant.

- The first requirement was that all claimants had to undergo medical assessment. If they were still alive, they had to go for a medical examination. If they had died before the medical exam, the medical panel could look at documents in their medical history to see if there was good evidence that they had suffered from silicosis. Workers who did not have Silica Related Disease (SRD) could not be compensated by the Trustees.

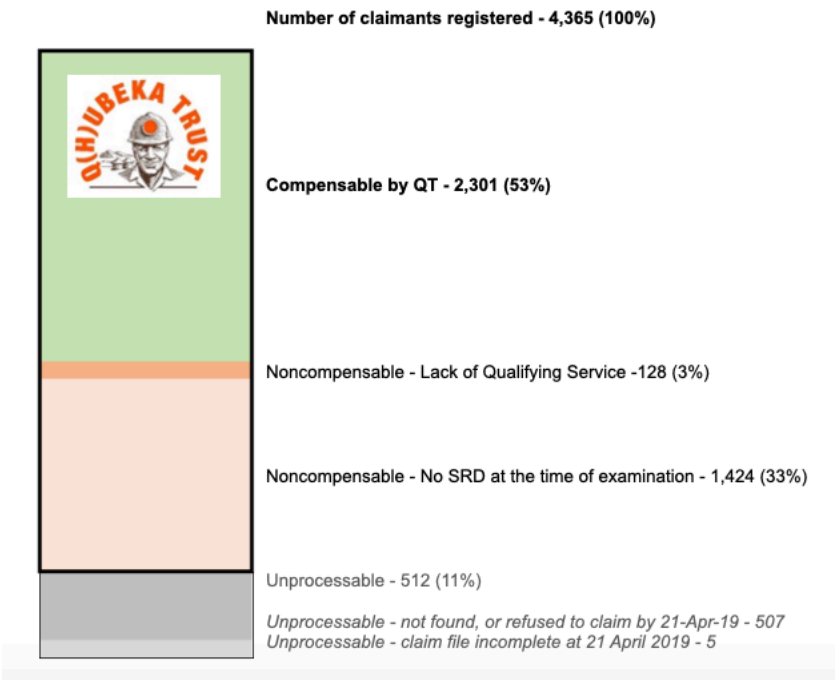
- The second requirement was that compensation could only be paid if there was solid proof that the worker had worked underground for at least two years at one of the gold mines listed in the Trust Deed. 128 claimants (3%) who were medically examined and had silicosis had worked in other mines. They lacked "qualifying service". The Trustees could not compensate them under the terms of the Trust Deed, but they sent the information to the Medical Bureau for Occupational Diseases (MBOD), to assist these workers at least to submit claims for statutory compensation from the government.

- The third requirement was that only claims lodged and fully processed within 3 years (by 21 April 2019) could be considered by the Trustees.

The three year time limit set for the Trustees meant they had to work fast. 85% of claimants (or families of claimants) were traced. The QT staff helped them to complete the claim forms and medical assessments by the deadline set by the Qualifying Period. The mines and TEBA provided recruitment and work records – when they could do so – for claimants to prove they had qualifying service. 3,725 claimants became "Qualifying Claimants" that the Trustees could consider for compensation in terms of the Trust Deed.

Despite all the efforts of the Trustees – and outreach teams in Eastern Cape, Lesotho, Gauteng, Free State and eSwatini – 507 of the original claimants could not be contacted or traced (or, on very few occasions, they refused to submit claims). In addition, there were 5 instances where

claim files were incomplete at the cut-off date. These 512 claims were marked "Unprocessable" on the computer system. In total, 11% of claimants dropped out of consideration for compensation. The bar graph shows how the 4,365 claimants were divided up:



The 3,853 who were medically assessed (with categories)

This is the letter the Trustees sent out for all the claimants who were diagnosed with silicosis (translated into Xhosa or Sotho, as required):

WHAT IS SILICOSIS

Silicosis is a dust-disease of the lungs caused by inhaling silica which comes from sand, rock or quartz, like the fine quartz dust one breathes in on South African gold mines. If too much dust is inhaled, the mine-worker is likely to develop silicosis.

Silicosis is scarring of the spongy parts of the lungs. The scars appear around the dust particles that are inhaled. Tiny scars forms around the millions of small air sacs in the lungs and these eventually over 10 or more years cause the mine-worker to have shortness of breath. Silicosis is diagnosed in former mine-workers using chest x-rays. Doctors also need to examine the former mine- worker and do lung function tests or blow tests, to see if there is loss of function and how bad the silicosis is.

A mine-worker with Silicosis usually gets TB more easily than a person with no silica dust in their lungs. Silicosis gets worse over time, and the scarring in the lungs can worsen over time even if the miner is no longer working in dusty conditions. This means that silicosis can develop many years after working on the mines. As the scarring worsens, the scars inside the lungs grow together and get bigger and bigger. If the scars grow to 1cm or more in size, it's called Pulmonary Massive Fibrosis (PMF), which is a definite worsening of silicosis. There is no specific treatment or cure for silicosis. People with silicosis should

be extra careful not to breathe in dust, and also ensure that any cough or other chest symptoms they develop gets treated early, especially because it might be TB which is worse in people with silicosis. It is also very important to avoid smoking as it will make the silicosis worse.

An independent panel of occupational medical specialists reads each and every file and chest x-ray of every claimant. They look at all the available tests and then categorize the former mine-worker's claim into one of five categories, being Category 0, Category 1, Category 2, Category 3, or Category 4. These categories are set out in the Trust Deed.

Category Explanation

Category 0	No silicosis is seen on the evidence (medical records) available.
Category 1	Silicosis, but there is no lung function loss, no TB nor Pulmonary Massive Fibrosis (PMF).
Category 2	Silicosis with either MILD lung function loss, or TB or PMF.
Category 3	Silicosis with MODERATE lung function loss. Claimants may or may not have TB or PMF as well.
Category 4	Silicosis with SEVERE lung function loss. Claimants may or may not have TB or PMF as well.

Outcome of Medical assessments

Unprocessable - not found, or refused to claim by 21-Apr-19	507							
Unprocessable - claim file incomplete	5							
Claimants medically assessed	3,853							
C0:Noncompensable - No SRD at the time of examination		1,424	C0					
Claimants dignosed with SRD		2,429		2,429				
			C1	970				
*includes **128** who are noncompensable by QT due to lack of qualifying service*					includes	C1(d)	166	
					includes	C1(s)	457	
			C2	996				
			C3	301				
			C4	162				
Number of claimants registered	4,365							

2429 minus 128 = 2,301 compensable by QT

The 2,301 who were awarded compensation for silicosis

The Trustees had a pool of money to divide up fairly between the qualifying claimants who were diagnosed with silicosis. (This was R395-million plus accrued investment income, amounting to a total of R425-million during the life of the Trust.)

The Trust Deed, specified that more compensation should be allocated to claimants with more severe impairment from silicosis. The Trustees relied on medical experts and actuaries (mathematical experts) for advice on how much to pay in each category. In general, within each category, more compensation was allocated to younger people – as they could be expected to live longer with silicosis.

The highest level of compensation awarded by the Q(h)ubeka Trustees was R397,003. This amount was paid for eight C4 claims, where the claimants were about 50 years old when they were medically examined. The compensation for the two oldest C4 claimants who were still alive in 2016 was set at R312,024. Both passed away before receiving their compensation – at the ages of 88 and 86 years. The money was paid to their families.

Payments were made in two lump sums, called 'tranches': the first was paid immediately a claimant's claim was fully verified (starting in 2017); the second was paid after 2021. It was only after all diagnoses had been finalised that the final distribution could be calculated exactly by the actuaries. The actuarial estimates proved very accurate with the second tranche just ten percent more than the first. The Covid pandemic, which started in 2020, delayed payments, as well as the struggle to find a way to pay claimants who died before they had a medical examination.

Summary of compensation ranges awarded by the Q(h)ubeka Trustees to the qualifying claimants

Diagnosed category			
C0	Noncompensable - No silicosis, so no compensation		
C1(s)*	R 62,404	to	R 81,596
C1	R 87,367	to	R 114,235
C2	R 196,575	to	R 250,111
C3	R 246,499	to	R 322,304
C4	R 312,024	to	R 397,003

* C1(s) compensation amounts were awarded when claimants had passed away before they had been medically examined, and where there were no medical records available. Medical experts developed a unique 'predictive model' to determine if there was sufficient evidence that claimants had been affected by silicosis. This model is described below and in the interviews.

The statutory compensation for silicosis paid by the government compensation system is far less than the Q(h)ubeka awards. From April 2022, the CCOD paid up to R71,605 for "1st degree compensation" and up to R159,444 for "2nd degree compensation". Tuberculosis benefits are 75% of lost earnings for up to six months, during TB treatment. TB without silicosis was not compensable by Q(h)ubeka. The Trust submitted claims to MBOD on behalf of 1,370 mineworkers that COMP diagnosed with SRD. 193 claims had still not been paid by June 2023

(according to QT records). The CCOD admitted to Parliament that it had a backlog of 85,972 unpaid claims in 2022, amounting to R1-billion.

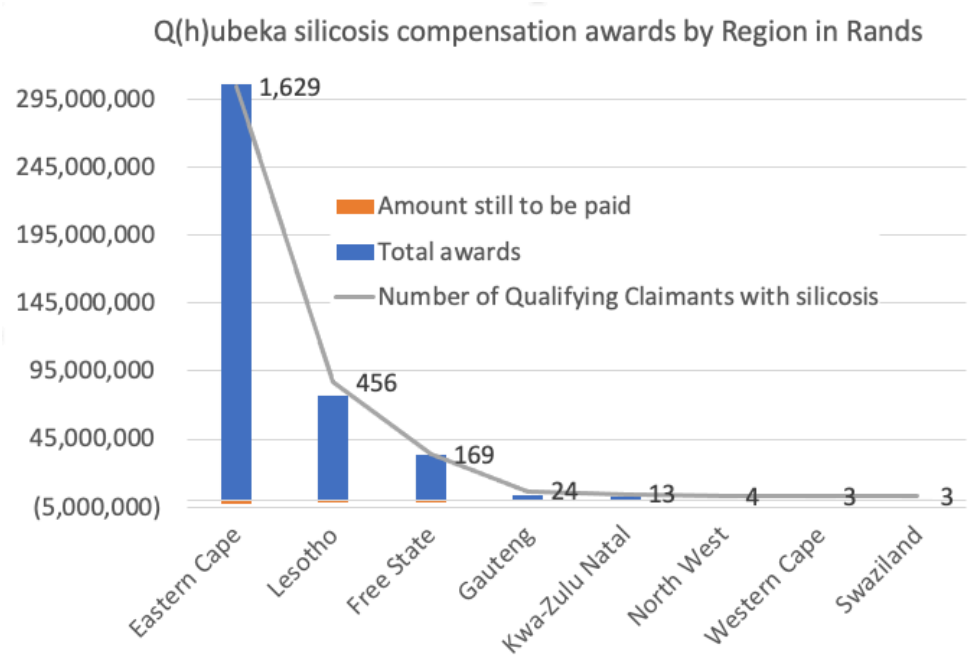
Q(h)ubeka Trust: Award payments over time

Year	Compensation payments	% paid	
2016	R 5,453,381	1%	
2017	R 88,592,144	22%	
2018	R 54,564,911	35%	
2019	R 24,448,674	41%	
2020	R 11,544,402	43%	*Payment delayed by the pandemic*
2021	R 168,193,154	83%	
2022	R 67,565,316	99%	
2023	R 1,427,162	99%	
Total paid up to 21 April 2023	R 421,789,144	**99.18%**	**of the compensation awarded was paid out during the life of the Trust**
Total unpaid	R 3,503,660	0.82%	saved securely, for families to claim
Total awards	**R 425,292,804**	**100.00%**	

The 2,301 compensation awards by Region at 21 April 2023

Region	Total compensation awards (Rands)	Amount still to be paid	Number of Claimants awarded compensation
Eastern Cape	306,355,893	(3,092,508)	1,629
Lesotho	77,254,610	(185,992)	456
Free State	33,651,383	(225,160)	169
Gauteng	3,522,585	-	24
Kwa-Zulu Natal	2,692,343	-	13
North West	858,571	-	4
Western Cape	525,148	-	3
Swaziland	432,271	-	3
Totals	425,292,804	(3,503,660)	2,301

Number still to be paid: 37



The 453 families paid where claimants died before medical examination

A unique feature of the Q(h)ubeka process was the decision of the Trustees to commission a scientific study that allowed the Trustees to provide compensation for the families of 453 claimants where no medical records were available from the mines, and who passed away before they could attend the medical examination.

These families are not entitled to any compensation under the state compensation system.

The existing individual medical records (if they could be found) did not yield sufficient proof that workers suffered from silicosis – but analysis of the medical data and work histories of workers who *had* been examined showed patterns that allowed a confident prediction of silicosis, depending on the exposure time to dust, the intensity of exposure revealed by work records and the length of service amongst other parameters.

Families across the region benefited from this compensation, which averaged R70,000 per family.

The action of the Q(h)ubeka Trustees – and the scientists who assisted them – marked an internationally significant development in compensation of workers for occupational diseases.

Because claimants had died, families had to produce proof that they were entitled to the estate, as wives, children or siblings of claimants. The very general lack of wills delayed and complicated the process of payment. (The Master's office in Mthatha, recognising the range of problems arising from intestate deaths, held a "Wills Week" in 2022 where Department of Justice officials helped people to make a will. This is a lesson other Trusts should take note of. – See the interview with Mzamo Dlamini, below.)

Claim Payments Analysis (Predictive Model C1s) - at 21 April 2023

Region	Total awards (Rands)	Amount still to be paid	Number of Claimants diagnosed because of the predictive model
Eastern Cape	23,358,369	1,055,265	330
Lesotho	6,534,049	71,803	94
Free State	1,520,748	71,803	21
Gauteng	220,505	-	3
Kwa-Zulu Natal	74,511	-	1
North West	77,020	-	1
Western Cape	64,257	-	1
Swaziland	137,948	-	2
Totals	**31,987,407**	**1,198,871**	**453**

Number still to be paid: 17 (21-Apr-23)

The 37 unpaid beneficiaries, and the amounts being held in trust for them

As the Q(h)ubeka Trust began to wind down its activities in 2022, the Trustees were worried about what would happen to the unclaimed compensation payments. They first investigated transferring the money due to these estates (all but one of the unpaid claimants had passed away) to the government. The Department of Justice manages a number of "Guardians Funds" that look after money due to the heirs of deceased estates.

It became clear that these funds are managed in a very inflexible manner. They require a detailed individual application before they will agree to take charge of any funds, and they will not indicate a time line for these decisions. The Trust had to close by 21 April 2023, so an alternative was found.

The alternative required an amendment of the Trust Deed – which proved more complex than imagined. But eventually the Trustees agreed with Fairheads Umbrella Trust that they will hold the remaining claims safely for the correct heirs to claim. Fairheads was registered in 1991 to manage death benefits under the Pension Funds Act. Today it is a 100% BEE company.

Q(h)ubeka Trust—Claim Data at 21 April 2023

Area	Compensable claimants	Total Award	Number where SOME payment is still due	Amount still owed	Amount paid to date to 2,264+16= 2,280 claimants	% of total amount paid	Number FULLY paid
Eastern Cape	1,629	R 306,355,893	32	R 3,092,508	R 303,263,385	99.0%	1,597
Free State	169	R 33,651,383	3	R 225,160	R 33,426,223	99.3%	166
Gauteng	24	R 3,522,585	0	R -	R 3,522,585	100.0%	24
KZN	13	R 2,692,343	0	R -	R 2,692,343	100.0%	13
Northwest	4	R 858,571	0	R -	R 858,571	100.0%	4
Western Cape	3	R 525,148	0	R -	R 525,148	100.0%	3
Lesotho	456	R 77,254,610	2	R 185,992	R 77,068,618	99.8%	454
Eswatini	3	R 432,271	0	R -	R 432,271	100.0%	3
TOTAL	**2,301**	**R 425,292,804**	**37**	**R 3,503,660**	**R 421,789,144**	**99.2%**	**2,264**

The table is complex because claims were paid in two tranches (roughly half and half). 2,264 claimants have been paid BOTH tranches and are fully paid. 16 claims have been partly paid (first tranche only) and 21 claims – all now for deceased claimants – have not been paid anything.

What the Q(h)ubeka Trustees did [‘sound-bite’ summary]

The lawyers gave the Q(h)ubeka Trustees a list of 4,365 claimants. They had all worked underground in South Africa’s deep and dusty gold mines. Together they sued the mining companies for dust-related lung diseases, which they believed were contracted from working in unsafe conditions in the mines.

The Trustees arranged 3,853 medical assessments by a panel of doctors and medical technicians. They determined that 2,301 were ‘qualifying claimants’ in terms of the trust deed, who could share in the compensation. The Trustees decided how much to pay claimants, depending in each case on their degree of sickness from silicosis and their age.

The Trustees had approved the payment of 98.8% of the compensation money by the time the Trust came to the end of its life on 21 April 2023.

Only 37 claims (amounting to R3.5-million) remained unclaimed, for reasons explained in detail below in the interviews. This money has been set aside for families to claim – as soon as they have all the necessary official documents from the Department of Home Affairs and the Courts.

The Historical Timeline of Q(h)ubeka Trust

Background to the establishment of the Trust.

The Q(h)ubeka Trust started with the settlement Agreement.

The Trustees had nothing to do with the court case – they were given the Trust Deed by the lawyers of the former mineworkers and the mining companies. The Trustees had no part in deciding the content of the Trust Deed. The Trustees are independent people – all experienced, and sharing expertise in law, justice, finance and occupational health. They were chosen by the lawyers and the "settlors" (the mining companies that provided the money for the Trust.)

The Trust Deed was agreed between the attorneys representing ex gold mineworkers (Leigh Day & Company and Mbuyisa Neale Attorneys), and Anglo American South Africa Limited (AASA) and AngloGold Ashanti Limited (AGA).

The Trust began its life on 22 April 2016, when the Q(h)ubeka Trust Deed was formally registered with the Master of the High Court, Gauteng.

The first job of the Trustees was to identify which of the claimants had silicosis. Only those diagnosed with silicosis by the Trust's medical assessment panel (COMP) were eligible for compensation. And within those who had SRD, claimants could only be paid if they had at least two years of qualifying service on a specific list of mines that had been managed by 'Anglo'.

A timeline is needed to appreciate the achievement of the Trust.

Over many decades, mineworkers were subjected to a dusty and unhealthy working environment underground. The mine-owners followed the laws that applied but these proved inadequate when it came to health and safety. There was sufficient research to show to both the government of the day and mine-owners that the working conditions were hazardous to the health of mine employees. The workers – represented to different degrees in a range of trades unions – were unable to match the power of business and the state, but they did secure statutory compensation systems when they suffered harm at work. The laws were intended to medically assist and compensate workers for occupational diseases and for injuries at work – if they survived. And to compensate widows and dependants if workers died because of their work.

The laws were often not effective. They discriminated unfairly against black workers. The compensation payment amounts were low and rarely adjusted for inflation. In addition, the statutory compensation system, even today, is very poorly resourced. In 2022, the Compensation Commissioner for Occupational Diseases revealed to Parliament that his organisation had a backlog of over 80 thousand unpaid claims.

Q(h)ubeka ended its life with 37 unpaid claims. Enormous efforts lie behind this achievement.

Date	***Timeline Details*** *[background developments are given in italics]*
2011	*The Constitutional Court rules - after some five years of court battles - that mineworkers can sue their employers for compensation if they suffer from occupational diseases. Lawyers now develop specific court cases to force the mines to pay compensation.*
2011	Lawyers Leigh Day & Co and Mbuyisa Neale Attorneys visit mining labour recruitment areas in Eastern Cape, Lesotho, Free State, Gauteng and Swaziland (eSwatini) to sign up former mineworkers from 'Anglo' gold mines to join a court case to demand compensation for silicosis from the mining companies, Anglo American South Africa Limited and AngloGold Ashanti Limited.
2012	The "Qubeka" court case begins and continues for another four years as the lawyers argue. (This is different from the silicosis class action case which led to the establishment of Tshiamiso Trust in 2020.)
Jun-2015	The lawyers organise x-rays for a random sample of 116 potential claimants, to determine the likelihood that a claimant would have silicosis, and to what degree of severity. 55% of the sample have silicosis and 11% have moderate or severe impairment. By 2015, 6% of the original potential claimants have died. Families will still get compensation, provided there is evidence that the claimant had contracted silicosis.
Mar-2016	The Q(h)ubeka Trust Deed, the legal document establishing the Trust and naming the first trustees, is signed, after Anglo American South Africa and AngloGold Ashanti reach a negotiated settlement with the lawyers. The settlement is 'closed' and applies *only* to the 4,365 named claimants, not to any others of the hundreds of thousands of mineworkers who were victims of occupational diseases. The Trust Deed also limits compensation to silicosis only - it does not pay for tuberculosis.

<u>Appointment of trustees:</u>

The Trustees of the Q(h)ubeka Trust:

Mr Goolam Aboobaker; Dr Sophia Kisting-Cairncross, Chairperson; Mr John Doidge; Ms Alicia Kistan

22-Apr-2016 **The Q(h)ubeka Trust is registered with the Master of the High Court, Gauteng.**

Groundwork in setting up infrastructure

The Trustees begin the work to identify which of the claimants have silicosis. Only those diagnosed with silicosis by the Trust's medical assessment panel (COMP) are eligible for compensation. And among those with silicosis, claims may only be paid if claimants have two years of qualifying service on a specific list of mines that had been managed by 'Anglo'. Trustees have a strict time limit of three years to medically assess claimants. Claimants (or their families) who do not formally apply to the Trust for compensation by 21 April 2019 cannot receive compensation from Q(h)ubeka. This is an absolute stipulation in the Trust Deed.

25-May-2016 The mining companies pay an initial R300-million into the Trust bank account. They also pay R8-million to cover administration expenses, as the Trustees set in motion the machinery to recruit staff, trace claimants, process claims, and conduct the medical assessments. They appoint managerial and administrative staff and the recruit medical experts to undertake the work.

Reaching out to claimants

2016 “Trustees made a first visit to the Eastern Cape where about two thirds of the Q(h)ubeka claimants were resident. We had the singular honour of meeting with Mr Qubeka and to witness his dignity and resolve to live his best life with debilitating silicosis. We visited both public and private medical service providers, radiologists and radiographers to assist us with the examination of claimants. We subsequently visited Lesotho and the Free State. These visits provided trustees with the unique opportunity to meet with claimants and service providers in person. This was most enabling to all of us. It also sensitised us to the local conditions and helped us to have a deeper understanding of the context within which our claimants lived and in which our service providers operate.” – Dr Sophia Kisting-Cairncross

2016 As the staff trace the claimants from 2011, they are all referred to local doctors and clinics for X-Rays and lung function tests. Medical assessment by the independent panel of medical experts (COMP) reviews every set of results. There are five diagnoses. Where no SRD is found, claimants are categorised as Category 0. Otherwise they are grouped from Category 1 to Category 4 (which is "Silicosis with SEVERE lung function loss….")

In every case where silicosis is diagnosed, Q(h)ubeka Trust submits all the medical and other documentation to MBOD to support a claim for government statutory compensation for silicosis.

The actuaries appointed by the Trustees submit a proposed table of awards for the different degrees of silicosis. They propose paying a 'first tranche' to claimants, as soon as they are diagnosed, with a second tranche to follow after 2 years or so, when the diagnosis for every claimant has been determined. (See the interview with Gary Scott, below)

Sep-2016 Over 2,852 qualifying claimants have submitted claims, so the mining companies make an additional deposit of R50-million into the Trust bank account to pay compensation.

Payment of the 'first tranche' begins in December 2016

09-Dec-2016 Just 8 months after the establishment of the Trust, **the four Trustees approve the first Compensation payment from the Trust.** The award is R163,613 to a 66 year old former loco driver in Tsolo, who had been diagnosed as suffering from "C4 silicosis with severe lung function loss" by the expert medical panel. This is the first of two tranches of what will be a total payment of R344,866 by 2021. Sadly, the claimant died in 2018, but the second tranche payment was paid to his widow.

Feb-2017 Over 3,291 qualifying claimants have submitted claims, so the mining companies make an additional deposit of R45-million into the Trust bank account to pay compensation. This is the final payment, as the next threshold for payment in the Trust Deed (of 3,729 qualifying claimants) was not met. This brings the total amount paid out by the Settlors for silicosis compensation to R395-million.

Jun-2017 Between June and September 2017, the mining companies pay over a final amount of R10-million to fund the day-to-day operations of the Trust.

2018 2018 to 2022: Tracing agents appointed by the Q(h)ubeka Trust visit last known addresses to contact claimants and their families. They are assisted by QT head office and outreach staff, by TEBA and by the MDA (Mineworkers Development Agency).

22-Apr-2019 **End of the three year 'Qualifying Claims Period'.** Only claims lodged with the Trust before this date are eligible for consideration for the payment of compensation by the Trustees.

