Identifying and evaluating the social and psychological impact of workplace accidents and ill-health incidents on employees

Prepared by Human Reliability Associates Ltd for the Health and Safety Executive 2006

RESEARCH REPORT 464
Identifying and evaluating the social and psychological impact of workplace accidents and ill-health incidents on employees

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This research, and the literature review that preceded it, was commissioned by HSE. The review confirmed that there are few studies that have explicitly examined the impact of serious workplace-related injury and ill health on individuals, their families and their immediate social network. The study reported here examines the nature and extent of this impact in two specific work sectors: the construction sector and the healthcare sector. These sectors were pre-selected by HSE as representing two priority areas.

The research involved three complementary strands of work: short telephone interviews with a sample of employees within the relevant sectors who had experienced a serious workplace accident or suffered from a reportable illness, personal home interviews with a limited subset of the more serious cases and their family members, and lastly, further follow-up interviews with a subset of cases who took part in the home interview survey.

The study clearly demonstrates that serious work-related accidents and illness can have a widespread impact on individuals and their families. Many will find that their working life is significantly affected: they may be unable to return to work, need a change of job or role to accommodate new restrictions or be conscious that they now approach their work with a level of caution and deliberation not previously in evidence; many will also experience longer-term physical problems. There are also immediate and longer-term economic consequences, both in terms of loss of income (most evident in the construction sector) and the need for extra expenditure associated with the accident or illness. The results of this study also suggest that many individuals (regardless of sector) assign responsibility for both accidents and illness to their employer and will seek redress through financial compensation.

This report and the work it describes were funded by the Health and Safety Executive (HSE). Its contents, including any opinions and/or conclusions expressed, are those of the authors alone and do not necessarily reflect HSE policy.
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EXECUTIVE SUMMARY

This research, and the literature review that preceded it, was commissioned by HSE. The review confirmed that there are few studies that have explicitly examined the impact of serious workplace-related injury and ill health on individuals, their families and their immediate social network. The study reported here examines the nature and extent of this impact in two specific work sectors: the construction sector and the healthcare sector. These sectors were pre-selected by HSE as representing two priority areas.

The research involved three complementary strands of work: short telephone interviews with a sample of employees within the relevant sectors who had experienced a serious workplace accident or suffered from a reportable illness, personal home interviews with a limited subset of the more serious cases and their family members, and lastly, further follow-up interviews with a subset of cases who took part in the home interview survey.

The study clearly demonstrates that serious work-related accidents and illness can have a widespread impact on individuals and their families. Many will find that their working life is significantly affected: they may be unable to return to work, need a change of job or role to accommodate new restrictions or be conscious that they now approach their work with a level of caution and deliberation not previously in evidence; many will also experience longer-term physical problems. There are also immediate and longer-term economic consequences, both in terms of loss of income (most evident in the construction sector) and the need for extra expenditure associated with the accident or illness. The results of this study also suggest that many individuals (regardless of sector) assign responsibility for both accidents and illness to their employer and will seek redress through financial compensation.

Following an accident, day-to-day activities and family life are often seriously affected, in many cases for lengthy periods of time. Chronic conditions, such as Hand Arm Vibration Syndrome (HAVS) or latex allergy, were also shown to have a significant impact on the quality of life, often in ways that intrude on more personal and intimate levels of daily and family life. Behaviour is often affected with many individuals reporting changes such as disturbed sleep, adverse changes in temperament and a decrease in sexual activity. Whilst the study has shown that many family members, and particularly partners, are generous and often unwavering in their support, these effects can also impact on others, adversely affecting the behaviour of family members, including children. Although some individuals and family members reported a strengthening of relationships, others felt their relationships had suffered. The latter was more prevalent in the construction sector, where restricted mobility led to feelings of frustration and boredom. Lastly, the study provides strong evidence that there may be serious and long-standing psychological consequences of both workplace accidents and illness. In particular, the prevalence of anxiety and depression was high across both groups and sectors and there was evidence of collateral psychological impact on partners.

Overall, the study results indicate that individuals are primarily reliant for support on their close family and friends. Whilst employers, managers and colleagues also provide informal support, there was little evidence of any formal return to work policy or plans being invoked in either sector. Specialist support from Occupational Health departments or Human Resources was only provided in a relatively small number of cases, even in the healthcare sector, and despite the scale of the psychological impact, most individuals had not discussed their problems with their doctor or other appropriate professional. Taken in their totality, the results of the study have implications for the management of these cases by employers, health professionals and HSE. Accordingly, areas for improvement in practice are identified in respect of all three groups.
1 MANAGEMENT SUMMARY

1.1 BACKGROUND

This study examined the vocational, economic, social and psychological impact of workplace accidents and incidents of ill health on employees. A literature review had previously demonstrated that there had been few studies that explicitly examined these issues within the UK workforce. Accordingly this is a landmark study and the first to systematically highlight the extent and severity of these effects. The study focused on two specific work sectors: the construction sector and the healthcare sectors - these sectors were pre-selected by HSE as representing two priority areas.

Aims of the study

The principal research aims of the study were defined as follows:

- To identify the social, vocational and economic impact of serious workplace related accidents and ill-health on employees and their families
- To identify the psychological and behavioural impact of serious workplace related accidents and ill-health on employees and their families
- To examine the impact of these accidents and incidents of ill health over time.

1.2 OVERVIEW

The study provides compelling evidence that serious workplace-related accidents and ill health have a detrimental impact on the lives of many individuals and their families, over and above the physical injuries that they suffer. The results of the study also provide a strong indication of the problems that need to be anticipated and managed by employers and professionals who have responsibility for the identification, support and rehabilitation of those injured or otherwise impaired at the workplace. Taken in their totality, the results of the study have implications for the management of these cases by employers, health professionals and HSE. Accordingly, areas for improvement in practice are identified in respect of all three groups (Appendix 1).

1.3 METHODOLOGY

The research involved three complementary strands of work. A total of 237 short telephone interviews were carried out with a sample of employees within the construction and healthcare sectors who had experienced a serious workplace accident (classified as ‘Major’ in RIDDOR) or suffered from a reportable illness. These interviews were carried out between 10 weeks and several months after the accident or onset of ill health. Personal home interviews were carried out with a limited subset of the more serious cases and, where available, their family members (80 cases comprising 40 cases from the construction sector and 40 cases from the healthcare sector). Further follow-up interviews were carried out in a subset of cases from the home interview survey (40 cases in total across both sectors) and these home interviews are described as case studies in the main report.
1.4 KEY FINDINGS

The consequences of injury and ill-health are considered under five headings: psychological, behavioural, social, vocational and economic.

1.4.1 Psychological consequences

Psychological consequences were evaluated using a mixture of open-ended questions within the interview schedules and established measurement instruments. All cases were asked if they felt the accident or illness was still affecting them emotionally. In the case of accidents, the degree to which individuals may have been experiencing significant symptoms of trauma (including post traumatic stress disorder (PTSD)) was also assessed (at the telephone stage using the Trauma Screening Questionnaire (TSQ). The extent to which individuals in both the accident and illness groups were exhibiting symptoms of anxiety or depression was also assessed at the home interview stage (using Goldberg’s anxiety and depression scales).

The main findings from the telephone survey (which covered 237 cases in total) are summarised in Table 1.1.

**Table 1.1 Main findings from telephone survey**

<table>
<thead>
<tr>
<th>Category</th>
<th>Reporting still affected emotionally at the time of the telephone interview (all cases)</th>
<th>Reporting symptoms indicative of PTSD as assessed by the TSQ at telephone interview (accidents only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction accident</td>
<td>60%</td>
<td>27%</td>
</tr>
<tr>
<td>Construction illness</td>
<td>63%</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Health sector accident</td>
<td>57%</td>
<td>31%</td>
</tr>
<tr>
<td>Health sector illness</td>
<td>61%</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

The results for the home interview sample (a selected subset of 80 cases assessed as having more serious social or psychological consequences) are summarised in Table 1.2.

