The Committee will meet at 10 am in Committee Room 6.

1. **Rights of Relatives to Damages (Mesothelioma) (Scotland) Bill:** The Committee will take evidence at Stage 1 of the Bill from—

   Paul Cackette, Head of Civil Justice, Law Reform and International Division, Scottish Executive;

   Lorna Brownlee, Bill Team Leader, Scottish Executive;

   Anne Hampson, Bill Team Member, Scottish Executive;

   Alison Fraser, Office of the Solicitor of the Scottish Executive; and

   Bob Cockburn, Deputy Principal Clerk of Session, Scottish Court Service.

Callum Thomson
Clerk to the Committee
Papers for the meeting—

Agenda item 1

Note by SPICe (PRIVATE PAPER)  
[57x741]SPICe briefing on the Rights of Relatives to Damages (Mesothelioma) (Scotland) Bill  
[57x685]SPICE summary of written evidence received on the Rights of Relatives to Damages (Mesothelioma) (Scotland) Bill

Documents not circulated—

Copies of the following documents have been supplied to the Clerk:

- Custodial Sentences and Weapons (Scotland) Bill – Regulatory Impact Assessment; and
- Scottish Executive Statistical Bulletin – Homicides in Scotland, 2005-06

These documents are available for consultation in Room T3.60. Additional copies may also be obtainable on request from the Parliament’s Document Supply Centre.

Forthcoming meetings—

Wednesday 6 December, Committee Room 6;
Wednesday 13 December, Committee Room 4; and
Tuesday 19 December, Committee Room 1
JUSTICE 1 COMMITTEE
BRIEFING PAPER

Rights of Relatives to Damages (Mesothelioma) (Scotland) Bill

Summary of Evidence Received by the Justice 1 Committee and Scottish Executive

When it issued its call for evidence on the Bill, the Committee stated that if a response had already been made to the Scottish Executive’s consultation and the responder had nothing further to add, it was not necessary to make a further response. This paper provides a summary of both the responses to the Scottish Executive consultation and the responses received by the Justice 1 Committee. Responses have been grouped according to their perspective on the Bill.

Overview

Most respondents to the Committee’s call for evidence supported the Bill in principle, although some felt a change to the law to be unnecessary. The Scottish Executive published a Summary of Responses to Consultation Paper which highlights that all 15 respondents agreed that the existing law is problematic. 12 agreed that the problem should be remedied by disapplying section 1(2) of the Damages (Scotland) Act 1976 (the 1976 act). 10 respondents agreed that the Bill should be confined to cases of asbestos related mesothelioma. 7 agreed that Scottish Ministers should have the power to extend the new provision to other diseases or forms of personal injury, while 6 disagreed and 2 offered no direct comment.

INTEREST GROUPS

Clydeside Action on Asbestos (CAA)

CAA submitted responses to both the Committee and the Scottish Executive’s consultation. Responding to the Committee, Harry McCluskey, secretary of the CAA, described how CAA had been actively campaigning on the issue, particularly in respect of Petition PE336 on speeding up damages claims for mesothelioma sufferers. He argued that the creation of a fast track system, whereby sufferers would be able to claim for damages in their own lifetime, highlighted the dilemma faced by sufferers of whether to claim during their lifetime or allow their relatives to do so after their death. CAA considered it unacceptable to place such an additional burden on the terminally ill and felt the Bill as proposed would remedy the situation. In its response to the Scottish Executive Consultation, CAA raised the same issues, adding that the Bill should cover all other types of personal injury for terminal cases, and by implication include a ministerial power to amend the provisions to add further medical conditions.

Des McNulty MSP

Mr McNulty responded to both the Committee and the Scottish Executive expressing his strong support for the Bill, the introduction of which led him to withdraw his own bill. He argued that it “addresses a fundamental issue of human
rights” in no longer preventing a victim’s relatives from claiming damages after the victim’s death, even although the victim had themselves claimed damages while alive. He said the contribution of the Parliament in passing the Bill will be considerable, particularly when taken in combination with the provisions of the Compensation Act (Westminster) that was the subject of a legislative Consent memorandum. Responding to the Scottish Executive, Des McNulty MSP did so in his capacity as a MSP for Clydebank and Milngavie, where prevalence of mesothelioma is particularly high. He cited among the campaigners for an amendment to the 1976 act, Clydebank Asbestos Group, Clydeside Action on Asbestos and Action Asbestos Tayside; West Dunbartonshire Council, Frank Maguire at Thompsons Solicitors, and trade unionists at the STUC, TGWU, GMB and UCATT. Several of these bodies also submitted evidence, as set out below. On the specific questions posed by the Executive, he agreed that the current law poses problems and s1(2) of the 1976 Act should be disapplied to families of mesothelioma sufferers. He went on to say, “It may be appropriate that the bill should include provision to allow the disapplication of section 1(2) to affect other diseases … but only provided that this does not slow down or make more complicated the immediate task of dealing with compensation for mesothelioma sufferers.”

UNIONS

Scottish Trades Union Congress (STUC)
The STUC responded to both the Committee and the Scottish Executive. It welcomed the introduction of the Bill, arguing that the current law is unjust and also recognising that the dilemma facing mesothelioma sufferers has arisen following new Court of Session procedures. It supported the disapplication of s1(2) of the 1976 Act to relatives’ non-patrimonial loss following the victim’s death. In its response to the Scottish Executive the STUC said it would welcome a provision allowing ministers to include other occupational disease or injury claims within the provisions of the Bill. It then said in response to the Committee that although the primary objective is relative to mesothelioma, there is justification for including other medical conditions. However, in its submission to the Committee, the STUC accepted the Executive view that the bill should be confined to mesothelioma.

The STUC suggested that the comments Association of British Insurers (ABI) on interim payments, as discussed below, in England and Wales were erroneous and misrepresentative. The STUC cited evidence from the chair of the Greater Manchester Asbestos Victim Support Group, which argued that the use of interim payments is unpalatable and not commonly sought in England and Wales.

Upon considering the financial impact of the Bill, the STUC said that it did not feel that providing full compensation to victims and families would pose a significant burden to insurers or the state. Any increased costs to the insurance industry would be reflected in employers’ liability premiums and could be offset by employers taking occupational health and safety seriously. The STUC also argued that projected compensation is “insignificant in comparison to profits”.

Union of Construction, Allied Trades and Technicians (UCATT)
UCATT expressed the belief that members suffering from terminal diseases should receive full compensation, which should include compensation for family members. It believed the current situation to be unjust. UCATT considered that unless there
is a legislative change, most members would forego compensation in favour of families receiving compensation after their deaths; family payments should not rely on victim’s decisions. UCATT argued that disapplying s1(2) of the 1976 act would remedy this injustice and would entail minimal financial impact on insurers. The Union said it would welcome any provision allowing Ministers to include in the amendment “future claims for compensation for occupational disease or injury that similarly disadvantages victims and their families.”

INSURERS / CONSUMERS

Association of British Insurers

The ABI did not believe the proposed legislation to be necessary, yet recognised the current law can cause problems for claimants and their relatives. It argued that this could be resolved by, “encouraging claimants to initiate their claim, make an application for interim damages, and then sist\(^1\) the claim until after their death. This process would enable the claimant to receive a sum of money whilst still alive, and for their family to claim damages after their death”.\(^2\) However, the ABI accepted that if a change to the law was necessary, it would support it on condition that its provisions remained limited to mesothelioma, on the ground of the uniqueness of the condition. In evidence to the Scottish Executive consultation, the ABI argued against giving Scottish ministers powers to extend the provisions to conditions other than Mesothelioma. The ABI also argued that insurers set premiums based on the law at the time of selling the policy. Regular revisions create uncertainty which leads to higher premiums.

Forum of Scottish Claims Managers

Taking a similar line to the ABI, in its response to the Scottish Executive consultation, the Forum of Scottish Claims Managers contended that the existing law is problematic, but that it can usually be resolved through an interim payment made to the claimant, with the claim then sisted until after their death. The FSCM agreed that s1(2) of the 1976 act should be disapplied, but argued that care should be taken to avoid ‘double accounting’, that is compensating for loss of wages as well as loss of family support. The FSCM, too, argued that provisions should be confined to mesothelioma.

HBM Sayers, Solicitors and Solicitor Advocates

David Taylor of HBM Sayers submitted a response to the Scottish Executive Consultation in his capacity as Regional Representative of the Forum of Insurance Lawyers. He felt the Executive consultation had been predicated on the premise that by accepting any damages the victim prevents his family from pursuing a claim for solatium, and that this premise was incorrect. He argued that the existing law provides an adequate mechanism for payment to the victim while preserving the rights of relatives to a claim for loss of society and loss of support. He cited rules of court that allow an interim payment to be made to the pursuer of an amount not exceeding the total damages likely to be paid to the pursuer. He argued that lawyers for the pursuer ought to be able to produce information on legal causation that would be adequate for an interim payment to be made that would be adequate

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1 Stay or suspension of court proceedings or the addition of another person to the proceedings as a litigant, e.g. an executor.
2 In its response to the Committee, the STUC called this argument ‘erroneous and misrepresented’.
for the pursuer’s needs. He suggested, that following the payment, an early
motion could be made to the court to have the action put temporarily in abeyance
(sist). Following the victim’s death, section 2 of the 1976 Act would be available to
relatives of the deceased. His contention was that in these circumstances, the
“dilemma” would not arise.

Based on this argument, Mr Taylor felt there is no need to repeal s1(2) of the 1976
Act. He submitted that where a fatally injured or diseased person settles a claim
on a full and final basis, thereby enjoying the benefits of s9 of the 1976 Act (that
allows damages for patrimonial loss on the presumption that the deceased would
have lived until the date he would have expected to die had he not become ill),
such a settlement should preclude any further claims arising out of the death. This
would avoid duplication of damages and involve the repeal of s2(1) of the 1976 Act
(inserted by the Damages (Scotland) Act 1993). He submitted that this is a
complicated matter and should be referred to the Scottish Law Commission for
review. Any review of the current law should be comprehensive and take into
account the whole of the law of damages in fatal claims.

On confining the terms of the Bill to mesothelioma, Mr Taylor said, “To legislate for
a specific disease as proposed would in our view dilute, obscure and damage [a
system of Scots law based on general principles].”

Dundee City Council

Dundee City Council submitted a response to the Scottish Executive Consultation.
The council responded expressly from an Employers Liability Insurance
perspective. It agreed that the existing law poses a problem, but that the proposed
Bill would not solve the problem. The council argued for exploring greater use of
interim damages and said that the case had not been made for interfering with the
balance of pursuer and defender interests contained in the 1976 act. The Council
also felt that no delegated legislative powers should be given to Scottish ministers
to extend the provisions to other medical conditions, as this would ‘open the
floodgates’ and run contrary to the principle of legislation being open to
parliamentary debate.

Scottish Consumer Council (SCC)

The SCC responded to both the Scottish Executive consultation and to the Justice
1 Committee call for views. To the Committee, the SCC conceded a lack of
knowledge of mesothelioma, so limited its response to access to justice issues. In
its response to the Scottish Executive the SCC agreed that the existing law
appears inappropriate and should be amended. It noted that the more streamlined
claims process following the Coulsfield Report has had the “unfortunate side effect”
of forcing sufferers to choose between claiming while alive and leaving relatives to
pursue the action after their death. The SCC agreed that the 1976 act should be
amended as proposed, and also that Scottish Ministers should have the power to
add other medical conditions to its provisions.

LEGAL AND ACADEMIC RESPONSES

The Law Society of Scotland

In its response to the Committee, the Civil Procedure Committee of the Law
Society of Scotland recognised the dilemma faced by mesothelioma sufferers
under the present legal regime. The Society wanted it recorded that it agreed with
the principles of the Bill and welcomed the proposal as a step towards providing a suitable legal framework for mesothelioma sufferers and their relatives.