2019 Development of the predictive model

At the end of 2019, all the living claimants have been medically assessed, and most have been paid the first tranche (about half) of their compensation.

The Trust Deed allows for compensation for the families of claimants who died before they could be medically examined either by the MBOD or by the Q(h)ubeka Trust, provided the Trustees have 'sufficient evidence' to believe they had silicosis.

The Trustees initiate the development of a "predictive model", based on statistical modelling, which enables medical certification for compensation in cases where there were insufficient medical records available for deceased claimants. The QT predictive model is an entirely novel development in the field of certification for occupational lung disease compensation. The Trustees were able to compensate over 400 families who are not entitled to apply for government compensation for silicosis.

Clause 16.2 (ii) 1 in the Trust Deed –

> *For the avoidance of any doubt, Dependant Claimants shall not be entitled to compensation unless the Trustees are reasonably satisfied that the deceased had contracted silicosis. Such assessment shall be by reference to medical records, such as (but not limited to) post mortem results, clinical records and chest x- rays, by reference to the deceased's employment history and/**or any other evidence that the Trustees deem to be credible and reliable**.*

This clause was interpreted by the Trustees to allow development of a predictive model by medical experts to determine whether it was possible, by means of statistical modelling, to estimate the

probability of deceased claimants with insufficient medical information having had silicosis at the time of their deaths.

Dr Mohamed Jeebhay – Professor of Occupational Medicine, UCT Medical School, explained

"I worked with distinguished local and international epidemiologists on the statistical analysis of the QT database of medically certified claimants to create a "predictive model". This was capable of accurately assigning claimants with incomplete medical records to the 4 categories of disease. A second study was undertaken by a different team of scientists to refine this model, and it was finally accepted by the Trustees for the purposes of compensation of dependents of these deceased miners. The model was applied in each individual case with the data available on them, to decide whether, and how much, to compensate their dependents. A panel of four specialists scored these cases and reported to the Trust on them, for payment in the 2nd phase of operations. There were around 400 such cases decided by this method."

The predictive model is the subject of a peer-reviewed academic journal article:

Myers, J.E., Thompson, M.L. Statistical modelling to predict silicosis risk in deceased Southern African gold miners without medical evaluation. *S Afr J Sci.* 2022;118(7/8), Art. #12502. https://doi.org/10.17159/sajs.2022/12502

[See the interviews below with Professors Jeebhay, Myers and Thompson.]

2020 *AngloGold Ashanti sells its last remaining mine in South Africa. Neither of the companies involved in settling the Q(h)ubeka case – both international mining giants - has any further interest in gold mining in South Africa.*

2020 The COVID Pandemic hits South Africa and the world. The government declares a state of disaster. It imposes strict 'lockdowns' that severely limit movement of people and, consequently, Q(h)ubeka claims processing and payment.

08-Sep-20 **The Trust pays the first claim for a deceased claimant found to have silicosis based on the predictive model.**

Payment of the 'second tranche' begins in December 2020

2020 From December 2020: The Trust begins to pay the **second tranche** of compensation to the 2,301 qualifying claimants who were awarded silicosis compensation. Award amounts in the second tranche are about 10 per cent more than the first tranche.

Where claimants have passed away before being fully paid, Q(h)ubeka Trust writes to the local office of the Department of Justice to ask for the details of "the individual who has been appointed Executor of the deceased's Estate". No direct reply is ever received to any of these letters. The families have to be found. Organisations of ex-mineworkers, the Mineworkers Development Agency, TEBA and officials of the Office of the Premier, Eastern Cape provide assistance to the Trustees and QT outreach teams.

2022 There are still over 100 claims that have not been paid, due to various problems (outlined in detail in the interviews below). The Trustees seek and get the agreement of the Settlors of the Trust to extend its legal life for an additional year, to 21 April 2023.

01-Oct-22 The Trustees ask Sr Nodu Nolokwe to go to Mthatha for the last 2 months before the office winds down, to liaise with the Office of the Premier and the Deputy Master

of the Mthatha Court and help to get documents finalised for claims. [See the interview with Sr Nolokwe, below.]

2022 Everyone struggles with the intense load shedding: cell phone towers run out of power and communications are cut, and courts and all government offices—and some banks—have to close completely during the persistent cuts in Eskom power. People struggle to get the help they need and end up having to go back to court, Home Affairs offices and banks, again and again. The Trust helps with transport money for claimants and family members.

2022 As allowed in the Trust Deed, the Trustees had made anonymised data from the work of the Trust available to academic researchers. The first result of this policy is **a scientific research paper published** in the *International Journal of Environmental Research and Public Health*

03-Dec-22 Last official work day for the outreach team based in the Eastern Cape. The Lesotho and Welkom outreach teams (with their work largely finished) had already been disbanded. Several of the former field workers, in Lesotho and in the Eastern Cape, continue to provide assistance to families to lodge claims.

Dec-2022 **The Trustees approve the payment of the final claim - bringing the total number of compensation awards to qualifying claimants to 2,301.**

31-Jan-23 Mthatha and Johannesburg offices of the Trust close; remaining staff all work remotely.

Mar-2023 The settlors of the Trust agree to a proposal from the Trustees that all remaining 40-or-so unpaid claims should be lodged with a third party so that there is more time for families to claim. This requires an amendment of the Trust Deed - which is delayed by legal requirements until April 2023.

Apr-23 453 C1(s) claimants have been awarded R32-million by the Q(h)ubeka Trust, based on its Predictive Model. By 3 April 2023 all but 17 of these claims had been fully paid to the families. The money for the few unpaid claims is now held safely in trust, in the hope that the families will come forward. They each need a Letter of Authority (LOA) from the court to claim.

None of the claims of C1(s) claimants has been forwarded to the MBOD because the law does not recognise claims by the families of deceased mineworkers unless they have been proved to have silicosis by an MBOD medical examination or an autopsy. There is no sign that the government is planning to change the law and to remedy what Q(h)ubeka Trust's Predictive Model research has shown to be an avoidable injustice.

21-Apr-23 Q(h)ubeka Trust comes to the planned end of its existence, after distributing over R420-million to qualifying claimants who were diagnosed with silicosis - or to their families. 98.8% of claims had been paid by this time and the 37 unpaid claims have now been transferred to Fairheads Umbrella Trust who will pay when the heirs to the claimants can be confirmed.

The Interviews

Interviews have been edited for length and clarity. Interviews were conducted by Peter Lewis in 2022/23, on behalf of the Trustees, with footnotes added to clarify issues.

Experiences of the Lead Attorney, Q(h)ubeka Trustees and Staff

The Litigation and Settlement: 2003 to 2016

Contribution from Richard Meeran, Lead Attorney, Leigh Day UK

Background to the litigation

In early 2003, around the time of the settlement of the South African asbestos miners' litigation against Cape plc, Leigh Day was approached by a community organisation in Welkom in the Free State with a request to assist ex-gold miners in seeking compensation for silicosis.

We turned to Professor Tony Davies of the National Institute for Occupational Health (NIOH) for information about the silicosis and TB among South African gold miners and about the conditions on the gold mines. Tony and Prof David Rees from NIOH and Professors Jonny Myers, Rodney Ehrlich and Sophie Kisting from the Occupational and Environmental Health Unit at the University of Cape Town, were crucial in providing invaluable expert explanation and evaluation throughout the following 13 years of the litigation. Their assistance had also been vital in the Cape plc case.

It was obvious that there were broad parallels between asbestos-related diseases and silicosis in South Africa, in terms of the nature, causes and scale of the diseases, the flagrant disregard of the health of mineworkers by the industries involved, and the lack of access to justice or meaningful compensation available to affected workers and their next of kin. A key medical difference was the absence among gold miners of an equivalent of mesothelioma but the existence of silicosis in an environment of endemic TB. The key difference, legally, was that whereas Cape plc was domiciled, and could therefore be sued in England, the gold mining companies were all South African, which meant legal action in the South African courts appeared to be the only option. Given that the Cape plc case had been allowed by the UK Supreme Court to proceed in England on the basis that funding for legal representation (in the form of legal aid or lawyers willing to act on a contingency basis) was unlikely to be available in South Africa, contemplating legal action against the gold mining industry in the South African courts was daunting. Had we known then that the litigation would continue until 2016, it is doubtful whether it would have been considered feasible.

South African litigation must be conducted by South African attorneys. The Legal Resources Centre, who had assisted Leigh Day on the Cape plc case, decided to act as attorneys with Leigh Day as their consultants. The South African Legal Aid Board was approached regarding funding. Having been in a state of bankruptcy in 1999, public funding for civil damages cases had fortunately been reinstated and the Board had established an Impact Services Unit to fund strategic litigation. The Board indicated that funding could in principle be made available to fund the expenses of test case litigation, and the fees of the LRC and the advocates. It was never

proposed that the Board would pay Leigh Day, who effectively agreed to act on a no win no fee basis (and ultimately did not receive any payment at all for the silicosis litigation until 2016). The funding arrangements were approved by the Law Society.

During the same time, discussions took place with senior officials of Government and the National Union of Mineworkers. It was made clear that Government did not want us to pursue silicosis litigation for gold miners on the grounds that the industry had claimed that the gold mines were operating on the margins of profitability and that litigation would threaten the economy of the industry and jobs. This however did not take account of the rights of injured and disabled workers and their families. For the first few years, the NUM sat on the fence, no doubt for the same reasons.

The position of the Government and NUM contrasted, strikingly, with their previous active and vociferous support for the Cape plc victims. Of course, at the time of the legal action against Cape plc, it had no operations, investments, or employees in South Africa. To emphasise the difference, the Minister of Justice at the time – who had personally driven the Government intervention in the UK Supreme Court, in support of the continuance in the UK courts of the case against Cape plc – criticised the involvement of foreign lawyers (namely Leigh Day) in the prospective silicosis litigation. That said, the timing was perhaps unfortunate, as it closely followed in the wake of the announcement of the controversial Apartheid Reparations litigation in the United States.

Strategic litigation

Five key factors determined the legal strategy that was pursued from 2004 when the first cases were instituted, until the Mankayi decision of the Constitutional Court in 2011 (concerning the right of miners to sue their employer for occupational disease), and the Supreme Court of Appeal decision in the Children's Resource Centre v Pioneer Foods case in 2013[1] (confirming the availability of opt-out class actions in South Africa).

First, the prevailing, though uncertain, opinion among South African lawyers was that the bar against suing an employer – contained in the Compensation for Occupational and Industrial Diseases Act (COIDA), which had replaced the colonial Workmen's Compensation Act, applied to claims by mineworkers, even though miners' compensation was dealt with under different legislation, the Occupational Diseases in Mines and Works Act (ODMWA), which paid lower compensation than COIDA.

Secondly, the alternative to a claim against the employer (that is, the operating subsidiary of the mining house) was a claim against mining house parent company, but this was subject to the so-called "corporate veil" hurdle, which renders shareholders legally immune, save in specific circumstances, from the liabilities of companies in which they invest. At that time, although we had, through UK cases against Cape plc, Thor Chemicals and Rio Tinto, been trying to develop the concept of a parent company duty of care under English law, the principles had not been confirmed, and there had not been any cases on point in South Africa.

Thirdly, opt-out class actions, by which a representative can bring a claim on behalf of a wider class, had not been endorsed in South Africa. The scale of silicosis however was such that it would have been practically and financially impossible to obtain instructions and institute claims on

[1] Trustees for the time being of Children's Resource Centre Trust and Others v Pioneer Food (Pty) Ltd and Others (050/2012) [2012] ZASCA 182

behalf of every victim. Moreover, the priority was to seek to establish the legal principles under which silicosis victims generally could obtain compensation.

Fourthly, the complexity of mining operations and potential variation between the operations, over a period of decades, of different corporate groups, meant that pursuing claims on behalf of miners employed on different mines by different companies, would entail a huge amount of investigation factual and technical information, which would detract from the need to focus resources on the objective of establishing the legal principles of liability. The fact that miners frequently worked at many mines during their careers of 20 years or so, exacerbated this problem.

Fifthly, it was clear that black miners who had worked underground had the highest dust exposures, and risks of contracting silicosis and TB.

The President Steyn miners' test cases (Alpheos Blom & Others)

In view of the above, a decision was taken to focus attention on underground miners at one mine, President Steyn in the Free State, and one corporate defendant, Anglo American South Africa Ltd (AASA). As with AASA's gold mines in general, the work force had largely comprised miners from the former migrant labour sending regions of the Eastern Cape and Lesotho.

From 2004, test cases were filed in the Johannesburg High Court against AASA on behalf of 23 black miners who had been diagnosed with silicosis or silico-tuberculosis and who had worked, exclusively or predominantly, for many years, as underground miners on the President Steyn mine for the President Steyn Gold Mining Company Ltd, a former AASA subsidiary. The diagnoses were confirmed by the NIOH.

The case progressed slowly for several years. A significant reason for this was a series of legal challenges (known in the jargon as "exceptions") raised by AASA against the formulation of the claims. These were underpinned by the COIDA definition of "employer" as including "anyone controlling the business of the employer". (As indicated above, COIDA bars claims against an employer, and it was understood at that time that COIDA applied to mineworkers). AASA's exceptions were designed to elicit the clarification that an allegation of control of President Steyn by AASA was an essential condition of the claims and thus barred by COIDA. Whilst the claims were based on an allegation that AASA had negligently advised, or failed to advise, the mine with respect to health and safety risks, AASA's argument was that unless it was alleged that AASA was able to ensure that its advice was heeded (that is, through control of the subsidiary) there would be no causative link between any failure on the part of AASA and harm to miners. Consequently, in further clarifying the allegations, a careful balance had to be struck which translated into a viable legal claim without falling into the trap of alleging control. The need to walk this tightrope ended following Richard Spoor's victory in Mankayi.

The evidence of negligence of the gold mining industry, with respect to silicosis and silico-tuberculosis in black miners, was already compelling. However, the President Steyn miners' case was given a specific boost by the publication, in 2008, of an epidemiological study by Girdler Brown et al. showing high dust exposures and high rates of TB and silicosis (almost 25 percent) among former President Steyn miners from Lesotho.[2]

[2] The Burden of Silicosis, Pulmonary Tuberculosis and COPD Among Former Basotho Goldminers, Brendan V. Girdler-Brown, Neil W. White, Rodney I. Ehrlich, and Gavin J. Churchyard, *American Journal of Industrial Medicine* 51:640–647 (2008)

The slow progression of the litigation and deaths of 8 of the 23 original claimants prompted an agreement with AASA to remove the case from court and to switch to arbitration of the case before three arbitrators who had been appeal court justices: Sandile Ngcobo (former Chief Justice and President of the Constitutional Court), Noel Hurt and Ian Farlam (who chaired the Marikana Inquiry). The case was settled on a confidential basis for substantial damages in 2013.

The Mankayi judgment

In March 2011, in Richard Spoor's landmark case of Mankayi, the Constitutional Court decided that the COIDA bar did not apply to miners who fell within ODMWA.[3] Consequently, miners were able to sue their employer. In most instances the operating company employers were defunct and employer's liability insurance was unavailable, as this had only been required for higher paid employees who did not fall within ODMWA. (As explained below, a notable exception was AngloGold Ashanti, which had remained the employer of miners at the Vaal Reefs mine where Mr Mankayi had been employed). Consequently, in practice, the legal benefit of Mankayi to gold mining silicosis victims was that it permitted claims to be advanced against mining house parent companies on the basis of their negligent control of mining operations (such a control allegation by mineworkers no longer carrying the risk of falling foul of the COIDA bar).

The Flatela Vava proceedings

Under EU law, to which the UK was subject prior to Brexit, a defendant that was domiciled in an EU state could be sued in the courts of that state as of right. The domicile of a company was defined to include the place of its central administration. Anglo American plc ('AAplc'), based in London, had become the headquarters of the group in 1999. Although there was no basis for assigning liability to AAplc (as its coming into existence post-dated silicosis), there did appear to be potentially valid grounds for arguing that the place of the central administration of AASA was in London where AAplc was based and from where important financial and strategic decisions that applied to AASA, which held all the group's South African mining assets. The advantage of English proceedings was that they were likely to be much speedier.

Thus, following the Mankayi ruling, Leigh Day, began taking instructions from ex-miners who had worked on a range of former AASA mines (including President Steyn), with a view to pursuing their claims in England. Proceedings were commenced at the end of 2011. Predictably, AASA challenged jurisdiction, specifically the contention that their place of central administration and domicile was England. Having initially forced AASA to disclose documents that would shed light on this issue, the High Court and then the Court of Appeal in 2013 upheld AASA's contention and dismissed the UK proceedings.[4]

The Qubeka case

The claims that had been filed in England were then instituted by the LRC in the Johannesburg High Court and later developed into the Qubeka proceedings.

Following the 2013 decision of the Supreme Court of Appeal in the Children's Resource Centre v Pioneer Foods case (run by Charles Abrahams), Richard Spoor and Charles Abrahams, backed respectively by US class action lawyers, Motley Rice and Hausfeld, began developing a gold miners' silicosis class action. Initially, the LRC with Leigh Day had contemplated including the Qubeka claimants in this endeavour. Indeed, the argument for transmission of general damages

[3] Mankayi v AngloGold Ashanti Ltd (CCT 40/10) [2011]

[4] *Young v Anglo American South Africa Limited & Ors* [2014] EWCA Civ 1130 – this appeal case addressed issues in the "Vava" action, *Flatela Vava and others v Anglo American South Africa Limited.*

for pain and suffering to the estate of a deceased miner, so that it could be claimed by widows - that ultimately succeeded before the court in the class action and changed South African law on the issue - emanated from our contribution to the class action application, and reflected the position under UK law, where legislation ensuring such transmission had been in place since 1934.

In due course however, Leigh Day and Zanele Mbuyisa, a South African attorney who had worked with us from the days of the Cape plc case and had established her own firm, Mbuyisa Neale (MN), concluded that the class action route was not in the best interests of the Qubeka claimants, for three reasons. First, the age and state of health of the claimants meant that speed in securing compensation was as important as its amount. Secondly, the proposed class action was against 32 mining companies and certification was bound to be hard fought and protracted. By contrast, the Qubeka proceedings were making progress and could not be challenged on jurisdictional grounds. Thirdly, the Qubeka claimants had all been identified, and in many cases subject already to confirmation of work history and silicosis diagnosis, the members of the class had yet to identified. It was inevitable that this would make the class action process, including settlement, far lengthier. In the circumstances, there was a divergence between the Qubeka proceedings and the class action, with MN and Leigh Day, decided to continue the Qubeka proceedings and the LRC joining the class action group.

Instructions were taken from further ex-miners from AASA's 13 former gold mines in respect of which, prior to 1998, AASA had been the head office parent company. One of these was Vaal Reefs, operated by AngloGold Ashanti ('AGA') which was therefore the direct employer of the Vaal Reefs miners. This was important. In a claim against a parent company it would be necessary not just to prove that the operations were conducted negligently but also that the involvement of the parent company was sufficiently significant as to impose a legal duty on the parent to safeguard the health of mine workers. However, in a claim against an employer, such a legal duty was axiomatic. Prior to 1998, AngloGold Ashanti (then known as Vaal Reefs Gold Mining Company) and the Vaal Reefs mine had been part of the AASA group. Consequently, it was possible for silicosis claims by former Vaal Reefs miners to be brought against AGA or AASA. For the reasons indicated however, a claim against AGA had one less significant layer of factual and legal complexity to prove.

Ultimately, there were a total of 4,365 claims. Proceedings against AASA – comprising claimants who had worked on AASA's former gold mines, apart from Vaal Reefs, formed one group, and proceedings against AGA, on behalf of former Vaal Reefs miners, formed the other group.

To obtain instructions from, and advise, each of these individual claimants, Zanele and MN, assisted by Leigh Day, spent substantial periods over a few years, and on numerous occasions, travelling to communities across the Free State, Eastern Cape and Lesotho, seeing former miners who wished to pursue claims. 65 percent of the claimants were from Eastern Cape, 27 percent were from Lesotho and 7 percent were from the Free State. Their average age was 61.

Arbitrations against AASA and AngloGold

Although it had been concluded that the class action route was contrary to the interests of the Qubeka claimants, the speed of litigation in South Africa remained a general concern, and indeed, as indicated above, it was for this reason that agreement had been reached with AASA to arbitrate the President Steyn miners' test cases.

For the same reasons, separate arbitration agreements were reached with both AASA and AGA with respect to the Qubeka claims. The same arbitrators, Ngcobo, Hurt and Farlam, were appointed to the dispute with AASA and the three arbitrators for the dispute with AGA were Farlam, former Supreme Court of Appeal President, Craig Howie and Schalk Burger SC. Arbitration would have been a less attractive option if the normal rules of private proceedings and trial judgments and sharing of the costs of proceedings had applied. However, it was agreed that the hearings and trial judgments of the Qubeka arbitrations would be public, and AASA and AGA agreed to bear the costs of the arbitrations. Having three highly experienced arbitrators hearing the case (rather than a single judge) and no appeals, was a significant further attraction of arbitration.

Negligence of the gold mining with respect to silicosis and silico-tuberculosis

The scale of the silicosis epidemic was clear from a series of epidemiological studies that were published from the end of the 90s onwards. These studies indicated that in the region of 25 percent of long-term black miners had developed silicosis and that these miners also had high rates of TB.

Given that tens of thousands of gold miners contracted silicosis and that systemic and widespread excessive levels of dust exposure must have occurred in order generate this level of disease, negligence might be assumed to be obvious. However, an essential element of negligence was proof that the companies knew, or ought to have known at the time that the operations presented a foreseeable and unacceptable risk of silicosis and that they failed to take reasonable steps to eliminate or reduce the risk sufficiently. In this regard the inexcusable failure of the industry to conduct epidemiological studies on silicosis increased the difficulty in demonstrating prior awareness. However, there was evidence from some published studies and within the extensive discovery of tens of thousands of documents produced by AASA during the litigation, from which the legal team and the experts were able to compile a compelling case on negligence.

One study that was central to issue of negligence was published in 1972 on data from a Dr Beadle, who had been the leading mining industry expert on dust monitoring during the 1950s and 60s. Their dust exposure/silicosis risk curves indicated that at the dust levels that were present on the mine, an underground miner employed for 20 years had approximately a 15 percent chance of contracting silicosis. Although I did not appreciate at the time that he was referring to the work of Beadle, I remember Dr Rudy du Toit, another eminent mining industry expert, who had in the later years of his career had worked at NIOH, hand drawing and explaining these silicosis curves over a couple of tea at his home in 2003 and my being completely stunned by the obvious implications.

BEADLE'S CURVES[5]

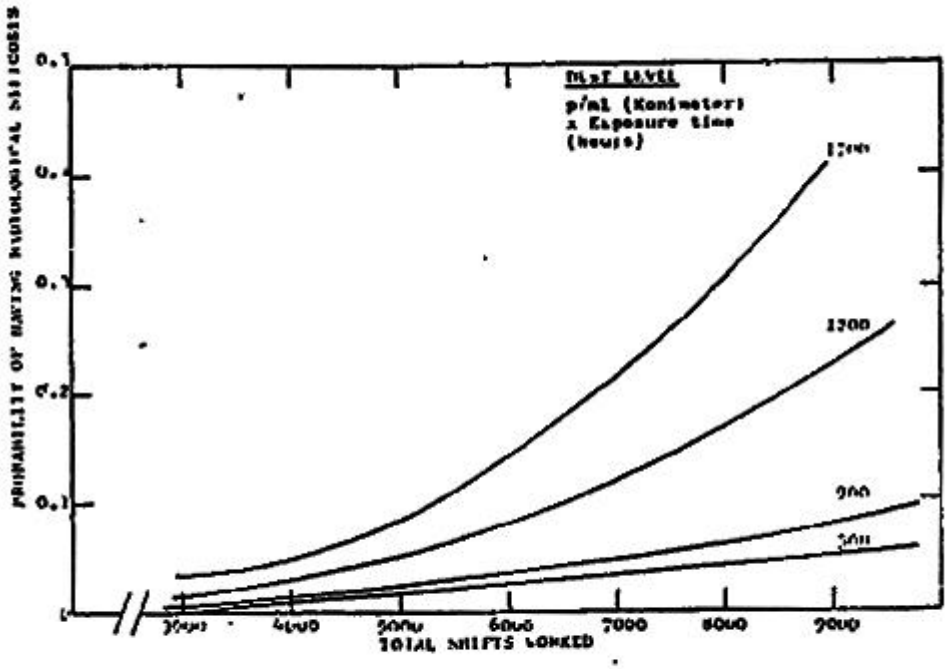


Fig. 5—Probability of having radiological silicosis at the stated number of shifts for dust levels as measured by the Konimeter

The 1994 Leon Commission concluded that dust levels on the mines had not improved for 30 years. The corollary was that the mines had continued operating under the same conditions for 20 years knowing that long-term underground miners were being subjected to a 15 percent risk of silicosis. Given that they were also aware of increased risk of TB, in circumstances where silicosis sufferers were more susceptible to TB, and where TB was known to be endemic in the migrant labour-sending communities from which the miners came, allowing this state of affairs to continue was scandalous.