**Table 1.2 Results for home interview sample**

<table>
<thead>
<tr>
<th>Category</th>
<th>Reporting symptoms indicative of PTSD at the time of the telephone interview</th>
<th>Reporting symptoms of anxiety or depression at the time of the home interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction accident</td>
<td>40%</td>
<td>70% above threshold for anxiety 90% above threshold for depression</td>
</tr>
<tr>
<td>Construction illness</td>
<td>Not applicable</td>
<td>85% above threshold for anxiety 80% above threshold for depression</td>
</tr>
<tr>
<td>Health sector accident</td>
<td>40%</td>
<td>60% above threshold for anxiety 75% above threshold for depression</td>
</tr>
<tr>
<td>Health sector illness</td>
<td>Not applicable</td>
<td>45% above threshold for anxiety 60% above threshold for depression</td>
</tr>
</tbody>
</table>

Overall the findings of the telephone and home interview surveys indicated that:

- **Serious workplace-related accidents and ill health result in high levels of psychiatric morbidity.** However, only a small proportion of individuals discuss these issues with their doctor.
• The TSQ results indicate that a significant proportion (between 27% and 31%) of those who suffer from a serious workplace-related accident displayed symptoms indicating that they were at risk of Post Traumatic Stress Disorder (PTSD). These findings are broadly comparable to estimates in the literature of PTSD in motor vehicle accidents (39%) and victims of violent crime (26.8%).
• The proportion of cases above the threshold for anxiety and depression in both the accident and illness groups are between double and three times the level reported in the HSE control group who completed the Goldberg scales in the HSE household survey of work-related illness reported in 1998.

1.4.2 Behavioural consequences

These issues were not addressed in the telephone survey. Findings from the home interviews indicated that:

• The most common behavioural effects across both sectors and across both accidents and ill health groups are disturbed sleep and noticeable changes in temperament such as increased loss of temper or loss of patience.
• Cognitive functions, such as ability to concentrate or make decisions, can also decline in some cases.
• A decrease in sexual activity was reported by some individuals, especially where there are physical restrictions associated with an accident.
• There is increased use of prescription and non-prescription drugs across both sectors and groups.
• In the construction sector (predominantly male outdoor workers) there is an increased desire to leave the house and socialise – this pattern was not identified in the healthcare sector.
• In many cases these behavioural effects persist for several months.
• There can also be noticeable changes in behaviour in those who live with individuals who have experienced work-related accidents or ill health. In particular, there was evidence that the behaviour of children was affected detrimentally. Interviews with family members suggest that the affected person may tend to underestimate or underreport the magnitude of these changes.
• The reported pattern of these changes suggest that many of the significant behavioural effects are not specific to the injury, illness or sector and hence a generally predictable outcome of most serious work-related injuries or illness.

1.4.3 Social consequences

Findings from the telephone survey are summarised in Table 1.3:

<table>
<thead>
<tr>
<th>Category</th>
<th>Experienced restriction on one or more Activities of Daily Living (ADL)</th>
<th>Experienced restriction on mobility</th>
<th>Experienced restriction on social life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction accident</td>
<td>63% - 77%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Construction illness</td>
<td>39% - 67%</td>
<td>39%</td>
<td>17%</td>
</tr>
<tr>
<td>Health sector accident</td>
<td>81% - 86%</td>
<td>81%</td>
<td>68%</td>
</tr>
<tr>
<td>Health sector illness</td>
<td>56% - 73%</td>
<td>55%</td>
<td>52%</td>
</tr>
</tbody>
</table>
Findings from the telephone survey show that:

- Work-related accidents and ill-health have a pervasive and damaging impact on personal and family life, typically restricting many normal and routine activities. The impact is particularly evident in the case of accidents.
- The social impact of conditions such as work related upper limb disorders and latex allergies in the healthcare sector is also extensive.
- Many of the restrictions discussed above inevitably spill over into family life with social and recreational activities particularly affected.
- In the case of accidents, social support is predominately provided by partners, but also involves parents, older children, friends and siblings. In cases of ill health in the construction sector personal support is also provided primarily by partners; in the healthcare sector there is evidence of a wider network of support.

Findings from the home interviews also indicated that:

- In some cases, restrictions continue for a long period of time, leading to feelings of personal frustration and, where mobility is seriously affected, feelings of depression and social isolation. In some cases the follow-up interviews indicate some activities are unlikely to return to normal.
- The restrictions associated with work related upper limb disorders and allergies such as latex allergy can lead to feelings of great frustration and anxiety about the future.
- Support from partners and family is critical. In both sectors (and in both accidents and ill health groups) nearly all of those who lived with a partner identified them as the primary source of emotional and practical support.
- The number of changes in the overall quality of relationships is relatively small and some individuals experienced a strengthening of their relationships. Where deterioration in relationships is reported, problems typically revolve around financial worries and concerns.
- Those who live alone face particular problems in terms of social isolation, financial vulnerability, restricted mobility and lack of emotional and day-to-day practical support.

### 1.4.4 Vocational consequences

Table 1.4 summarises the actual or predicted impact of the accident or ill health on an individual’s job at the time of the telephone survey. It should be noted that in some categories the sample is small and that each category includes a wide range of different cases.

<table>
<thead>
<tr>
<th>Category</th>
<th>Number in sample</th>
<th>Job affected or likely to be still suffering residual physical effects**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction accident</td>
<td>94</td>
<td>40%</td>
</tr>
<tr>
<td>Construction illness</td>
<td>36</td>
<td>66%</td>
</tr>
<tr>
<td>Health sector accident</td>
<td>43</td>
<td>58%</td>
</tr>
<tr>
<td>Health sector illness</td>
<td>64</td>
<td>63%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>79%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td>78%</td>
</tr>
<tr>
<td></td>
<td>85%</td>
</tr>
</tbody>
</table>
Includes cases where individuals had taken early retirement on ill health grounds, those individuals who had changed jobs or expected to change jobs as a result of the accident or ill health and those who felt the way they carried out their work was affected by the accident or ill health

** Independently of work status individuals were asked if they considered they were still suffering residual effects of the accident or episode of ill health

Findings from the telephone survey show that:

- Over half of the individuals reported that their working life is, or will be, significantly affected following a serious accident or episode of ill health. This ranged from being unable to return to work, needing a change of job or role to accommodate new restrictions or now approaching their work with a level of caution and deliberation not previously in evidence. Many will also experience longer-term physical problems.
- In terms of length of time off work, accidents tend to result in more time off work than illnesses in both construction and healthcare sectors. **Work-related illness often resulted in no loss of time off work.** However, those suffering from work-related illness in the healthcare sector were more likely to take time off work than the equivalent group in the construction sector.
- In summary, accidents are traumatic in nature and can require lengthy recuperation before return to work. In the ill health group, conditions are typically chronic in nature, often resulting in no time off work but nevertheless having significant impact on work outcomes. Both groups incurred additional costs on employers in terms of aspects such as work reorganisation, loss of performance and potential loss of staff.

Findings from the home interviews also indicated that:

- Individuals working in the construction sector are often under significant financial pressure to remain at work or to return to work early and, typically, have few alternative job prospects.
- In the construction sector, and to a significant but lesser extent within the healthcare sector, there is little evidence of any formal policy or plan to manage return to work. Support and contact with individuals tends to be informal and at the behest of individual managers and colleagues. The involvement of Occupational Health and Human Resource departments is minimal even in the healthcare sector.
- Following return to work, there is often a failure to sustain the necessary level of support to ensure full integration back into the workplace.