The University of Stirling

Professor Andrew Watterson and Tommy Gorman of the Occupational and Environmental Health Research Group at the University of Stirling responded to the Scottish Executive consultation. They argued that the existing law causes problems and should be amended to allow relatives to claim non-patrimonial damages even if the victim made a claim in their lifetime. They said it could be argued that the more streamlined claims procedure following the Coulsfield Report, could be accessed fully only with the proposed amendment to the 1976 act. Professor Watterson and Mr Gorman also argued that the provisions of the Bill should not be confined to mesothelioma cases on the ground that experts claim that “for every case of Mesothelioma there is at least one case of asbestos-related lung cancer.” They noted that through the Social Security (Industrial Injuries) (Prescribed Diseases) Amendment Regulations 2006, the UK Parliament had broadened acceptance of asbestos-related lung cancer as a prescribed industrial disease for Industrial Injuries Disablement Benefit claims.

Ronald Conway, Bonnar & Company, Solicitors

Ronald Conway responded to the Scottish Executive consultation, arguing that the present law is problematic and that the proposed amendment would remedy the situation, saying that it is anomalous that the discharge of the victim’s claim should operate to extinguish that of the victim’s relatives. He suggested that the problem emerged with the improvement of court timetables following the Coulsfield Report, and that it would be unsatisfactory if the reforms were to lead to anguish. He contended that the Bill should confined to mesothelioma, “The proposal that the disapplication be confined to sufferers of mesothelioma is right and proper and the suggested reservation preserves the future position.”

COUNCILS

West Dunbartonshire Council confirmed that some sufferers were indeed forgoing their claims for the benefit of relatives after their deaths and that families did face a dilemma. It was agreed that disapplying s1(2) of the 1976 Act should remedy the problem. The Council’s view was that the Bill should be confined to mesothelioma cases, but argued that Ministers should have the power to extend the new provision. In support of this, the council noted – as did Professor Watterson and Mr Gorman of Stirling University – that “for every case of mesothelioma there is at least one case of asbestos related lung cancer.” In its submission to the Committee, the council argued that the Bill would allow sufferers to die with dignity and peace of mind that relatives would be provided for after their death. No comment was made on the ministerial power, which was absent from the bill as introduced and on which the council was commenting.

The Scottish Executive received 6 responses from city councils, of which 5 offered substantive comments. Aberdeen City Council confirmed that it had no observation to make. The only council to respond to the Justice 1 Committee was West Dunbartonshire Council, who also responded to the Scottish executive consultation. The response of Dundee City Council was included with those of insurers as the response was made expressly from an Employers Liability Insurance perspective.
Perth & Kinross Council responded to the Scottish Executive’s consultation, acknowledging that a dilemma is posed by the current law that would be solved by the proposed amendment. The Council argued that the new law should be mesothelioma specific, and that Ministers should not have the power to add medical conditions to its provisions.

Similarly, North Lanarkshire Council agreed the current law poses problems that would in principle be solved by the proposed Bill (subject to provisions on prescription). The council agreed the provisions should be confined to mesothelioma and that Ministers should not have the power of amendment proposed in the Executive consultation, due to the uniqueness of mesothelioma.

Stirling Council agreed with all three questions put in the Executive consultation including that Ministers should be given the power of amendment. No reasons were advanced for the answers given.

HEALTH BODIES

NHS Greater Glasgow and Clyde

NHS Greater Glasgow and Clyde was the only National Health Service body to respond to the Scottish Executive consultation. NHS Greater Glasgow and Clyde said it has “one of the largest local authority clusters of mesothelioma cases in the UK” and indicated its full support for the proposals. It argued that the existing law creates a dilemma that could be remedied by amending s1(2) of the 1976 act to allow non-patrimonial damages to be claimed by relatives after the sufferer’s death. It also argued that Ministers should be able to add to the conditions covered by the provisions.

Health and Safety Executive

The Health and Safety Executive responded to the Committee saying: “… although HSE has no statutory interest in this area, it is clearly, in the light of our broad experience with asbestos, an anomaly that should be addressed.”

Murray Earle
SPICe
16 November 2006

Note: Committee briefing papers are provided by SPICe for the use of Scottish Parliament Committees and clerking staff. They provide focused information or respond to specific questions or areas of interest to committees and are not intended to offer comprehensive coverage of a subject area.
The Rights of Relatives to Damages (Mesothelioma) (Scotland) Bill (SP Bill 75) was introduced to the Scottish Parliament on 27 September 2006. The Justice 1 Committee has been appointed lead committee on the Bill. The Bill aims to amend the law concerning the right of relatives of a deceased person to claim damages in respect of mesothelioma.

This Briefing considers mesothelioma first from a medical point of view before looking at discussion of mesothelioma in the Scottish Parliament through debate, public petition and committee inquiry.

It considers the Scottish Executive proposal to amend the law of damages as it applies to relatives of those who contracted mesothelioma as well as the law of personal injury damages more generally.

The Briefing will go on to address issues surrounding the Bill itself, including applicable statutory history, the Compensation Act passed at Westminster (the subject of a Legislative Consent Memorandum in the Scottish Parliament) that overturned the House of Lords judgement in Barker v Corus.

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www.scottish.parliament.uk
KEY POINTS TO THIS BRIEFING

- mesothelioma is a type of lung cancer that is almost always fatal; most cases are caused by asbestos

- sufferers are able to claim statutory benefits if suffering an asbestos-related condition such as mesothelioma, and where they were exposed to asbestos in the course of their employment

- if a person dies as a result of a work-related personal injury and that person has not claimed damages in their lifetime, their relatives have the right to a claim in damages from the deceased’s employer

- the Rights of Relatives to Damages (Mesothelioma) (Scotland) Bill aims to ensure that even where the deceased has claimed within their lifetime, relatives’ claims for non-financial damages will still be admissible

- the issue of mesothelioma has been considered in the Scottish Parliament since the Members debate in the name of Duncan McNeill MSP (S1M-1273) on 16 November 2000 on compensation for mesothelioma sufferers

- petition PE336, received on 29 January 2001 and reported on by the Justice 2 Committee, called for a review of existing judicial mechanisms open to mesothelioma sufferers in Scotland (mesothelioma was also the subject of petition PE1006)

- the Scottish Executive took account of the work of the Justice 2 Committee in launching a consultation of July 2006 on amending the Damages (Scotland) Act 1976

- the Compensation Act 2006 (Westminster) was the subject of a Legislative Consent Memorandum

- the provisions on mesothelioma damages in the Compensation Act 2006 overturn part of the House of Lords judgement in *Corus v Barker*
INTRODUCTION

Because the issue of mesothelioma has a long history in the Scottish Parliament, this Briefing will consider mesothelioma from several points of view. It will begin by looking at the medical definition and clinical indications of the condition and go on to consider statistical trends in the United Kingdom and in Scotland. The briefing will go on to summarise consideration of mesothelioma in the Scottish Parliament over the past six years, through debate, public petition and Committee Inquiry. It will then look at the issues surrounding the Rights of Relatives to Damages (Mesothelioma) (Scotland) Bill. This will include the Scottish Executive consultation on the Bill, as well as the common law and statutory provisions applicable to compensation of those who contracted mesothelioma in the workplace.

MESOTHELIOMA

It is instructive to consider the medical literature, as this will affect the legal inquiry of the courts, particularly that into the cause of the harm: that is whether the pursuer’s medical condition was caused – in the factual and legal sense – by exposure to asbestos in the workplace (this legal point is discussed later in this briefing).

MEDICAL DEFINITION

Mesothelioma (pronounced ‘mee-zoh-thee-lee-oh-mah’) is a cancer of the ‘mesothelium’ – a thin lining in the chest and in the abdomen.

For detailed patient focused information about the disease see ‘Mesothelioma’ on the website of the British Lung Foundation and ‘Mesothelioma’ on the website of Cancer Research UK. The main features of the disease are summarised below.

The two main types of mesothelioma occur in the chest and in the abdomen. Abdominal mesothelioma occurs more frequently.

- **mesothelioma in the chest (pleural mesothelioma):** the chest lining has two layers - the inner layer lines the lung, and the outer layer lines the chest wall. The space between the two layers contains a small amount of fluid which lubricates the two surfaces and lets the lungs and chest wall move and expand as a person breathes. A tumour grows within the chest lining, causing it to thicken at first. The tumour then spreads within the space between the layers. The tumour often produces fluid, sometimes several litres

- **mesothelioma in the abdomen (peritoneal mesothelioma):** the abdominal cavity and the bowel are covered by a lining. Like the chest lining, it has two layers. The inner layer covers the organs in the abdomen (e.g. the stomach) and the outer layer lines the wall of the abdomen. A tumour starts in this lining. It causes the lining around the organs to thicken; a lot fluid can also be produced

In the early stages mesothelioma has few symptoms. When symptoms develop, they are often caused by the cancer growing or pressing on a nerve or other body organ. The main symptoms of mesothelioma in the chest are pain in the lower back or the side of the chest, a persistent cough, shortness of breath, a hoarse or husky voice, loss of more than 10% of body weight when not dieting, sweating and fevers and difficulty swallowing. The main symptoms of mesothelioma in the abdomen are pain in the abdomen, swelling in the abdomen, feeling or being sick, poor appetite, loss of more than 10% of body weight when not dieting and diarrhoea or constipation.

Although scientific advances tend to discourage the use of “never” or “always”, there is currently no cure for mesothelioma and it is almost invariably fatal. Any case reports of survivors may represent misdiagnoses or early discoveries of small tumours. Prevalence statistics published
by the Information and Statistics Division (ISD) indicate survival rates (Information and Statistics Division 2006). Many deaths occur within a few months of diagnosis. Most deaths occur within 14 months (Scottish Executive 2006a, para 1.1). There is, however, a long ‘latency period’ between exposure to asbestos and death from mesothelioma:

“The typically long delay between first exposure to asbestos and death from mesothelioma (seldom less than 15 years, but possibly as long as 60 years) means that deaths occurring now and most of those expected to occur in the future reflect industrial conditions of the past rather than current work practices. This latency period means that the effectiveness of current controls cannot yet be assessed from the mesothelioma mortality figures. A history of asbestos exposure at work is associated with about 80 percent of all cases. However, mesothelioma has been reported in some individuals without any known exposure to asbestos.”¹ (Health and Safety Executive 2006)

The main forms of treatment aim to control the symptoms of the disease and include treatment with steroids, various levels of painkillers, drugs to improve appetite, laxatives and drugs to improve breathing. Where the disease is in the chest, the fluid can be removed on a regular basis, but this can become increasingly difficult as the disease progresses. Doctors may also try to stop the fluid accumulating altogether by putting talc or another chemical in the space between the two layers of the chest lining. In both forms of the disease, radiotherapy and chemotherapy can be used to kill or control the cancer cells, with the aim of relieving symptoms and improving quality of life.

**Mesothelioma and asbestos**

According to the British Lung Foundation, exposure to asbestos is the cause of over 90 per cent of cases of mesothelioma ([British Lung Foundation – Mesothelioma](http://www.britishlung.org/mesothelioma/)). The other causes of the disease are not fully understood. Smoking does not cause mesothelioma.

Asbestos is an insulating material that is heat and fire resistant. In the past, asbestos was used widely in the construction, shipbuilding, rail and motor industries. The use of asbestos was very heavy in the years after the Second World War. The connection between mesothelioma and asbestos was discovered in 1960, but it was not until the mid-1970s that the dangers of asbestos became generally recognised and action was taken: the use of asbestos within industry began to be phased out and health and safety regulations were updated.