As the conclusion of the arbitrations approached, powerful reports on negligence were obtained from eminent medical and mining experts including Professors Rodney Ehrlich, Jonny Myers and David Rees. Reports on dust measurement and conditions and the adequacy of dust prevention on the mines were obtained from mining engineers, Professor Dave Verma (McMaster University, Ontario), Professor Raja Ramani (Penn State University) and Bob Haney (formerly an expert with NIOSH, the US national health and safety regulator).

Settlement and the Q(h)ubeka Trust

Settlement negotiations began in 2015. The most significant challenge was over the total amount of damages. The problem was that the companies' failure to monitor and keep records of the health of miners meant that the vast majority of claimants did not have proof that they had contracted silicosis. Neither was it possible to use the published epidemiological studies to calculate the rate and severity of silicosis among the claimant group. The absence of information on the incidence and severity of silicosis among the claimant group created a stalemate in that as

[5] Page Shipp RJ and Harris E. A study of the dust exposure of South African white gold miners. *Journal of the South African Institute of Mining and Metallurgy* 1972; 73(1):10-24

a matter of caution, the claimants' lawyers wanted the defendants to set aside a total sum that reflected a maximum incidence and severity of silicosis, but the defendants were not prepared to agree to this.

The impasse was broken by developing an approach of which we had had experience in the Cape plc case. There, the company had required radiological examination of batches of 200 x-rays of the claimants selected at random. It was evident that the asbestosis rate in the second 200 was the same as in the first set of 200. Even though Cape insisted on a review of 5000 x-rays, the rate remained unchanged. A statistician advised that a random sample of at least 110 individuals should be a representative of the group of 4,365. A computer program was used to generate a random sample of 120 individuals from an alphabetical list of the claimants. These claimants were x-rayed by a mobile team and their x-rays were reviewed by independent radiologists and clinicians. They advised that 55 percent of the claimant group had silicosis (a rate which I believe corresponds to that observed by the Q(h)ubeka Trust). This information and data were provided to AASA and AGA and enabled an overall damages figure to be negotiated.

The March 2016 settlement (by AASA and AGA) was reached prior to a 6-weeks trial scheduled for April 2016. It followed two and half years after the President Steyn miners' settlement and entailed an initial payment of R300 million, to be followed by further payments (up to a maximum of R461 million) depending on the total number of claimants who were found to qualify as having been employed on mines within the AASA group. Payments were to vary depending on the severity of silicosis and silico-tuberculosis and age of the claimant. Unlike the subsequent class action settlement, no compensation was payable to miners who contracted TB without silicosis. A further potential financial benefit under the settlement was to allocate the function to the Trust, of assisting claimants in making claims to the Medical Bureau of Occupational Diseases for statutory compensation under ODMWA.

Due to their advanced age and ill-health, deaths among the Qubeka group seemed to be accelerating. Initially, AASA declined to agree that widows should receive the pain and suffering entitlement of their late husbands. AASA were supported in that respect by the position at that time under South African law. This stipulated that such damages would only be transmitted if a defence had been filed at the time of death[6]. It was for this reason that instructions had not been taken in cases where death had already occurred. Nevertheless, the protracted nature of the proceedings combined with the age of the claimant group (averaging over 60), meant that between the start of the proceedings and the time of settlement, hundreds of deaths among the group occurred. Denying compensation to their widows would have been grossly unfair and unjust. AASA agreed that the widows should be eligible for compensation, after it was pointed out to them that, Mark Cutifani, then the CEO of Anglo American plc, had been reported to have recently visited the Vatican for spiritual guidance.

While the silicosis victims in the Qubeka case had all been alive when their instructions were taken, the same was obviously not true of gold mining silicosis victims in general. Thus due to the time that had elapsed before pursuing legal compensation claims became feasible, hundreds of thousands of miners with silicosis will have died, leaving widows and extended families impoverished. The legal impediment to transmission of general damages to the estate of a deceased person was an issue that was of even greater significance in the subsequent silicosis class action. In anticipation of that, the contrast between UK and South African law, and the

[6] This contrasts with UK law which provides for such transmission under the Law Reform (Miscellaneous Provisions) Act 1934

unfairness of the latter especially to widows of silicosis victims, was a point that we recommended should be pressed by the LRC in its class action submissions.

Since a substantial amount of work needed to be done to identify claimants work records, medically evaluate them, process claims under the terms of settlement and distribute compensation, a settlement trust was necessary to perform these functions. The Q(h)ubeka Trust, named to signify the lead claimant and the Xhosa word "to go forward" was accordingly established with an expert medical panel and administrative role. It was very reassuring to have the eminent and highly experienced combination of Dr Sophia Kisting chairing the Trust, with co-trustees, Goolam Aboobaker, John Doidge and Alicia Kistan. The implementation of the settlement has undoubtedly been a gruelling exercise and entirely the result of their efforts and expertise.

Some perspectives

The scale of the huge burden of silicosis among South African gold miners was unprecedented globally and constituted a public health disaster perpetrated by an exploitative and callous industry. The industry continued, for decades, to expose black miners to levels of dusts that it knew would cause them to contract silicosis but avoided accountability and payment of compensation, by failing to carry out studies into silicosis and due to obstacles to victims' access to justice. During that period, a substantial proportion of victims will have contracted silicosis and died, thereby reducing the final compensation bill to the industry. The lack of proper work records kept by the industry has increased this injustice.

In addition, the relationship between silicosis and endemic TB in impoverished former migrant labour sending regions – so aptly described by Professor Tony Davies as 'a river of disease flowing out of the gold mines' - has served to significantly worsen the scale and severity of silicosis in a South African context and represents an elevation of the tragedy of exploitation and disregard by the gold mining industry to another plane.

Nevertheless, not before time, the malpractices of the gold mining industry have been exposed and the companies have been held to account, legally, by the series of cases outlined here and culminating in the silicosis class action settlement. It is the combination of these cases and the strategies and collaborations that they entailed that has led to this outcome. First, the assistance of the Legal Aid Board in funding the President Steyn test cases and the collaboration between the LRC, Zanele Mbuyisa and Leigh Day. Secondly, the Mankayi and Children's Resource Centre judgments, which removed the shackles from miners' claims against 'anyone controlling the business of the employer' and enabled access to justice to be obtained for tens of thousands via a class action mechanism. Thirdly, the developing jurisprudence in the UK involving the principle of a parent company duty of care, which is likely to have influenced South African judges considering the position under South African law. Fourthly, AASA and the other mining companies involved in the class action would have been well aware of the progress achieved in the Qubeka proceedings with regard to evaluation of detailed technical and expert medical and mining evidence, which would have been deployed by the same experts in the class action. Fifthly, the settlement of the Qubeka claims and the Q(h)ubeka Trust, effectively as a pilot and model for the much larger ground-breaking class action settlement by Richard Spoor and Charles Abrahams, which led to the establishment of the Tshiamiso Trust.

Finally, an important feature of these cases has been the collaboration between South African and foreign lawyers. This has enabled victims to fight powerful corporations on a more level,

albeit still uneven, playing field. Hopefully, this will serve as a salutary warning to all corporations to be more mindful of the health and safety of their workers.

Richard Meeran, Leigh Day, June 2023

The Q(h)ubeka Trustees

Dr Sophia Kisting-Cairncross, Occupational Medicine Specialist, Trust Chairperson the Q(h)ubeka Board

Clause 8.2 (111) the Q(h)ubeka Trust Deed states:

> "The Trustees shall at all times comprise at least one Occupational Medicine Specialist with minimum of 10 years' experience, one attorney or advocate with at least 10 years' experience, and 1 trustee with at least 8 years' experience as qualified chartered accountant".

This influenced the composition of the Board of four trustees as well as the responsibilities the Trustees carried through-out the life of the Trust.

I worked with Richard Meeran and his colleagues on the Cape Plc. asbestos case. This was mainly through engagement in my work with the Industrial Health Research Group (IHRG) at the University of Cape Town. It concerned asbestos exposed workers in mines, asbestos-cement factories, power stations and more. Community members were exposed when their environments were extensively contaminated by asbestos mining as well as the wide use of asbestos-cement products especially in housing for the poor. My overall involvement in the historic Parliamentary Asbestos Summit was part of the process. I was a trustee of the short-lived Hendrik Africa Trust that was born after the Cape Plc. settlement. Tragically for South African claimants Cape reneged on the settlement agreement and the Trust could not continue to operate. Very little money was made available directly to banks to pay out claimants in South Africa [7]. It was however a very important learning experience for me to meet and engage with Sarah Leigh, Richard Meeran and their colleagues in Leigh Day in the UK. It so much deepened my understanding of the interconnectedness of work in different countries and the legal and human rights of workers in the context of preventable sickness from work.

In 2003 I was asked by Richard Spoor, the lawyer leading the litigation that created the Asbestos Relief Trust (ART) to be a Trustee along with Mr Crosby Moni,[8] the late NUM Deputy Vice

[7] https://asbestostrust.co.za/

[8] https://num.org.za/News-Reports-Speeches/ArticleID/282/NUM-mourns-the-passing-away-of-its-former-deputy-president-comrade-Crosby-Moni

President elect. Crosby and I were appointed from the claimant's side. John Doidge was appointed the chairperson of the ART. John taught me the importance of understanding Trust Deeds well and how to work within the prescriptions of the Trust Deed yet try your utmost for the beneficiaries. I set up the initial medical process of the ART and the majority of those service providers engaged continued with the ART and subsequently the Q(h)ubeka Trust. To this day I remember how wonderful it was in 2003 to have the late Prof Neil White as well as the former professor of radiology at UCT, Prof Hillel Goodman joining our Trust certification panels. They both had a profound impact on our work.

The ART was a very positive experience, and so when Richard Meeran and Zanele Mbuyisa[9] invited me as an occupational medicine specialist on to the Q(h)ubeka Trust Board, I agreed and regarded it as a duty to assist the disadvantaged and uncompensated workers sick with silicosis and silico-tuberculosis. Q(h)ubeka is the very first settlement in the overall public domain for silicosis in the gold mines in South Africa. That is significant. The details of the Blom settlement which preceded Q(h)ubeka was not in the public domain, and it did not have a Board of Trustees implementing the object of a Trust Deed.

There were great opportunities and great challenges in the Q(h)ubeka Trust. The three-year claims qualifying period prescribed in the Trust Deed created enormous challenges for trustees. We were rightfully anxious and concerned that three years to locate, examine and compensate all 4,365 mineworkers or their relatives was insufficient given the enormous challenges we faced. About 42% of the Q(h)ubeka Trust claimants have passed away. That is significant, more so from the gender perspective. The service and medical records obtained from the mining companies were often incomplete and of poor quality. At times woefully so, especially for the older mineworkers. It is amazing what the medical records of mineworkers tell us about the conditions under which they worked and the diseases and injuries they battled stoically as well as their discharge from duty for ill-health and their poverty. These records were almost too painful to go through as there was at times a lack of respect evident including misspelling of names. Often many workers were assigned to a single birth date such as 1 January of different years. It is our hope that some of our young researchers will record these problems lest we forget and repeat the injustice to the lives of men and families who helped to build the wealth of their countries.

It was not always easy to provide medical services as close to sick mineworkers as possible, ensure compliance with the requirements of the Trust Deed through training, monitoring and quality assurance and constantly reach out to new areas. We approached both public and private service providers. In the end we had an excellent group of local service providers. We owe the doctors, nurses, radiographers, radiologists, pathologists and other medical colleagues an enormous gratitude for their very professional and dedicated services. We were deeply saddened to learn of the passing of the dedicated Dr Nobuntu Songca in the Eastern Cape during the COVID pandemic. Many workers spoke highly of her medical services. She has left a void not only for her family but for mineworkers who had great faith in her services

Trustees had to engage with the field work on a regular basis during those first three years. In the first six months it was like working double shifts without a break. I vividly recall my fellow trustees painstakingly engaging with the banks in those early months to sort out the many hurdles for mineworkers, especially biometrics and opening of bank accounts in far flung rural areas. Many banks did not have biometric services in place at the start of the Trust. Payments in two tranches, often widely separated, made for an enormous workload for staff and for ourselves.

[9] https://mbmlaw.co.za/about-us/

However, the workload was tempered by the fact that we were facilitating and reaching forgotten former mineworkers, bringing that long awaited medical examination and possible compensation closer to them. We observed the enormous struggle of women and children seeking a measure of justice when the mineworkers have passed away.

What kept me motivated was working with my fellow trustees, meeting with Richard Meeran and Zanele Mbuyiso, the competence and dedication of staff and especially meeting some of the mine workers in person. Hearing the workers' stories and listening to their families in the Eastern Cape, Lesotho, Eswatini, Free State and beyond, and believing that every day we must anchor ourselves by affirming that we must try our utmost to sort out compensation. It became a sacred task! We can say we have examined the workers but unless we overcome all the challenges right to the point where claimants actually get their money in their pockets, we have failed. We worked to ensure sick workers have their money in their pockets!

The Q(h)ubeka Trustees submitted claims on behalf of 1,370 claimants to the MBOD for certification and possible payment by the CCOD. This included claimants who did not qualify for Q(h)ubeka compensation as they did not have sufficient qualifying service, but potentially qualified for statutory compensation.

Our collaboration with the MBOD/CCOD has been of critical importance as we could harness our mutual strengths to provide possible additional compensation for mineworkers already compensated by the Trust but also for those diagnosed with Tuberculosis or other occupational lung diseases.

On 1 November 2022, the Trustees wrote to the CCOD to ask for a report on the outcomes of the applications QT had made on behalf of its claimants for statutory compensation. We are awaiting a full report.

According to the data available to the Trustees in June 2023, there are 193 claimants that the MBOD certified with a compensable disease but where payment has not yet been made by the CCOD. The Trustees are hopeful that the great majority of the remainder of the 1,370 workers, on behalf of whom they submitted specific compensation application data-sets, have received the compensation due to them. However, in some cases where a Q(h)ubeka claimant was diagnosed by the Trust certification panel as suffering from a silica related disease, the MBOD did not find signs of compensable disease. These claimants were paid by the Trustees but have not been passed for payment by the MBOD. The Trustees asked the MBOD to review these cases. The MBOD readily agreed to do so and that process has started. We are awaiting the report on their findings. We continue to collaborate with both the MBOD and the CCOD in order to assist more mineworkers to obtain compensation.

Our compensation work for mineworkers benefitted from the collaboration with the Office of the Premier of the Eastern Cape and the Eastern Cape Ex-Mineworkers Council. This has come about in the latter part of the work of the Trust. We are appreciative of the assistance provided through collaboration, networking and the experience, knowledge and wisdom shared. We hope to continue to strengthen this collaboration in the future.

Research was very important for the Q(h)ubeka Trustees. Once the Trust data was as complete as possible, trustees posted a research policy on the website indicating that anonymised data can be made available for research purposes. Any researcher especially locally, nationally and

regionally, but globally as well, can utilize the data provided they meet the research policy criteria. The primary requirement is that the research must further public health and the health of mineworkers and contribute to the prevention of silicosis and TB and other occupational lung diseases in Africa and beyond. Thus far three studies have been completed. The third study is being finalised. The published studies are:

1. Statistical modelling to predict silicosis risk in deceased Southern African gold miners without medical evaluation. *South African Journal of Science* https://sajs.co.za/article/view/12502 .

2. The Utility of Length of Mining Service and Latency in Predicting Silicosis among Claimants to a Compensation Trust. https://pubmed.ncbi.nlm.nih.gov/35329249/ .

The trustees will make available the anonymised data for research to different academic and other entities for future research.

At the request of the trustees, national and international specialists used research on the Q(h)ubeka Trust data to develop a predictive model to determine whether, in the absence of medical records, a claimant who died before he was medically examined by the Trust, may have had silicosis. In this way 453 deceased claimants were diagnosed with silicosis. The research related to this predictive model is in the public domain and can be found at the following link: https://sajs.co.za/article/view/12502. This collective effort has been of enormous importance to the families of deceased mineworkers. It is our hope that this research will be emulated for the greater benefit of other families awaiting compensation. We are grateful to all the researchers who have contributed for their dedication, their profound professionalism and for doing the work at no cost or very little cost.

Artificial intelligence is being used to develop algorithms to read chest X-rays for TB and thus far met with reasonable success. We haven't arrived at a model yet that can robustly work for silicosis. There is absolutely no reason why we cannot use the new developments in science and technology to the benefit of those who have been disadvantaged through history, work and illness. Otherwise, they remain uncompensated. I hope that making our anonymised data available for future research will continue to encourage researchers to do research on the data. We will make the anonymised data available for further research at academic institutions under their ethical and professional guidance. Our young scholars, students and academics, especially the children of mineworkers from our labour sending areas across southern Africa, will then be able to take up some of this research, build on it and hopefully enrich it for greater prevention of these crippling diseases.

If I assess our impact, I would hope our work has helped to further highlight the urgent need for greater and ongoing *prevention* of silicosis and TB at workplaces. I believe the very high prevalence of silicosis and TB found among older Q(h)ubeka workers is close to the true burden of disease. This suggest an underdiagnosis of silicosis in our region which we should urgently address.

A settlement trust is a prescribed legal entity with a short lifetime, and it has a limited brief with certain tasks that must be carried out. But it can be very prescriptive and sometimes problematic to fully implement. On the other hand, these trusts have been an enormous step forward for many, many workers and families in southern Africa to achieve a measure of redress and social justice. Going forward, we are in great need of a compensation system that is preventive of occupational diseases and injuries. Litigation and Settlement Trusts cannot replace the great

need for a well-funded and well-resourced statutory compensation system in the public domain in southern Africa. It is of paramount importance that the various parts of such a system are interdependent. These include the different levels of our governments, the medical profession, the legal profession, the nursing profession, the large numbers of community members who are both personal carers and health care service providers as well as the private health care services sector. Given the legacy of silicosis and tuberculosis in our country, with its history influenced by so many factors, including the legacy of the apartheid era, we cannot achieve such a reconstruction without coordination and interdependence of all these parts that take full account of human rights and gender equity.

As chairperson of the Q(h)ubeka Trust it is my honour to thank my fellow trustees, our dedicated staff, all our service providers, our many collaborators and our stakeholders. Our deepest appreciation go to the claimants and their families who made it possible for us to walk this journey with them. The struggle for prevention, good health and adequate compensation continues.

Derived from an Interview with Peter Lewis, 19-Nov-2022

John Doidge, Attorney and Trustee

I started my career as a qualified compositor in the printing industry. Later on, while working on the night shift for Creda Press, I studied law at the University of Cape Town and was admitted as an attorney at a law practice. I worked there for a while, and since then have been involved in Trusts of one kind or another for over forty years. I was general manager at Syfrets in charge of their fiduciary services and I've started a couple of companies in that field.

In 2003 I was approached to be a Trustee for the Asbestos Relief Trust. I remained there until about five years ago, when I resigned. That was where I met and worked with Dr Sophie Kisting, and some years later she approached me to find out if I was prepared to be a trustee of the Q(h)ubeka Trust when it was set up. My background in trusts had a lot to do about looking after widows and orphans, on the side of the angels, and I could identify with that. In the case of the Asbestos Relief and the Q(h)ubeka Trusts, the angels are the mine workers, and sometimes you have to go to battle for them to ensure they receive a fair deal when they become affected by one of the various diseases common to the industry.

With Trusts there is very often conflict. At various times there will be conflict between different branches of the family, especially where it comes to children of different spouses. Being on the side of the angels means you need the wisdom of Solomon.

As trustees of another trust, we had to deal with a case where people who were not eligible for compensation nevertheless demanded to be paid. The group was able to gain the support of senior politicians who requested us to hand over millions of Rands to the group because the trust had lots of money. Needless to say this did not happen.

In one matter, it was necessary to obtain an interdict against the Premier of one of the provinces to prevent undue interference in the affairs of the trust.

What a number of people don't understand is that the powers of a trustee are set out in the trust deed. In trusts like the Q(h)ubeka Trust, the beneficiaries are clearly spelt out as well as the amount of compensation due to them. The qualifying criteria to become a beneficiary are also very clear. The trust deed usually stipulates that the claimant must have worked for one of the parties establishing the trust and they must be medically certified to have been infected by diseases such as silicosis.

Every asset of the Trust must be accounted for and the financial records of the trust must be audited annually. Every decision of the trustees must be aimed at achieving the objectives of the trust. In the exercise of those decisions, trustees are obliged to consider their duty of care to the beneficiaries of the trust. Section 9(1) of the Trust Property Control Act requires that a trustee must exercise his powers with the care, diligence and skill of a person who manages the affairs of another. This is a very high objective standard and, I would suggest, is a higher standard than that required of a company director.

Before a Trustee can act, he or she has to apply for a Letter of Authority from the Master of the High Court. Until the trustee receives that authority, he is not authorised to act and any action taken by a trustee without that authority is void and cannot subsequently be ratified. There is sometimes a misperception that the Master appoints trustees. This is not the case, the parties creating the trust make the appointment, the Master grants the trustee the authority to act as trustee. Having granted the trustee the authority to act, the Master retains ultimate oversight over trusts.

I am extremely grateful for the time I spent as a trustee of the Asbestos Relief Trust. A huge amount of the spadework we did at that trust stood us in good stead when setting up the administration of the Q(h)ubeka Trust. Dr Kisting was involved as a trustee of with the Asbestos Relief Trust at the outset and helped set up the medical screening processes which were adopted. Together with Dr Jim te Water Naudé, professional standards for X-rays and spirometry were established. Medical practitioners were given assistance in ensuring high quality spirometer readings at all times.

Turning more specifically to the Q(h)ubeka Trust, this trust, like all of the other similar trusts for the compensation of mine workers, is the consequence of an agreement flowing out of litigation. Attorneys for the mining houses involved, and the attorneys for the mineworkers affected by silicosis reached an out of court settlement. As part of the settlement, the trust was formed and the parties negotiated the terms of the trust deed as well as the quantum of money to be paid to the trust. The terms of the trust deed are very specific as to who is to benefit, the amount each is to benefit and the medical diagnosis required for compensation.

When we started on the Q(h)ubeka Trust, the biggest concern was that we only had a three-year window through which people could claim. Another challenge as that we then had a limited period of a further three years to pay qualifying beneficiaries. We set up offices in various catchment areas to reach out to potential beneficiaries. Every effort was made to locate the persons who were party to the out of court settlement. During the lifetime of the trust, a large number of beneficiaries passed away. This required us to locate the heirs and dependants of the deceased claimants and to make payments to them. The heirs of the deceased claimants needed to obtain letters of executorship from the Master of the High Court. As identity documents, birth certificates and the like were not always readily available, this has made the issue of letters of executorship very difficult to come by.

The trust deed required that the trustees use biometric testing to confirm the identity of the beneficiaries. This proved to be a huge challenge but was solved with the assistance of banks. Each beneficiary was required to open a bank account to receive payment. The banks, in turn, obtained biometric verification of the identity required by the trust deed.

Though the years of working with the Asbestos Relief Trust and the Q(h)ubeka Trust, a common feature was that it was very rare to receive complaints from Beneficiaries. It has, however, been quite common for persons with no direct interest in the affairs of the trusts to try to muscle in on the work of the trustees. Politicians were worst of all.

Despite these problems, however, there have been very good things happening along the way with the operational work of the Trust, and a lot of them were because of the legacy of skill and experience from the Asbestos Trust. For much of the life of the Trust we were able to employ Tina da Cruz as manager, who I had worked with for a long time on the Asbestos Trust. A lot of the spade work for the work had been done by the Asbestos Relief Trust. So, for example, there was an established medical panel that we used again for the Q(h)ubeka Trust, and they had invaluable experience in these things. Prof. Goodman is in his 80s, and it is unbelievable what he can see in a chest X-ray.

In comparison, with the Asbestos Relief Trust, the Q(h)ubeka Trust was quite simple insofar as we knew how many potential claimants there were that needed to be medically examined as well as their names and some other details. What made this trust more difficult is that in a large number of cases, all we had to go by was the names of the claimants and totally insufficient contact details. Staff had to visit remote villages to try to track down claimants or to find someone who might know the whereabouts of the claimants or their family. Having established that many of the claimants were deceased, it has often been extremely difficult to establish who should receive the compensation that was due to the claimant.

At the outset, the trustees visited the Eastern Cape to establish a panel of specialists who could perform the mandatory medical tests required in terms of the trust deed. We found that medical officers needed assistance with the production of ILO standard lung function tests so Sister Nodu was dispatched to assist with training for lung function tests. We were pleasantly surprised to find that many of the small to medium sized towns in the Eastern Cape had good X-ray facilities in the public and private health services. So, building on the experience from the Asbestos Trust, our specialist, Dr Jim te Water Naude, went down there to assist radiographers to produce ILO standard digital X-Rays to avoid having to redo any of them.