### 1.4.5 Economic consequences

Findings from the telephone survey show that:

- Those experiencing serious accidents in the construction sector (and consequent loss of time from work) typically experience a significant loss of income and are clearly under serious financial pressure; the equivalent group in the healthcare sector lose significantly less income. In practice, whilst those working in the NHS typically remain on full pay, some staff experience loss of regular income because of an inability to work overtime or ‘bank’ work.
- Both work-related accidents and illness often result in additional financial demands on the household, principally in additional transport costs (higher in the accident than the...
illness groups) and additional medical costs (typically medication and prescription costs).

• Other family members or friends may also lose time from work and associated pay. This is more common in relation to accidents (where more physical support may be required) than illness.

Findings from the home interviews also indicated that:

• Although they may not lose time from work, those experiencing work-related ill health in the construction sector often end up on a reduced salary because of redeployment, restricted work hours or loss of overtime.
• In the construction sector, the additional expenditure associated with the accident or illness places a further burden on already limited and stretched resources.
• There may be significant expenditure on private medicine, and, in the case of chronic and long-standing conditions such as upper limb disorders some investment in complementary medicine.
• Most individuals feel that their employer, manager, co-worker or other external party is partially or fully responsible for their accident or ill health. They are also likely, particularly in the case of accidents, to seek compensation from their employer (in the construction sector, 25 out of the 40 cases were involved in such claims and in the healthcare sector the equivalent figure was 16 out of 40).
2 INTRODUCTION

2.1 BACKGROUND AND AIMS

Research has already demonstrated that major trauma can have a significant social and psychological impact on individuals and their families. However, much of this work relates to non-occupational related trauma or is limited to small and unrepresentative samples. The survey described in this report was specifically designed to extend our knowledge of the social and psychological impact of workplace related accidents and ill health on employees and their families. The survey, and the supporting literature search carried out prior to the survey\(^1\), form part of a research programme commissioned by the Health and Safety Executive in 2002.

The research reported here was limited to following up serious accidents and incidents of ill health in two sectors: construction and healthcare. These sectors were pre-selected by HSE as representing two current priority areas. Preliminary work on the survey started in September 2003 and interviews were completed in October 2004.

The principal research aims of the survey were defined as follows\(^2\):

- To identify the social, vocational and economic impact of serious workplace related accidents and ill-health on employees and their families
- To identify the psychological and behavioural impact of serious workplace related accidents and ill-health on employees and their families
- To examine the impact of these accidents and incidents of ill health over time
- To examine whether and to what degree there is variation in impact across key groups: for example, gender, age and sector.

In addition to extending the limited knowledge base in this area, the other main driver for the research was the need to provide better support and guidance for HSE inspectors who are required to interview those affected by workplace trauma. It is envisaged that the output of this research will also assist inspectors in carrying out interviews in a more informed and sensitive fashion by supporting them in the following ways:

- Raising their general level of awareness and sensitivity to the range and scale of consequences that may follow the occurrence of serious injury or ill health. This should help prepare inspectors to deal with the range of individual and family responses that they may be exposed to in their work;

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\(^2\) The research aims listed here were generated following the completion of the literature search. In general, these aims reflect the objectives identified within the original research proposal. However, the original survey design was also intended to include the impact of fatalities on families and work colleagues. With the agreement of HSE, this group of cases have not been covered because of difficulties in gaining access to relevant cases.
• Providing a basis for any future development of procedures and training for inspectors that explicitly addresses the social and psychological implications of serious work-related accidents and ill health
2.2 MAIN RESEARCH METHODS

The survey structure involved three complementary strands:

2.2.1 Initial telephone interviews

Telephone interviews were carried out with employees who had experienced a serious workplace accident or suffered from a reportable illness within the construction and healthcare sectors. These interviews were originally intended to act as a vehicle for recruiting cases for personal interview and for screening those individuals who were most seriously traumatised and might require a particularly sensitive approach. However, initial interviews proved extremely valuable and, in practice, the content of the interview was extended to collect a range of information relating to the consequences of the accident or illness. The 237 telephone interviews that were carried out form the primary database for the main quantitative analysis included in this report.

2.2.2 Personal interviews with affected employees and family members

Because of the sensitivity and complexity of some of the issues being addressed, it was always recognised that personal interviews would be required with a sample of affected employees. In total, 80 such interviews were carried out with a subset of the telephone sample that agreed to be visited at home. A further 40 home interviews were carried out with family members or partners of the affected employee. All of these interviews were extensive in content, allowing time and opportunity to discuss the impact of the accident or illness on the employee and family. These 120 interviews form the primary database for the qualitative analysis included in the report.

2.2.3 Follow-up telephone and home interviews

An important element of the research was to try and capture some feeling for the progressive impact of serious accidents and ill health over time. In part, this objective was accomplished by carrying out home interviews to a subset of employees some time after the telephone interview. In order to provide a more extended time line, further telephone or home interviews were carried out with 40 of the 80 affected employees some months after the first home interview. These interviews have been used to provide more insight into those consequences that have a more prolonged impact on employees and their families. There were acknowledge limitations to this aspect of the research and these are discussed in some detail in the final discussion section of the report.
2.3 ETHICAL CONSIDERATIONS

It was recognised in the original research proposal that some individuals and families could be contacted under conditions of some stress and uncertainty and that the interviews themselves would cover some very personal issues. The study team were therefore required to meet the requirements of the HSE ethical guidelines and submit a detailed research protocol, including all proposed data collection instruments, to the HSE internal Ethics Committee. Following a series of consultations, and culminating in a formal presentation to the Ethics Committee, the final research protocol was agreed. During this process, the following issues of note were addressed:

- The degree to which the research design allowed participants to opt-in to the research rather than opt-out. It was finally agreed that, whilst the design was fundamentally opt-out, the process via which potential participants could decline to participate should be as simple as possible. In the event, because of the nature of the HSE database on occupational illness, the process was essentially ‘opt-in’ for all cases of workplace related ill health.
- The requirement for confidentiality including the anonymity of participants and the need to develop and maintain a secure database.
- The need to provide the fullest possible information to potential participants covering the nature of the research, the use of the data being collected, confidentiality issues and their right to withdraw from the study at any time. This requirement was met through the provision of a comprehensive ‘Participant Information Sheet’ developed in line with HSE ethical guidelines.
- The need for an appropriate screening technique to identify individuals still experiencing psychological distress or otherwise deeply affected by the accident or illness. This screening would allow the interviewer to be aware of, and particularly sensitive to, some of the more personal issues that could be raised at interview.
- The need to have trained interviewers with the experience to carry out potentially difficult interviews and the availability of specialist interviewers should particularly difficult cases be identified.
- All interviewers including those carrying out telephone interviews were to be provided with dedicated training in the administration of the survey instruments and how to deal with difficult interviews.
2.4 STRUCTURE OF THE REPORT

The remainder of the report is structured as follows:

- **Section 3** provides a description of the final samples obtained in both the telephone and home interview surveys.

- **Section 4** briefly summarises the issues covered in both surveys and details of the interview schedules that were administered.

- **Section 5** summarises the results of the telephone survey.

- **Section 6** provides an overview of the results for each of the four groups of cases covered in the home interviews: construction sector accidents, construction sector illnesses, healthcare sector accidents and healthcare sector illnesses. Each overview is followed by a case summary for each of the 20 cases included in each group.

- **Section 7** provides an extensive overview of the findings from both the telephone and the home interview surveys.

- **Section 8** summarises the implications for practice and associated areas for improvement that have emerged from the research.
3 SURVEY METHODOLOGY – SAMPLE STRUCTURE

3.1 SAMPLE STRUCTURE

3.1.1 Target sample for home interview survey

The target sample for the home interview survey was specified in the HSE tender specification. Details of this sample are reproduced below in Table 3.1.