There are three types of asbestos: blue, brown and white. Blue and brown asbestos are known to be the most dangerous and are linked to mesothelioma. They have been banned since the late 1980s and cannot be imported into the UK. White asbestos is now also thought to be harmful. The use of all asbestos was banned in 1999 in the UK.

**STATISTICS AND TRENDS**

Incidences of mesothelioma are proportionately higher in Scotland than in the United Kingdom as a whole and higher in the west of Scotland. The disease is more prevalent among men than among women and rarely affects anyone under 40 years of age. The Information and Statistics Division of NHS National Services Scotland, collects and publishes statistics on the morbidity (incidence and prevalence) of and mortality from mesothelioma in Scotland (Information and Statistics Division 2006). The Health and Safety Executive does a similar thing in respect of mesothelioma across the United Kingdom (Health and Safety Executive 2006).

**Morbidity: incidence and prevalence**

The following table and graph indicate increase in prevalence rates between 1980 and 2003, particularly among the male population.

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Table 1: Scotland: mesothelioma prevalence rates per 100,000 person years at risk

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Notes:
EASR - rates standardised to the European standard population
WASR - rates directly standardised to the World standard population
Mortality: total deaths in Scotland


The table below\(^2\) gives figures for both prevalence and mortality of mesothelioma in Scotland, as well as statistics for Kaposi’s sarcoma, because based on their allocated ICD-9\(^3\) codes, deaths prior to 2000 attributed to mesothelioma and Kaposi’s sarcoma cannot be identified separately.

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Notes
\(^1\) Data extracted May 2006. Cancer registration is a dynamic process. The database is amended and updated on an ongoing basis, making use of additional data received later. The data presented in this table may differ from other published data relating to the same time period.
\(^2\) 'Death Certificate Only' registrations have been included in these figures.
\(^3\) '0.0' = < 0.05; '-' = no events.
\(^4\) Registration diagnoses for years prior to 1997 have been converted from ICD-9 codes and ICD-O morphology codes to ICD-10. Causes of death for years prior to 2000 have been converted from ICD-9 codes to ICD-10. The ICD-10 code C97 - malignant neoplasm of independent (primary) multiple sites - is not used by the cancer registry since each independent primary malignant neoplasm is recorded separately.
\(^5\) Based on their allocated ICD-9 codes, deaths prior to 2000 attributed to mesothelioma and Kaposi’s sarcoma cannot be identified separately.

Sources: Registrations - Scottish Cancer Registry, ISD; Deaths and estimated populations (for rates) - General Register Office Scotland (GROS).

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\(^2\) Source ISD Scotland Scottish Health Statistics: Mesothelioma.
\(^3\) International Classification of Diseases, 9th Edition.
**Trends**

The annual number of mesothelioma deaths in Great Britain has increased from 153 in 1968 to 1,874 in 2003 (the latest year for which statistics are available). As the breakdown above suggests, most of those who die from mesothelioma each year are male. In 2003 there were 1,591 male deaths in the United Kingdom, approximately 85% of the total number ([Health and Safety Executive Mesothelioma](https://www.hse.gov.uk)). In Scotland in 2003, there were 175 deaths in the male population, compared to 18 from the female population (90% male). There have been no recorded incidences in men under 40 years of age between 1999 and 2003, although there were three incidences among women.⁴ Geographical trends are discussed below.

**Projections of peak levels of future deaths**

Hodgson *et al* ([Hodgson et al 2005](https://www.hse.gov.uk), see also [Mesothelioma mortality in Great Britain: estimating the future burden](https://www.hse.gov.uk), (Health and Safety Executive 2003a) relating to the same work) recently published their projections of peak levels of future deaths caused by mesothelioma. The authors predicted that the annual total number of male deaths aged 20-89 in Great Britain would peak at a level of 1950 to 2,450 deaths during the period 2011 to 2015. They predicted that annual total female deaths would peak at a level of 250 to 310 deaths (although this estimate is less certain since it is derived simply by applying the results for males to the average proportion of deaths among females).

The online Health and Safety Executive publication relating to the same work notes that there is uncertainty about the rate at which numbers for men and women will fall after the projected peak is reached (Health and Safety Executive 2003a).

**High risk occupations**

An online Health and Safety Executive publication ([Mesothelioma Occupation Statistics for Males and Females Aged 16-74 in Great Britain 1980-2000](https://www.hse.gov.uk)) shows that occupations where males had the highest risk of mesothelioma were metal plate workers (including shipyard workers) and vehicle body builders (which includes railway carriage and locomotive building). A number of the other high-risk occupations identified are associated with the construction industry, such as plumbers and gas fitters, carpenters and electricians.

The analysis also showed that although the total number of male mesothelioma cases has increased almost three-fold since the early 1980s, in most cases proportions of mesothelioma deaths across occupational groups have remained stable over time.

Occupations identified as relatively high risk for females included metal plate workers, chemical workers (including those classified as ‘process workers’), plastics workers and other foremen / labourers (including those classified as ‘factory workers’).

**Geographical concentration**

Two online Health and Safety Executive publications ([Mesothelioma Area Statistics: County Districts in Great Britain 1976-1991](https://www.hse.gov.uk) and [Mesothelioma Mortality in Great Britain: an Analysis by Geographical Area 1981-2000](https://www.hse.gov.uk)) provide a breakdown of mesothelioma deaths by geographical area in Great Britain.

These publications also show ‘Standardised Mortality Ratios’ (SMR) per geographical area. An SMR is a useful indicator. It is a ratio, expressed as a percentage of an observed number of deaths to that expected based on the age and sex specific rates from a standard population, in this case Great Britain. Thus an SMR of over 100 signifies a ratio where the observed number

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of deaths is greater than that expected and conversely a ratio of less than 100 signifies fewer observed deaths than expected.

Unsurprisingly, the major geographical hotspots highlighted in the data are all areas close to known industrial sites where asbestos has been used in the past. Male deaths in Scotland are concentrated around ports and dockyards. The district with the highest SMR for men was the shipbuilding area of Clydebank which had an SMR ten times higher than the average for Great Britain. Other port and dockyard areas within Strathclyde (Dumbarton, Bearsden and Milngavie, Glasgow City, Renfrew and Inverclyde) and Dunfermline also had high SMRs.

Some port areas in Scotland (e.g. Clydebank) also had high SMRs for women, due probably to the number of women whose husbands worked in shipbuilding and who were exposed to asbestos from their husbands’ work clothes. This is demonstrated in Table 3 below and the graph that follows.

Table 3: Mesothelioma (ICD-10 C45) Incidence by NHS Board Area of Residence, Scotland, number of registrations, by age: 1999-2003

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<td>6</td>
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Evidence of this geographical trend can also be found in the answers to Parliamentary Questions S2W-2268 and S2W-27979 on incidence and on mortality. These have been reproduced in the Annex to this Briefing.

ISD Scotland has published a five year summary of incidence of Mesothelioma by age, sex, network and health board\(^5\) (Information and Statistics Division 2006). This indicates a significantly higher prevalence in the west of Scotland, compared to the north and the south east of Scotland. It also gives SMR data explained above. These figures have been collated in Table 4, below.

Table 4: Mesothelioma (ICD-10 C45): Incidence by NHS Region of Residence, Scotland

Numbers of registrations, with age-specific and age-standardised incidence rates, by age 1999-2003

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</table>

Notes
1 North of Scotland includes the following NHS Boards: Grampian; Highland; Orkney; Shetland; Tayside; Western Isles.
2 South East of Scotland includes the following NHS Boards: Borders; Dumfries & Galloway; Fife; Lothian.
3 West of Scotland includes the following NHS Boards: Argyll & Clyde; Ayrshire & Arran; Forth Valley; Greater Glasgow; Lanarkshire.

Crude rate is calculated per 100,000 person-years at risk
EASR: age-standardised incidence rate per 100,000 person-years at risk (European standard population)
WASR: age-standardised incidence rate per 100,000 person-years at risk (World standard population)

Note: confidence intervals for age-standardised rates (EASR and WASR) have been calculated using a formula which works only when numbers are sufficiently large. They are therefore set to 'not applicable' in the event of there being 50 cases or less.

SIR: standardised incidence ratio
Source: Scottish Cancer Registry, ISD. Data extracted: May 2006
MESOTHELIOMA AS AN ISSUE IN THE SCOTTISH PARLIAMENT

There have been two Members Business debates in the Scottish Parliament on the issue of asbestos related illnesses.

Mesothelioma debate

On 16 November 2000 the Members Business debate was in the name of Duncan McNeill MSP on motion S1M-1273. It was supported by Research Note RN 00-95 Lung Cancer and Asbestos (Mesothelioma) (Earle 2000). The motion for debate read:

That the Parliament notes the plight of shipyard workers and their families who were exposed to asbestos, became ill and have now contracted mesothelioma; expresses concern over the length of time their compensation cases are taking to reach conclusion and the use of so-called "blanket denials" by the defenders, and notes that this practice victimises and denies justice to these cancer sufferers.

As the Official Report of 16 November 2000 (Scottish Parliament 2000) indicates, the motion was supported by Clydeside Action on Asbestos as well as 44 back bench MSPs. It sought to bring to the attention of the Parliament the plight of sufferers and the difficulties faced in receiving compensation from employers and former employers. The debate also drew attention to the fact that women suffer from mesothelioma from fibres on the clothing of male shipyard workers, and to some of the medical statistics available at the time.

It emerged from the debate that not only shipyard workers are affected, that mesothelioma is incurable and that the prevalence of asbestos-related illnesses was thought to be heading for ‘epidemic proportions’ by 2018. There was a call for a no-blame system of compensation to be set up for sufferers (Shona Robison MSP and Richard Simpson MSP; Scottish Parliament 2000 col 225-6).

The Deputy Minister for Health and Community Care (Malcolm Chisholm MSP) noted that the issue was more about justice than about health, but that he would be winding up on behalf of the Minister for Justice. He said the Executive recognised the plight of sufferers and their families, and that compensation should be available, “as quickly as possible” (Scottish Parliament 2000 col 228). He pointed out that the total cost, up to the date of the debate, of the scheme under the Pneumoconiosis (Workers’ Compensation) Act 1979 of more than 12,000 claims was £72.5m, which amounted to an average of £15,160 for sufferers and £6,561 for dependents. He conceded, however, that the scheme was designed as a ‘safety net’ for those without an employer against whom claims could be made.

Of interest to the present Bill, Malcolm Chisholm said:

“Even though the Damages (Scotland) Act 1993 has amended the law to transmit to the executor of a deceased person the like rights to damages, the effect of the current provisions is that a claim by the executor does not necessarily have the same value as the claim that might have been pursued by the deceased would have had.” (Scottish Parliament 2000 col 229)

Asbestos-related illnesses debate

On 3 June 2004 the issue was again debated in the chamber, this time on a motion in the name of Des McNulty MSP. The motion for debate on S2M-866 was:

That the Parliament notes with deep concern recent projections regarding the increasing prevalence of asbestos-related illnesses in Scotland; notes that the historic concentration of heavy industry on Clydeside has left a devastating health legacy, affecting many former shipyard and engineering workers and their families; notes that although former shipyard communities show the highest incidence of asbestos-related disease, evidence now shows that ever-increasing numbers of workers from other parts of Scotland have also become victims of asbestos-related illnesses due largely to the past use of asbestos in construction; considers that
the Scottish Executive should give urgent consideration to bringing forward an integrated strategy to assist all those affected by asbestos-related illnesses, which should combine screening and testing people who may have been at risk in order to ensure early diagnosis, counselling and support for victims and their families, and the provision of specialist palliative care, and further considers that the Scottish Executive should work along with COSLA, NHS boards and other key bodies, including the Health and Safety Executive to ensure that necessary information is made available to potential sufferers from asbestos-related illnesses and all those professionals in health, local government and other services who may be in the position of assisting victims and their families.