In Lesotho, we met with the Minister of Health. It was a real pleasure dealing with such a humble and down to earth man. The minister was very supportive of what we were doing and oiled the wheels to make our work there so much easier.

Q(h)ubeka was a pioneer in developing two or three panels of medical experts to get the medical certification work done in time, but readings of x-rays were often different between the panels. So under Dr Sophie Kisting's guidance we brought them all together in a workshop to standardise X-ray readings, so that there would be a standardisation of diagnosis in the system.

A unique feature of the Q(h)ubeka Trust deed is that it required the trustees to provide assistance to claimants to lodge compensation claims with the MBOD. The deed required that if the

claimants had not been paid within twelve months of submission of their claims, this was to be reported to the founders of the trust who were then required to institute litigation to claim the compensation. To avoid the need for litigation, the trustees established a working relationship with the MBOD. A dedicated person was hired by the trustees and placed in the offices of the MBOD to expedite the claims process, although this relationship was at times rather fractious.

The impact of litigation for occupational disease is limited by its very nature. Every single one of these claims is based on historical injury and on the idea of social justice for wrongs committed in the past, but they don't address the burden of future disease. So, they are not addressing the problem, which is that the MBOD and CCOD's funding should be massively boosted by government and employers. That would remove the need for these class action law suits because there will be enough money to find, examine and compensate miners over long periods of time. Most of the ex-mineworkers of the Q(h)ubeka Trust had not claimed from the MBOD. This is rather unfortunate as it is their absolute right to claim workmen's compensation.

Government and the mining industry need to urgently review the compensation system to ensure that ex-mineworkers get a fair deal. Class action law suits deal with the problems of the past, they do not create remedies for the future. It is essential that solutions are found for the future to avoid the needs for these class action cases.

The Department of Health should have rural clinics all over the place so that those people actually get their medical benefit examinations for the rest of their lives and get decent pay-outs as they get sicker.

I am pretty certain that there are going to be other class actions law suits following the silicosis cases. Human rights lawyers are looking at the impact of manganese, coal and other minerals on the health of mineworkers. There is a need for all role players to get together to create a master plan for the compensation of all mineworkers rather than to wait for the matters to go to court.

Mineworkers are deeply indebted to the outstanding pioneering work of Richard Spoor who won the support of the Constitutional Court to allow the class action suits to be launched. Others, like Richard Meeran from the UK, have established a base of case law which can be used in compensation cases in the future. Hopefully someday their courageous work will receive the recognition it deserves and will be recorded in the history of our country. Their efforts have resulted in close to R2 billion becoming available, to date, to compensate ill mineworkers.

Interview with Peter Lewis, 29-Sep-2022.

Goolam Aboobaker, Medical Physicist, Economist and Trustee

I was born in a village outside Surat, India, and was one of eight children born to Halima and Aboobaker Atcha. My dad, as a young boy of not more than 10 years of age, was left by his father with a trading family in Bulwer, KwaZulu-Natal. As an adult, my dad returned to India to marry and then visited every couple of years to spend time with his family. In 1952, he sent for my mother and their five children; we arrived and settled in Rossburgh, a small industrial area outside the city centre of Durban. They had three more children in South Africa. My dad worked practically all his adult life as a shop assistant; in his childhood, he was a domestic worker. His meagre income was supplemented by my mother who took on work as a dressmaker and a Madrassa teacher. Their collective efforts enabled all my siblings (besides my eldest sister who stayed at home to help with the 'house-work' and was in a sense a carer to her younger siblings, including myself) to complete their schooling and send five of us to university!

The late 1960s and the early 1970s was a period of heightened political activities much of it centred in Durban: the emergence of the Black Consciousness movement; the initiation of working class organisations like funeral benefit societies and trade unions. The 1973 Durban strikes and 1976 Soweto students uprising gave impetus to the political revival. In this period I became involved together with others in the building of mass-based civic organisations in Chatsworth and on the Cape Flats when I moved to Cape Town.

It was a 'perilous' path that led to my involvement in the launch of the United Democratic Front 40 years ago! It also led to me losing my job as a medical physicist at Groote Schuur Hospital in 1985, followed by a period in detention by the police under the State of Emergency that was declared later that same year. Thereafter, I took up a role as a special assistant and advisor to the Rector of the University of the Western Cape, Prof Jakes Gerwel. After 1994, I held posts in the Offices of President Mandela and President Mbeki.

In terms of education I gained an honours degree in Physics (1971) and years later a master's degree in economics (1992) at the School of Oriental and African Studies, University of London. I worked as a medical physicist at the King Edward VIII and Groote Schuur hospitals. I was involved in ANC activities from the early 1970s up to the 1994 elections, when I went full time into Public Service and gave up an active role in politics as I felt strongly about the separation between 'state and party.' I was the Director of Cabinet Research in the Office of President Mandela in 1994 and then moved to the newly established Policy Unit in the then Office the Deputy President Mbeki in 1998. I continued working in the Unit when Mbeki became President in 1999 until 2007. I spent three years between 2007 and 2010 as a representative of the SA government at the International Monetary Fund. On my return, I worked for the National Treasury responsible, *inter alia,* for liaison with National Economic Development and Labour Council (NEDLAC). Between 2013 and 2015 I was the CEO of the Government Pensions Administrative Agency.

It was both an honour and a privilege to be asked to serve as a Trustee for the Q(h)ubeka Trust. I tried to bring into the activities of the Trust the experience I had gained as an activist, a civil servant and administrator, and as a policy analyst.

Its establishment was an acknowledgement of the immense contribution of mineworkers from the Southern African region to the economic and social development of our country at great cost to their health, and in many instances resulting in a shorter life.

Establishing the work of the Trust entailed appointing a manager with a core administrative staff, establishing a Medical Panel to evaluate whether the claimants had silicosis, and the extent of the disease. Then we looked at what kind of structures we would require in the areas from where our claimants came. We anticipated that our main challenge would be finding as many of those claimants as possible. We had their names, a contact telephone number, and the regions from which they came. We had addresses on paper but quite often these had changed. Most of our claimants came from deep rural areas in the Transkei and from Lesotho. Our staff in Welkom, as well as in Mthatha and the ex-mineworkers of Lesotho contributed greatly. They were the foot soldiers who located our claimants and brought them to the medical doctor for an examination, a lung function test and a radiograph of their lungs.

Before the examinations, we had to establish what medical facilities were available to our claimants in the regions where they live. The Trustees went to the Transkei to inspect medical facilities in Matatiele, Butterworth, and Mthatha to see what kind of doctors they were and whether they would be able to conduct preliminary Medical Examinations. Some doctors had an X-ray machine but did not have the skills to interpret the radiographs adequately to diagnose silicosis. Often their staff or the medical doctor, not being a radiographer, did not have the skills to take good X-rays.

We came across a radiographer in Matatiele who had an X-ray machine which was quite old. She could take X-rays but didn't have the technology to digitise them so they could be sent on to specialists for review and medical certification for compensation. As an example of our capacity-building work, we contacted Discovery Health's enterprise development unit to help. They were very helpful, followed up with the radiographer and agreed to get her some newer technology. This enabled her to take many X-rays of good quality for our claimants. It also supported one of our aims in fulfilling the terms of the Trust Deed to leave behind skilled persons who would be of great value in the region, but also to the Tshiamiso Trust. So, the first part of the work was setting up those kinds of networks.

Skilled and experienced people would also come to us to assist us. Two of them had worked on the asbestos compensation Trust. One of them was Sister Nodu Nolokwe, a registered nurse who was a specialist in administering lung function tests - that was a huge, huge plus. She was wonderful in that she could also empathise with the workers she examined and is completely committed. Meeting and working with such people has been humbling and uplifting.

Our trip to the Eastern Cape at the beginning was very moving. We actually met Mr Qubeka, the man who was the first claimant in the litigation, and after whom the Trust was named. When we met him he looked like a strong and healthy individual, but after he walked about 50 steps you could see the difficulty he had with breathing. So, silicosis is quite a shifty disease - like a silent killer. You don't know you have it - only that something is making it difficult for you to breathe.

We had a similar experience when we visited our satellite office in Welkom. The Welkom staff filled a small hall with about 150 of our claimants who wanted an update on the claims process. In spite of their illnesses and age, they were patient, and full of gratitude when they received their first tranche of compensation. The Welkom Q(h)ubeka office staff were also very committed and would drive long distances to fetch people for the meetings.

There were two big challenges we had to meet: (i) getting the claimant to a doctor in the rural areas to undergo a medical evaluation, a lung function test and an X-ray; (ii) to establish expert panels in the metro area to review the medical information gathered for each claimant. This was a costly task in terms of time and resources.

At one point we realised that we were not going to meet the three-year deadline for the qualifying claims period for all 4,400 beneficiaries, so we investigated whether we could get the Deed amended with an extension on the time. We took legal advice and consulted a senior counsel on the matter and he advised that this was not possible. There were just over 500 beneficiaries who we were not able to trace and medically certify during the three year qualifying claims period. Of these, we estimate that about 300 may have had silicosis. Of course, we also cannot refer them to the Tshiamiso Trust either, because their Trust Deed excludes Q(h)ubeka claimants.

The exclusion of these Q(h)ubeka claimants from the Tshiamiso Trust appears iniquitous particularly for the reasons mentioned above. Another iniquity is that Q(h)ubeka Trust does not compensate for tuberculosis (TB), whereas the Tshiamiso Trust does. But again, our claimants cannot claim for TB there. Legally, there does not appear to be much that can be done on this issue. These 300 or so likely silicotic, many of them with uncompensated TB, continue to give us sleepless nights.

Another problem that also concerned us was how to compensate the dependents of those claimants who have died without having had medical benefit examinations, especially as we approached the end of our allotted time. Neither did the mining houses have records for these claimants. We knew that at least 63% of the deceased claimants could have had silicosis based on those living claimants we had examined and certified. But how do we know which of them would have died with silicosis, leaving a benefit for their families? There are only two ways of doing it: a verbal autopsy, or a statistical method for classifying each of them accurately. It turns out that verbal autopsy is very time-consuming and labour-intensive, and we didn't have time on our side.

On the statistical side, we engaged with three sets of epidemiological statisticians. The first one pinpointed only 10% of the deceased workers as having had silicosis with any degree of certainty. However, the second one developed the model further, until finally, the third model, which we call "the algorithm," hit the nail on the head. It was developed by Prof Jonny Myers, an industrial health specialist, and Prof Mary Lou Thompson, a biostatistician who lives in Seattle, USA. Their work was incredible, and they must be deeply thanked and complimented for what they did to solve our problem to identify the dependents (of our claimants) who had to be compensated. We had a few meetings with Prof Myers in which he explained the algorithm to us, and how accurate it was—100% for all intents and purposes. We then engaged senior legal counsel to advise us whether using it would be in harmony with the Trust Deed, and the answer came back positive. So, we went ahead, and hundreds of dependents were paid out on that basis. I *do* think that the method that was developed for us could be used in other settings where people get sick from work, but their medical records are insufficient to pinpoint the occupational cause. Their methodology may prove valuable in other industrial settings where workers are exposed to harmful air particles.

I think that litigation of the type that has led to the asbestos and silicosis settlements has been a huge help. It is an imaginative use of the strengths in our Constitution. There are so many potential class action issues, starting in the sphere of formal employment, such as the vast amount of unclaimed pension and provident fund money that has not been disbursed to those

entitled to it, and these people are from all over the subcontinent. Looking more widely, there are issues such as housing, and xenophobia and the dispossession that it has led to, that could be taken up as class action lawsuits.

I think the State's Legal Aid provision can be used to develop the class action law much further. This becomes more and more important as our organisational approaches to critical issues is weak and can gain from the legal initiatives that are ongoing. Our trade unions, and our civic organisations can be strengthened by them. In our case, there are the associations of ex-miners which the Trusts could and should engage, with the proviso that these organisations hold regular formal meetings with those they represent, who must take the important decisions, give mandates and the leadership take mandates from those they represent.

An idea worth exploring is whether the huge amount in unclaimed pension and provident funds could be used to establish a sovereign wealth fund that could be utilised for the benefit of poor communities, particularly for communities that have historically sent workers to the mines.

Interview with Peter Lewis, 3-Oct-2022.

Alicia Kistan, Chartered Accountant and Trustee

Before I joined the Trust I was employed at Anglo American, which is one of the settlors of the Q(h)ubeka Trust. Q(h)ubeka Trust exists because in the past, mining companies did not have the right processes for the safety, health and environmental side of their operations. Their interest was to get as much ore out of the ground at the least cost and the attention to responsible mining in those days, was hardly considered. The current leadership in mining , through evolution, learning from past mistakes and consequences such as death of miners through poor health conditions and practices, is now motivated to mine responsibly—which includes having standards on Safety, Health and Environmental conditions. We know that South Africa is a country that is very rich in mineral resources, and this is supposed to drive the betterment of the country, but the onus is upon miners to do it in the responsible way, giving credence to the ways of working that promotes good health of employees. This was my most important motivation for joining Q(h)ubeka Trust. Before that I didn't have any experience on this type of trust, so it was a big leap of faith for me.

The reason I was brought in is because I have a very strong financial background being a Chartered Accountant. I had no knowledge of the medical or legal side of the Trust, and my job is to ensure that the monthly financials are accurate, valid and complete. Together with the strong processes for financial management, there is governance behind every single number that appears in the financials because we are governed by the Trust Deed. The proof lies in the fact

that we have had clean financial audits every year of the Trust's existence. The trustees must manage the Trust with the best interests of the beneficiaries in mind within the governance framework provided by the Trust Deed. I had a fiduciary responsibility as well as a purely technical role to play in the financial management. The Trust is also a non-profit entity, and that is what differentiates it from a normal company.

When I started, I did not have all the context and it took a few weeks, maybe months, to actually understand how all the different aspects fit together. We had a compensation team of medical practitioners and doctors that were involved in the assessment of silicosis using X-rays, and sitting with them as they assessed whether silicosis was prevalent in a person's lungs and the severity thereof, was a major learning and eye-opener for me. I gained insight into the health issues being faced by our claimants, who are the beneficiaries, and even in financial management it is necessary to understand everything about why we are paying these people, why we will go to the *nth* degree to track and trace them so that they can actually get what is due to them.

When we started, the Trust had 4 trustees, a day-to-day overall manager, and a compensation panel of about 20 doctors from various specialisms, based in the 3 major cities in South Africa. Each panel had a leader, who had served on other similar Trusts like the Asbestos Relief Trust, though Q(h)ubeka was the first one to deal with the silicosis issue, so there was a learning curve for everyone. Then we had four nursing staff, who would assist the claimants with the medical tests that were required, such as lung function tests. They were based in Johannesburg, Mthatha, Lesotho, and Cape Town. Sadly, one of our senior nurses Sister Faieza Desai, passed away, which was an extremely emotional time for everyone. Some comfort was gained from that fact that she was engaged in a job that was her deep passion before she passed away.

We also had administrators and a financial manager, who worked under the General Manager to make sure linkages between all the moving parts were working smoothly, and that people got referred to the correct teams at the different stages of the work.

To find claimants, we engaged track and trace organisations to get the correct documentation to and from them, or their dependents if they had passed on. In the areas we were operating in, there could only be limited cooperation from government departments, as they did not have the means themselves to track and trace people, especially in rural areas.

Because of the locations, especially of our migrant workers, it's a huge challenge to track and trace people. People seem to have moved location all the time and you don't have postal addresses to assist with easy tracking. Employment records did not always easily confirm whether claimants qualified in terms of the 2 years minimum length of service in the mines covered by the settlement, and more work had to be done to corroborate evidence to ensure claimants were all dealt with properly and in line with the Trust Deed requirements.

Apart from these teams, we had financial auditors, and tax advisors to help us work in the most tax-efficient way possible. Trusts are legal persons, so for tax purposes they are treated as individuals, which are taxed at the highest proportion of income, unless tax experts are drawn in. Actuarial expertise was also required to determine pay-outs to claimants.

With hindsight, I think the Deed should have given the trustees a little more discretionary power. There were issues about the amount of time available for the Trust to do its work. What has kept me up at night is the thought that we wouldn't pay all the certified claimants within the life of the

trust, because they could not be traced by closure. If we could not pay tranche one to a beneficiary, it would have a knock-on effect for that person receiving tranche two of their compensation, because the tranche two payments for the different disease categories in the Trust Deed depended on how much of the settlement amount had been paid out in tranche one.

The epidemiological algorithm that was developed specifically for us by experts, Professor Johnny Myers and Professor Mary-Lou Thompson, was vital for us to have in time to pay all of the first tranche out to beneficiaries who had passed on. This was because it allowed us to decide whether dependents of miners who had died since the settlement should or should not be paid out, as they had passed on before they were medically certified as having silicosis. All we had beyond dispute for these miners was the fact that they had been claimants, that they had qualified in terms of the minimum two years length of service at the mine, and the work periods they had served in the mine. The algorithm then used our data on living mineworkers medically certified in different disease categories to decide to a very high degree of confidence what disease categories our deceased and undiagnosed miners would have fitted into. We, as Trustees, accepted that the algorithm developed was robust enough to ensure that the terms of the Trust Deed were satisfied, and that dependents who should have been paid tranche one, were paid out, and that those who should not be paid out were validly excluded. In turn, this enabled us to know how much money was left for the second payment to all claimants.

This algorithm was vital and because there was nothing like it available in all the scientific literature up to that point, it had to be developed from our own databases containing our own certification experience. We had a lot of discussion and debate with the epidemiologists who developed it, many a time late into the night. Greatest of appreciation goes out to them for the pain-staking, sterling work they produced on this algorithm, which has served a great cause!

We, as trustees, did consider another alternative to developing the algorithm, which was verbal autopsy – a highly specialised way to interview family members and people from other relevant agencies and professions, to make a diagnosis after death. However, this was rejected as an option because the degree of certainty in this method was not watertight and could have left us open to challenge.

All of this was done at great speed and under pressure, but with utmost care and diligence. We could not have risked further delay as this would have meant that more miners would die from their disease without seeing any payment, and the money then paid into the estate for dependents is not as much as would have been paid to living miners. It was a tricky balancing act!

The highlight for me was getting feedback from the beneficiaries. I did not have much interaction with beneficiaries, but we did invite some of them to our AGM's, and it was a very humbling experience. We had living proof of what we were trying to do, and every single one of those payments made everyone we were serving extremely grateful, which validated our hard work, and made it real. It is something I will never forget.

The covid lockdown was a low point because tracking and tracing had to be suspended, and we had to dig in our heels somewhat, and resolve issues whilst working from home. Our hands were tied by something that was greater than us, and beyond our control, so we asked the settlors for a one-year extension during phase 2 (the pay-outs) and got it because of the pandemic. Of course, some of our staff members and their families were affected directly by Covid as well, which had

an obvious impact on our work. We also have no way of knowing whether some of the beneficiaries died with covid.

The Trustees had some animated disagreements too, but it was only because everyone wanted to succeed in meeting the terms of the Trust Deed. So, in an environment such as this, maturity is key and one must see the big picture and the end goal and not take things personally, because everything we have done springs from the absolute duty of care that we have for the claimants, despite working in an uncharted environment.

Hindsight is always 20/20 vision. I think that we could have been a little bit more forceful with the settlors as well, when there were things they needed to have an influence in, like the CCOD and MBOD issues, that needed closing out. Our role was to register and assist the claimants to make claims from the Q(h)ubeka compensation settlement, and refer them on to the MBOD and CCOD for their statutory entitlement on top of that. What those organisations did with that work was the responsibility of the settlors and I believe, this could have had more focus and influence from them.

To assist, we even placed someone in the MBOD to assist them with their backlog and administration of our claims, at no cost to them. She had to look at their records of the beneficiaries and matched them with ours. Once that was done, there was still the fact that they had a different path to assessment, using different levels of severity with regard to silicosis. Looking at the difference between the proportion of silicosis diagnoses our doctors made in QT claimants and the MBOD's assessment, it is clear that one can't easily isolate silicosis from tuberculosis. My understanding is that TB is the visible manifestation, but silicosis is much more difficult to diagnose.

My thought on private litigation is that this this had happened because of injustices that were not addressed either by government or the mining industry. So, I am not seeing litigation as a strength, but rather as an alternative, which should never have been the case. Hopefully, in the future, things will be different. I am optimistic about the future as mining companies are now hiring people who are trained in disciplines related to occupational health and are passionate about it. It is a good thing that they are now bringing in strong, capable people who are properly financed to do their work. It also removes the need for a lawsuit which always leaves a bad taste, and has a limited function of mere remedy, whereas mining houses need a preventive health system that cares for the people without interruption and into the future.

I do think that government needs better processes and establish more clout. They need to be at the forefront propelling it, because there's definitely a huge difference in the quality of the output if there are consequences for poor organisation, missing coordination between different functions, and performance. Our government could learn from many private organizations, in the broader sense, about coordination between different types of services. They need to be all working towards the same goals, as we did in the Q(h)ubeka work. At QT, everybody knew what they were doing and there was immense collaboration between the different functions.

In the mining industry, the financial people will say we need to provide for lawsuits, maybe as a percentage of our bottom line. But I don't believe that today's CEO's think about it that way - there are so many different conversations we have about how these things can be prevented. In developing countries like those in Southern Africa the license to operate includes an obligation to create a certain number of jobs. The question is: what jobs can you create in a place where

education is lacking? That is the responsibility of the government. It's these types of jobs that put people's safety and health at risk and this is what happened in the past. If you look at the same situation in other gold mines in the developed world they are entirely mechanized, and the operatives just control the machine that digs underground, instead of people risking their health going underground. The jobs are different to ours, more elevated. Education and skills development takes away the desperation to do menial work as a livelihood. This in turn would solve the problem of working in environments where health is an inherent risk. Sadly, we could have started this 30 years ago, but we haven't and now we are still facing the problem of 30% unemployment in South Africa.

Interview with Peter Lewis, 30-Sep-2022.

Q(h)ubeka Management and Administration Work Streams

Tina Da Cruz, Attorney and Executive Manager of the Trust

When I was at a law school, I was offered articles with one of the attorneys representing a number of South African claimants who had brought a case in the UK against Cape Asbestos Mining PLC. They had no operating asbestos mines left in South Africa, so in essence the case was about damages for lung disease that they left behind them when they closed and exited their investment in South Africa.

After I qualified as an attorney, I went to work for Richard Meeran at the UK law firm on the Cape PLC court case. So, I spent some time in the UK working on it.

My family has some mining history, so it all seemed to come together and make sense. I had a great- uncle on my mother's side of the family, and they lived in Mozambique. He worked as a labourer in underground work in the gold mines in South Africa. He would travel to the mines on the train and return after his contract. Though I never met my great-uncle I grew up hearing stories about him from my mother and grandmother.

After working with Richard Meeran in London, I returned to South Africa and started working for Richard Spoor on two successive cases – the Asbestos case leading to the Kgalagadi Relief Trust,[10] and then came the start of the class action that led to the establishment of the Tshiamiso Trust. That is how I got into management of this kind of Trust work.

I started as the Q(h)ubeka Trust manager when it was into its sixth month of operation. The immediate challenge was to finalise the claimant information management system (CIMS) because it would have been very difficult to manage the documentation and claims from start to finish without an electronic system (*see interview with Ken Gliddon below for detail on CIMS*). At the time the track and tracing and medical examinations had started, and we had the list of the 4,365 claimants. I had to go out and find the balance of the claimants, beginning in the Eastern Cape where the bulk of them lived. I also had to establish our operations in Lesotho, and there were many challenges there. The claimants' data that we had received for Lesotho wasn't as comprehensive and consistent, so we had problems finding and confirming that we were dealing with the correct claimant.

[10] https://asbestostrust.co.za/krt/

We didn't always have sufficient information to confirm that the claimant met the two-year exposure criterion at the mines in question. We had quite a number of paper records that we got from the claimants' attorneys, so the first step was to upload those records and capture that information in CIMS. Confirming qualifying service was really a challenge for us. The paucity of information in previous mine data had us jumping through many hoops to try and find information and that was a challenge that we had to work at daily. We chased information until the very last day when we could accept claims. We had to physically count the days worked at AngloGold Ashanti mines.

And then second, of course, there is the confirmation of compensable disease in terms of the provisions of the trust deed, so we needed medical records generated by the mines during the course of the claimants' employment there, especially for the deceased claimants. We reached out to Anglo Gold Ashanti for those records, and they had to go through a legal process to release confidential medical records to us, but that was resolved eventually. I had to drive through to the mine hospital in Carletonville, which they were busy decommissioning, to pick up medical records from the claimants' entry medical examinations and the subsequent medicals each time they returned to the mine for another work contract, as well as the exit medical exams when they left the mine for good. These also helped fill in some of the gaps in their service records. We also approached TEBA. This was something the attorneys had also done but there were gaps. So, we agreed with TEBA that we would pilot a new process to try and find records of service based on biometric information. TEBA records are digitized, but they also have an archive of probably millions of pages of records dating back to the 1920's. The critical point is that they indexed records using the miners' fingerprints. So, where we had insufficient service information for a claimant, we agreed that they would take their fingerprints at their nearest TEBA office, which would then be sent to the TEBA national headquarters, who would try and find the person in their archives by searching and matching the fingerprints. They have specialised experts who can do that kind of work.