Table 3.1 Provisional sample structure for home interviews

<table>
<thead>
<tr>
<th>Healthcare Sector</th>
<th>Major Accidents*</th>
<th>Ill Health</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Construction Sector</td>
<td>Fatal Accidents**</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>20</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Major Accidents</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Ill Health</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>TOTAL NUMBER OF CASES</td>
<td>60</td>
<td>20</td>
<td>80</td>
</tr>
</tbody>
</table>

*Injuries classified as ‘Major’ under RIDDOR
**Fatal accidents were subsequently excluded from the study
***Cases of individuals who live on their own not originally specified in HSE tender specification but added in HRA research proposal on the basis that social and psychological consequences may differ for this group

The original sample structure also required interviews with children, partners, parents and siblings of the individuals concerned. However, these requirements were modified considerably as the development work for the research proceeded. In practice, the HSE Ethical Committee reinforced the study team concern about interviewing children and refused permission for children to be interviewed as a discrete target group. Obtaining access to cases of fatal accidents and illness also proved extremely difficult and, although a small number of cases were eventually followed up, these are not included in this report. To compensate for this loss of cases, and following discussions with HSE, it was decided to increase the number of non-fatal cases to 40 cases within each of the two categories of major accident and debilitating ill health. Lastly, it was recognised that it was sometimes neither practically possible, nor appropriate, to interview partners and other family members and hence the difficulty of meeting target numbers in these cells was also acknowledged.

It is important to note that the allocation of an accident to the category of ‘Major’ under RIDDOR does not, of itself, mean that the resulting injury has either serious or long-term implications for the individual. The category embraces a wide range of injuries, some of which may, in practice, have very short recovery times and negligible consequences. At the request of HSE, the selection of cases for home interview was to be biased to those cases that were likely (based on the results of the telephone interview) to be more serious either in terms of physical or psychological consequences. Because of the implications of this bias in the sample, this issue will be referred to as appropriate within relevant sections of the report.

---

3 RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
3.1.2 Sampling framework – telephone interview survey and home interview survey

As noted in the introduction, the telephone interviews were originally designed to act as a vehicle for recruiting suitable cases for the home interview survey. However, it was always recognised that the survey had the potential to generate a useful database in its own right. It was therefore felt important that sufficient numbers of cases should be included in the telephone interview to make it broadly representative of the population of accidents classified as ‘Major’ under RIDDOR and of the population of reportable illnesses under RIDDOR.

In order to specify the relevant sampling framework for both telephone and home interviews an analysis of retrospective data on RIDDOR cases in the Construction and Healthcare sectors for a six-year period (report years 1997/1998 to 2002/2003) was carried out\(^4\). The resulting analysis for the variables of age and gender are shown below in Table 3.2.

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Healthcare</th>
<th></th>
<th></th>
<th>Construction</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accident</td>
<td>Ill Health</td>
<td>Accident</td>
<td>Ill Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2,775</td>
<td>29%</td>
<td>164</td>
<td>18%</td>
<td>25,279</td>
<td>99%</td>
</tr>
<tr>
<td>Female</td>
<td>6,820</td>
<td>71%</td>
<td>773</td>
<td>82%</td>
<td>317</td>
<td>1%</td>
</tr>
<tr>
<td>Not Known</td>
<td>807</td>
<td>8%</td>
<td>215</td>
<td>23%</td>
<td>2,530</td>
<td>10%</td>
</tr>
</tbody>
</table>

An additional analysis by ‘nature of injury’ and ‘site of injury’ was also carried out for all accidents in the six-year period and by ‘nature of illness’ for all illness cases in the equivalent period. Together these analyses provide the reference framework for both the telephone interview survey and the home interview survey.

3.1.3 Target sample structure by age and gender

The retrospective analysis of RIDDOR data referred to above was also used to try to further define the target sample structure for the home interview survey. Based on the gender and age profile shown in Table 3.2 above, the relevant target sample structure for the home interview survey is shown below in Table 3.3.

Table 3.3  Proposed sample structure for home interview survey*

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Healthcare Accident</th>
<th>Healthcare Illness</th>
<th>Construction Accident</th>
<th>Construction Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>4</td>
<td>4</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

*These figures were based on the original HSE target figures that included fatalities; target figures for non-fatal accidents and illnesses were subsequently revised to reflect the fact that the total target figure for accidents was increased to 40 and for illnesses to 40.

Although the aim was to interview a range of cases so that the above profile was matched as closely as possible, it was recognised at an early stage that it would be difficult to obtain a close match because of the difficulty in achieving access to sufficient numbers of serious cases within the project timescale.
3.2 METHODS OF APPROACH TO POTENTIAL PARTICIPANTS AND SELECTION OF CASES

This section summarises the way in which potential participants were first identified and then subsequently contacted. Because of key differences between the RIDDOR databases on accidents and illnesses that only became evident as the study progressed, the identification of potential cases and the invitation to participate differed significantly between the two groups. Since these differences have an impact on the nature of the final samples, these issues are discussed in some detail below.

3.2.1 Accidents

Type of data feed from HSE

Although the retrospective data analysed to provide the sampling framework could have been used to identify cases for follow up, it was recognised that ideally individuals should be interviewed as soon as possible after the accident. This required relevant RIDDOR cases being fed to the study team at the earliest possible opportunity. However, in practice, this objective was constrained by the requirement to postpone contact to a minimum of at least six to eight weeks post accident in order to avoid compromising any HSE investigation that may have been instigated.

Details of accidents were therefore fed to the study team after an elapsed time of approximately six weeks. The cases were fed in tranches: the first covered a four-week period and subsequent downloads weekly periods. In all sixteen downloads were received from HSE spanning an accident date range of June 1st 2003 to 27th October 2003. The final download was received on December 18th 2003.

The following information was made available for each case:

- CCID Code (HSE internal case reference number)
- Name and address of individual involved in the accident
- Nature of injury
- Site of injury
- Classification as Major/Fatality

Data retrieved from the RIDDOR downloads were entered into a new study database. Cases of fatalities were excluded, together with any duplicate cases and cases where either the address or telephone number was incomplete or missing. In total this comprised approximately between 40% and 50% of each download.

Method of approach to potential participants

The approach adopted was fundamentally an opt-out design in that the study team had already been provided with contact details of relevant individuals by HSE. However, to protect the right of individuals to decline to participate in the study, and to meet ethical requirements, the study protocol that eventually evolved was relatively complex. It should also be noted that, where appropriate, partners and other family members were required for interview; this added a further stage to the process.
The final protocol incorporated the following main features:

- The first contact with all individuals (including family members) was by letter; this letter outlined the background to the research and indicated they would be contacted by telephone to request their participation in the survey.
- Individuals could decline any further contact on receipt of the first letter and at any subsequent point in the study.
- The preliminary telephone interview was followed by the application of a screening questionnaire designed to identify those still experiencing significant symptoms of psychological distress so the home interview could be handled appropriately.
- During the telephone interview individuals were asked if they were willing to participate in the home interview survey.
- All individuals who were not needed beyond the telephone survey (because of sampling requirements) or declined to participate in the home interview survey were sent a letter thanking them for their help.
- Full details of the study in the form of a ‘Participant Information Sheet’ were sent to all those indicating they were prepared to participate in the home interview survey (including family members).
- Individual consent forms were completed and signed at the time of the home interview.
- All individuals participating in the interview survey were left information sheets containing appropriate contacts should they need further information or support.
- Agreement to a possible further follow-up interview was obtained at the time of the first home interview.

Selection of cases for telephone interview and home interview

The overarching objective of the study design was to meet the requirement to carry out detailed home interviews with a minimum sample of 80 individuals who had experienced a serious workplace accident or illness together with family members who had been affected by this event. Since cases for home interview were to be selected primarily on the basis of severity, the principle sampling framework that was used was the distribution of cases by ‘type of injury’ and ‘site of injury’ discussed earlier. It was however recognised that with a small sample of 40 accidents it would be difficult to fully represent this distribution. In addition, there was need to try and achieve a reasonably representative distribution by age and gender.