As the motion suggests, attention was drawn (see Official Report 3 June 2004 col 8981 Scottish Parliament 2004) to an increasing prevalence and geographical concentration of the disease.

The debate also highlighted measures that had been taken to curb the use of asbestos in industry, in recognition of its harmful effects, while at the same time acknowledging the latency period intrinsic to mesothelioma, highlighted earlier in this Briefing. The motion called for greater and more integrated support from health and social services, but did not go into the matter of compensation. Margaret Ewing MSP did, however, draw attention to the issue of compensation, congratulating Pauline McNeil MSP and the Justice 2 Committee for, “mov[ing] things forward for people seeking compensation.” (Scottish Parliament 2004 col 8985)

Trish Godman MSP also drew attention to compensation, particularly to the pace of claims in the courts and more significantly to the view that “Before the law was changed in Scotland anent court proceedings, it was commonly believed – with justification – that insurance companies procrastinated on the basis that a case for compensation dies when the victim dies.” (Scottish Parliament 2004 col 8987) These views were echoed by Jackie Baillie MSP and Frances Curran MSP.

In closing, the Deputy Minister for Health and Community Care (Tom McCabe MSP) said:

“We are aware of the distressing consequences of asbestos-related disease. Action is proceeding in a joined-up way on a wide front, across the responsibilities of the Scottish and Westminster Administrations. There is a common resolve to do what we can to help those who are affected by this terrible disease and to reduce the risk of people acquiring it in the future.”

(Scottish Parliament 2004 col 8998)

**Justice 2 Committee work on Petition PE 336**

Between the two debates summarised above, the Justice 2 Committee, under the convenership of Pauline McNeill MSP, considered and reported upon a petition by Mr Frank Maguire on behalf of Clydeside Action on Asbestos. 6 Petition PE 336, lodged on 29 January 2001 called,

“for the Scottish Parliament’s Justice Committees to initiate a review of the powers and procedures of the Court of Session in handling cases involving victims of asbestos poisoning, to ensure that the real issues between the parties involved are properly identified; that delay is minimised; and that interim payments and jury trials are made available to victims.”

A summary of the progress of the petition indicates that on 18 December 2002 the Justice 2 Committee considered the Reporter’s report on petition PE 336 and agreed to adopt its recommendations. This led, on 8 January 2003, to the 2nd Report 2003: Petition PE336 on civil justice for asbestos victims Vol. 1 Report (Scottish Parliament 2003a). Although the remit of the report is not directly applicable to the provisions of the Rights of Relatives to Damages

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6 A further petition on mesothelioma is PE1006, lodged on 3 October 2006 by Bob Dickie, on behalf of Clydebank Asbestos Group, calling on the Scottish Parliament to urge the Scottish Executive to ensure that the current prescribing arrangements for mesothelioma sufferers under which Alimta is made available are continued.

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*providing research and information services to the Scottish Parliament*
providing research and information services to the Scottish Parliament

(Mesothelioma) (Scotland) Bill, it did deal with related issues of court procedure, delays and costs.

For the sake of completeness, it is worth adding that the Justice 2 Committee recommended implementing the recommendations of the Coulsfield Report (implemented in April 2003, Scottish Executive 2006a para 1.6) to accelerate the time it takes to reach a point at which the parties can reach a settlement. The changes recommended by Lord Coulsfield to achieve this were summarised in the Evidence to the Justice 2 Committee of the Lord President (Scottish Parliament Justice 2 Committee 2003a):

- automatic fixing of a diet of proof or jury trial when defences are lodged, on a date about 12 months ahead (but no earlier than that)
- a timetable for specifying by what date successive procedural steps must be taken by each party, with a role for the court in monitoring and reminding the parties as key deadlines approach; this will be supported by enhanced IT
- introducing provisions for early and automatic recovery of documents which might include medical, pathology and employment records
- simplified written pleadings
- a requirement for the pursuer to submit a breakdown of the monetary value of the claim; and a deadline by which the defenders must submit their own valuation of the claim, to focus attention on areas of dispute
- a requirement to hold a "pre-trial meeting" between the parties at least 4 weeks before the case is to be heard, to discuss possible settlement and agree as much as possible. There would be no judicial involvement in this meeting although the fact that it had taken place and the outcome would have to be certified to the court.

The Committee added the caveat that there is a sound case for special treatment of mesothelioma and recommended the introduction of special procedures in such cases. The Scottish Executive subsequently said that the new arrangements to expedite such cases have meant that cases are concluded within 12-13 months (Scottish Executive 2006a, para 1.5).

During the taking of evidence on the petition, points were raised which were pertinent to the provisions of the Rights of Relatives to Damages (Mesothelioma) (Scotland) Bill. For example, when considering delays, the submission from the Forum of Insurance Lawyers in Scotland (Scottish Parliament Justice 2 Committee 2003b) had this to say about multi-defender cases:

In law the Pursuer requires to take proceedings against those Defenders who have caused the harm. It is not appropriate for the Claimant to proceed against one Defender where there are other Defenders who have a responsibility.

By way of background information it may be helpful for the Committee to appreciate that Defenders attempt to try and resolve matters amongst themselves so that a lead Defender is identified and will conduct most of the action and investigations on the part of all the Defenders but it is open to each Defender to investigate and carry out their own enquiries.

The lead Defender is usually identified initially on the basis of the statements contained in the Claimant’s writ.

The position has been somewhat complicated as a result of the decision in the English case of Fairchild - Glenhaven which is directly involved with disease claims involving mesothelioma/pleural plaques but this problem appears to have been resolved by the House of Lords today (16 May 2002).

On this point and among the Justice 2 Committee recommendations (Scottish Parliament Justice 2 Committee 2003a), the Report said:

30. One of these arises from the fact that employees have often worked for, and been subject to asbestos exposure in, more than one company. While the pursuer may be taking action against only one of these employers, there is a procedure whereby a defender may serve notice on another party who is then automatically brought into the action. Often this notice is served just
before the record is closed and the additional defender may require time to prepare their own case. The resolution of the Fairchild case means that the pursuer is not required to prove (as appeared to be possible before the House of Lords judgement in that case) which period of exposure to asbestos caused the illness. We note that there are adequate existing procedures to allow liability to be apportioned between different employers once the case has settled. We suggest therefore that, in the abbreviated procedure we are proposing, the rules of court might be amended so that an additional defender can only be brought in with the leave of the court.

The issue of causation in the Fairchild case is discussed below, as is the court’s development of the law in Barker v Corus and the subsequent overturning of the Barker judgement by the UK Government.

**The proposed Asbestos (Improved Compensation) Bill**

During Scottish Executive Question Time on 18 May 2006, Mesothelioma was discussed again (Scottish Parliament 2006a), this time in the context of health needs of sufferers. Des McNulty MSP then expressed the hope that his proposal for a bill would be supported. The proposed Asbestos (Improved Compensation) Bill, lodged on May 17 2006, aimed to, “improve compensation for asbestos victims and relatives of persons deceased through personal injury attributable to asbestos-related diseases.” The proposal was withdrawn by the member on 23 June 2006. This happened following a statement on 22 June 2006 in the Parliament by the Minister for Parliamentary Business (Scottish Parliament 2006c col 26820). The Scottish Executive acknowledged this in the consultation paper (Scottish Executive 2006a) that led to the Rights of Relatives to Damages (Mesothelioma) (Scotland) Bill.

**COMPENSATION FOR MESOTHELIOMA SUFFERERS**

**THE COMMON LAW**

*Bringing a legal action in damages*

Also known as ‘substitutionary redress’, the purpose of damages is to compensate a pursuer for a loss suffered as a result of the defender’s breach of a legal duty. Courts’ approach to the remedy differs according to the foundation of the claim, be it in the law of contract or the law of delict - and indeed what sort of delict. The law of delict deals with harm caused by the defender’s conduct. Although the delictual conduct may be intentional (e.g. fraud, assault, defamation) it is usually unintentional (negligence).

Compensation is most often assessed in monetary terms. Although the idea of damages is to restore the person to the position they were in prior to the wrongful damage, in cases involving medical conditions money may not be able to do this. There are, however different heads of damages that may be awarded by a court, that would go some way to restoring the pursuer’s position. Under Scots law, damages are compensatory and heads of damages found in some North American jurisdictions such as exemplary or punitive damages are unknown. In other words, damages are a reflection of the pursuer’s harm, rather than of the defender’s fault.

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7 It was also brought up, again by Des McNulty, on 15 June 2006 (Scottish Parliament 2006b col 26663) in the context of Judicial Independence

8 See Proposed Asbestos (Improved Compensation) Bill statement of reasons (52KB pdf posted 06.06.06)


10 Ibid., citing Black v North British Rly Co 1908 SC 444 at 453, 15 SLT 840 at 843 per Lord President Dunedin.

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providing research and information services to the Scottish Parliament
Heads of damages for the injured person, their executor or their relatives

A person contracting mesothelioma may seek damages under one or more heads, as may the executor of the estate or relative of a person who died as a result. Damages may be sought under one or more of the following heads:

- **Solatium** (‘solace’) or non-patrimonial loss, represents the pursuer’s pain and suffering. Sums awarded are artificial in being unable to measure how individuals will relate to the discomfort of injury and to the at times irreparable damage following negligence (e.g. the negligent amputation of the wrong limb). Courts will take into account past and future suffering, the extent of the injury, loss of amenity and enjoyment of life, and awareness of any diminished life expectancy. Awards are based on awards made in similar cases, taking inflation into account. Solatium awards in Scotland are lower than those in England by 10-15%. As it applies to relatives of the injured party, solatium would include such heads of damages as:
  o grief and anxiety suffered by relatives in contemplation of pre-death suffering of the deceased
  o grief and sorrow of the relative caused by the deceased’s death; and
  o loss of deceased’s society and guidance

The Scottish Executive has noted that payments made under s1(4) of the Damages (Scotland) Act 1976 to relatives for non-patrimonial loss have been on the increase. “In 1992, the amounts awarded to a widow ranged from £5,500 to £12,500 and to a child from £600 to £10,500. However, recent awards of section 1(4) damages have increased from £20,000 to £28,000 to a widow and £5000 to £10,000 for an adult child and £3,000 to £10,000 for an elderly parent losing an adult son.” (Scottish Parliament 2006h para.7, Scottish Executive 2006a para. 3.7)

- **Patrimonial loss** represents all monetary and material loss suffered by the pursuer as a result of the negligence. This includes past and future loss. In calculating future patrimonial loss, courts will consider the pursuer’s future prospects of employment, for example the loss of promotion prospects in the case of disorders associated with head injuries. Patrimonial loss may be sub-divided into several elements.
  o Loss of earnings, both between the date of injury and the date of proof, and future earnings. Courts use actuarial multipliers to arrive at a total lump sum. A further lump sum may be awarded on the basis of future employability having been impaired.
  o Loss of pension rights.
  o Expenses. This includes (past and future) medical expenses and other outlays, including nursing and palliative care costs and the cost of disability equipment.
  o Loss of services: that is services the pursuer is no longer able to perform for relatives or those relatives are no longer able to render to the pursuer. For example, a pursuer whose ankle injury rendered her unable to do the washing and ironing for her husband and son was awarded an additional sum in damages, which recognises the economic value of work in the home. Relatives are defined in the Damages (Scotland) Act 1976, as amended. This will be discussed later in this Briefing.