We also approached Harmony Gold. They took over some of the mines from AngloGold Ashanti, so we assumed that Harmony would have employment records handed over by AngloGold Ashanti when it sold. We had names and certain identifiers, but in some cases, particularly amongst the Lesotho claimants, we just had names and industry numbers, whilst in other cases names and passport numbers or ID numbers. It was a mixed bag. Harmony was very helpful with that as well, running the names through their database, and passing on what information they had to us. The collaboration was good. It really did take a lot of time, and three years seemed to go very fast for identifying gaps and looking for solutions.

Then of course, we also collaborated with the MBOD, with queries for information where they had a record of the person's exposure to risk work, which could corroborate claimants' work history. I think that part of our collaboration was successful, and we certainly did get the information we asked for if it existed.

At the end of the three-year verification of claims period of the Trust's operation, there were about two hundred claimants for whom we still did not have all the information needed to approve a claim. So as the deadline approached, we reached out to the South African Social Security Agency (SASSA) in the Department of Social Welfare, to get updated contact and personal details so that we could try again to contact those for whom we still needed information for the claim. We also reached out to Richard Spoor to cross-check with his database of all the claimants who were

signing up for the Tshiamiso class action. The chances were that they would come across some of our claimants and we were right about that. His firm were very helpful indeed and did find some of our claimants and we were able to amplify our database with new information. Those claimants would have been ultimately excluded from the Tshiamiso Trust settlement because its Trust Deed explicitly says that our named claimants cannot join the Tshiamiso settlement, not even for TB claims, which Q(h)ubeka Trust does not compensate. They must be referred on from us to the MBOD for their additional statutory compensation entitlement.

There is a serious problem though, because if our claimants have a silica-related disease but don't qualify on the Q(h)ubeka two-year criterion for duration of service at AngloGold Ashanti, but do have mine work experience at other mines covered by the Tshiamiso Trust, they are excluded from potentially receiving substantial compensation through that settlement in addition to the amount that they are entitled to under the Statutory ODMWA system. The Q(h)ubeka settlement did not incorporate that exclusion, but the Tshiamiso Trust settlement did. That is a failure of these private settlements, because the reason why they were set up in the first place was that the Statutory system had failed to compensate the claimants adequately, or even at all, and these are serious diseases which in many cases are a death sentence.

That is the nature of the legal process in these sorts of settlements. We also found that some of our claimants never ever worked at AngloGold Ashanti so were excluded from being compensated if they had a compensable disease. The legal process should have excluded them from the list, and then they would have been able to claim from the Tshiamiso Trust. They lost out, and their families also lost out if they were deceased claimants. The cases of TB without silicosis, and those who were unable to meet the 2-year criterion are left only with the settlements offered by the MBOD.

The second three-year period of the Trust's operation was the Covid part. So, what was to be a period of wrapping up and paying people out turned into a challenge in itself, as all organisations that Q(h)ubeka depended upon to verify and pay out claims were also affected. During this period, we were already developing a model for the diagnoses of deceased claimants in the absence of medical records. Before this problem was solved, it presented huge challenges, as the deceased claimants ended up being about 20% of all of them, a significant number. It took us a long time to have the scientific work completed to arrive at a diagnostic algorithm that was reliable, repeatable, and defendable as a diagnostic tool, so that we could be certain that we would not compensate claimants that did not have silicosis.

The algorithm could definitely be used in other Trusts of this nature, but before the MBOD would even contemplate it, I believe that there would have to be a change in the ODMWA Statute, which determines the processes required for them to pay out a claimant. At present, lack of a medical benefit examination would rule any claimant from a compensation award.

With the benefit of hindsight, I would extend the three-year qualifying claims period in the Trust Deed. I don't know the rationale for dividing the 6 years of operation into two periods of three years. We could just as easily have had five years for the qualifying claims period, and then one year for wrapping up and paying out. It is important that the legal team that is negotiating these settlements should consult with individuals and organisations that can really give input on what is reasonable from an operational point of view, because we really did struggle with that.

The other thing that should not have been part of the Trust Deed was having to prove the two-year qualifying period of service at the mine concerned. I understand the argument that the companies did not want to accept full liability for lung disease for workers who only worked for them for a short time. But that did not require that such people must be excluded altogether from lodging a claim. Another way to have done this would have been to allow them to lodge but to give them a reduced award, pro rata with the proportion of their total mine career that was spent at the settlor's mines. That was how the Asbestos Relief Trust dealt with this issue. As I understand it, *any* exposure to respirable silica dust contributes to the development of the disease of silicosis, so I think that was a very unfortunate provision in the trust deed.

I certainly think that these legal settlements promote prevention of occupational disease on the mines, by driving changes to practices and laws. Companies cannot afford to be repeatedly sued for damages, so they must take action to prevent the disease in the first place. Changing the law is not easy because the law on these issues is complex and dates back a very long time.

Interview with Peter Lewis, 8-Oct-2022.

Gary Scott, Actuary appointed by the Trust

I qualified as an actuary in 1988 with the Institute of Actuaries in London and have worked as a professional consultant for the past 35 years in both South Africa and the United Kingdom. My work with disease compensation trusts started in 2003/4 with the Asbestos Relief Trust where I developed a multi-state model to advise the Trustees on the development and management of the claim award structure. The settlement monies and duration of the Trust was fixed following a group legal action against the owners of the asbestos mines. The Trustees needed advice on the nature and quantum of the claim awards to maximise the amounts paid to claimants while ensuring that the Trust remained financially sustainable.

I co-authored a paper with Dr Jim te Water Naude that we presented to the Actuarial Society of South Africa in 2006. The paper set out the workings of the model used to advise the Trustees and provided an important peer review of the methodology and assumptions adopted.

In 2012, I was appointed by Anglo American South Africa to review estimates provided by the actuarial advisor to the Chamber of Mines for the potential value of compensation for occupational lung diseases in current and ex-workers in the gold mining industry. This engagement ceased in 2014 and my appointment by the Q(h)ubeka Trust followed in 2016. Much of the modelling work underlying the Q(h)ubeka Trust was done by the actuarial advisor to the Chamber of Mines in advance of the establishment of the Trust. This simplified the work for both the Trustees and me as their actuarial advisor.

In 2021, I was appointed as actuarial advisor to the Tshiamiso Trust where I lead a team of actuaries who assist the Trustees with the establishment of financial budgets for both the claim awards and administration expenses. The Tshiamiso Trust provides compensation to those miners in the gold mining industry not covered by the Q(h)ubeka Trust. With the Tshiamiso Trust, the claim award structure was finalised before the Trust was established. Although qualification criteria for the awards is defined in the Trust, the number of qualifying claimants and hence the total amount that will be paid by the Trust is unknown.

I have enjoyed my interaction with the Trustees and administrators of all three Trusts. The people that I have had dealings with have often overlapped and some of these relationships span 20 years. Particular mention must go to Dr Jim te Water Naude, John Doidge, Tina da Cruz, Dr Sophie Kisting and Richard Spoor.

Together we have developed considerable experience and expertise in this specialised area of providing compensation for diseases following mining activities in Southern Africa. I am immensely proud of my part in this.

Contribution from Gary Scott, 13 June 2023

Nomsa Ngwenya, Office Administrator

My mother is from Gauteng, and my father from Mpumalanga. His people were farmers, but he worked in a company. I was born and raised in Alexandra township. I was living in Germiston, and I am now in Alberton with my own little family. I'm married with three daughters.

I worked with Richard Spoor on his litigation for ex-miners that led to the Tshiamiso Trust. My manager there was Tina de Cruz. She eventually joined Q(h)ubeka Trust as its manager, and she invited me to move with her, when the search work for claimants was complete for the Tshiamiso Trust. So, I became the Office Administrator for the Q(h)ubeka Trust. I had experience working in the retail sector, and that was a good preparation because in retail you work with people, you learn to provide excellent customer service, and working with ex-mine workers who have silicosis you are working with elders who really need your kindness. It is very important how you speak to them.

When it comes to claimants, my job has been to make sure I am in constant touch with the claimants and help to guide them if they have to go to the magistrate's courts, or open bank accounts. I must help with all the necessary documents to finalise their claim for payment.

For the people who did not qualify for compensation from Q(h)ubeka, but still have illnesses, we sometimes had to refer them to TEBA for documentation so that they can apply for statutory compensation under the ODMWA. Some of them had TB, and some other diseases like Asthma. This was difficult because miners do not understand the difference between silicosis, which Q(h)ubeka Trust compensates, and TB, which it does not. They were confused about this. My take on it is that when they registered for the legal case years ago, they were not educated completely on what they would be compensated for, and what were the different stages they would have to go through to qualify for that. So, when it came to the end of the process, they were confused. We had to send out letters to the ones that did not have silicosis explaining the difference between TB, other diseases, and silicosis, and that if they don't have silicosis but another mine disease, they can now apply for the compensation from the MBOD.

It looks unfair to them, and they don't take it very well. I had to be very diplomatic, kind, and well-informed to explain it to them. Towards the end, when the Trust period was extended, several contracts for administrative workers at the Trust came to an end, so all the queries on the MBOD cases came to me in our office in Joburg, which was just me and a switchboard operator, and it was a challenge.

During the Covid lockdown we were impacted because we couldn't send our claimants to the banks because they were closed. The magistrate's courts were also closed, so we couldn't get the necessary letters of authority for bank accounts. We had to move on to assessing and checking the documents working from home it all came to a stand-still and the whole process was delayed.

The issue of compensating the dependents of deceased claimants was difficult in the beginning. We found it impossible to get the necessary documentation together, when the man had died before medical examination was done by Q(h)ubeka Trust. Attempts to get the mine medical documentation were not successful, they just did not have proper records at the mine hospitals. The Trustees solved this problem very well by developing a model that could decide if the man had died with silicosis according to basic information and documentation that we had on him, like his age, and his years of service at the mine, and so on. That got rid of that bottleneck.

During the first tranche payments the banks were quite cooperative and assisted us to set up the accounts for the claimants to receive the money. However, when it came to the deceased claims that were going to be paid out to dependents, there were a lot of problems with the bank accounts. You have to create what is called an Estate Account, which takes 14 days, and though you might get somewhere with a particular bank official, they would then be replaced, and you would have to start all over again, because they did not hand over the job to their replacement. Often, payments would be made to accounts created, but it would keep coming back to us. I helped the field workers deal with that issue by calling claimants to go back to the banks.

The appreciation from successful claimants when they get their payments has been a highlight for me. They tell you that without the Q(h)ubeka Trust they would not have received a cent, because the mine didn't pay them anything. That makes me sleep well at night.

It most cases after paying the claimants we normally get a call where claimants express their gratitude and they sometimes let us know how they will use the money; I will quote just few statements from them:

> "Thank you to Q(h)ubeka trust for paying my father, I feel like we got an inheritance from him, we really are grateful."
>
> "I can now be able to finish a house that we started building it years ago and my kids will have a home now, I don't have words to express what I'm feeling, thank you Q(h)ubeka (ndiyabulela) please keep up the good work may God bless you all" says the widow while in tears.
>
> "I have received the money and thank you Q(h)ubeka Trust, I can now send my kids to school, I've been applying to the MBOD but nothing. I will save some money, I'm a happy man right now. Please do to others what you did to me."
>
> "Thank you Q(h)ubeka Trust for paying my husband's money, it came on time-I can be able to pay debts that are created for his burial and I can be able to put a tombstone for my husband."

Here are some testimonials where the claimants will express their dissatisfaction with Q(h)ubeka Trust.

> "This is not the money that the lawyers promised us, we were told that we will be getting the money from R200,000" says a claimant who got paid for a C1 level.

> "it's not fair that our husband's will go and work for so many years on the mines and come back with nothing and now they are dead with such little money" says the widow whose husband died before the trust was formed and have no proof of dying from silicosis. We tried our best but sometimes we could not find all the solutions.

My name means kindness, and that is what I am about. I just like to give to others. Of course, at the same time I grieve for the ones that did not qualify for a Q(h)ubeka payment. I think it is just not fair that they cannot apply to the Tshiamiso Trust if they have been a Q(h)ubeka claimant. Q(h)ubeka Trust did not include TB for the good reason that they did not think they could win it, because TB is a curable disease, whereas Silicosis is not. Even the MBOD pays a little bit amount for TB, sometimes only three thousand rand. So, it is understandable how that happened.

I think that the legal cases have had a real impact on prevention of disease on the mines. If they are clever, the mines will have to change their behaviour because they have had to give away money for the diseases when they are already paying the MBOD to do it for them. I think it opens their eyes and their minds that they need to do more to prevent these diseases.

Interview with Peter Lewis, 12-Oct-2022.

Marietta Sauls, MBOD Liaison

My first exposure to working for Trusts focussing on occupational diseases was a project for the ART. Then I was invited to join the Q(h)ubeka trust in March 2018, to conduct its liaison with the MBOD, in the second phase of its work. For this I was seconded to the MBOD to work in their offices in Braamfontein. From the Q(h)ubeka Trust side my work was supervised by Tina da Cruz, who was then the General Manager of the Trust. She was however not based at the MBOD and I felt as if I was thrown into the deep end at the MBOD!

My job there was to do verification of all documentation for each Q(h)ubeka Trust beneficiary whose medical records were being forwarded to the MBOD for statutory compensation. I had to make sure all the details were correct and then created agendas for the Certification Committee of the MBOD. I was unfortunately not trained on the system and had to learn it alone by using my eyes and ears. There were two other women working with me on similar tasks but for other organisations. One was seconded by Harmony Gold.

To be honest, for the first six months, I was not able to achieve much. I made batches of ten claimant files because only ten files in one week were accepted for certification. I submitted these to the panel, but some weeks I was told nothing could be done, and I was not yet given access to the digital system. It was psychologically stressful for me at the beginning because there was so much uncertainty. But Tina helped me a lot, by also sending emails to the MBOD supervisors whom we worked with. Tina would always encourage me indicating that I was on a steep learning curve, to do my level best for the mineworkers and collaborate with the staff.

At times the tension was very high because we were additional staff. The permanent staff felt uncertain upon the reason for our presence. There is such a lot of unemployment and so often job losses that one can understand the uncertainty about newcomers who were merely seconded to assist their own organisations. For about six months I moved Q(h)ubeka files from one point to another for safe keeping.

At one point the permanent MBOD trade union members went on strike This was from March/April 2019 involving many staff members at the MBOD. There were different departments like the verification section and the data capture side. There was also the roughly ten people in the CCOD section as well. The strike was not reported in the media, and there were no physical picket lines. During the strike our supervisors would advise when to come to work.

By the time I was about three years into the project other colleagues who had been seconded to the MBOD have completed their time, leaving only three of us. There was a time that we had to go work in Parktown at the Harmony Gold offices for about two or three months. Eventually, the Harmony placements' contracts came to an end, and for a while I was left alone as an outside liaison person.

After the strike it was possible to start making more friends at the MBOD. This was encouraging. Unfortunately, for a number of reasons at a certain point I had to start work at six in the morning before the rest of the staff arrived. I would liaise with other colleagues when I had to submit the completed files to one of the doctors on the medical panel. When I needed to make copies of documents, I would go to the Q(h)ubeka Parktown office and do it there. My final office location was in the basement document storage place. I was quite happy there but very vigilant because I was alone on that floor. And I was there at 6:00 in the morning.

After about a year I obtained access to the digital files that are stored in what is called the Metro system, which was a system provided by a private company to the MBOD. Up till then, when I needed files, I had to pull them physically, because if I requested one, it could take up to two weeks for it to arrive. Colleagues shared their trolley with me to enable me to carry files up the stairs from the basement. I brought my own coffee, kettle, and toilet paper, so at times I traded the use of my kettle for the trolley when I needed it. Once I had learned the Metro filing system, both of us seconded staff could use it very efficiently. Quite soon, I could complete about 50 files a day. I finished a year back and out of the 1000 plus Q(h)ubeka files I was busy with there was only 45 files left that had elements missing or that we were waiting for. So, I almost completed the mission when I left at the end of my contract with the Q(h)ubeka Trust.

As a smoker, I would go outside with others to smoke in the car park. I saw miners coming in to find out what has happened to their claims. They come far from the Eastern Cape travelling all night and arrive at about 5:00 o'clock in the morning in, say, 4 taxis with 15 people each. This impressed on me the importance of doing our work properly. Often when I was arriving at work miners were arriving from different locations and when I was leaving round about three o'clock, the taxis were still there. The men would be sitting around in a boardroom and wait for further information. They spoke different languages but mainly spoke Zulu, or Setswana or Xhosa. I will never forget one man from Kimberley. He travelled with others several times to obtain information on the progress of their compensation. They were always so dignified and respectful. Sometimes women would arrive to enquire about their husbands or their fathers' pay-out. These encounters with the mineworkers and families humbled and saddened me. But it also enriched my life as I understood more deeply what they were going through and the importance of us doing our work to the best of our ability.

After some time I gained competence and could do claim Verification, Capture and Agenda for about 80 files in one day. Verification is simply ensuring that the forms and information for the claim do not contain contradictions or incorrect ID numbers of names and so on. Sometimes you

find that on the Metro system the miner has four differently numbered files, and you need the MBOD staff to indicate which is the correct one. We collaborated well on that and managed to eliminate the problem for the Q(h)ubeka claimants' files.

I also worked with colleagues from the One-Stop-Shops set up by the MBOD/CCOD. Harmony is helping with that. There were the same verification challenges for the One-Stop-Shops then the problems we encountered e.g. ID numbers and passports for people from Lesotho and other foreign countries, and there were a lot more claimants than we had to deal with in Q(h)ubeka. Sometimes I would get to the office before 6am and helped them with 20 or 30 files from the one-stop shops. They had the same problems that I had and I was grateful to be able to assist them with the experience I have gained. At times there was a problem as files sometimes were getting lost. This required many more hours of additional work to complete the processes again.

Interview with Peter Lewis, 05-Nov-22 [original content edited in consultation with Marietta, 19-Apr-2023]

Ken Gliddon, Data Scientist and Systems Analyst

At the beginning of this journey, I met with one of the doctors, Jim te Water Naude on a Friday evening. They had spent an inordinate amount of time and resources trying to figure out how to a process a large volume of data on the Q(h)ubeka Trust claimants. He told me the details of the problem, and I said, "when are we going to get to the difficult bit?" By the Monday morning, I think we had about 80% of what we currently have and called it CIMS – "clinical information management system". We had the framework and the system design to assimilate the large volume of data, as well as the mechanism behind the storage of the data. This bought us some time to focus on other aspects of the problem that needed a lot more consideration.

I had been involved in quite a few class actions and a very common problem with them is that they start with a list of names in the action, but thereafter everything is done in a rather piecemeal way. Each time, everything has to be reinvented. There is no existing financial system, and no enterprise planning system, and one cannot use off-the-shelf software because these are too rigid for your needs - a bespoke software development project is required.

I had done this in about 2012 or 2013, for the British market, and it didn't take too much to adapt it conceptually for use in South Africa. There are plenty of initial similarities, but thereafter there was quite a steep learning curve. The first obvious difference is that South Africa does not have an efficient postcode system. So, we had to develop a system to geolocate people and their relatives if they were deceased.

Then, we agreed that with all this data, there must be only one version of the truth about any particular case. So, we had to upload every tiny scrap of information, including things such as X-ray films, into each case file, so that there is no other source of information in some filing cabinet somewhere on that case. That was a conversation that didn't go down well at first, but eventually we got to a point where we agreed conceptually that whichever party was looking at that record, they would see the same information as anyone else. It would be an entirely paperless system.

That decision has also been taken up in other class actions since Q(h)ubeka – such as the Listeriosis class action, and others in the coal industry. It is very heartening to hear people

involved in these cases saying “one version of the truth”. So, at present, when the Q(h)ubeka Trustees are reviewing a particular case to decide whether the person should be compensated, they access the CIMS database and then utilise the X-rays, lung function test results, or anything else they need to make the decision. CIMS now has 1.3 million records and counting.

In another case we had a lot of Mozambiquan miners who have contracts which are all handwritten and freeform. They are difficult to read, never mind correlate, so we had to have algorithmic systems that can not only “understand” what these documents are saying, but translate them from Afrikaans or Portuguese into English, and correlate them with other key information about the particular case. We also have systems using old algorithms which can extract information written on forms and store it systematically, using Optical Character Recognition techniques. We have been able to get the proportion of claimant records that remain problematic to around only 2%. Furthermore, a lot of the learning we have been doing to get there is filtering back into the departments in order to help them function better. Up till now, they had been using a claimant case management system called Metrofile, which is really a primitive digital library card system. Physical folders get damaged, they get wet, they get burnt. It's fundamentally flawed. With sustained pressure and investment, all records can be digitized. In one of the class actions, I have been responsible for assimilating all the details for 68,000 miners who were identified during the litigation period. What we are using is not artificial intelligence in the strict sense, but quite a small algorithm using a few heuristic factors. I call it “assisted intelligence.”

The development of the statistical model to diagnose silicosis after the fact for a deceased miner who did not have a medical examination, or an autopsy record was very important. I was only involved in some of the data cleaning on that project for the statisticians, but we have used something similar, based on the *balance of probability* of something being correct, in the Listeriosis case against Tiger Brands. For that we built a thing called an Onyx File which is a machine learning model. Using Artificial Intelligence techniques, you apply it to all of the data points that you have. The absence of a data point is as important as the existence of a data point. The deeper you go into the matrix the more likely, or unlikely your proposition is shown to be, and you can specify exactly how confident you can be of the conclusion. We would never have gotten to that point if Q(h)ubeka Trust had not pioneered the balance of probability model. The overall concept is that of a heuristic model for medical decisions – a kind of digital triage that uses the concept of the balance of probabilities.

Interview with Peter Lewis, 30-Nov-2022.

Thandikaya Mgoqi – Claims Administrator

Q(h)ubeka Trust was established in March 2016 and I joined it on 01 August 2016 as a Claims Administrator.

I was primarily responsible for processing of claims. My duties included the receiving of claim application forms, interrogating claimant information, ensuring that the requisite claim information is received. To capture that information on the Trust’s Claim Information Management System (CIMS) and checking all criteria has been met before processing qualifying claims for payment as well as liaising with regional staff and claimants directly.

Due to the nature of the work, Claims Administrator's role required an individual who is service oriented with good interpersonal skills, high degree of professionalism, respect and integrity with good written and verbal communication skills plus ability to work both as a part of a team and independently. Fortunately, I gained experience in the Eastern Cape interacting and ex-mineworkers and mineworkers who were members of my family. For many years I worked in different field research studies of the University of Cape Town. This helped me to interact with a deeper understanding of problems on the ground.

Q(h)ubeka Trust claimants asked some important questions. These include:

1. Will Q(h)ubeka Trust pay all mineworkers? My answer to them was "No". Q(h)ubeka Trust was established to pay only those mineworkers who worked in qualifying gold mines during qualifying periods and found to be affected by silicosis and silico-tuberculosis. Qualifying gold mines are those mines that contributed in the establishment of Q(h)ubeka Trust. We have to do our work in the Trust according to the Trust Deed.
2. Do claimants pay when claiming at Q(h)ubeka Trust? My answer to them was "No". Claimants do not have to pay a single cent to anyone who assists them with the claims process or the medical examination. Claims handlers and doctors who do the benefit medical examinations (BME's) are paid for their services by the Q(h)ubeka Trust. The main reason behind that question was that they (mineworkers) heard that there are people who were moving around claiming to be claims handlers who will help them get all their monies from Q(h)ubeka Trust provided they first pay a certain amount to them before their claims can be processed. I told them they must never pay anybody as Q(h)ubeka Trust has done that already but rather report such individuals to authorities or the Q(h)ubeka Trust.
3. Widows and children often struggled to get compensation once a mineworker has passed away before he received his compensation. It was good to be able to assist them over and over with the right information in their home language. Once they received the compensation the women very often contacted us to report on it.
4. One of the most difficult parts of the work was to explain to a claimant or to his family that the medical examination did not show silicosis. Especially if they have worked in the mines for many years. We also advised about possible medical examinations with the MBOD for future years. I think we all need special training to deal with the sharing of news that claimants find difficult to accept.

Contribution from Thandikaya Mgoqi, 03 July 2023

Martin Nicol, claim verification

I came into the Q(h)ubeka Trust about a year before the Trust closed, to assist with the verification and disbursement of successful claims. I was trained into the work by the Operational Manager, Jud Cornell, and Ken Gliddon, who designed the digital system for information management (CIMS). There are all sorts of bureaucratic difficulties. Firstly, the payments for each claimant are split between two tranches, with quite a long time between the two. Then, for someone who's been found to have silica related disease to be compensated, they must sign all sorts of forms confirming that they're not going to launch a case against the mine, or against Anglo-American, for further compensation, and those forms have to be saved and verified. The second thing I must verify is just to make sure that the ID numbers, and all of the tiny details on the forms are consistent so the Trust is absolutely certain that it's paying the right person. There

are complications however, when a claimant dies before receiving either the 1st or the 2nd Tranche. This raises the question of who the money goes to. Most mine workers die without making a will.