In the first instance, initial contact letters were sent to all of the valid cases provided in the initial HSE downloads. Cases from subsequent downloads were then selected on the basis of achieving a reasonable distribution of injury types. Since the flow of cases had to be matched to the resources available to carry out preliminary telephone interviews and subsequent home interviews, data from some downloads were in practice not used. In total some 1024 initial contact letters were sent out.

As noted earlier, serious cases could not easily be pre-identified from the RIDDOR database. Some further selection was necessary as not all accidents classified as ‘Major’ under RIDDOR were deemed to have sufficiently serious consequences to be included in the home interview survey. The telephone interviews however provided further clarification of injury severity together with details of the immediate and longer-term consequences of the accident or illness. This information was then factored into the selection of cases for home interview. In general terms, cases were selected for such an interview where they fell into one of the injury categories that had, a priori, been identified as representing the severe end of the accident spectrum (for

Fatalities and duplicate cases were excluded from the database. Cases were also excluded where either the telephone number or address were invalid or missing.
example, amputation, multiple fractures or needle stick injuries associated with an infectious patient) or where the accident was known to have subsequently had a significant impact on the individual or family (for example, lengthy period of time off work, inability to continue with original job, limitations on family or personal activities, evidence of on-going psychological distress). Where appropriate, and with the agreement of the individual, home interviews with partners or other family members who had been significantly affected by the accident were also carried out by prior arrangement.

Selection of cases for a follow-up interview after the initial home interview

The original study design had envisaged the first home interview would be conducted a relatively short time after the accident had been reported and that further (telephone) interviews would be required to track the impact of the accident and the progress of recovery. In practice however the first telephone interview often took place a minimum of eight to ten weeks after the accident. This timescale reflected the six-week delay imposed by HSE (to allow for investigation), the time needed to validate each download and prepare appropriate contact documentation, and the requirement of the Ethical Committee that individuals be allowed at least a week following receipt of the initial contact letter to decline to participate. There was then a further delay before the home interview to allow the additional documentation such as the Participant Information Sheet to be sent out and considered by the relevant individual.

The consequence of this delay was that, in some cases, individuals were interviewed when they had either fully recovered or were well on the way to recovery and it was clear there would be no further significant consequences. Cases were therefore only followed up with a further telephone or home interview when they met one or both of the following criteria:

- There were still on-going physical or emotional effects at the time of the home interview
- Individuals were still off work at the time of the home interview

It should also be noted that in some cases that met the first criterion, follow-up interviews were not possible either because individuals could not be contacted (after repeated attempts) or felt that a further interview was too intrusive

Home interviews were carried out in preference to a telephone interview where the accident had resulted in particularly serious consequences.

3.2.2 Illnesses

Type of data feed from HSE

The nature of the RIDDOR database for workplace related illness differs significantly from that held for accidents in that, for reasons of medical confidentiality, it does not contain the contact details of the relevant individual only of the relevant employer. This had significant implications for the way in which potential participants could be identified and approached. In essence, individuals were required to opt-in following contact via their employer (see below for detailed approach). Early take up rates were extremely low and hence following two small downloads of cases from HSE (covering cases reported in October 2003 and received in December 20036) the study team requested a complete download of all cases reported in 2003 –

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6 There was a six week delay as with accidents to avoid compromising any HSE investigation
a total of 1021 cases across the construction and healthcare sectors. This download was received in February 2004.

The following information was made available for each case:

- CCID Code (HSE internal case reference number)
- Name of individual affected by illness
- Name and address of employer
- Nature of illness

As with accidents, data retrieved from the RIDDOR downloads were entered into a new study database. Duplicate cases were excluded together with any cases where either the employer address or telephone number was incomplete or missing. These only comprised approximately 5% of the total download of 1021 cases.

Method of approach to potential participants

As noted above, the approach adopted was essentially an opt-in design. Letters of invitation addressed to the affected individual (or individuals where an employer had several employees identified in the database) were sent to the relevant employer. Employers were asked to pass the letter on by mail or by hand as appropriate. The letter to the individual was similar in content to that developed for accidents in that it introduced the study and invited the individual to participate. If the individual felt they were happy to be involved, they were asked to notify their employer to indicate they were willing that their contact details be passed onto the study team. Alternatively, they could contact the study team directly. After a suitable interval employers were then contacted by the study team to confirm that they had passed the invitation letter on to the relevant individual (or individuals) and to identify those individuals who had agreed to participate. Because of the time consuming nature of this process and the difficulty in obtaining feedback from some employers, the invitation letter was subsequently modified to ask the individual concerned to notify the study team directly if they were willing to participate (this approach was used with the bulk of potential participants). However, employers (starting with the most recent cases) were still telephoned to confirm the letters had been passed on to relevant individuals.

This final protocol, adopted for all cases of illness, reflected all of the ethical requirements incorporated in the accident protocol as described earlier.

Selection of cases for telephone interview and home interview

In total 950 letters of invitation were sent to individuals via their employees. All of those agreeing to participate in the study (up until the time the sampling requirements of the home interview survey had been met) were included in the telephone survey; additional telephone interviews (within the project time constraints) were also carried out to reach a comparable sample size to that achieved for the accident group.

In line with the HSE requirement, cases for home interview were selected on the basis of severity of consequences as judged at the time of the telephone interview. In general, they were also selected to represent the main categories of serious workplace related illness as identified in the retrospective analysis. However, because of the difficulties in obtaining relevant cases of illness.

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7 On an anecdotal level, employers in the private sector were more difficult to get feedback from than those in the public sector. Also those employers who proactively contacted the study team with employee details were solely in the public sector.
workplace related illnesses, satisfying the sampling requirements in terms of both nature of illness and distribution by age and gender was particularly difficult. It is also important to note here that those participating in the illness survey had either voluntarily agreed that their contact details could be passed on by an employer or had telephoned the study team directly. This is in contrast to the accident group, where potential participants were contacted for the telephone survey unless they had previously informed the study team that they did not wish to participate. There is therefore a possibility that the illness sample is biased towards those that either had strong feelings to communicate about their illness or the way in which they had been treated by their employer. This potential bias was particularly noticeable in the healthcare sector. The implications of this bias are covered in the discussion section of the report.


3.3 DETAILS OF FINAL SAMPLE STRUCTURE

3.3.1 Overview of final sample

The overall sample structure and final numbers of interviews completed are shown in Table 3.4.

<table>
<thead>
<tr>
<th>Category</th>
<th>Telephone interviews</th>
<th>Home interviews*</th>
<th>Family Interviews**</th>
<th>Follow-up interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction accident</td>
<td>94</td>
<td>20</td>
<td>14 (13)</td>
<td>9</td>
</tr>
<tr>
<td>Construction illness</td>
<td>36</td>
<td>20</td>
<td>12 (11)</td>
<td>8</td>
</tr>
<tr>
<td>Healthcare sector accident</td>
<td>43</td>
<td>20</td>
<td>9 (9)</td>
<td>9</td>
</tr>
<tr>
<td>Healthcare sector illness</td>
<td>64</td>
<td>20</td>
<td>5 (5)</td>
<td>14</td>
</tr>
<tr>
<td>TOTAL</td>
<td>237</td>
<td>80</td>
<td>40 (38)</td>
<td>40</td>
</tr>
</tbody>
</table>

* Home interview sample represents a subset of the telephone interview sample

** Figures in brackets represent the number of cases on which these family interviews are based

3.3.2 Detailed sample breakdown

Telephone survey

The distribution of the 237 telephone interviews by age and sex is shown in Figures 3.1 to 3.8. Comparative data based on the analysis of retrospective data on RIDDOR cases classified as ‘Major’ in the Construction and Healthcare sectors for a six-year period (report years 1997/1998 to 2002/2003) are also shown.