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12 Ibid., p. 524 et seq.
13 Required by the provisions of the Damages (Scotland) Act 1976, s9.
14 Administration of Justice Cat 1982 s8(1) as amended by the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990, s69(1)
15 Williamson v GB Papers plc 1994 SLT 173
The defender will also be liable for interest on the amount awarded. The interest rate is at the court’s discretion. No interest is payable on future patrimonial loss, but past patrimonial loss is charged at half the court rate of interest (as set out in various Acts of Sederunt).

On the basis of these categories of loss or legal injury, a pursuer would bring a claim in negligence, and be required to prove a number of elements for their claim to succeed.

In the presence of a legal injury, in order to qualify for an award in damages, a pursuer must establish the presence of a duty of care between pursuer and defender, the breach of that legal duty and the fact that the breach caused the injury suffered.

**The duty of care and its breach**

A duty of care will arise between two parties where their actions are sufficiently proximate to found a duty of care, for example that between doctor and patient and employer and employee. It has been trite law for more than a century that a doctor owes a duty to a patient to take due care in diagnosis and treatment of that patient and an employer owes a duty to provide a safe working environment for employees. In *Donoghue v Stevenson* the duty of care was based on the foreseeability of acts or omissions causing injury to others within the “neighbourhood”, that is those potential pursuers brought within sufficient proximity to the defender to give rise to duty of care. In this instance the duty was on a manufacturer (of bottled ginger beer) to ensure that their products did not cause damage to ultimate consumers (by way of a snail having found its way into the bottle).

It was later said of the neighbourhood principle that it should apply unless there is a valid reason for its exclusion. This, in turn, was later elaborated by a so-called “two-staged” approach. It asked first whether a relationship of proximity and foreseeability of harm gave rise to a prima facie duty of care. It then asked whether any public policy considerations should militate against the presence of a duty of care. A ‘policy consideration’ often envisaged is that holding a duty of care to exist in a given set of circumstances may lead to a flood of similar claims.

There was subsequently been a retreat from this two-stage approach. While it remained necessary to establish a relationship of proximity, the Law Lords began to ask not whether policy considerations militated against imposing a duty of care, but whether in the circumstances of the case it was fair, just and reasonable to impose such a duty. Some years later this was further elaborated to re-introduce the public policy caveat.

To establish a duty of care, a pursuer must prove that:

- loss suffered was reasonably foreseeable
- there is a relationship of proximity between pursuer and defender
- it is fair, just and reasonable to impose a duty of care
- the imposition of a duty of care is not contrary to public policy consideration

Having established that a duty of care exists, it is necessary to establish that it was breached. This could be a question of fact if it is tied to the duty itself: if the duty is to take a certain

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17 Interest on Damages (Scotland) Acts 1958 and 1971,
19 1932 SC (HL) 31
21 In *Anns v Merton London Borough Council* [1977] 2 All ER 492
22 *Yuen-Kun-yeu v A-G of Hong Kong* [1987] 2 All ER 705 as elaborated
23 *Caparo v Dickman* [1900] 2 AC 605
precaution, and the precaution was in fact not taken, the duty of care is said to have been breached.

This part of the enquiry becomes more complex with the introduction of ‘reasonableness’. It is necessary to establish that the act or omission of the defender was unreasonable. Judicial dicta have set out tests for assessing breach of a duty of care. A court will impose liability only if the defender acted as the objective reasonable person in a similar situation would not have done.24 A doctor is to act as the reasonable doctor would; indeed a junior doctor acting in the capacity of a more senior doctor is expected to achieve the degree of skill and care of a senior doctor.25

In the context of employers’ liability towards their employees, the duty is to act as the reasonable employer would have done. Where considerations of employee safety are concerned, much of the enquiry will be determined by the current state of scientific and technical knowledge at the time, the magnitude of the risk and the reasonableness and practicality of taking precautions.

Most legal obligations imposed on employers are statutory and enforced by the Health and Safety Executive. Yet an employer will still have common law duties in respect of the safety of the place of work and the system of work. This duty is non-delegable.26

The standard of care in respect of industrial injuries such as mesothelioma, are perhaps better illustrated when considering the next stage of the court’s enquiry: causation.

Caustion and contributory negligence

This is arguably the most complex part of the law of delict. One of the principles of the law of damages is that only those injuries caused by the breach of a legal duty - by an act or omission to act where the duty called for action - qualify for compensation. Courts ask first whether the injury would have occurred but for the act or omission of the defender. This is the enquiry into factual causation. It is usually straightforward, but may be more complex where several possible causes exist, for example where the defender’s conduct adds a causal element to a pre-existing situation. In such circumstances, it has been held that a proof of a material contribution to the injury is sufficient to establish causation.27

This approach was further developed by the court in M’Ghee v National Coal Board.28 That case involved the omission to provide washing facilities at a brick kiln, leading to the pursuer contracting dermatitis. Bringing the defender’s skin into contact with brick dust was not negligent, but the omission was. Requiring the pursuer to cycle home covered in the dust contributed to his condition. Knowledge of the medical aetiology was at the time unclear, so it was possible only to state that the prolonged exposure materially contributed to the injury. The court found that this was sufficient. If there was another possible contributory cause, it was not necessary to prove that the original cause would have been sufficient of itself to cause the injury. The pursuer, therefore, was required to prove on balance of probabilities that the negligent act or omission caused or materially contributed to the injury.29

24 See Nettleship v Weston [1971] 2 QB 691
25 See Wilsher v Essex Area Health Authority [1988] 1 All ER 871. On the application of the objective test, see Glasgow Corporation v Muir [1943] SC (HL) 3
26 Naismith v London Film Productions Ltd [1939] 1 All ER 794. See McManus and Russell Ibid. p 252
27 See Wardlaw v Bonnington Castings Ltd 1956 SC (HL) 26, 1956 SLT 135
28 1973 SC (HL) 37
It was subsequently recognised that it was not correct that a material increase in risk equated to a material contribution to harm as establishing causation. In *Fairchild v Glenhaven Funeral Services Ltd*, the court found that the strict requirements of the test for factual causation may be relaxed. This might happen where the pursuer is unable to prove that the harm would not have occurred but for the negligence of the defender, yet is able to prove something less stringent. The *Fairchild* case involved deaths following mesothelioma contracted by employees working variously as builder, cement manufacturer and in the construction of packing cases for transportation of asbestos lined industrial ovens. The employers were in breach of their duty to prevent employees inhaling asbestos dust. The Court of Appeal found that the pursuers had failed to prove that but for the negligence they would not have contracted mesothelioma. On appeal, the House of Lords found that the ‘but for’ test may be relaxed in certain circumstances, for example where the negligence constitutes a material contribution to the harm. In this way the court was not applying the ‘but for’ test for causation at all; it was applying a different, less stringent, test.

The inquiry into factual causation is followed by an inquiry into legal causation. This test is based on remoteness. If the harm is too remote from the negligence, no liability will follow. However, it has also been held that where harm would not have resulted but for the actions of a defender, another defender may be liable where he has been independently negligent and this contributed to the harm. Remoteness is determined by asking whether the harm was a reasonable and probable consequence of the conduct.

Questions of causation are often related to questions surrounding contributory negligence. This is a partial defence open to the defender where they are able to show that their conduct caused (or materially contributed to) the pursuer’s injury, but that the injury was also partly caused by the defender themself. The effect of a successful defence of this sort would be to reduce, by an appropriate proportion, any damages award paid to the pursuer. Significant to the present topic of mesothelioma, the workplace and consecutive employers, is the situation in which there is more than one employer, each of whom contributed to the injury. Where the pursuer’s conduct also contributed to the damages, the liability of each defender will be reduced proportionately.

The issues of causation and of contributory negligence in the law of delict are those in which legislatures have sought to reverse the judicial direction of travel.

**The Barker v Corus ruling**

In the *Fairchild* case, discussed above, the House of Lords decided that a worker who had contracted mesothelioma after being wrongfully exposed to asbestos dust at different times by more than one employer or occupier of premises could sue any of them, even though he was unable to prove which exposure had caused the disease. Because there was more than one employer, the plaintiff was unable to establish that but for the omission of a particular defendant, he would not have contracted mesothelioma. Because mesothelioma was considered exceptional, and on the ground of justice, the court held that a relaxed ‘but for’ test should be applied.

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31 [2002] UKHL 22 at 45


33 Ibid. para 432, citing *Grant v Sun Shipping Co Ltd* 1948 SC (HL) 73, 1949 SLT 25

34 See Rodger, B.J. ‘Defences to Delictual Liability’. Ibid. para 403 and The Law Reform (Contributory Negligence) Act 1945 (c.28) s1(1)
The case of *Barker v Corus* involved a Mr Barker who had had three material exposures to asbestos during his working life: while working for ‘Graessers Ltd’ while working for ‘Corus’ and while self-employed. His widow sued in damages on the basis of the negligent exposure having made a material contribution – and hence having caused – the mesothelioma form which he died.

The House of Lords asked first what are the limits to the so-called ‘Fairchild exception’? It held that for the exception to operate, the impossibility of proving that the defendant caused the damage must have arisen from the existence of another causative agent. In other words that it would be impossible to prove that employer A caused the damage where the damage could have been caused by employer B.

The second question for the House was what should be the extent of liability, for example should each defendant be liable only for their contribution to the risk or should defendants be jointly and severally liable, as was the orthodox approach prior to this judgement. The Trial judge and Court of Appeal held that each employer should have to contribute to the damages based on how long they exposed the employee to the asbestos dust. This should take account of the element of contributory negligence during which Mr Barker exposed himself to asbestos and damages should be reduced accordingly. On appeal, the House of Lords upheld this position. As Lord Walker pointed out in his judgement, Mrs Barker did not challenge the finding of the lower courts.

The judgement was not well received by campaigners and asbestos litigation specialists. For example, Ian McFall, Head of Asbestos Litigation for Thompsons who acted for the claimants, has been quoted as saying, “The court has, on a legal technicality which will make no sense to anyone but the driest of lawyers, deprived our client of full compensation for the death of her husband. The real winner here is the insurance industry which now stands to save billions of pounds. We will be urging Trade Unions and asbestos victim support groups to press for legislation to counteract this gross injustice.” On that point, McDonald has pointed out that, “The desirability of Parliament acting as the last arbiter on these matters was echoed in Lord Rodger’s strongly worded dissent. He argued that the majority’s decision in effect rewrote both McGhee and Fairchild in making contribution to the exposure of the risk the basis of liability, rather than deeming the defendants liable on the basis that they had caused the damage complained of.”

**UK Government and Scottish Executive response to Barker v Corus**

On 20 June 2006, the Department for Constitutional Affairs announced that the Government [is] to Act on Mesothelioma Claims to effectively reverse the judgement in *Barker v Corus*. Subsequently, the Secretary of State for Work and Pensions (John Hutton MP) pointed out in a Written Ministerial Statement on Claims Handling (Mesothelioma) (House of Commons 2006),

> “... the Government have introduced amendments to the Compensation Bill to reverse the effects of the Law Lords ruling on *Barker v Corus*. This would have caused delays in resolving claims and made it more difficult for mesothelioma sufferers to recover full compensation. We are changing the law to make it easier for them to get full compensation as quickly as possible.”

There was also reaction in the Scottish Parliament. Des McNulty MSP brought a motion expressing concern at the judgement in *Barker v Corus* (19 June 2006 S2M-4576 Justice for...
Mesothelioma Sufferers), although the motion was not selected for debate. This is possibly because, in announcing the Executive’s Legislative Programme, the Minister for Parliamentary Business (Margaret Curran MSP) said on 22 June 2006 (Scottish Parliament 2006c col 26821):

We are concerned about the implications of the recent Barker judgment in the House of Lords, which might reduce some compensation payments. I am sure that members are aware that the United Kingdom Government has announced its intention of legislating to overturn the ruling, and we remain in close contact with it. We will seek to reverse the ruling by the quickest possible means to ensure that all Scots are advantaged where that is possible, whether through our own bill or possibly by means of a legislative consent motion before the end of this parliamentary session. We will move as swiftly and efficiently as we can.