For all these verification tasks the CIMS system provides an extraordinary and immediate record of all the documentation which has been uploaded for each claimant. That is, all the medical files, the lung function tests the X-rays, the determinations of the compensation panels, and absolutely everything in between. CIMS also provides for tracking when documents were put on the system when payments were made. There are also comment fields where you can see how people have tried to trace members of the family or the mine worker, or reminding the mine worker that they must go to the next step for acquiring documentation or proceed to a claim with the MBOD. The field teams which have been employed to track and trace don't put documentation on CIMS, but they keep their own record of what they are doing and for the last couple of years, they have been able to use cell phone technology to send photographs of documents they acquire for the claimants on WhatsApp to the Q(h)ubeka office, where they are immediately captured on the system so that saves a lot of time. My job has been to verify that the documents required by the settlors in the Trust Deed are indeed there and that they are signed and visible.

There are a lot of frustrations because whoever designed the forms made them difficult to complete, because they are not completely unambiguous in important respects. If the name field for the claimant is not filled in, we have to go back and ask them to fill it in again. The second issue is that in the initial stages the lawyers neglected to include some aspects of protection for the mines from litigation if a miner was to die and there was a dependent who claimed. In this case, they must reissue all the forms which people had to sign again. All this information is on CIMS and so there is a lot of duplicate material which has to chronologically tracked.

Thankfully, there is no longer a requirement for certified copies of ID's, because the banks require biometric and other verification in terms of the Financial Intelligence Centre Act (FICA) before they will open a receiving bank account to pay in the compensation amounts, and their identity proofs are much stronger than a certified copy of an ID book. However, the problem with the banks has been huge. I can't tell you how many cases there are where people find the money returned by the bank because they haven't been FICA-ed, or some other reason. It seems that if you open a deceased estate bank account, they require a deposit of fifty rands or five hundred rands depending on which bank it is, but they will only keep the bank account open for a limited period if there is no deposit into it. So, because of the time it takes to verify and pay out claims, there are situations where people must open bank account after bank account, at different banks. This is an abuse of these poor communities by the banking system, and it's a total disgrace, because as I see it, if someone is found to have silicosis, they should be compensated, and yet they are all these steps and hurdles and difficulties that are placed in the way of them getting their money. It's been impossible to arrange a sort of overall tailor-made and standard agreed banking system because each of the banks are different. You've got Capitec, Standard Bank, and so on, with different procedures in South Africa and Lesotho, and the banks don't have an industry organisation. If they did, it would probably be illegal in terms of the Competition Act. So, it's impossible to have a swift way of doing this and the Q(h)ubeka beneficiaries have had to climb on to the existing systems of financial control that we have for preventing money laundering and financial crime. It is a bitter irony that the big money launderers and criminals have been evading these controls in gigantic quantities for years, but when poor miners and their families try to receive monies that they are legally entitled to, the system is a minefield, and cannot be fixed.

I just sit behind a computer, but I can read into the documents the extraordinary lengths to which the Q(h)ubeka field support teams have had to go to make sure that legitimate claimants are traced, identified and eventually paid out. There are weird things that happen: people changing their ID's, people changing their names, people having different names at different times of their life. In Lesotho until recently there was no single identity number. People had passports and that was the only way that you could identify someone. And people would have three or four passports. So, you'd have all these for each of the Lesotho claimants. There might be 6 or 7 numbers which must be verified before you can be sure that the correct person is being paid. Again, in Lesotho, women particularly change their names as they become mothers to different children.

Finally, of course, there are injustices with legal settlements which we have become aware of as the Q(h)ubeka experience unfolded. We had about five hundred claimants who signed with the lawyers during the litigation phase, but who were never found after the settlement was agreed. We also had about one hundred and thirty claimants who had silicosis but did not qualify because they did not work on the mines covered in the settlement for the required minimum period of two years, and of course all the 4,365 Q(h)ubeka claimants are excluded from the large class action Tshiamiso settlement by its own Trust Deed. We also have some who "opted out" of the Q(h)ubeka settlement (by refusing to attend the medical exam in time), because they were told by dubious lawyers that they would get more if they relied on them to pursue their claims, for a fee of course! Then there are those who simply did not make the three-year deadline for the submission of their claims, despite all the Trustees' efforts to track and trace them in time. This all very sad, but these individuals could not be compensated under the Q(h)ubeka trust deed.

So, there are injustices and inequalities that arise from private litigation. It is only possible to eliminate them by means of a properly functioning comprehensive statutory system.

Interview with Peter Lewis, 12-Oct-2022.

Q(h)ubeka Claimant Medical Certification Work Stream

Dr Mohamed Jeebhay, Professor of Occupational Medicine at UCT Medical School

I started work in this field of large-scale occupational medical assessments required for compensation claims arising from occupational or environmental disasters when we established a Medical Reference Panel (2001-2003) to assess residents who were exposed to high levels of sulphur dioxide vapours after the Macassar Fire, which was caused by an explosion at the Somerset West AECI explosives plant.

From that experience, we went on to assess compensation claims of ex-asbestos miners and their families related to asbestosis and mesothelioma under the auspices of the Asbestos Relief Trust. That work went on from 2004-2016 through the work of the Specialist Occupational Medicine Panels that involved occupational medicine specialists and experienced radiologists. We evaluated chest X-rays and lung function tests and the medical histories of workers from the asbestos mining areas in South Africa, in Kuruman, Msauli, and Penge. These medical panels certified the presence of occupational respiratory disease claims eligible for compensation by the Trust established through litigation between the workers and the asbestos mining industry owners.

All of this experience and institutional memory fed into the operations of the Q(h)ubeka Trust. The Trustees selected other colleagues and myself as an occupational medical specialist having a wealth of experience in these processes, as well as my certified training as a NIOSH B-reader in reading chest X-rays using the ILO standards for classification of pneumoconioses. I worked with other colleagues in one of three medical panels (Specialist Occupational Medicine Panel – SOMP) comprising two occupational medicine specialists and a radiologist in each of Johannesburg, Durban, and Cape Town. This work was coordinated by Dr Jim Te Water Naude based at the Cape Town office who, together with other staff, compiled and collated information from the existing medical records and work histories of claimants. This information entailed establishing whether the claimants qualified as having worked on the mine/s in question, and to assess their exposure to quartz dust in terms of years worked and available dust measurements. Together with the medical information, the SOMP was able to certify the individual as having a compensable disease.

To explain the entire process a bit more, the claimants were first seen and evaluated by a panel of private doctors as near as possible to their places of residence. Some of these consultations also took place in a few public hospitals that had the necessary facilities in the Eastern Cape. This was the first level of diagnosis, using X-ray and Lung Function testing as stipulated in the Trust Deed. We developed a questionnaire on work history, and a Form for them to record their medical findings. We also had, a highly experienced Registered Nurse, Sister Nodu Nolokwe, to train some of their staff on lung function testing, so that methods used were standardised and following standardised procedures.

The SOMPs were the second level of medical certification and operated on the basis of consensus as to the X-ray readings, which were done according to the ILO standard classification of chest X-rays for the purposes of detecting silicosis, TB, or silico/TB. Initially, the X-rays had to be physically sent from the first level doctor panels to the SOMPs in the 3 cities, but in due time they were digitised and could therefore be transferred on the internet. For complex cases of disease, if the SOMP were split on the diagnosis, the case was referred to a third level of adjudication, called the Medical Review Panel. After a considerable time on the second level of certification (SOMP) from 2016-2017, I moved over to the Review Panel, which operated from 2018-2020. This panel was chaired by Assoc Prof Shahieda Adams, occupational medicine specialist, and also included Dr Qonita Said-Hartley, consultant radiologists, both from UCT. All the information was collated in a medical evaluation form, together with the certification decision of the panel.

The aim of this extensive medical network was to authoritatively situate each claimant in one of the four categories stipulated in the Q(h)ubeka Trust Deed:

1) Silicosis with normal lung function
2) Silicosis with mild lung function loss
3) Silicosis with moderate lung function loss
4) Silicosis with severe lung function loss

The complex cases usually involved differentiating between TB and silicosis with or without progressive massive fibrosis on X-ray, and complications arising from the presence of malignancy (cancer). For these cases, we usually had to arrange CT scans in addition to the routine X-rays, in private health facilities, with some in the public hospitals where machines were available. For that too, we had to develop capacity of the SOMP members to read digital X-rays, and equipment

bought to be able to read the digital radiographs. The CT scans were read by very experienced radiologists.

It is very important to say that in the case of the QT, we as medical experts had complete independence and could exercise our clinical judgement in the determination of diagnosis, and there was no interference from representatives of the settlors, or lawyers or non-medical professionals advising on the requirements of the Trust Deed. This is an important learning from private class action litigation over these matters.

The Trust Deed included compensation for the families of miners who had died before they could be compensated, either by the MBOD or by the Q(h)ubeka Trust. An important parallel task was to develop an approach for medical certification for compensation in cases where there were insufficient medical records available or no recent X-ray film of the deceased miners. There would also be instances when the latest extant X-rays for these deceased miners were of very poor quality to use for diagnosis. I recall in the mid-1990's I conducted over 50 mine visits and audits of various mines while working at the Industrial Health Research Group (IHRG) upon request of the National Union of Mineworkers (NUM) to examine retrench workers and their medical records for purposes of identifying a compensable occupational lung disease. During these audits I found that many mines still used outdated X-ray equipment, producing poor quality radiographs and in the earlier days mini chest X-rays. The quality and meticulousness of recording the results of lung function tests were very also very poor. After the Leon Commission of Inquiry into occupational health in mines during this period, the 1996 Mine Health and Safety Act (MHSA) assigned the function of inspecting mine occupational health services to mine medical inspector, who were commonly registered occupational health nurses. During my work with the Trust, we also encountered poor quality medical records of some of the deceased miners whose families were claiming compensation. Death certificates also are nowhere near as detailed or specific as would be required in these cases to establish cause of death. We therefore needed to work-around this and come up with a solution to assigning these workers to one of the four compensation categories.

Aside from the clinical assessment of individual living claims we also conducted research on the statistical analysis of the QT database of 1300 medically certified claimants to create a predictive model for silicosis tin order to assign claimants with incomplete medical records to the four categories of disease. A second study was undertaken by a different team of scientists to refine this further for about 400 deceased claimants, and it was finally accepted by the Trustees for the purposes of compensation of dependents of these deceased miners.

Though the formation of the list of about five thousand claimants during the litigation phase of the settlement that led to QT included TB cases, in the final settlement, TB was excluded from the ambit of the final Trust Deed. All of the QT certified claimants were however referred to the MBOD for their statutory compensation as well as any additional compensation offered in the QT Deed. However, the ODMWA only provides for TB compensation if the onset of TB occurs within one year of leaving mine service, since it is deemed possible that the TB is contracted by community infection rather than caused by exposure to silica. This restriction is not defensible, in the light of increasing evidence that silica exposure significantly increases the lifetime risk of contracting TB, and of recurrence of treated TB, even in the absence of silicosis.

Recognising that the ODMWA categories of lung disease for certification and compensation were restrictive and not taking into account updated scientific knowledge, the Q(h)ubeka Trust Deed's

four categories were more nuanced, and ensured that milder forms of silicosis, which can progress to more severe forms in time, were addressed. The comparison is approximately (but not exactly) as follows, and it shows that QT claimants had much better eligibility for benefits than those who only have claims submitted to the MBOD:

QT Compensation categories for 4 compensation payment groups (from smallest payout to largest)	ODMWA/MBOD compensation categories for groups (from smallest payout to largest)
1. Silicosis with normal lung function	Not compensable
2. Silicosis with mild lung function loss	Not compensable unless ILO 2/2
3. Silicosis with moderate lung function loss	First degree
4. Silicosis with severe lung function loss	Second degree

The question of progression of disease was problematic for QT because the Trust had a lifetime of six years. So miners who might be diagnosed with category 1 or 2 by QT medical panels, might later progress to category 3 or 4, but not quickly enough to be additionally compensated before the Trust wound up. In theory, they could of course proceed in that eventuality to Second Degree claims at the MBOD, but those payments would be much smaller than the QT payments. However, with these claimants in particular, the MBOD has not established permanent services near to where they live, so it is unlikely that access such compensation benefits would be easily accessible when the QT are disbanded. However, we did see claimants more than once, because their disease had unfortunately progressed more rapidly, and we were therefore able to compare their past medical evaluation records with the new ones. Where indicated, we reassigned them to a higher category of disease, and were eligible for additional payments.

We began this work decades ago because we were committed to environmental and social justice through alleviating the poor quality of life and consequent poverty that these sick ex-miners suffer. We had to ensure that they had the best chance of being medically evaluated, using the best and most sensitive methods available so that borderline cases were not missed, and the best chance of accessing what money they were entitled to under the Trust Deed. We had to ensure that people living in remote rural areas could get to see the medical doctors on the panels at primary level. Finally, it was a big undertaking to ensure that dependents of deceased miners lacking medical documentation could receive the compensation they were entitled to.

Another very important outcome of the work with QT was that all medical certification teams worked in the academic environment as academic occupational medicine and radiology specialists, so we were able to use the experience gained in the QT in teaching medical students at diploma, degree, and doctoral level who were becoming occupational medicine specialists to develop the knowledge and skills in the recognition, management and compensation of occupational lung diseases. This is a major contribution to capacity building in this field in South Africa.

Interview with Peter Lewis, 11-Dec-2022 [with significant changes made on 8-Sep-2023]

Dr Jonny Myers and Dr Mary Lou Thompson, medical experts

Dr Jonny Myers (JM), is Professor Emeritus, Centre for Environmental and Occupational Health Research, School of Public Health and Family Medicine, University of Cape Town, and Dr Mary Lou Thompson (MLT), is Professor Emerita, Department of Biostatistics, School of Public Health, University of Washington, Seattle, USA.[11]

JM: I had no hesitation in embarking on the project to develop a statistical method to solve the problem of identifying, for the presence of silicosis, the Q(h)ubeka claimants who had died before being medically evaluated by the QT, as required by the Trust Deed. I hold Dr Sophie Kisting who requested my help in the highest esteem, and I knew from her that there were four to five hundred such deceased miners whose dependents would not receive benefits to which they might have been entitled, should these miners have had silicosis, and that would have been unfair. I also had sight of attempts to estimate the deceased miners' probability of having had silicosis by other colleagues at UCT and elsewhere and could see this required the expertise of a professional biostatistician to finalise. So, I suggested Mary Lou, with whom I have worked for many years, and who is a highly regarded research professor in biostatistics.

MLT: In turn, I saw that this was an important issue that would have a meaningful impact on these families, and that Jonny and I had the skill set required to address it. The Trust had 4,365 claimants, and, by the end of December 2019, the situation was that there were 466 of them who had died after claiming, but before they could be medically assessed by the QT. Their families were potentially entitled to compensation, but this could not be determined by a medical assessment of any kind.

So, the question posed to us was, would it be possible to use the information the Trust had already from the substantial group of beneficiaries who *had* been medically assessed (for whom silicosis status was known) to statistically assign a likelihood of having had silicosis to those who had died without a diagnosis? To address this question, we developed a statistical model that would assign a likelihood of silicosis to each claimant, using available information from the medically assessed group on factors known to be associated with silicosis status (present/absent). In addition to that information, Jonny reconstructed a silica exposure index for each beneficiary, which we were also able to use in the model. The factors we included were silica exposure, the miner's age at the end of December 2019 (for deceased claimants this was the age they would have attained at this date), his history of tuberculosis, vital status (alive or dead at the end of December 2019), and years of life lost prematurely if they were deceased. Vital status was strongly associated with silicosis amongst those who had obtained a diagnosis; 96.4% of those who were deceased by the end of December 2019 had a positive diagnosis for silicosis.

[11] The interview deals with the model used by the Q(h)ubeka Trustees to decide whether dependents of deceased miners in the settlement should receive compensation in the event that the miner's medical records were not adequate to decide compensation on the basis of diagnosis of silicosis, as they had died before the Q(h)ubeka medical team could diagnose them. The scientific basis for the model is presented in Myers JE, Thompson ML. "Statistical modelling to predict silicosis risk in deceased Southern African gold miners without medical evaluation." *S Afr J Sci.* 2022;118(7/8), Art. #12502. https://doi.org/10.17159/sajs.2022/12502

JM: I estimated cumulative exposure to silica from previously published work by JM and MLT and others on silicosis in gold miners in South Africa[12]. This included detailed occupational hygiene data for different jobs worked underground for gold miners who had retired early from an Anglo mine. The raw data was provided by an in-house occupational hygienist. I also used silica dust levels measured by Beadle for many underground job categories in the 1950's and 1960's, which are also in the public domain. So, for each person whose work history had been taken by Richard Meeran during the litigation, I was able to place them in a certain job category for which average silica exposure could be estimated, whether they were trammers, or rock drillers, or performed other jobs. I was able to construct a job exposure index value for each worker by combining their average respirable dust concentration multiplied by the number of years in their main job.

MLT: We then used standard statistical tools to develop the silicosis prediction model including these factors, and for each of the 466 potential beneficiaries the model assigned a likelihood of silicosis being present. All estimated likelihoods of silicosis for this group were above 70%.

JM: It is worth pointing out that the association of cumulative exposure with silicosis status was modest, meaning that the index had relatively weak explanatory power for the silicosis outcome. Dilution of the cumulative exposure effect is a most likely explanation for this as a result of misclassification of individual exposure of claimants. The mining companies have successfully resisted any independent occupational hygiene assessment of underground exposure. I was doing quite a lot of work with SIMRAC (Safety in Mines Tripartite Research Advisory Committee under the Mine Health and Safety Act) and one of my proposals that was initially accepted by SIMRAC was to conduct an independent silica exposure assessment of a gold mine with assistance from an occupational hygiene expert from the US National Institute of Occupational Safety and Health. However, that project was cancelled. We had put a great deal of work into designing the study but were never given an explanation as to why our accepted proposal was suddenly dropped by SIMRAC. To this day, in more than a century, there has never been an independent respirable silica exposure assessment in the South African gold mines.

MLT: This is an example of a wider problem of incomplete information held by the industry for its workforce.

JM: Indeed! I don't think the mines' medical services even recorded their employee's age in personal individual miner medical records. This might have been recorded elsewhere, by WENELA and TEBA, the recruitment agencies, or the MBOD if miners had been compensated. But the mines medical records such as they were didn't seem to have even the most basic individual miner's information.

MLT: So, we used graphical and numerical statistical methods to demonstrate that our model predictions were in line with what we observed in the claimants who had had a medical assessment (i.e., the statistical model was a good fit to the observed data). The next step was to ascertain from the Trust what they would consider to be a suitable threshold of silicosis likelihood above which dependents of the deceased claimants without medical assessment would be entitled to compensation. This involved considerations of the accuracy of our model and trade-offs

[12] The article I refer to for the Anglo occupational hygiene findings is G J Churchyard, R Ehrlich, JM teWaterNaude, L Pemba, K Dekker, M Vermeijs, N. White, J Myers. Silicosis prevalence and exposure response relationships in South African goldminers. *Occup Environ. Medicine* 2004;61(10):811-817

between false positives (saying somebody had silicosis at death when they did not) and false negatives (saying someone was free of silicosis at death when in fact they had silicosis). Based on these statistical considerations and our estimation that all the deceased miners had greater than 70% likelihood of dying with silicosis, we recommended that ***all*** of their dependents should be compensated. Applying this threshold of 70% to the deceased claimants who had been medically assessed was associated with accuracy of 96.4%.

JM: That is a great lay person's explanation of the problem and solution. There are two components there: the first thing was developing a model for the likelihood of silicosis from the people whose information was complete, including whether or not they actually had silicosis. The second component was more difficult, which was explaining to the Trustees the trade-offs associated with different likelihood thresholds for compensation. The Trustees wanted to know why the threshold could not be raised to near 100%. Mary Lou was able to guide the Trustees to critically examine the risk threshold statistically, showing that if you went beyond a 70% likelihood threshold, you would increase the number of false negatives, whilst doing little to reduce the false positives. A further important point was that, based on the information from the deceased claimants who had been medically assessed, a very small proportion of the deceased claimants were likely to be silicosis negative.

MLT: Yes, because in the larger group who had been medically examined, the vast majority of the deceased amongst them had silicosis. This indicated the importance of vital status as a variable in the model. So false positives amongst those claimants without medical examinations and diagnoses were always going to be very rare.

JM: That was something the Trustees grasped intuitively, because they knew that so many of the miners had died within a short space of time after they had registered as claimants when the litigation started. This combination of silicosis and TB can be fatal. These considerations persuaded the Trustees that the industry would be likely to accept this method for deciding on compensation. What convinced them was the high accuracy of the model at the threshold of 70% likelihood of having had silicosis, the relative impact on false positives and false negatives, and the very good fit of the predictive model to the data from the miners who had been medically evaluated.

MLT: Choice of the risk threshold was very important. For each of the deceased miners without medical assessment, our predictive model assigned a specific likelihood of silicosis, expressed as a percentage. The question was: what would be an acceptable level of likelihood to trigger compensation of his dependents? Whatever threshold you choose, there's potential for depriving dependents of compensation due to false negatives, or erroneously compensating them due to the model generating false positives.

JM: So, the Trustees had to weigh up what would happen to the trade-off between false positives and false negatives as you move the risk threshold for silicosis and subsequent compensation higher and higher. They had to decide on a particular cut-off for the threshold, above which dependents were to be compensated, and below which they would not be. Clearly, the Industry would have liked to move the threshold as close as possible to 100%, which would minimise the number of false positives. We were able to show that increasing the risk threshold for compensation above 70% would make very little difference to the number of false positives - erroneously paid out dependents - but a material difference to the number of false negatives – dependents deprived erroneously of due compensation to the detriment of the beneficiaries of

the Trust, whose interests the Trustees were trying to serve. From our statistical analysis, we chose a 70% likelihood of silicosis as the best trigger for compensation of dependents taking into account these considerations about the balance between false positives and negatives. We were able to show the Trustees that, applied to the group of 361 claimants who were deceased but had had medical assessment, with any likelihood threshold for silicosis between 51% and 70%, there would have been no false negatives (compensation denied to those who would have qualified), and only 13 false positives (erroneous pay-outs to dependents). At a 75% threshold, there would be four false negatives, with false positives remaining at 13. At a 95% threshold, false negatives (erroneously denied compensation) would shoot up to 70 cases, whereas false positives (erroneous pay-outs) would be reduced to five cases (*see Table 9 of the paper presenting the model, footnote on page 75)*. It was therefore clear that a 70% threshold likelihood for assignment of silicosis in the undiagnosed deceased miners was of no disadvantage to the Trust fund, was in the interests of social justice, and that higher thresholds would be a material disadvantage to the dependents.

MLT: Statistically, this disproportionate trade-off between false negatives and false positives as the threshold for compensation increased is what we would expect when the condition of interest (silicosis) was so common in the class of people we were dealing with. The Trustees were of course careful to also obtain an independent legal opinion that using the model was legally allowable in terms of the provisions of the Trust Deed.

JM: It is enormously frustrating that the much larger Tshiamiso Trust settlement now under way does not have the clause include in the Q(h)ubeka Trust Deed that enabled the Trustees to use a statistical model like ours to determine whether dependents of undiagnosed deceased miners who were part of that litigation should be compensated. The Tshiamiso settlement is so much larger than the Q(h)ubeka settlement, with potentially more than one hundred thousand beneficiaries – no-one knows how many there really are. As the Q(h)ubeka Trust experience showed, many of them will die before they are medically evaluated for compensation by the Tshiamiso Trust, and without something like our model being applied, their dependents will get nothing. That is terribly unfair. When the Tshiamiso Trust has completed its work in about 10 years' time, it should be known how many of its potential beneficiaries died between being registered as compensation claimants under the settlement and before they were medically examined. Data on the predictor factors for silicosis would be available for these men, and a similar model will be able to predict how many of their dependents were denied compensation to which they were entitled. This calculation should be made at the end and made known in the public domain.

MLT: It is important to point out that the use of statistical methods to predict medical outcomes is common in public health contexts. This is the kind of work I have been doing for decades. Quite often, the "other" group, whose outcome is to be predicted, is in the future. I can give two examples of this. The first involved predicting pregnancy outcomes and was work starting in the late 1980's, with community obstetricians in the Western Cape. Many pregnant women attending busy antenatal clinics at that time would not routinely get to see a doctor, so we developed models based on historical data to predict problem pregnancies such as pre-term delivery or pre-eclampsia, using low technology information available about the pregnancy. When the model predicted such conditions would occur during the pregnancy, women could be referred to higher level care.