**Figure 3.1** Age profiles in construction accident group (%)s
Figure 3.2  Age profiles in healthcare accident group (%)s

Figure 3.3  Age profiles in construction illness group (%)s

Figure 3.4  Age profiles in healthcare illness group (%)s
Figure 3.5  Gender profiles in construction accident group (%s)

Figure 3.6  Gender profiles in healthcare accident group (%s)

Figure 3.7  Gender profiles in construction illness group (%s)
In interpreting these results, the following should be borne in mind:

- Although there is a reasonable age spread in all groups, by definition telephone surveys require people to be at home at the time of interview. Although resources were allocated to evening interviews this can still lead to a systematic bias towards older individuals. This bias was reflected in the age distribution for accidents and illness in both sectors.
- This bias is particularly noticeable in the illness cases where there were no participants in the youngest age group. This is contrast to the 35 to 49 age group that is particularly well represented. It is likely that this is due to the ‘opt-in’ protocol applied in the case of illness that may favour those who feel most strongly about voicing their opinions about their experiences.
- The distribution of cases by gender within the telephone survey is reasonably representative, though females are proportionally over-represented in both construction illness and healthcare accident groups.

**Home interview survey**

The distribution of the 80 home interviews by age and gender is shown in Tables 3.5 to 3.8. Comparative data for the target sample structure are also shown.

**Table 3.5** Age sample profile and targets, accident groups

<table>
<thead>
<tr>
<th>Age group</th>
<th>Construction Target</th>
<th>Construction Actual</th>
<th>Healthcare Target</th>
<th>Healthcare Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>25-34</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>35-49</td>
<td>7</td>
<td>3</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>50-64</td>
<td>4</td>
<td>9</td>
<td>4</td>
<td>11</td>
</tr>
</tbody>
</table>
Table 3.6  Age sample profile and targets, illness groups

<table>
<thead>
<tr>
<th>Age group</th>
<th>Construction</th>
<th>Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Actual</td>
</tr>
<tr>
<td>16-24</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>25-34</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>35-49</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>50-64</td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>

Table 3.7  Gender sample profile and targets, accident groups

<table>
<thead>
<tr>
<th>Gender</th>
<th>Construction</th>
<th>Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Actual</td>
</tr>
<tr>
<td>Male</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Female</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 3.8  Gender sample profile and targets, illness groups

<table>
<thead>
<tr>
<th>Gender</th>
<th>Construction</th>
<th>Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Actual</td>
</tr>
<tr>
<td>Male</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>Female</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

Considering the above, the following should be noted:

- The small number of cases in each group (20 cases in total in each of the four categories) is small; achieving an exact match would have been extremely difficult.
- The selection of cases for home interview was based on both severity of injury or illness and severity of outcome (including vocational, economic and social impact).
- The home interviews were carried out with a subset of those already interviewed on the telephone.
- The age-group 50-64 is over-represented in both accident and illness groups in both construction and healthcare sectors. The younger age-groups are under-represented in all groups with the exception of the construction accident group.
- In an attempt to capture the full range of illnesses in the construction sector, a small number of interviews were carried out with females.

The distribution of cases by whether the individual lived alone or with a partner or family members is shown in Table 3.9. Comparative data for the target sample structure are also shown in brackets.

Table 3.9  Distribution of cases by whether individual lives alone or with partner/family

<table>
<thead>
<tr>
<th>Category</th>
<th>Lives with partner/family</th>
<th>Lives alone</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction accident</td>
<td>17 (15)</td>
<td>3 (5)</td>
<td>20</td>
</tr>
<tr>
<td>Construction illness</td>
<td>16 (15)</td>
<td>4 (5)</td>
<td>20</td>
</tr>
<tr>
<td>Healthcare sector accident</td>
<td>18 (15)</td>
<td>2 (5)</td>
<td>20</td>
</tr>
<tr>
<td>Healthcare sector illness</td>
<td>18 (15)</td>
<td>2 (5)</td>
<td>20</td>
</tr>
<tr>
<td>TOTAL</td>
<td>69 (60)</td>
<td>11 (20)</td>
<td>80</td>
</tr>
</tbody>
</table>
Although the sample requirements were not matched exactly there is still a reasonable sample of individuals who lived alone and who might exhibit a different pattern of support and social impact to those who live with a partner or family members.
4 SURVEY METHODOLOGY – ISSUES ADDRESSED

4.1 BACKGROUND LITERATURE SEARCH

The study team completed an extensive literature review prior to the start of the survey. This review examined available literature on the impact of injury and ill health on individuals, their families, and their immediate social and work network. The review confirmed that much of the available research on the impact of accidents and illness relates to other domains (primarily road traffic accidents) and that there are few studies that have explicitly examined the consequences of work-related injury and illness.

However, the literature search identified a number of strands of related research, carried out in non work-related domains, which contribute to the general body of knowledge about the consequences of accidents and illness on individuals and their families. Taken as a whole, the findings of the review reinforced the significance of the social, psychological, economic and vocational impact of serious accidents and illness. However, it also highlighted many gaps and deficiencies in the current knowledge base, in particular, the lack of studies explicitly focusing on work-related events. It was concluded that the proposed survey, would substantially add to the body of knowledge in this area.

The literature search was used to develop a framework of issues representing the type and range of consequences that could potentially occur following a serious workplace accident or illness. The matrix of potential consequences and affected parties that was developed is shown in Figure 4.1. This framework was used to drive the development of the interview schedules used within the survey and also underpins the presentation of the survey findings in this report.
### Figure 4.1: Matrix of potential consequences and affected parties

<table>
<thead>
<tr>
<th>Affected Parties</th>
<th>Social</th>
<th>Psychological</th>
<th>Behavioural</th>
<th>Economic</th>
<th>Physical</th>
<th>Vocational</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Affected person</strong></td>
<td>Daily activities</td>
<td>Anxiety</td>
<td>Substance misuse</td>
<td>Loss of wages</td>
<td>Disability (direct physical impact of injury/illness)</td>
<td>Nature of employment</td>
</tr>
<tr>
<td></td>
<td>Quality of life</td>
<td>PTSD</td>
<td>Altered sleep patterns</td>
<td>Unemployment</td>
<td>Pain</td>
<td>Status of employment</td>
</tr>
<tr>
<td></td>
<td>Relationships</td>
<td>Depression</td>
<td>Anger</td>
<td>Legal costs</td>
<td>Impairment</td>
<td>Productivity</td>
</tr>
<tr>
<td></td>
<td>Personal growth</td>
<td>Despair</td>
<td>Aggression</td>
<td>Additional outgoings</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sexual problems</td>
<td>Shame</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feelings of isolation</td>
<td>Stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Compensation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>neurosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Family and Social Network</strong></td>
<td>Relationships</td>
<td>Anxiety</td>
<td>Substance misuse</td>
<td>Loss of wages</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disruption to family life</td>
<td>Depression</td>
<td>Altered sleep patterns</td>
<td>Change in employment status (due to caregiver role)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feelings of isolation</td>
<td>Stress</td>
<td>Anger</td>
<td>Legal costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Aggression</td>
<td>Additional outgoings</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>External Bodies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Unemployment benefits (State)</td>
<td></td>
</tr>
<tr>
<td><strong>(community and state)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Compensation from Insurance companies</td>
<td></td>
</tr>
</tbody>
</table>
4.2 OVERVIEW OF KEY ISSUES COVERED IN THE SURVEY

The following summarises some of the key findings identified in the literature review. Based on the structure shown in Figure 1, these findings formed the basis of the interview schedules for both the telephone and home interview surveys. As discussed in the introduction, this literature review is available as a separate report and hence its findings are not covered in detail. It should also be noted that few studies were identified that explicitly examined the consequences of work-related injuries and illnesses and hence many of the findings identified below are associated with other major trauma, most significantly serious road traffic accidents. In addition, much of the literature that was reviewed originated from non-UK studies.

4.2.1 Vocational issues

There was clear evidence that serious trauma and illness can have significant consequences for the affected individual in terms of job loss, career disruption and the potential need for job change. There were also some consistent findings that the attitudes and behaviours of co-workers and colleagues may be adversely affected by exposure to serious workplace accidents. The importance of employer and supervisory support in returning the affected individual to work was also reinforced.