The Compensation Act

The *Legislative Consent Motion was debated* on motion S2M-4634 on 29 June 2006 (Scottish Parliament 2006e): “that the Parliament agrees that the UK Parliament should consider those provisions of the Compensation Bill, introduced in the House of Lords on 2 November 2005, which will legislate in the devolved area of damages law in respect of joint and several liability, as laid out in LCM(S2) 8.1.” The motion was passed without division.

On the passage of the Compensation Act 2006 (c 29), the Government announced on 26 July 2006 that, “Victims of mesothelioma, a form of lung cancer, will also benefit from the new Act. It will ensure that those suffering from mesothelioma due to another's negligence will be able to receive full compensation from any responsible person as quickly and easily as possible. The responsible person will then be able to claim back contributions from other responsible persons.”

This restores the position to that before the judgement in *Barker v Corus*. Mesothelioma damages are expressly addressed by section 3. It renders liability joint and several, although curiously this does not prevent one responsible person from claiming a contribution from another. Neither does it preclude a finding of contributory negligence (s3(3) and (4)).

**RIGHTS OF RELATIVES TO DAMAGES FROM MESOTHELIOMA**

**SCOTTISH EXECUTIVE CONSULTATION**

The Scottish Executive *consultation paper* (Scottish Executive 2006a) described the causal relationship between asbestos and mesothelioma and drew attention to those occupations posing most risk to workers of developing the disease.

On compensation, the Executive noted that sufferers are able to take action against employers and can apply to the Benefits Agency for industrial injuries benefit of £127 per week until death (Scottish Executive 2006a para 1.4). If the employer is no longer in business, they may receive a lump sum payment of £13,000 under the Pneumoconiosis (Workers’ Compensation) Act 1979.

The Executive argued that the new accelerated claims processing arrangements served to highlight a predicament that exists in the terms of s1(2) of the Damages (Scotland) Act 1976. The terms of s1(2) mean that where a mesothelioma sufferer makes a claim while living, this will extinguish any claim open to their relatives. The result may be that mesothelioma sufferers are forced to choose between claiming while alive, or not claiming so that their relatives will be provided for after their death. (Scottish Executive 2006a para 3.6)

The Executive proposed, “to amend section 1(2) of the 1976 Act to enable the immediate family to claim non-patrimonial damages even when the deceased have settled their own
claims while alive.” (Scottish executive 2006a para 2.1) The Executive said (Scottish Executive 2006a, para 3.16):

“It is proposed that section 1(2) of the 1976 Act should be disapplied so as to allow the immediate family of a mesothelioma sufferer to claim damages for non-patrimonial loss under section 1(4) of the 1976 Act even where the deceased has already recovered damages or obtained a settlement, but only:

- where the sufferer has sustained personal injuries as a consequence of mesothelioma which have diminished his or her expectation of life and dies as a result of those injuries;
- where the sufferer has recovered damages or obtained a settlement after the date when the Bill comes into force. Where the liability of the responsible person has been discharged prior to that date, that discharge should continue to bar any claim by the immediate family.

“The immediate family will have the normal limitation period of three years after the death of the mesothelioma sufferer in which to make their claim.”

Although the proposal would limit the provisions of the Bill to mesothelioma, the Scottish Executive also proposed that, “Scottish Ministers should have the power to extend the new provision to apply to other diseases or kinds of personal injury if experience shows this to be necessary.”38 (Scottish executive 2006a para 3.17).

Terms

The Scottish Executive consulted on the terms of the Bill, by way of the following three questions:

1. Do you agree that the existing law, which prevents the immediate family of mesothelioma sufferers from claiming damages for their non-patrimonial loss on the death of the sufferer if that person has already recovered damages or settled their claim during his or her lifetime, causes problems?

   If you do not agree, it would be helpful if you would say why.

2. Do you agree that these problems should be remedied by disapplying section 1(2) of the 1976 Act so as to enable the immediate family of mesothelioma sufferers to claim damages for non-patrimonial loss, even although the deceased had already recovered damages or obtained a settlement in his or her lifetime?

   If not, what do you see as an alternative solution?

3. Do you agree that the Bill should be confined to cases where the sufferer has contracted asbestos related mesothelioma with Scottish Ministers having the power to extend the new provision to apply to other diseases or other kinds of personal injury if experience shows this to be necessary?

   If not, why do you think it should not be mesothelioma specific?

Scottish Executive analysis

The Scottish Executive published a Summary of Responses to the Consultation Paper (Scottish Executive 2006c). Of the 16 responses received, 15 made observations. Of those 15, all agreed that the existing law is problematic and 12 agreed that the problem should be remedied by disapplying section 1(2) of the 1976 Act so as to enable the immediate family of mesothelioma sufferers to claim damages for non-patrimonial loss, even although the deceased had already recovered damages or obtained a settlement in his or her lifetime. Interestingly, 7 agreed that Scottish Ministers should have the power to extend the new provision to apply to other diseases or forms of personal injury, while 6 disagreed and 2 offered no direct comment.

Because the terms of the damages acts and the Bill deal with the entitlement to bring a civil action in damages in a Scottish court, it is appropriate to set out briefly what this means.

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38 This proposal has not been included in the Bill as introduced. See below.
CURRENT STATUTES

As mentioned earlier in this briefing, under section 2 of the 1976 Act, if the injured person dies without having recovered damages, any claim to damages which that injured person had at the time of his or her death transmits to his or her executor (the person responsible for winding up his or her estate after death), subject to certain modifications to ensure that certain damages are limited by reference to the period before death.

If an injured person dies in consequence of personal injuries and has not recovered damages during his or her lifetime, section 1 of the Damages (Scotland) Act 1976 (c 13) Act confers upon certain relatives of the deceased the right to claim damages. These damages are intended to compensate relatives for their own loss and not those of the injured person. The possibility of a victim claiming damages for *solatium* expired with the death of the victim. This arguably served as an incentive for defenders to delay reaching proof until after the pursuer’s death, because it would confine to patrimonial loss those damages the victim’s relatives may claim.

The 1976 Act was amended by the Damages (Scotland) Act 1993 (c 5) in respect of non-financial loss (*solatium*) to clarify the law in respect of awards for ‘loss of society’ of the deceased. This allowed *solatium* heads of damages to transfer to the executor upon death. *Solatium* is calculated up to the date of death.

In summary, under the 1976 Act as amended, financial and non-financial damages may be claimed by a sufferer’s relative only after their death and only as long as the deceased did not make a claim in their lifetime.

THE BILL AS INTRODUCED

The *Rights of Relatives to Damages (Mesothelioma) (Scotland) Bill*, if passed, will allow defined relatives of the deceased to claim non-patrimonial damages even if the deceased made a successful claim during the deceased’s lifetime. Liability is limited to damages under s1(4) of the 1976 Act, that is to non-patrimonial loss. This means that where the deceased claimed for patrimonial loss during his or her lifetime, that part of the claim will have been extinguished. This is because the damages claimed by the deceased would already have taken family support into account (Scottish Parliament 2006g). Where the deceased made a claim for *solatium* during their lifetime, this will not bar the deceased’s relatives from a claim in *solatium*, for loss of society for example.

The usual limitation period of three years will apply, which means that relatives must bring their claim within three years of the death of the deceased.

Definition of ‘relative’

Although ‘relative’ is defined in Schedule 1 of the 1976 Act, it was amended by section 35 of the Family Law (Scotland) Act 2006 (ASP 2) and is reflected in the definition of ‘relative’ in the reflected in Human Tissue (Scotland) Act 2006 (ASP 4). For deaths on or after 4 May 2006 the definition of “immediate family” is:

- **spouses or civil partners**: the spouse or civil partner of the deceased
- **cohabitants**: any person not being the spouse or civil partner of the deceased who was immediately before the deceased’s death living with the deceased as husband or wife or in a relationship which had the characteristics of a relationship between civil partners
- **parents and children**: any person who was a parent or child of the deceased
• **accepted as children:** any person who was accepted by the deceased as a child of the family

• **brothers and sisters etc.:** any person who was the brother or sister of the deceased or who was brought up in the same household as the deceased and who was accepted as a child of the family which the deceased was a child

• **grandparents or grandchildren:** any person who was the grandparent or the grandchild or the deceased.

As there is no equivalent position in the Compensation Act 2006, this did not form part of the subject matter of the Legislative Consent Memorandum considered above.

**OTHER ISSUES**

**Other options open to mesothelioma sufferers**

People suffering from asbestos-related diseases can usually take legal action in the courts against employers who have exposed them to dangerous quantities of asbestos. This was discussed above. There are further mechanisms of compensation available to sufferers, who may apply to the Benefits Agency for industrial injuries benefit if they suffer from various asbestos related conditions known as “prescribed diseases”. Typically, the sum payable is £127 a week until death.

**Ministerial powers**

As mentioned above, the Scottish Executive expressed the intention to empower Scottish Ministers to extend the new provision to apply to other diseases or kinds of personal injury if experience shows this to be necessary." (Scottish Executive 2006a para. 3.17) This provision has not been included in the Bill as introduced. Given the title of the Bill, it is questionable whether an amendment of this scope would be competent.

**Retrospective claims**

The policy intention of the Executive is that the provisions in the Bill will apply only where application for recovery is made on or after the Bill comes into force, that is on or after seven days after Royal Assent. (Scottish Parliament 2006h para 21) In this way, the provisions of the Bill will not apply those claims already settled at the date of commencement of the Bill. The Bill is retrospective only in the sense that its provisions will apply to cases currently going through the courts.
**SOURCES**

British Asbestos Newsletter [online]. Available at: [http://www.lkaz.demon.co.uk/](http://www.lkaz.demon.co.uk/)


http://www.publications.parliament.uk/pa/cm200506/cmhansrd/cm060720/wmstext/60720m0164.htm#06072031000052


Information and Statistics Division, NHS National Services Scotland, Mesothelioma (statistics on the morbidity and mortality from mesothelioma in Scotland. 2006. Available at: http://www.isdscotland.org/isd/Mesothelioma


Mesothelioma UK [online]. Available at: http://www.mesothelioma.uk.com/


APPENDIX: PARLIAMENTARY QUESTIONS ON MESOTHELIOMA

Health

S2W-27983 - Stewart Maxwell (West of Scotland) (SNP) (Date Lodged 28 August 2006): To ask the Scottish Executive whether it intends to continue allowing Alimta to be prescribed to patients who have mesothelioma.

Answered by Mr Andy Kerr (13 September 2006): I refer the member to the answer to question S2W-27982 on 13 September 2006. All answers to written parliamentary questions are available on the Parliament’s website, the search facility for which can be found at http://www.scottish.parliament.uk/webapp/wa.search.

It is the responsibility of an individual clinician to make appropriate decisions on treatment in the circumstances of the individual patient. Patients who are currently receiving the drug should continue on their existing course of treatment until their clinician directs otherwise.

S2W-27982 - Stewart Maxwell (West of Scotland) (SNP) (Date Lodged 28 August 2006): To ask the Scottish Executive whether NHS Quality Improvement Scotland will issue guidance on Alimta following the National Institute for Health and Clinical Excellence’s rejection of the drug for use in cases of mesothelioma.

Answered by Mr Andy Kerr (13 September 2006): NICE is currently considering appeals against their Final Appraisal Determination before publishing firm advice for Pemetrexed (Alimta®) disodium for the treatment of malignant pleura mesothelioma.

Once published this will be considered by NHS Quality Improvement Scotland.