The second example is work I have been doing in the USA in recent times. We developed predictive models to estimate how US war veterans will fare after amputations, again based on historical data. These models are able to predict what the outcomes for the next cohort of veterans are likely to be with regard to outcomes such as mobility and mortality.

There are myriad public health settings where this kind of model-building and model evaluation has been used globally to make robust predictions which can be hugely useful to medical practitioners who treat patients. It is doubly hard therefore to understand why this approach was not used in the Tshiamiso Trust Deed.

Joint Interview with Peter Lewis, 28-Mar-2023.

Nodu Elizabeth Seloane Nolokwe, Nursing Sister

I was born in 65 Rubusana Street, Langa Location. I was the 7th child to Mr Daniel and Mrs Nontsuntsu Mahloane. We were eight kids - four boys and four girls. Now only two ladies are alive. I did my Primary Education at St Cyprian's Primary School (Etshetshi) up to Std 6, then went to Marymount Boarding High School in Uitenhage, then to Healdtown Teachers training school, Fort Beaufort. I became a teacher just for six months at Despatch Higher Primary School and resigned. I realized this was not what I wanted for my life.

I then followed a career in General Nursing, Midwifery, Community Health Nursing, Psychiatric Nursing, Nursing Administration, and took a B. Tech in Occupational Health, Audiometry and Lung Function Testing and Occupational Safety.

I then worked for Good Year Tyre Company, Everite Asbestos Company, Asbestos Relief Trust, and Tshiamiso Trust - doing training on the Lung Function Test on the quality required by the Medical Specialists.

My work for Q(h)ubeka Trust has been to make sure that all qualifying claimants go through the required medical process, especially the lung function test, giving the claimant medical results after they have worked many years in the mines. I will always ask them to let us pray that you have no silicosis so that you will live longer than those who have been diagnosed with the disease. When a miner is diagnosed with *no* silicosis, very few accepted this, as money is the main focus in life. I have never met a single one being worried that he *has* been diagnosed with Silicosis.

During this work I have gained valuable skills in counselling, and I enjoy it and I think I am good at it now. I have reached acceptance when I am faced with a sad, or a rude situation.

Once, a dependent claimant came to the office as three of her kids were sent home from school as the school fees could not be paid. The mother was still waiting for the late husband's Q(h)ubeka compensation payment. She wanted to commit suicide. I had to counsel her, and we all prayed with her in the office. When she got home in the village, she called back and thanked me for the counselling and praying for her and saving her life.

Another time, a group of men and women came to the office and their plan was to toyi-toyi as some did not qualify for consideration for compensation by Q(h)ubeka because they did not have the necessary work records. Some of them were the wives of miners and they did not have their

late husbands' documents. They could not get assistance from TEBA. I had to address them and explain the details needed, asked them for any documents they may have available and also explained the possibility of compensation form the MBOD/CCOD. Subsequently we managed to assist some of them further. Communication in the languages our people speak is so important.

To help trace claimants, I even went to schools and asked the principal if there was any child with the same surname as a claimant. I met with Kings and chiefs and went to different churches to inquire after particular people amongst the claimants or their dependents. When they were found, I went with them to the doctor's place and supported them all the way and conducted training on good quality lung function testing. Some claimants were coming from too far, and the medical doctors that we were working with even gave claimants overnight accommodation in their premises. The interaction with the medical panels in the three cities was great, and because some of our claimants were coming from far places, they were attended to first in their workplaces. The medical staff were really concerned about the condition of some of the mineworkers. For example, one of them one day was referred to hospital by ambulance. They were accommodating and respectful of our claimants. The same was true of the Doctors in Lesotho, and I also did some training for their workers on how to handle the older claimants and supported them to obtain good lung function tests.

The Trustees were responding very quickly and taking immediate action to information that we forwarded to them. That was one of the things that made me enjoy working with Q(h)ubeka Trust and the Trust Deed was well created. Here is a letter I wrote to Martin and Judith who were responsible for making sure that successful claimants were paid out:

> *"Dear Martin and Judith,*
> *Just sharing yesterdays experience of visiting Mount Fletcher with Mzamo.[13] The roof of the house the lady is staying in is not OK. It was leaking because it was raining, and there were buckets in the house for rainwater. The toilet was not working. I was so desperate to use the toilet. The documents from her area King, and proof that she was married to Jason, were left in Matatiele where she was claiming for a policy. In Matatiele the name of {N+claimant's surname} was on the documents and she does not know her. At the bank her account no longer works because of no funds. We took her to the Police Station for an affidavit. Today she will go and activate her account. I am just sharing the experience of dealing with only one case the whole day. She did fill in all the forms. We arrived 9pm last night and we left 8am in the morning yesterday.*
> *Regards, Nodu"*

NB: This claimant received her benefit from the Trust.

The following are some of the experiences I recall:

The doctors who examined claimants were very supportive of them. This was in the provinces in South Africa and in Lesotho. They understood the difficulties claimants were experiencing. Their meals were delivered to the premises and some doctors allowed claimants to sleep on their premises overnight.

[13] See the interviews below with those who worked in the Eastern Cape office for the Q(h)ubeka Trust tracking, tracing, and verification program. Sr Nodu's interview with Peter Lewis, was on 2-Jan-2023.

The radiographers and the radiologists set aside certain hours for us to bring claimants and we developed a very good working relationship.

We had meetings at the TEBA offices to find more information about the work records for claimants.

There were some families where there were 2 wives and their children. We tried our best to get the paperwork sorted so that the families can share the dependent payment. At times this was very difficult as it involved so many legal steps and agreement between the families.

On one occasion we went to the home of a family to encourage an elderly blind man to come with us for his medical examination. The family representative chased me away and said they have their own advisors who are telling them how best to get their compensation.

A few of the claimants and sometimes women and their children came to our offices after they received their money. They wanted to give us money for sorting out their compensation. They were surprised when I explained that we do not need any money from them because it is our work. I told them all we need from them are their prayers to help us do our work well. At times we prayed together with them.

Thank you to all the people we worked with. The trustees, the doctors, administrative staff, radiographers, radiologists, courier staff, our outreach workers, TEBA offices, those who prepared meals for the claimants, the taxi services and the nursing sisters. A special remembrance for Sister Faieza Desai who is late. She was a very professional, hard- working and humble colleague. Always helpful and ready with a smile. May her soul rest in eternal peace. Thanks to God that we could all assist the sick mineworkers.

Remembering Sr Faieza Desai: The first Medical Coordinator of the Trust.

Compiled by Sophie Kisting-Cairncross supported by Nodu Nolokwe, Bethusile Bana and Tina da Cruz.

Many others and I had the wonderful opportunity to work with Faieza in the Workers Clinic of the Industrial Health Research Group (IHRG). She was deeply committed to workers health and safety. Her love and deep commitment to her family, to the struggle for a better life for all and her commitment to her work was evident in her work each day. She had the amazing ability to make things happen at great speed and her commitment to follow-up and finding solutions to intractable problems was legendary.

Faieza was appointed to the position of Medical Coordinator of Q(h)ubeka Trust in September 2016 to April 2017 when she resigned due to illness. At the start she was the first and only choice for this position, we knew that we had to have her on board. Fortunately for us, she agreed.

Through her considerable effort the Trust's Medical Office was set up in Cape Town. She was also instrumental, together with Sr Nodu Nolokwe as Field Coordinator, in developing and implementing the Trust's medical programme in South Africa and Lesotho; a programme that saw not only medical screening services taken closer to the claimants, but also the investment in and development of diagnostic capacity in occupational lung diseases in outlying areas. She helped introduce policies and practices to benefit mineworkers and Trust claimants.

It was a joy to work with Faieza. She was a good person, hardworking, committed to and passionate about her work; committed to and passionate about our claimants, and workers in general - a colleague of many years recently remarked that very few people in this world who worked with old, indigent and often illiterate people had the patience and dedication that she had.

Faieza had unique qualities, caring, warm, soft spoken, a ready smile and dignified manner. She was non-judgemental and listened to people; many staff regarded her as a mentor and a confidante.

At her memorial service I had the opportunity to speak and selected to also quote the beautiful poem written by former Mozambican President Samora Machel for his late wife Josina. It epitomised so much of who Faiza was and the need for so many of us to find ways to continue her wonderful work.

JOSINA YOU ARE NOT DEAD

Josina you are not dead because we have assumed your responsibilities and they live in us.

You have not died for the causes you championed were inherited by us in their entirety.

You are gone from us, but the weapon and rucksack that you left, your tools of work, are part of my burden.

The blood you shed is but a small drop in the flood we have already given and still have to give.

The earth must be nourished and the more fertile it is the better do its trees flourish, the bigger are the shadows they cast, the sweeter are their fruits.

Out of your memory I will fashion a hoe to turn the sod enriched by your sacrifice . . . And new fruits will grow.

The Revolution renews itself from its best and most beloved children.

This is the meaning of your sacrifice: it will be a living example to be followed.

My joy is that as patriot and woman you died doubly free in this time when the new power and the new woman are emerging.

In your last moments you apologised to the doctors for not being able to help them.

The manner in which you accepted the sacrifice is an inexhaustible source of inspiration and courage.

When a comrade so completely assumes the new values he wins our heart, becomes our banner.

Thus more than wife, you were to me sister, friend and comrade-in-arms.

How can we mourn a comrade but by holding the fallen gun and continuing the combat.

My tears flow from the same source that gave birth to our love, our will and our revolutionary life.

Thus these tears are both a token and a vow of combat.

The flowers which fall from the tree are to prepare the land for new and more beautiful flowers to bloom in the next season.

Your life continues in those who continue the Revolution.

Samora M. Machel

Xavier Da Silver, Nursing Sister

I was raised in a beautiful town called Rehoboth in Namibia, yet it was only by chance that Doctor Sophia Kisting realized after a few meetings that we come from the same tiny town, though years apart! When I was at the tender age of nine, my mother had a full-blown stroke. And of course, this affected the family and my childhood financially, so as a child I was put into Holy Cross convent. So, I was really blessed with two amazing grandmothers, and a group of nuns that stood by me and raised me. But the incident left me with an infallible determination in my adulthood that I do need to do something in life, so I found the love for nursing. I completed my matric at the Convent and then did my Bachelor of Nursing at UCT and then the UCT program introduced me to occupational health which I loved, so I continued working in that field for the last 20 odd years. I worked with Dr Shuaib Manjra and Dr Shahieda Adams in the factories.

I was doing locum work, when I got a call one day from Doctor Adams and Tina de Cruz. A beautiful Sister working in the position of medical coordinator for Q(h)ubeka Trust was terminally ill and they asked me could I come and assist. When somebody like Doctor Adams and Tina da Cruz calls you, you are instantly on duty! I had to learn about silicosis straight away, and Dr Jim te Water Naude and Amira, his assistant at the time, took me through what was required, and I was working through the panels and making things happen slowly but surely.

Q(h)ubeka Trust just stole my heart. You know, it's like one of those moments when you realize you have been on the right life path from where you initially started your career, and I was working with doctors and sisters who are truly passionate in their careers. There is no time limit, and nobody sticks to an eight-to-four day. It is beyond the calling, one of those legacy moments, like when you're 60 and you're sitting on the stoop, and you can say what is that quintessential moment in your career? For me it would be the Q(h)ubeka Trust.

I came into the role as medical coordinator, where I worked together with Sister Nodu and the field workers. They had physical contact with the claimants and organised the medical benefit examinations, including the spirometry and X-rays. They would then Courier the films and graphs through to me in Cape Town. When we got closer to the end of the qualifying claims period, we moved on to a paperless system. I was responsible for putting all that medical documentation together and passing it on to the panel consisting of a radiologist and a doctor, who would scrutinise about 30 cases in a session, and I would then process all the information and their findings on a beautiful data management system (CIMS) designed by our IT specialist, Ken Gliddon. When they had been certified for compensation by the medical panellists, Tina and the Trustees were able to see the results for each claimant and pass them on to the payments section of the Trust. So, I was the melting pot that put all the information coming from the Eastern Cape and Lesotho and processing everything to the next level.

When I started, we were at pioneering level for a system for silicosis in these remote rural areas, finding the service providers, making sure the doctors are qualified and have a spirometer, and Sister Nodu would go through to give the appropriate training. Not all X-ray departments in the Eastern Cape have got digital X-ray format, and it was a challenge to find a radiologist that could give you the quality of X-rays that you needed. We had to set up a compensation panel room with digital screens, calibrated so that the doctors could all see the same quality of X-rays. Even the lighting of the room had to be exactly at the right contrast for them to read properly.

As well as the Eastern Cape and Lesotho, claimants came from Welkom in the Free State, Limpopo, and we had a clinic in Swaziland that we dealt with. There were several different occupational health units in Cape Town as well. Wherever there was a claimant, we would try and find a doctor.

I am dyslexic, but what I learned as I grew up with the disorder was that your vibration and your energy is a universal language. I speak Afrikaans from remote parts of Namibia, which is an African language with Damara roots. So, when claimants come into the office and I had to get a translator, they could see my demeanour was to help and to provide service. And you know, you could take them through their documentation with a translator and all would be good. So, I feel that energy is real, and it can be powerful.

I have gained many professional skills working with the Trust, and this is a benefit to my clients in the future. As a sister, I wouldn't have any interest in an X-ray, but working with Q(h)ubeka Trust I started trying to read them, and after a while they become second nature to me, you know? At first, I could not see those little dots indicating silicosis, but now they are clear to me. I can also read spirometry graphs and understand what they are saying about someone's lung function. I have also learned so many valuable interpersonal skills. Coming from a purely nursing background I did not have managerial skills, but I had to learn them, and Q(h)ubeka put me through some courses to help me with that. Finally, working with the CIMS system and Ken Gliddon, I gained a lot of new IT skills as well. I was not raised in the digital age, but I had to gain important abilities to make sure all the information we had on each claimant was properly captured.

There have been so many touching moments when a claimant will contact me and thank us for his compensation. One man sent me a picture of the little house that he has bought with the money. Another sent me a picture of a small Ford bakkie that he bought for use by his whole village, because he struggled so much with getting transport to organise everything for his claim. You don't forget those things.

One important goal of the Trustees was that they were very determined that once Q(h)ubeka Trust left an area, it would leave behind a General Practitioner with a good knowledge of occupational respiratory medicine who would be able to read X-rays, provide the chronic patients with appropriate clinical follow-up, and be able to submit an ODMWA claim on their own if the patient's silicosis became more severe over time, or if TB recurred. With silicosis, closer to the end, there is no treatment for the disease, only palliative care. After their work with Q(h)ubeka, the doctors can make sure the family knows the diagnosis, which is very important so that they can assist the claimant's chronic care, and the doctors can treat all other chronic conditions, high blood pressure, sugar, diabetes, HIV and so on. And then also they would provide a little bit of steroids. Most of our claimants also need oxygen therapy.

The doctors can also work with the families on their right to autopsy after death for the claimant. They can sit with the family when the time comes, to explain how a miner's post-mortem is their right, and free of charge. They explain how the lungs and the heart will be removed and that they will be examined, and that if the National Institute for Occupational Health finds occupational disease the family can get compensation. The family can then process this information and think about consent together. The uptake of the right to post-mortem is increasing. If there is resistance from the older generation, we speak to a younger family member who then takes the issue up with their elders. Or a wife who will talk to her sick husband. In the asbestos areas around Kuru

man, there are people who now go around and explain this to people, and it has become second nature in that culture that people will fill in a post-mortem consent form before the funeral of a miner. It is an excellent service, and you have a direct line to the NIOH twenty-four hours a day. You contact them, and they send out the yellow bin with all the documents and information for the family to the funeral home or whoever is going to be performing the autopsy and make all the transport arrangements.

Another legacy of Q(h)ubeka Trust is that Doctors and Radiologists in these more remote areas who previously did not use digitalised X-ray film have now moved on to that system, so instead of them having to send full-sized films by courier to medical panels like the Trusts or the MBOD panels, everyone now can send a file stored on a USB flash drive in an instant, and bob's your uncle. That is a major improvement in data management and speeds up claims.

At a later stage we started using the Aurum Institute's mobile units[14], who have all the necessary occupational medicine and health skills. They work with the Tshiamiso Trust and the MBOD as well on claims. We would coordinate with them to get services to our own claimants. I also would identify a GP near a claimant and connect him to a radiologist who could do the X-rays. This was easier in mining areas like the Free State where these skills are used frequently. We would double-check the quality of the X-rays and explain what is required of them, before approving a service provider for our purposes. Then Tina da Cruz, our overall manager and legal eagle, would go in with the contracts and make sure they know what services we wanted them to provide. This has a knock-on effect on local doctors' skills. If a GP finds out that a patient hasn't only got chronic Obstructive Airways Disease or repetitive TB or asthma, he is now empowered to ask for that particular type of digital X-ray to be done to look for silicosis. Some of the provincial hospitals can do that.

When we were working with deceased claimants who did not go through our medical benefit examinations, we would go to the nearest Provincial hospitals, and ask them "pretty please, can you go search for Mr So-and-so, who passed away, to see if you may have treated him for TB?" So, they were instrumental in assisting us for the deceased claimants because, with the culture of many of our deceased claimants, we found that that once the person had passed, the family would burn their documentation as part of the ritual. And this included medical documentation, identifiable ID, passports, employment histories and so on.

These instances of lack of information for deceased claimants was a real worry, and it just tugged at my heartstrings. It made me more determined, and luckily, I had Doctor Sophie Kisting and Tina da Cruz to help me. As a manager, once Tina has an idea going, she is very strong. She went to those mines to get those work histories and search for those lost X-rays and records.

Several mines came to the table to assist us, and their occupational health units searched for older X-rays of the claimants. In the old days the mines only used the Ernest Oppenheimer and Carletonville hospitals, but now the individual mines are providing services. I think it's steadily picked up as occupational health started picking up. So, either the mines do it themselves by employing an occupational doctor, or they are outsourcing it, to comply with the Mine Safety and Health Act requirements for medical surveillance, and the ODMWA requirement for 2-yearly medical benefit examinations for ex-miners.

[14] https://www.auruminstitute.org/

Eventually, after we struggled for a long time with these problems, the Trustees employed medical scientists to develop an algorithm to make the decision about compensating deceased miners' dependents. It was a successful strategy because it meant that we only needed basic information on each deceased claimant to confirm a diagnosis for silicosis.

The other important pressure we had was that the three-year qualifying period for us to find the claimants on the list and organise medical benefit examinations was too short. None of us knew how difficult it would be to accomplish the task, and it worries me that there are still one or two souls that we never reached because of the time limit.

I feel that we in Q(h)ubeka Trust have been pioneers. There wasn't really a trust at that level, and we were stepping up to it and moving ahead. Now, those doors and relationships that we have opened up with the MBOD, and the service providers are opened to everyone working in this field. I'm still using them now in a different but similar role.

Interview with Peter Lewis, 2-Dec-2022.

Prof Shahieda Adams, Professor of Occupational Medicine, University of Cape Town

I was born in Strand, a little town close to Gordon's Bay. I did my primary schooling there. I was the eldest daughter of five children at the time, and my mom has now remarried, so we are now eight siblings. We all went to the local community primary school, which was predominantly Afrikaans. I wanted to escape both Afrikaans and needlework, so I did my high school at Trafalgar High School in District 6, then under the apartheid so-called "Coloured Education Department". I went on to study medicine at the University of Cape Town. I was married with two children before I qualified as a medical doctor – to this day I don't know how I quite managed that!

I did a little bit of general practice and locum work for two to three years before deciding to work as a GP, which is what we were all doing at that time. My practice was slow to take off the ground, so I did sessional worked in TB clinics and an Occupational Health Clinic for local government with little knowledge of what occupational health is. In the interim I was busy with my Masters in Family medicine because I realized I didn't really have all the skills for GP work, but ironically, I got very much more interested in occupational health. At the time my work in that field was limited to medically boarding people who could no longer work. At one point, I needed to refer a patient to the Workers Clinic, which was run by an NGO called Industrial Health Research Group (IHRG). It was a clinic for workers with occupational diseases which was free of charge to workers, based at Woodstock Hospital. The nurse working there, Sr Faieza Desai, encouraged me to join them. She had an important role in the Q(h)ubeka Trust subsequently, but sadly she died whilst there, and that was a big loss to all of us in occupational health. I agreed to join the Workers' Clinic back then in the late 1990's and obtained my post-graduate diploma in occupational health at UCT, under Professor Jonny Myers, and I have worked continuously in occupational health settings ever since. As an adjunct to that, I worked on the occupational medical specialist panel that was investigating and assessing claims from community members who had been exposed to excessive sulphur dioxide fumes when a massive fire swept through the Somerset West AECI fertiliser and explosives plant affecting residents from the Macassar township nearby. Farmers were immediately and handsomely compensated for their crop losses, but not the Macassar community members, who had to wait many years with little progress in

their compensation for damage to their health and well-being. We looked at claimants' medical data to see whether they had a case to litigate for compensation, and Sr Faieza Desai was heavily involved in conducting the medical assessments of these potential claimants.[15]

I was the first South African medical doctor to qualify as an occupational medicine specialist inside the country in 2007, following the creation of the specialty in South Africa in 2004. Others before me had pursued their postgraduate qualifications in occupational medicine abroad. I started my training as an occupational medicine registrar in 2004. My registrar post was funded by the Department of Labour as there were no funded posts in Occupational Medicine within the Department of Health.

I derived enormous satisfaction from that registrar period because just prior to my appointment, a group of occupational medical physicians from academia and the private sector, wrote a letter complaining to the Public Protector about the inefficiencies within the COIDA compensation system.[16] I think Department of Labour felt the heat a bit, and finally acted on powers in the Act to decentralise some of its functions and established medical advisory panels to assist the Compensation Commissioner's Office under COIDA. This was recommended in the Public Protector's report on the matter, as a sound measure to promote efficiency and counteract the delays of up to 10 years in paying out workers, if at all. These delays in part were caused by the centralized nature of operating and the fact that everything was still paper-based. So, the result was that the Western Cape Provincial Medical Advisory Panel was established. The late Prof Neil White was the chair of the panel, and Profs Ehrlich and Jeebhay were also panellists, alongside several others. The governance structure included the Chief Medical Officer for the Compensation Commissioner's office, and other support from the Department of Labour, I worked under the panel's oversight and essentially we facilitated and fast tracked the assessment and adjudication of claims. So, at one stage, practically most occupational disease claims were couriered to us in Cape Town, including X-rays and all other medical records. As a registrar, I would prepare the cases and an experienced occupational medicine physician, and a radiologist would evaluate the case and read the X-rays and make an assessment. This essentially shortened the turnaround time for occupational disease claims resolution, from up to a decade in some instances to about two to three months. Every two or three months we would get a batch of cases with X-rays to evaluate in this way. It worked so well that the Department of Labour started a similar panel in Durban as well, where there was academic expertise in occupational medicine to support such an initiative.

The assistance of the Medical advisory panels in tackling the backlog of occupational lung disease claims specifically, resulted in less reliance on assistance from the MBOD to support occupational lung disease certification. These claims were mainly from workers with respiratory disease from exposures emanating from working in metal industries, heavy engineering, and foundries. As we

[15] The contaminant was a from a fire in a huge sulphur dump in 1996. Since that time, there have been further explosions and fires in 2018 and 2021, and 2022 at Rheinmetall/DENEL which now owns the site and manufactures explosives there. In 2018, eight people died, and again there were casualties in the 2021 fire. Explosives are manufactured there for both the armed forces, and the mining industry for blasting rock faces. There is a widespread call from community and trade union circles for the government to revoke the plant's explosives manufacturing licence because of its atrocious safety record over decades. https://apnews.com/article/01c0e9ac112c50230ee5fce4b531b70e

[16] The Public Protector has mounted at least three investigations into the worker compensation system, as a result of this intervention from the occupational medical profession and victims of its near collapse in recent decades. See "*Report on a systematic investigation into allegations of poor service delivery by the Compensation Fund. Report No. 28 of 2009/10. Part 1"; Report No. 28 of 2009/10. Part 2"*; and *Report No 14 of 2019/20*

know, getting decisions to compensate out of the MBOD was also plagued by long delays and inefficiency at that time. So the Panels provided the necessary expertise to the Department of Labour to address some of the inefficiencies highlighted in complaints referred to the Public Protector's office. We demonstrated our value to the Department, and they acknowledged that. When the ILO was requesting member countries to have input into its new schedule of occupational diseases, we gave input there as well, to expand and update the schedule of compensable diseases. A few years later, I discovered when South Africa attended the ILO, they basically took our input as we had drafted it and presented it as the South African submission, and some of it was adopted as a global standard for compensation systems for occupational disease[17].