4.2.2 Financial issues

The majority of studies exploring the financial consequences of serious accidents and illness were non-UK based. Although it is difficult to extrapolate these findings to the U.K., because of the differences in benefit and compensation systems, there did seem to be clear evidence that major work-related injury or illness can lead to a significant reduction in family income, to financial pressure on partners and to resulting stresses on the family unit. Studies exploring financial compensation and litigation are also mainly North American in origin and therefore of only limited applicability to the UK. However, some studies did highlight the factors that may deter individuals from claiming compensation and some also demonstrate that non-adversarial systems of compensation can lead to lower claims and speedier closure.

4.2.3 Social issues

The social consequences of major trauma in other domains are well established in the literature. These can include feelings of isolation, restrictions on normal activities, increased demands on friends and family and often, problems with relationships. Quality of life is therefore likely to be significantly affected by the types of accidents and illnesses considered in this study. The literature search also demonstrated that the impact on families and caregivers can be extensive and long lasting. Social factors, including the support provided by family and friends were also been found to be important in influencing recovery and return to work. There was also evidence that some individuals who have been exposed to serious trauma can experience signs of ‘positive growth’ in that they take the opportunity to re-evaluate certain aspects of their life.
4.2.4 Psychological and behavioural issues

Studies also indicate that a significant proportion of individuals who are exposed to trauma may experience a wide range of psychological and behavioural symptoms. In particular, rigorous longitudinal studies carried out in respect of serious motor vehicle accidents have identified the following consequences: Post Traumatic Stress Disorder (PTSD), anxiety disorders, depression and anger. Long-term follow-up studies of these accidents have found consequences were still present up to 3 years after the accident. Although the literature review identified only a small number of studies that looked at work-related injuries, these indicate that psychological consequences, including work-related PTSD prevalence and symptoms, do not differ markedly from those reported in other contexts. Various behavioural consequences of serious trauma have also been identified; these include increased aggression, substance abuse, difficulties with interpersonal relationships and lack of libido. These effects have also been found to have a secondary impact on members of the immediate family or carers.

4.3 STRUCTURE AND CONTENT OF INTERVIEW SCHEDULES

The design of the interview schedules was based on the results of the literature search (as represented in the matrix shown in figure 4.1) with the inclusion of sufficient open-ended questions to capture issues that may not have emerged to date. The general areas covered within each of interview schedules are described below. Copies of the main interview schedules are included in Appendix 1.

4.3.1 Telephone interviews

The telephone interview was initially designed as a mechanism to recruit potential participants for the home interviews. There had been some concern that a telephone interview was an inappropriate vehicle for asking detailed questions about what may, for some, have been a potentially traumatic event. However, piloting of the telephone interview schedule demonstrated that a significant amount of information on the vocational, social and economic consequences of the accident or illness could be gathered at this stage. Although participants were asked if they were affected emotionally by the accident or illness, gathering details of any behavioural impact was reserved for the home interviews. It should also be noted here that the telephone interviews were carried out by a small number of interviewers who had received appropriate training and preparation to deal with participants who became in any way distressed during the course of the interview.

The general areas covered in the interview were as follows:

- Details of job/profession
- Details of any time lost from work and patterns of return to work including loss of time off work by others
- Details of pay and other financial support whilst off work together with any additional costs incurred
- Personal and family-related activities affected by the accident/illness
- Key individuals who had provided support and assistance
- Residual physical and emotional effects at the time of the interview
- Agreement to home interview
Lastly, in order to identify individuals who had experienced serious trauma and were still experiencing some degree of psychological distress at the time of the interview, the Trauma Screening Questionnaire (Brewin et al, 2002) was administered to the group of participants who were recovering from accidents. The TSQ is a ten item scale (covering arousal and re-experiencing symptoms) designed to predict PTSD. It was chosen in preference to other scales because of its ease of administration and interpretation (it has been used in similar telephone surveys), the clarity of the questions and required responses and the overall efficiency of the measure which is around 90% (that is the percentage of cases correctly classified as having or not having PTSD). This information was used to help select cases with serious consequences for the home interview sample and to brief the interviewer who would subsequently handle these interviews.

4.3.2 Home interviews

The home interview schedule was essentially an extended version of the telephone interview schedule; it covered the same general areas with the following main additions:

- Extended information on the impact of the accident/illness on return to work patterns and the types of support received from the employer and colleagues
- Attribution of responsibility for accident/illness
- Greater detail of financial support received and losses incurred as a result of the accident/illness
- Experiences of seeking compensation and legal redress
- Greater detail of the personal and family activities affected by the accident/illness
- Changes in the quality of relationships with partner or family members
- Details of the impact of the accident/illness on individual behaviour and the behaviour of other family members (including children)

Lastly, details of the psychological impact of the accident or illness were evaluated using two instruments: Goldberg’s short anxiety and depression questionnaire (Goldberg et al, 1988) was administered to all participants and the Impact of Events Scale (Horowitz et al., 1979) only to those who had suffered an accident. These instruments are briefly described below.

Goldberg’s short anxiety and depression questionnaire consists of two nine-item scales designed for use by non-psychiatrists in the assessment of affective illness. The instrument has been widely used in both clinical and occupational settings including the HSE 1995 Labour Force Survey (Health and Safety Executive, 1998). An individual with a score at the cut off of either scale (defined as five symptoms of anxiety or two symptoms of depression) has a 50% chance of having a clinically important disturbance, and above these scores the probability rises sharply.

The Impact of Events Scale (IES), (Horowitz et al, 1979) is a self-report measure designed to assess current subjective distress related to a specific life event. It has been used across a wide variety of different adult populations, for example, combat veterans, survivors of motor vehicle accidents, marine accidents and natural disasters. It has also been widely used to assess the ongoing effectiveness of different posttraumatic interventions. The IES scale consists of fifteen items, 7 of which measure intrusive symptoms and 8 tap avoidance systems. The sum of the two scores on the two subscales is the total stress score. Scores between 26 and 43 are indicative of moderate subjective distress and scores above 44 indicate severe distress.

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As defined in the Diagnostic and Statistical Manual of the American Psychiatric Association, 1995 (DSM IV)
The additional interview schedules used in the study are as follows: the schedule administered to family members reflected that used with the affected individual. It focused on the vocational, economic, social and behavioural impact of the accident/illness on them (in practice it was found difficult to focus these interviews on the family member concerned; there was a strong tendency for the interviewee to reflect what they felt was the impact on the individual concerned rather than on themselves). Any obvious discrepancies between the perceptions of the family member and that of the affected individual were also identified, particularly in relation to observed behaviours.

Lastly, follow-up interviews were based on the original home interview schedule in order to allow significant changes to be tracked and clarified.

4.3.3 Piloting of interview schedules

The telephone interview schedule was piloted by sending out an initial batch of 20 invitation letters to accident cases. These individuals were then contacted and the telephone interview schedule administered. Only minor amendments were required and these cases were subsequently included in the final sample.

The home interview schedules were piloted on five cases. In each case participants were informed that they were involved in the pilot stage of the survey and were asked for their help in identifying any limitations or problems with the content and administration of the interview schedule. Particular issues that were covered included their views on the following: clarity of the questions, structure and order of the questions, coverage of appropriate issues, sensitivity of different issues, usability of scales including design of flashcards and the overall style of the interviewer. In particular, the participants were asked to describe their feelings at various points in the interview. This allowed specific topics or questions that were particularly sensitive to be highlighted and questions that were likely to touch on socially unacceptable issues (for example, increased use of drugs or alcohol) to be identified.