S2W-27981 - Stewart Maxwell (West of Scotland) (SNP) (Date Lodged 28 August 2006): To ask the Scottish Executive when the Scottish Medicines Consortium approved Alimta for use in cases of mesothelioma.


S2W-27980 - Stewart Maxwell (West of Scotland) (SNP) (Date Lodged 28 August 2006): To ask the Scottish Executive how many patients have been prescribed Alimta for mesothelioma in the last year, broken down by NHS board.

Answered by Mr Andy Kerr (13 September 2006): The information requested is not held centrally. This is a matter for NHS boards.

S2W-27979 - Stewart Maxwell (West of Scotland) (SNP) (Date Lodged 28 August 2006): To ask the Scottish Executive how many people have been discharged from hospital with a diagnosis of mesothelioma in each of the last five years, broken down by NHS board.

Answered by Mr Andy Kerr (13 September 2006): The following table contains the number of patients discharged with a main diagnosis of mesothelioma from hospitals in Scotland by health board of residence for the five financial years (ending 31 March) to 2004-05:

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<td>45</td>
<td>1</td>
<td>12</td>
<td>2</td>
<td>259</td>
</tr>
</tbody>
</table>

Source: Scottish Morbidity Record SMR01 linked database – in-patient/day case discharge summaries from non-obstetric/non-psychiatric specialties.

Notes:
1. Main diagnosis of mesothelioma identified using International Classification of Diseases 10th revision (ICD10) code C45.
2. Patients with more than one discharge in a year are only counted once per NHS board area.
3. Figures for Scotland may not equal the sum of the individual NHS boards due to migration between board areas of residence.

**S2W-27978 - Stewart Maxwell (West of Scotland) (SNP) (Date Lodged 28 August 2006):** To ask the Scottish Executive how many people have mesothelioma, broken down by NHS board.
Source: ISD Scotland.
Ref: IR 2006-02465.

**Justice**

**S2W-26642 - Des McNulty (Clydebank and Milngavie) (Lab) (Date Lodged 8 June 2006):** To ask the Scottish Executive, further to the answer to question S2O-9490 by Hugh Henry on 30 March 2006, how many mesothelioma cases are currently being progressed and how many asbestos-related cases not involving a diagnosis of mesothelioma remain outstanding in Scottish courts, broken down according to whether the plaintiffs are from (a) island, (b) rural and (c) urban communities.
**Answered by Hugh Henry (19 June 2006):** As at 14 June, there were 32 cases involving a diagnosis of mesothelioma outstanding in the Court of Session and 384 other asbestos related cases. The court does not have a breakdown according to the pursuer’s place of residence.

**Health**

**S2W-26641 - Des McNulty (Clydebank and Milngavie) (Lab) (Date Lodged 8 June 2006):** To ask the Scottish Executive what studies have been undertaken to estimate the number of people who may suffer from mesothelioma in the next (a) 5, (b) 10 and (c) 15 years living in (i) island, (ii) rural and (iii) urban communities.
**Answered by Lewis Macdonald (19 June 2006):** I am not aware of any studies into the expected incidence of mesothelioma broken down by island, rural or urban communities in Scotland. However, the Health and Safety Executive have conducted a study into expected mortality from mesothelioma in Great Britain that was published in the British Journal of Cancer in 2005. The paper [The expected burden of mesothelioma mortality in Great Britain from 2002 to 2050](http://www.nature.com/bjc/journal/v92/n3/abs/6602307a.html) can be accessed at [http://www.nature.com/bjc/journal/v92/n3/abs/6602307a.html](http://www.nature.com/bjc/journal/v92/n3/abs/6602307a.html).

**S2W-26640 - Des McNulty (Clydebank and Milngavie) (Lab) (Date Lodged 8 June 2006):** To ask the Scottish Executive how many patients diagnosed with mesothelioma live in (a) island, (b) rural and (c) urban communities.
**Answered by Lewis Macdonald (19 June 2006):** The Scottish Cancer Registry records 913 patients who were diagnosed with mesothelioma in the five year period 1999-2003. Their distribution among the areas specified is:
(a) Island communities, six
(b) Rural areas, 125
(c) Urban areas, 788.
Justice

S2O-9490 - Des McNulty (Clydebank and Milngavie) (Lab): To ask the Scottish Executive how quickly cases of compensation for mesothelioma sufferers are now being dealt with by the Scottish courts following changes to the handling of such cases; how many mesothelioma cases are currently being progresses and how many asbestos-related cases not involving a diagnosis of mesothelioma remain outstanding in Scottish courts.

Answered by Hugh Henry (30 March 2006): In cases of mesothelioma, the waiting period in the Court of Session from the lodging of defences to allocation of proof is currently 46 weeks – within the period of 12/13 months recommended by Lord Coulsfield.

There are currently 88 mesothelioma related cases being progressed and there are 281 asbestos related cases not involving a diagnosis of mesothelioma outstanding in the Court of Session.

Health

S2W-23809 - Margo MacDonald (Lothians) (Ind) (Date Lodged 3 March 2006): To ask the Scottish Executive whether it plans to introduce legislation so that compensation paid to the families of mesothelioma sufferers in Scotland is paid on an equal basis to that paid in England and Wales.

Answered by Hugh Henry (24 March 2006): It is a matter for the courts in each jurisdiction to reach a view on the appropriate level of payment in individual cases. There are differences between the law of damages in Scotland and that in England and Wales. In Scotland, the Damages (Scotland) Act 1976 provides that where a person dies as a result of personal injury the deceased’s family may be entitled to claim damages for patrimonial loss and/or non-patrimonial loss. Patrimonial damages are awarded for loss of financial support, while non-patrimonial damages are awarded as compensation for distress and grief or for the loss of the deceased’s society. Only the “immediate family” is entitled to sue for non-patrimonial loss. We have recently legislated to update the list of persons who make up the deceased’s immediate family, for example to include same-sex partners, grandparents and siblings.

There is no claim for non-patrimonial loss in England and Wales. Instead, the Fatal Accidents Act 1976 provides for an entitlement to a bereavement claim, of fixed amounts, for a more limited range of relatives.

If the member has any concerns on specific aspects of damages law in Scotland I will be glad to hear more about them. In the meantime, the Scottish Executive has no plans to introduce legislation covering this area of the law.

S2W-2271 - Mrs Margaret Ewing (Moray) (SNP) (Date Lodged 29 August 2003): To ask the Scottish Executive what estimate has been made of the number of ex-servicemen requiring screening for mesothelioma and in which hospitals provision for such screening is being made and what contact it has had, in order to reach such an estimate, with the Ministry of Defence regarding which Royal Navy vessels were supplied with asbestos during the years of conscription, how many such vessels were based in Scottish ports and how many servicemen were employed on the vessels.

Answered by Malcolm Chisholm (26 September 2003): There is no effective screening test for mesothelioma. No provision has therefore been made to screen ex-servicemen.

S2W-2268 - Mrs Margaret Ewing (Moray) (SNP) (Date Lodged 29 August 2003): To ask the Scottish Executive how many deaths there were as a result of mesothelioma in each of the last 10 years, broken down by NHS board area.

Answered by Hugh Henry (26 September 2003): Before 2000, the information held centrally did not identify separately the cases where mesothelioma was the underlying cause of death. Because of this, the following table gives the numbers of deaths where mesothelioma was mentioned on the death certificate, whether as the underlying cause of death or as another factor.

Deaths in Scotland where Mesothelioma was Mentioned on the Death Certificate, 1993-2002 by NHS Board Area

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>118</td>
<td>129</td>
<td>153</td>
<td>140</td>
<td>133</td>
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<td>158</td>
<td>138</td>
<td>160</td>
<td>169</td>
</tr>
<tr>
<td>Argyll and Clyde</td>
<td>20</td>
<td>20</td>
<td>24</td>
<td>25</td>
<td>23</td>
<td>25</td>
<td>22</td>
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<td>19</td>
</tr>
<tr>
<td>Ayrshire and Arran</td>
<td>7</td>
<td>11</td>
<td>6</td>
<td>6</td>
<td>8</td>
<td>13</td>
<td>9</td>
<td>12</td>
<td>11</td>
<td>11</td>
</tr>
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<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Cancer

<table>
<thead>
<tr>
<th>Dumfries &amp; Galloway</th>
<th>3</th>
<th>2</th>
<th>2</th>
<th>1</th>
<th>1</th>
<th>3</th>
<th>2</th>
<th>6</th>
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<td>Highland</td>
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<td>1</td>
<td>7</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Lanarkshire</td>
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<td>13</td>
<td>12</td>
<td>16</td>
<td>14</td>
<td>22</td>
<td>11</td>
<td>16</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Lothian</td>
<td>14</td>
<td>12</td>
<td>23</td>
<td>11</td>
<td>12</td>
<td>14</td>
<td>22</td>
<td>17</td>
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<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
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<td>Shetland</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tayside</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>11</td>
<td>9</td>
<td>10</td>
<td>10</td>
<td>11</td>
<td>13</td>
<td>11</td>
</tr>
</tbody>
</table>

Information about referrals to named hospitals outside Scotland is not held centrally. Information is available of the total numbers of people referred to treatment in England:

Referrals to Hospitals in England for all Malignancies Excluding Non-Melanoma Skin Cancer

<table>
<thead>
<tr>
<th>Year</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>45</td>
</tr>
<tr>
<td>1998</td>
<td>58</td>
</tr>
</tbody>
</table>

Source: Scottish Cancer Registration database, ISD, Scotland, September 2002. 1998 is the last year for which cancer registration figures are available.

Note: There were no referrals for treatment of mesothelioma in either of these two years.

The treatment of patients with mesothelioma is a matter for specialists experienced in the management of cancer. For rare cancers such as mesothelioma, treatment may be arranged on a UK rather than national (Scottish) basis. Clinicians are responsible for making appropriate decisions on treatment in individual cases, in consultation with their patient.

S1W-29314 - Andrew Wilson (Central Scotland) (SNP) (Date Lodged 16 September 2002): To ask the Scottish Executive whether there are any specialist treatment units for mesothelioma and, if so, where they are located; how long any such units have been in operation, and what additional funding any such unit has received in each of the last five years.

Answered by Malcolm Chisholm (27 September 2002): I refer the member to the answer given to question S1W-28521 on 13 September 2002. All answers to written parliamentary questions are available on the Parliament's website, the search facility for which can be found at http://www.scottish.parliament.uk/webapp/search_wa.

Treatment for mesothelioma, and indeed for all cancers, is highly specialised and is delivered across multi-disciplinary networks involving clinical and medical oncologists based in Scotland's five cancer centres.

S1W-29313 - Andrew Wilson (Central Scotland) (SNP) (Date Lodged 16 September 2002): To ask the Scottish Executive how much it has spent specifically on research into mesothelioma in each of the last five years, expressed also as a percentage of the total amount spent on cancer research in each year.

Answered by Malcolm Chisholm (27 September 2002): The Chief Scientist Office (CSO) of the Scottish Executive Health Department has responsibility for encouraging and supporting research into health services and patient care with the NHS in Scotland. The CSO portfolio includes more than 57 cancer-related projects. Although none of these deals specifically with mesothelioma, many of the findings will be relevant to all tumour types.
The CSO also funds the indirect costs of cancer research. In 2001-02, approximately £7.7 million of the Research and Development Support Fund allocated to the NHS in Scotland for research was used in support of cancer studies - again with findings potentially relevant to all tumour types. The CSO always welcomes quality applications for consideration through their peer review and committee processes.

S1W-28521 - Andrew Wilson (Central Scotland) (SNP) (Date Lodged 20 August 2002): To ask the Scottish Executive (a) how many and (b) what the average age was of people who died from mesothelioma in each of the last three years; whether there any projections in respect of future deaths from the disease, and why there is no unit dedicated to the specialist treatment of and research into mesothelioma.