In 2007, former President Mbeki was replaced by former President Zuma as no.1 in the ANC structures, and there was huge political upheaval at all levels, and big changes in many of the top structures of government departments. The Compensation Fund in the Department of Labour was headed by a new Chief Operating Officer (COO) who favoured the involvement of primary care doctors to assist the Fund with COIDA claims. The Chief Medical Officers under COIDA who had supported the establishment and support for the Provincial panels comprising doctors with expertise in occupational medicine had both left to work at Eskom. Then, early in 2008, the new Chief Operating Officer informed us that the panels would be closed and the project terminated. We had built strong networks of expertise, but there was little understanding and appreciation for the fact that specific expertise and capacity was needed to diagnose and adjudicate occupational disease claims. In the view of the COO it was proposed that this work could be performed by General Practitioners as required. We had little choice but to terminate the program which sadly closed down at the end of April 2008. I was fortunate that by then, my training was done. I was a qualified specialist, but the registrar post at UKZN had to be supported with additional funding to help the registrar in training complete her qualification. Meanwhile, I had to put out feelers for a new position, and I began work on my Doctoral Thesis at UCT, on latent and active TB amongst the healthcare workforce, and continued with that till completion of all my fieldwork in 2011.

I subsequently began working for an insurance company, Metropolitan Health, in a unit called Qualsa at Work, which focused on the assessment of disability and incapacity claims in government workers, and the provision of employee assistance programs to workplaces. I began working there as a medical advisor focussing on medical incapacity claims for government workers from two provinces. We had a team of case managers, and as a medical advisor I signed off on whether incapacity leave should be granted or not. This got me very interested in thinking about disability and impairment evaluation of workers which has become a major area of interest to me now. I stayed there for 18 months and gained a lot of new skills in quality management systems resulting in our product achieving ISO 9001 certification. I found that the private sector could provide a very enabling environment, but I missed clinical work and the interface with clients. So, I went back to working, this time as a specialist, in clinical occupational medicine at the City of Cape Town, full circle from 20 years earlier. There was no established specialist post there, but I worked in the role of a specialist and focussed on cases needing incapacity management for the city of Cape Town. So in addition to the routine medical surveillance of diverse groups of workers such as landfill site workers, firemen, policemen and so on. I also did all their medical incapacity cases and continued doing this for three and a half years.

[17] The South African schedule in 2004 was https://www.labourguide.co.za/workshop/1682-schedule-3-coida/file The ILO schedule for 2010 was https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/publication/wcms_125137.pdf

I have always kept a foothold in academic medicine. In 2016 I became head of clinical medicine at Groote Schuur academic hospital, and an associate professor in the division in 2019.

Current challenges that remain is a lack of focus by the Department of Labour on adopting significant measures to assist the rehabilitation of sick and injured workers so that they can return to the workplace. We have a huge burden of chronic heart disease, stroke, and diabetes, as well as mental health problems especially amongst health workers because of the Covid19 disaster. Returning these people to work requires a nuanced, well-resourced, and multi-disciplinary response from expert health personnel. The Department of Labour is not effectively using the expertise on occupational injury and disease assessment and prevention that we have built up in South Africa. The Technical Advisory Committee on Occupational Diseases (TCOD) is a case in point. For a while there were highly skilled and experienced occupational medical specialists and academicians sitting on it at one time, but many have left as their proposals were not appreciated or entertained by the Commissioner's Office. I think the lack of focus on rehabilitation applies to the ODMWA as well for miners.

The poor compensation paid to workers is another issue as many workers are disabled by occupational lung disease. For this reason, some private litigation initiatives were initiated to ensure fairer compensation resulting in the establishments of Private trusts such as the Asbestos Relief Trust, the Q(h)ubeka Trust and more recently the Tshiamiso Trust. During my registrar years I was a member of the medical panel at the Asbestos Relief Trust, working with Dr. Sophie Kisting, who taught me a great deal. This experience stood me in good stead when I joined the Q(h)ubeka Trust as a member of the specialist medical panel, and subsequently as a member of the Medical Review Panel. As the review panel our mandate was to resolve differences between specialist assessments and determine the need for further investigations for complex cases. I served as chair of the panel, and Prof Jeebhay and a highly skilled radiologist, Dr Qonita Said-Hartley, constituted the panel. The Trustees felt that was necessary to give all claimants the benefit of any doubt there might be about their medical qualification for compensation under the Trust Deed. We wanted to effect a resolution of these cases informed by adequate information and evidence to support the compensation process.

At the Groote Schuur clinic, I regularly still see ex-miners and I work with the MBOD. We have access to their database, so we can look up our claimants and see where they are in the system. The database is not always up to date, but at least we have some access to information. We keep in touch with the Compensation Commissioner of Occupational Diseases' medical team if we are really stuck with cases. I don't think the system is really working as well as I would like. One of the most heart-breaking experiences for me was coming back in 2016 as the Consultant at the clinic where I trained as a registrar, seeing one of my old patients eight years later, with florid silicosis and still uncompensated. That crystallized for me an understanding that the Occupational Health Compensation systems problems are systemic and deep-seated. If you are a miner or ex-miner, where else would you get florid silicosis in South Africa? Why do they need proof of an employment history from mineworkers who have long exited employment on account of diseased lungs. It is a travesty that many of these people go uncompensated because of a lack of good information and employment records, through no fault of their own.

Interview with Peter Lewis, 5-Dec-2022.

Q(h)ubeka Claimant Tracking and Tracing Work Stream

Pasika Nontshiza, Outreach Consultant

I started out working for an NGO – Red Cross Society. I have never been employed by government, and I am coming up for retirement. I volunteered after 1994 – we were let down by the government, so I decided I must help people directly. So, I worked in an NGO reaching the poorest people in the Transkei. It was driven by old women, with young people helping them. I did that for 3 years, and then became Branch Manager for the Transkei, with 28 magisterial districts to cover, 95% rural. Towns were very small – mainly just a trading store. As a volunteer, my family were always asking how I can keep going. I was planting seeds amongst the poorest of the poor. My satisfaction was helping others.

In 2011 I was asked by Richard Spoor to assist in registering people for the class action in the Pondoland area. We had an office, and we registered people. When I left that office, we had registered 30,000. Then, Spoor recommended me to work for the Qubeka legal action.

I had done thorough research for Spoor, and this made Q(h)ubeka Trust work a lot easier. Also, my accommodation in the rural areas for tracking and tracing was arranged by the Q(h)ubeka Trust staff. With Spoor, I had to arrange my own accommodation with the traditional leaders in each district, and I sometimes travelled 250km on really bad roads.

There were very moving stories when I met with widows of miners. Widows. They say "you have come here employed to do this, you don't ask for money, we are forever grateful to Q(h)ubeka Trust. When my sick husband went to Pretoria to demand his compensation, he was teargassed, fighting for this money. I will go to his grave and tell him that it has finally come, and he will now rest in peace. My children's inheritance was this constant sickness problem for their father and family. Always going to hospital, attending government initiatives, only to draw a blank. But Q(h)ubeka Trust came to us and supported us. Even in this corrupt country, we got our money without a problem."

One child left her cashier job in Bloemfontein and came home, because her mother could not come to the city for registration for Q(h)ubeka Trust. The child then helped her get a letter of authority to receive for payment. Then she stayed and renovated her mother's house with the money.

Last week, a mother said her husband had succumbed to covid, and the funeral was restricted/banned. She said burying him was like dumping him because she had nothing, so he was not resting peacefully. So, I got a Letter of Authority, and got the money, and I have been praying to God in thanks ever since. She asked me to look up her son in Mthatha and tell him the news.

My experience of Q(h)ubeka Trust is that it has been like climbing Kilimanjaro – with proper planning! We had empirical data to use in our searches and accreditation. We were not fumbling. It has been a very good model for distributing services in these isolated areas. Not tokenistic, and very pragmatic.

People did not take offence if they were tested and did not qualify – we might give ten their medical benefit examination, and only one was positive, but the others were not offended. If I

found a homestead, and the woman of the house said, "*but my husband was also in the mine*", yet she was not on the Q(h)ubeka list, then we refer her to the Tshiamiso Trust for possible compensation.

We used the small hire cars – not suited to much of the terrain. But no-one has had a serious accident. However, I was out in a storm in early October 2022. The car went into a ditch, so I walked and found a nearby home to wait for a breakdown truck, which took six hours to arrive.

We have been to the ends of the earth to make sure people were compensated. The personal touch was important. People say, "we have been robbed a lot- so we are happy now with our payments".

Interview with Peter Lewis, 26-Oct-2022.

Mzamo Dlamini, Outreach Consultant

My hometown is in the Bizana district of the Eastern Cape. My father worked in the gold mines, but not for long, and he never got sick. It was very long ago. But there was another man the same age as my father who died since working at the mines. I also know of one man from my hometown, the same age as me, who went to the mines. There was also a TEBA office in my hometown.

I worked with the Amadiba Coastal Community Trust. Initially the community was 100% opposed to the Australian titanium mining proposal and wanted to preserve its existing tourism-related economic and environmental development model which the mining would destroy.[18] But the company offered people shares in the mine and it divided the community, so I moved on to working with my community on reviving tourism and agricultural projects.

Then I moved to Mthatha, where there is also a TEBA office.

Q(h)ubeka Trust fitted with my political and community activist role as a businessperson, and I wanted to make sure that people got the money they were entitled to, and I realised that I had the skills and experience to make it happen. I first got involved in the tracking and tracing work for what became the Tshiamiso Trust, meeting and collecting the names of ex-miners. I was involved in the first stage, holding meetings with them to alert them about the litigation, and registering people for it. That work finished when the centre of gravity moved to the litigation and court hearings.

In 2016, I was elected as ward councillor in my hometown, and my term of office finished October last year. Then I was hired by the Q(h)ubeka Trust. I was suited to the job because of my previous experience with Tshiamiso, and when I worked for SANRAL, I had conducted a social survey to examine community attitudes towards a proposed new road-building project. I went to Bityi district to track and trace claimants.

The banks have been functioning largely through covid and loadshedding, but there are 2 other difficult problems. Mthatha has several shopping centres, with 1-5 kms between them. Each bank branch has different minimum requirements for deposits to open a Deceased Estate Account. Some branches want the claimant to open an individual account, and they vary in what they

[18] Amadiba Crisis Committee: Overcoming Adversity with Community Solidarity

require. For example, the claimant was awarded R150,000, but one branch wanted the minimum deposit for estate accounts to be R500,000.

With some bank branches, you give them all the documents, prove your address, and they take document copies, but then they come back to you sometimes two or three weeks later and tell you that FICA requirements are not met. So, the account is blocked. This is a common problem. The bank has not verified the letter of authority with the magistrate who issued it. Forty percent of payments to banks are returned to the Trust because of this, and I do not have standing to sort it out with the bank. So, then I must take the claimant to another bank branch and start all over again. Claimants sometimes have to travel for more than 2 hours to get to the bank in Mthatha, and then queue, having to wait all day for the bus home because there is a very limited service. I take them to the bank if they do not have children who can help them with the questions that the bank official requires answers to.

I managed to make friends with some branch managers, who understood that there would be a steady stream of beneficiaries, so they caused less problems. However, now the problem is the centralisation of decision-making by banks in Gauteng, and the process of verification / FICA. Decisions are not always rational, or even consistent. With all these problems, I sometimes have to visit the Master of the Court and a bank branch 5 times each. It's very frustrating, but the Q(h)ubeka Trust QT happily shepherds them through the process.

There are special cases where, in the quite distant past, a miner would use the names of their grandfathers or fathers, but when they go home the family says you must change your name/ID to reflect the whole family. In one case in Port St. Johns a claimant applied for a new ID with new ID number, and his photograph and age were completely different from his original ID book. The Trust required a death certificate matching the ID card on his medical records and work history. The Trustees were very helpful in understanding these cases, but Home Affairs will not help you to reconcile the 2 ID's.

Some women register their marriages only after the husband has died, so the proof of marriage is not available when we need it. This underlines the importance of a will. It would solve a lot of the problems we have seen. It stops fights and solves problems. So, we educate the living claimants the importance of making a will, and how to do it. In August 2022, the Master of the High Court held a whole-day event with the Justice Department team to educate people on this as well.

If claimant is dead, and their dependent/spouse or children are dead without a will, the trail goes cold. I think it would have been better if the lawyers should have provided a will service when they registered all the miners for the lawsuit.

In one case, a living beneficiary miner said he did not trust the team and wanted to get his lawyer to check all the documents. The lawyer wanted a payment of R7000 for this before the claimant was paid out. We told the claimant that he was being ripped off, and that he should not have to pay anything to get the money. If a dependent of a deceased miner receives a payment of more than R250,000 to an Estate Late account (EL), she must have an executor for the Estate, but this does not have to be a lawyer – it can be another family member, or a trusted friend.

Another issue is "what about when the money is paid out?" Claimants were supposed to have attended a session on handling money. Most of these people have never handled more than

R2,000. So, we encourage them to save it or use it only for the most important family necessities. They are naïve about money. One widow of about forty years of age received R200,000 and drank it all away. She was living in town for small jobs and got into a fight in a shebeen and was killed. They found cases and bottles of alcohol in and around her residence. When she was buried, there was only R6,000 left in her account. But most of the people who receive the money are smiling a lot. They build big modern brick houses with 5 rooms, or extend their homes, send children to school, or make sure that rituals for deceased family members, previously impossible, are done properly. They tend graves, conduct traditional ceremonies – it's a beautiful thing. Some people handled it all very well, and there are many good stories. They assess the situation in the family – and spend or invest wisely, including into small businesses to make an income. Some make arrangements to share the money before they receive it.

Older people send us messages of blessing, to say that the family appreciates us.

In one case, the first tranche of payment is made, and then the money is used up and finished, and before the second payment can come through, the miner dies without a will. But there can only be one letter of authority for each claim. So, in that type of situation the dependents go to a lawyer to get the second payment but demands money for this before he will do anything. The dependent (say, a grandchild) might be eligible for only R30,000 in the original letter of authority, but the total amount that would have been paid out to the miner was R350,000. Again, this type of problem would be fixed if every miner had made a will, so that the remainder of the money could be paid out to dependents without the need for a second letter of authority. None of the deceased claimants have a will.

There are sometimes quarrels and fights over the money, before the payment, or afterwards. Sometimes this happens when the children and the mother do not see eye to eye. Or in one case, there were 2 wives, and only one had a marriage certificate. But the family does not recognise the certificated wife but favours the other one. In these cases, I don't resort to legal affidavits, but start with mediation in the spirit of Ubuntu, and it is usually very successful. If the older wife died, and he married a second wife, who had children with him, but also had children from another man, the mediation can establish who has the right to an agreed proportion of the pay-out before the money arrives. It goes into the designated bank account, and then the account holder pays out the agreed amounts to those who are to benefit by the agreement that everyone has reached through mediation.

Where there is bad blood about what happened in the past or grievances that demand to be assuaged, the method I use in such mediations is to say let bygones be bygones. Then I get people to focus on what the money should be used for, in the best interests of the whole family, and then to prioritise those needs. The father of a family wants everyone in the family to be happy. So, close the old slate, and start a new one. Then people will agree on a list of priorities, and then cost the list, and decide what is possible and what is not. That way, any silly desires like an expensive holiday by the beach will not be entertained, and everyone will benefit. The process resolves old enmities, and calms everyone down. Usually disputes come down to 2 sides, and the mediator must listen and get stories from both sides – to remain neutral as they head towards a solution.

There are rare cases who do not qualify for pay-out under the Trust Deed, because they were excluded in the search phase of the litigation by the rules issued by the lawyers. However, there were some mistakes made. So, we have to investigate these cases, ask for further documentation, and submit the claim again. But then if the claim is again refused, we have gotten people's hopes

up, but ultimately compensation is still denied. The work can be emotionally taxing. These are needy people, and the pay-outs can change their lives. They budget in advance for the money they expect to get and ask how long it will take to be paid out. We say weeks, but sometimes it is months and months. So, we have to follow up with them, but sometimes it feels like we are playing with people's lives. I find this very emotionally draining. I must keep positive, but it depends on trust, and what if there is no pay-out at the end of it? I feel bad for people because of all the glitches that happen along the way. But when a pay-out finally occurs and everything goes smoothly, everyone is happy and that is an emotional counterweight in the work.

For an example, today I went to see a widow of a deceased claimant who was applying for benefits under Q(h)ubeka Trust. She has no marriage certificate, and load shedding at the Magistrate's court which was officially opened in 2019, meant that a letter of authority could not be issued for her to open a bank account. The letter of authority from a magistrate makes her the executor of her husband's estate. So, I asked her to come to Mthatha, but even there the magistrate's court was not functioning because of load shedding affecting the network, which had also shut down during Covid as well. The banks require an ID for FICA regulations, which she did not have, but there are two Department of Home Affairs mobile trucks in the Mthatha district, so they processed her, she got her ID, and then could open a bank acct. So, she eventually got paid and she was smiling so much today!

Claimants are often very, very sick, and they are so frail that they cannot even be happy when they learn about the money, because anyway the money will not benefit them personally – they will die before receiving the money, and so cannot use any of it, and will not witness how it is used. It's too late for him, yet he has been in the process of documentation sometimes for a long time. It must feel like a wasted effort. That is why wills, and mediation where there are family feuds, are so important, because at least they would know that the money will be used wisely.

Interview with Peter Lewis, 25-Oct-2022.

Tankiso Christopher Letsie, Outreach Consultant, Lesotho

I am a Mosotho man born and raised in a small village called Khubetsoana in the Capital city of Lesotho-Maseru. I am self-employed businessman with a legally registered consultancy company. I have an experience of over ten years working in my country and South Africa, particularly in the field of Health Education. I am Currently working with Q(h)ubeka Trust based in South Africa-Johannesburg, it is a project that has paid millions to compensate former miners in my country, who were found to have silicosis. I was also employed by Leigh Day law firm from UK as a Paralegal during the legal battle between ex-miners and the gold mining organization that led to the Q(h)ubeka Trust Intervention. When the arbitration settlement was signed in 2016, I worked for the Mineworkers' Development Agency, leading a team working on the issue of Tuberculosis amongst ex-miners in Lesotho.

My motivation for the ex-miners' projects was fostered by Leigh Day and Mbuyiswa Attorneys based in Johannesburg, who gave me courage to thrive and never give up in life. The litigation for Q(h)ubeka Trust took longer than expected, but the attorneys kept battling with the mines. The Project was prolonged due to legal battles encountered and we were determined to complete what we had already started so that all the miners are compensated, and justice served at the end.

We tracked and traced TB cases and linked thousands of ex-miners with the Compensation Commissioner for Occupational Diseases. I coordinated another similar project called TB in the mining sector (TIMS) Pretoria. Our main target was randomly selected locations both local and peripheral setting and mobilize them for medical examinations and link those medical reports for benefit claims. That mobilisation also involved educating both ex-miners and family members so that if the core or main beneficiary dies before payments, the dependants have access and ability to follow claim issues and activities. It is very important to involve family members in the mobilisation because most of our claimants do not have good audible range.

During this litigation, we have registered over 27,000 Basotho ex-miners that led to establishment of the current trust fund Tshiamiso to ensure that eligible claimants receive the compensation that is due to them. One of day-to-day administration and efforts involved tracking, tracing, and documentation of the claimants for the Trust. Furthermore, we administered claimants' fingerprints, filling of compensation forms, and verification of their particulars.

The project challenges encountered were communication (poor telephone network, illiteracy and unavailability of telephone devices), transport (poor road infrastructure in remote areas) and financial constraint (bus fare). But we were able to reach our clients as we had well organized logistics such as 4x4 bakkies, local mode of transport such as horses and skate boats for smooth consultation, mobility of pitsos by village Chief, data collection surveys. I had to arrange the dates for the medical screening in clusters of claimants according to types and severity of diseases symptoms that had to be examined in 30 days under Dr Kolobe in Maseru as private physician who was engaged for this service by the Q(h)ubeka Trust.

Sometimes we have to use boats to cross the rivers to get to the villages which Sometimes took a whole day for just one client because of the bad roads, and inaccessible villages. For tracking and tracing claimants we had several strategies. If I have contact with a village chief by cell phone, he can help me find every ex-miner in his village, but it was only possible where there is a network coverage. Where there is no network connection, I had to do house to house consultation or go the Chief's office and leave a message for him to request a meeting on a particular date and time especially most of my targeted claimants are unavailable.

We had a very stressful time with the claimant's identity verification due to the fact that most of them had changed their particulars. For instance, you consult a claimant with the names given on our database, but he has changed his particulars, it becomes difficult to identify such an incumbent as the Chief himself and the villagers are unable to recognise the given information. Another example is different dates of birth not matching on every document, so the compensation payment is put on hold because it might not be the same person. The cause of this problem is that the miners would get a passport/visa from Home Affairs to work in the mines and return for further mine contracts. The mines in the Q(h)ubeka settlement had policies to exclude the older Sotho men from contracts. They often had quite several work visas, some with different dates of birth. To verify that they were who they said they are, we had to consult the Department of Home Affairs Lesotho for confirmation and verification of correct dates of birth.

Another challenge was when a claimant had a conflict with his village Chief, who will then decline to issue him the stamped letter required by the bank to open an account. So, I have to step up and mediate between them and also explain the importance of the project which will not only benefit the said claimant but the family as a whole. When the first payments were processed, most of the

claimants did not have bank accounts to deposit them. Initially, opening bank accounts for depositing the compensation payments was hectic. To solve this, I developed a good relationship with a particular bank due to long good service relationship.

It was an honour when I received a call from Dr Cornell offering to work with me for smooth running of the second batch of payments. She is a very good, dedicated leader and manager with vast experience. She travelled all the way to Lesotho to assist with claimants' outreach issues, programs and activities. One of her exciting experiences during her visit, we went to one of the most remote area uphill, while on our way and already drained, a man in a horse heading to a similar village came on our direction, she tipped me to talk to him and tell him our purpose of the trip. Then the man urged to return back and gather targeted claimants to come and meet us to a place both conducive to our team and them. That day our duty was as easy as a walk in the park.

Meeting and working with the claimants had been a striking experience. Most of them were very sick which sometimes left us in traumatic state as this silica dust has damaged their lungs. One could identify difficulty in breathing with whizzing sound. One would read on their dependents facial expressions that they were keen to seek justice. They would tell touching stories, how they struggled after their breadwinner got sick or passed away due to TB.

The worst nightmare has been informing claimants who went through the benefit medical examinations and everything else that they have not qualified for compensation, they were devastated but at the end they would comply. One could step in their shoes going through having to see their neighbour getting a chunk of compensation because of the effects of the mine dust that affected everybody, even at the same mine where they had such a bad working experience. We kept explaining to them why they are not eligible for compensation. We made them aware that not everybody's eligible for compensation, but only the people who have silicosis. That's how the settlement was, but still did not understand, The Q(h)ubeka Trust only focuses on compensating silicosis ex-miners' patients, but not TB. But usually, the uncompensated claimants would say that they had been in the government clinics and were told that they were diagnosed with TB. They will come back and say to us "*Why are you saying that I am not sick? Look I have medical booklet from the clinic, I am sick, I am sick!*". We then try to explain that TB can be treated and cured, but silicosis cannot. But they do not accept that this means that they will get no compensation from Q(h)ubeka. We have to tell them that they can get compensation from the MBOD for TB, because Q(h)ubeka Trust will pass their claims on to the MBOD, if the doctors found that they had TB when they had the medical benefit examination. I am always in touch with Doctor Kolobe here in Maseru, and Sister Xavier who visits the medical doctors who deal with Q(h)ubeka claimants' medical benefit examinations. They are very professional and determined people.

There is a need for a central agency to coordinate all benefits that ex-miners are entitled to, not just occupational diseases compensation. For example: many of them are entitled to pay-outs from the Mineworkers' Provident Fund as well as the Q(h)ubeka Trust fund. But each fund operates separately and has its own tracking, tracing, and registering process. It would be very good to have a central agency that works with an app on the cell phone system, using the miner's industry number, so that the miners and their dependents can see all the benefits they are entitled to and how to get their monies. That agency would then work with all of the stakeholders, the mines, the medical authorities, to process the claims in different channels. That would eliminate some of the duplication of efforts that each separate fund has to put in to carry out their

mandates. Ideally, this is Lesotho Department of Labour recommendation, and we have had contact with it during the Q(h)ubeka project.

I'd like honour to my team. They are Mr Mosala Letsolo, an economist, and Mrs Montsoang Makhutloane, a business manager. We did the second Q(h)ubeka payments together. I worked with Mr Mosala at the Mineworkers' Development Agency, and he was well equipped with necessary innovative skills for the project activities. These two were Heaven-sent and workaholics. Q(h)ubeka Trust head office staff also ensured that there is a smooth running of project implementation through both social and financial administration. They also offered speedy response to our inquiries about particular claimants or family members, and the issues they have in complying with requirements to receive their payments.

Interview with Peter Lewis, 25-Oct-2022.

The Q(h)ubeka Trust came to a planned end on 21 April 2023.

Its achievements are reflected in this booklet and on the website
https://www.qhubekatrust.co.za
which preserves all the annual reports and formal Trust information.

September 2023

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