Answered by Malcolm Chisholm (16 September 2002): The following table shows how many people died from mesothelioma in each of the last three years, and what the average age was. There are no projections of future deaths from mesothelioma.

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>All deaths involving mesothelioma</td>
<td>158</td>
<td>138</td>
<td>160</td>
</tr>
<tr>
<td>Mesothelioma coded as underlying cause of death but no mention of exposure to asbestos</td>
<td>N/A</td>
<td>116</td>
<td>137</td>
</tr>
<tr>
<td>Exposure to asbestos coded as underlying cause of death, with a mention of mesothelioma</td>
<td>N/A</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>Other underlying causes with a mention of mesothelioma</td>
<td>N/A</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Average age of all persons included in the total</td>
<td>71</td>
<td>70</td>
<td>71</td>
</tr>
</tbody>
</table>

Notes:

1. In Scotland, the cause of death recorded on death certificates is coded using the World Health Organisation's International Classification of Diseases (ICD). The Ninth Revision of the ICD, which was in use up to 1999, did not have a specific code for mesothelioma. However, all cases where mesothelioma was mentioned on the death certificate were identified by the General Register Office for Scotland (GROS).
2. The 10th Revision of the ICD, which has been used to code cause of death in Scotland since 1 January 2000, includes a specific group of codes for mesothelioma.

The Scottish Executive's strategy for all cancers is to ensure patients have access to the best care possible through multidisciplinary managed clinical networks involving clinicians drawn from among relevant disciplines. There are therefore no centres of excellence vested within particular institutions or facilities.

Through the Chief Scientist Office, the Scottish Executive funds a wide range of research into cancer. Many researchers and research groups are involved. Concentrating research in a single centre would not be an efficient way of ensuring that its benefits, in terms of improved treatment and organisation of care, are implemented as widely as possible throughout the health service.

S1W-11085 - Shona Robison (North-East Scotland) (SNP) (Date Lodged 9 November 2000): To ask the Scottish Executive whether trials of the new combination drug to treat mesothelioma which are currently taking place in Newcastle will be extended to Scotland.

Answered by Susan Deacon (30 March 2001): The Chief Scientist Office (CSO) within the Scottish Executive Health Department is aware of 25 current studies into mesothelioma in the UK, none of which take place in Newcastle. Details of these are available from the National Research Register, a copy of which is in the Parliament's Reference Centre.

A small scale Phase 1 clinical trial, was conducted recently in Newcastle General Hospital, where patients were given a combination of two drugs known as Carboplatin and MTA. CSO has no information as to whether there are plans to extend the trial nor whether any such extension would involve recruitment of patients from Scotland.

The results of research into mesothelioma undertaken throughout the UK will inform the future direction of research and treatment in this area.

S1W-13188 - Mrs Margaret Ewing (Moray) (SNP) (Date Lodged 7 February 2001): To ask the Scottish Executive, further to the answer to question S1W-12741 by Susan Deacon on 5 February 2001, when information on the number of newly diagnosed cases of mesothelioma in each health board area in (a) 1998-99, (b) 1999-2000 and (c) 2000-01 will be available.

Answered by Susan Deacon (19 March 2001): Collection and analysis of cancer registration data is an iterative process that ensures high quality data are being used in making comparisons within Scotland and across Europe and the rest of the world.
It is anticipated that 1998 cancer registration data will be complete by the summer of this year with each successive year's data following annually thereafter.

Cancer

S1W-12743 - Mrs Margaret Ewing (Moray) (SNP) (Date Lodged 23 January 2001): To ask the Scottish Executive how much was spent on research into the treatment of and possible cures for mesothelioma in (i) 1997-98, (ii) 1998-99 and (iii) 1999-2000 and how much is expected to be spent in 2000-01 and 2001-02.

Answered by Susan Deacon (23 February 2001): Details of expenditure on all research into the treatment and possible cures for mesothelioma are not held centrally.

The Chief Scientist Office (CSO) of the Scottish Executive Health Department has responsibility for encouraging and supporting research into health services and patient care within the NHSScotland. CSO is not currently funding any research into the treatment of and possible cures for mesothelioma but would be pleased to receive research applications which would be subject to the usual peer group and committee review.

Cancer is one of three clinical priorities for the NHSScotland and a specific research priority. The Executive's approach to cancer research in general is set out in my answer to S1W-10110.

S1W-10544 - Dorothy-Grace Elder (Glasgow) (SNP) (Date Lodged 20 October 2000): To ask the Scottish Executive what counselling is offered to people diagnosed with mesothelioma and their families.

Answered by Malcolm Chisholm (22 February 2001): There is no distinction between counselling and other support services offered to people suffering from differing forms of cancer. Referral to the appropriate services would normally be made by medical staff after discussion and agreement with patients.

S1W-10542 - Dorothy-Grace Elder (Glasgow) (SNP) (Date Lodged 20 October 2000): To ask the Scottish Executive, further to the statement by Professor Julian Peto, Senior Epidemiologist at the Cancer Research Institute in London, that there are now more deaths from mesothelioma than cervical cancer, what plans it has to ensure that Scottish hospitals participate in all future clinical trials related to those currently being carried out at Newcastle General Hospital.

Answered by Susan Deacon (22 February 2001): The Scottish Executive encourages patient entry into clinical trials but has no locus in setting these up.

The Clinical Standards Board for Scotland's core principles for cancer care, against which cancer services will be assessed, includes the statement that "Those involved in delivering cancer services will try to increase the participation of patients in well designed, ethical clinical trials".

The decision as to eligibility for inclusion and agreement to participate in a specific clinical trial is a matter for agreement between clinicians and their patients in individual cases.

S1W-10540 - Dorothy-Grace Elder (Glasgow) (SNP) (Date Lodged 20 October 2000): To ask the Scottish Executive how many people have been diagnosed with mesothelioma in (a) the Greater Glasgow Health Board area and (b) Scotland in each of the last five years.

Answered by Susan Deacon (22 February 2001): Figures for the period 1993 - 1997 (the most recent year for which completed information is available) are as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Greater Glasgow Health Board</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>50</td>
<td>132</td>
</tr>
<tr>
<td>1994</td>
<td>48</td>
<td>167</td>
</tr>
<tr>
<td>1995</td>
<td>41</td>
<td>155</td>
</tr>
<tr>
<td>1996</td>
<td>56</td>
<td>173</td>
</tr>
<tr>
<td>1997</td>
<td>40</td>
<td>142</td>
</tr>
</tbody>
</table>
Cancer


Answered by Susan Deacon (6 February 2001): Information is not available in the format requested. My response to question S1W-11268 provides the background to funding decisions by health boards.

Health

S1W-12741 - Mrs Margaret Ewing (Moray) (SNP) (Date Lodged 23 January 2001): To ask the Scottish Executive how many people were diagnosed with mesothelioma in (i) 1998, (ii) 1999 and (iii) 2000, broken down by health board area.

Answered by Susan Deacon (5 February 2001): The numbers of newly diagnosed cases of mesothelioma registered for each health board, for the years 1995, 1996 and 1997 (the most recent years for which completed information is available) are as follows:

<table>
<thead>
<tr>
<th>Health Board of residence</th>
<th>Year of diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll &amp; Clyde</td>
<td>28</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>5</td>
</tr>
<tr>
<td>Borders</td>
<td>5</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>2</td>
</tr>
<tr>
<td>Fife</td>
<td>15</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>5</td>
</tr>
<tr>
<td>Grampian</td>
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<td>Greater Glasgow</td>
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<td>Lanarkshire</td>
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<tr>
<td>Orkney</td>
<td>0</td>
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<tr>
<td>Shetland</td>
<td>0</td>
</tr>
<tr>
<td>Tayside</td>
<td>5</td>
</tr>
<tr>
<td>Western Isles</td>
<td>0</td>
</tr>
<tr>
<td>Scotland</td>
<td>155</td>
</tr>
</tbody>
</table>


S1W-11514 - Mr Duncan McNeil (Greenock and Inverclyde) (Lab) (Date Lodged 23 November 2000): To ask the Scottish Executive whether the Chief Scientist Office would consider favourably applications for research into treatments of mesothelioma.

Answered by Susan Deacon (7 December 2000): The CSO would be pleased to receive research applications into treatments of mesothelioma, which would be subject to the usual peer and committee review.

S1W-11090 - Shona Robison (North-East Scotland) (SNP) (Date Lodged 9 November 2000): To ask the Scottish Executive what steps are being taken to ensure that appropriate care and support is available to people diagnosed with mesothelioma.

Answered by Susan Deacon (30 November 2000): Cancer is one of three national clinical priorities for the NHS in Scotland.

Mesothelioma is a particularly distressing disease, for which the treatment options are the same as for all cancers i.e. chemotherapy, radiotherapy and surgery. Decisions on treatment options are reached in agreement between clinicians and their patients.

Similarly, a wide range of support services are available for everyone with cancer. Referral to the appropriate services would normally be made by medical staff after discussion and agreement with patients.
To ask the Scottish Executive whether it will conduct tests similar to those being carried out at Newcastle General Hospital into a new drug treatment for mesothelioma patients.

Answered by Malcolm Chisholm (30 November 2000): The Executive encourages patient entry into clinical trials but has no locus in setting these up.

To ask the Scottish Executive what representations it has made to the Director-General of the Cancer Research Campaign to bring in clinical trials on drugs to combat mesothelioma to Scotland.

Answered by Susan Deacon (22 November 2000): I and officials from my department have met with Cancer Research Campaign Director General on a number of occasions to discuss matters of common interest. As far as clinical trials are concerned, the Scottish Executive encourages patient entry into relevant clinical trials. Eligibility of individual patients and the decision to participate in each case is a matter for decision and agreement between clinicians and their patients.

To ask the Scottish Executive how many people died from mesothelioma in each year since 1980, broken down by health board area.

Answered by Susan Deacon (22 November 2000): The information is not available centrally in the format requested. It is not possible to identify separately the cases where mesothelioma was the underlying cause of death. The table below gives the numbers of deaths where mesothelioma was mentioned on the death certificate.

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Deaths in Scotland where mesothelioma was mentioned on the death certificate, 1980 - 1999, by health board.
S1W-10541 - Dorothy-Grace Elder (Glasgow) (SNP) (Date Lodged 20 October 2000): To ask the Scottish Executive what plans it has to liaise with the Medicine Control Agency and the Gene Therapy Advisory Committee to ensure (a) the continuation of the research into solid tumour treatments being conducted by Professor Moira Brown of Glasgow University and (b) that a phase one trial for oncolytic virus therapy for mesothelioma is conducted in Scotland.

Answered by Susan Deacon (10 November 2000): None. However, the Scottish Executive continues to be informed, and to have the opportunity to comment if it so wishes, about the work of the Medicine Control Agency and the Gene Therapy Advisory Committee, both of which are non-devolved bodies whose work includes the approval of research proposals on a UK basis that involve genetic manipulation in terms of human therapy.

The Scottish Executive is currently funding (to the total value of £253k) two projects on treatments for solid tumours where Professor Moira Brown is one of the researchers: one focuses on melanoma and the other on brain tumours using a mutant Herpes simplex virus. Should satisfactory progress be made on these, we would be pleased to consider any further submissions in this area through our funding mechanism which, at present, is largely response mode and subject to peer and committee review. This would also apply to any proposals for research on mesothelioma.

The results of the research projects into solid tumours, including mesothelioma, undertaken throughout the UK will inform the future direction of research and treatment in this area. Details of all UK projects are available from the National Research Register (NRR), a copy of which is in the Scottish Parliament Information Centre (SPICe).