In general, the pilot interviews demonstrated that the interview schedule had appropriate coverage and was robust and usable in design. The main learning from this stage was the need for interviewers to be particularly sensitive in handling certain parts of the interview. These issues were subsequently addressed in interviewer training and again, the completed schedules were included in the final sample.
5 RESULTS OF THE TELEPHONE SURVEY

5.1 INTRODUCTION

As described previously, the telephone survey proved a useful method in its own right to gather information on the effects of work-related accidents and illnesses, quite apart from its role as a screening tool for home interview case selection. In all, 237 interviews were completed, distributed as follows:

- Construction sector accidents: 94
- Construction sector illnesses: 36
- Healthcare sector accidents: 43
- Healthcare sector illnesses: 64

The range of different cases and circumstances covered in the interviews was wide. For example, the most serious injuries and long-term effects were encountered in the construction accident group. Though there were those where the effect was relatively minor, where a common injury required only a small amount of time off and was coped with well in the natural course of events, some interviews were carried out with individuals who had suffered seriously disabling and potentially life-threatening accidents. Thus the injuries ranged from small lacerations, healing quickly, to multiple fractures, amputations and severe internal injury, which required long periods of absence and extensive treatment. The incidents themselves were likewise variable: from falling on a building site and straining the arm, to being struck by and dragged under a vehicle on a road repair site. Many of the interviewees in this group needed special consideration when describing their cases and a small number needed to take a break, returning to the interview afterwards.

In the construction illnesses group, the dominant condition was Hand Arm Vibration Syndrome (HAVS). Many of these individuals were also in need of special care during the interview; though the condition is common in the industry, some sufferers had felt their lives permanently changed by their illness, with adverse consequences on home lives and work lives which they never expected. Note, however, that interviewees in this group, as in the healthcare illness group, were biased somewhat by self-selection. This group also included various cases of poisoning and infections, and also the most extreme cases that were encountered in the study: that of workers with serious lung cancers resulting from exposure to asbestos.

The most common injuries in the healthcare accident group were fractures and dislocations, usually incurred in hospitals, care homes and their grounds, and sometimes in the act of caring for or moving patients. In some cases, one of which was especially distressing for the interviewee, carers had been attacked by patients and had sustained both physical and psychological trauma. However, the severity of the injury in this group was somewhat lower than that in the construction accident group, with few multiple injuries, and no amputations, burns or electrical shocks.

In the healthcare illness group, there were two dominant conditions in the sample: occupational dermatitis, and Repetitive Strain Injury (RSI); together these accounted for well over half of the sample, and considerably more than that if we include Carpal Tunnel Syndrome and Tendonitis within the RSI category. Other conditions encountered were various infections, including some that were potentially life-threatening, occupational asthma and illnesses caused by side-effects...
from medical treatments. Both of the dominant conditions had resulted in major impacts on the lives of those interviewed and again, individuals needed to be treated with particular care consideration by the interviewers.

In the self-selected groups (illnesses), individuals were happy to take part in the study, even though in many cases they were clearly distressed or angry at the circumstances surrounding their condition. In the accident sector groups most people contacted were also happy to participate, pleased to have been approached and glad that their circumstances were being considered by the HSE.

5.2 THE TELEPHONE SURVEY SAMPLE

As described previously, there are two unavoidable potential biases in these samples and hence in the data. Firstly, the recruitment of illness subjects was essentially a self-selection process; secondly, the age-group interviewed in the accident survey may have been biased toward older people. A further question that may be asked regards the representative nature of the samples with the array of conditions found in the RIDDOR source data. To assess this, each sample was compared to the source data by category of illness or accident, with the results shown below (Figures 5.1 – 5.4). For the purposes of this comparison, categories with less than 2% occurrence in RIDDOR were pooled.

*Figure 5.1 Construction accident group – distribution by category (sample n = 94)*
In the construction sector, a good match was achieved, though with some under-representation in decompression sickness and the infectious condition leptospirosis in the illness sector. Overall, differences were not significant ($X^2$ with 5 and 9 df. respectively, ns).

Comparisons for the healthcare sector are shown below.
As can be seen, the healthcare accident group has good agreement between sample and source data ($X^2$ with 3 df, ns) whereas in the illness sector there is an under-representation of occupational dermatitis and an over-representation of RSI. The difference is significant ($X^2$, 4df = 23.6, P<0.001) and resulted from an anomaly of illness type in RIDDOR, where approximately 40% of the individuals listed as suffering from occupational dermatitis in RIDDOR, and responding to the call for cases, were found to be cases of RSI.

Notwithstanding the above, the overall samples are well-matched. Importantly, all major modes of accident and illness are well represented.

### 5.3 INTERVIEW STRUCTURE

Each telephone interview followed a fixed format, shown in as shown in Appendix 1.

After gathering basic demographic and employment data, the interview examined:

- Vocational issues, including time off work, effects of the accident or illness on employment, and whether carers had lost time
- Financial issues including lost pay, financial support and additional costs
- Effects on daily living and family life
- Residual physical and emotional effects and, in the case of accidents, the administration of the TSQ

Depending on the responses of the participant a series of different questions were then asked. The structural flow of the vocational section of the interview in particular was complex and, for clarity, is shown in detail in Figure 5.5.

In the cases of accidents, in both healthcare and construction sectors, interviews were carried out in most cases between nine and sixteen weeks after the event; for illnesses, which tended to be long-standing, interviews were carried out predominantly after more than one year since the onset of the condition.
Figure 5.5  Interview structure, vocational section

Interview structure - vocational section

Question B1 - are you still off work?

Yes

No

Lost no time

Question B3 - do you expect to return to work?

Yes

No

Don't know

Question B8 - is the event affecting your work?

Question B7 - have you gone back to the same job?

Yes

No

Don't know

Question B9 - is this as a result of the event?

Yes

No

Don't know

Question B9 - is this as a result of the event?
5.4 CONSTRUCTION SECTOR RESULTS

5.4.1 Construction Accidents

5.4.1.1 Vocational Consequences

Absence and return to work issues

In the construction accident group, the pattern of vocational effects is shown in Figure 5.6, which follows the interview structure set out earlier in Figure 5.5

Figure 5.6 Construction accident group, vocational consequences
Of the 49 participants still off work at the time of the telephone interview, the mean time absent to date was just under twelve weeks, with a mode of ten weeks. However, two outliers with long-term serious injuries, who had been absent for forty weeks each, may inflate this figure somewhat.

The participants were also asked how many more weeks they anticipated being off work. The mean time for these data is twelve weeks. Once again, an outlier with an expectation of requiring a further two years off could give a misleading impression here; excluding the case gives a mean expectation of additional time off as just under ten weeks.

The overall patterns presented in these data are as follows.

From a sample of 94 construction workers who had suffered from accidents at work, just over half were still absent at the telephone interview, and had been off for an average of approximately twelve weeks. The overall seriousness of the effects of the accidents is further underlined by the finding that for these workers an average of another ten weeks recovery would be needed before returning.

In this subset of the sample, there were some participants who had no expectation of returning to work - three cases, or 6% of those still off. In each of these cases the reason given was the accident. Additionally, all of those who expected to return to a different job eventually (ten cases) attributed this change to the accident.

Not surprisingly, those who had already returned to work at the time of the telephone survey were the less severely affected cases, and had been absent for an average period of seven weeks. For this subset of participants, only a small proportion had not returned to their original work; those that had not, attributed the change to the results of the accident. In these data, it is not clear whether the changed jobs were to be permanent or a return based initially on lighter duties.

It may be helpful to summarise the main categories in this sample, as shown below in Figure 5.7

Figure 5.7   Construction accident group - vocational outcomes (n=94)

(In the figure above, some categories of outcome are displayed with a frequency of zero. This is because the same format is used to present data for all groups, and to allow cross-group comparisons to be made).
Note that in all cases where a worker had returned to or was expecting to return to a different job, the reason was always given as a result of the accident. This applied in total to thirteen cases, or 14% of construction accidents. Added to the figure of 3% of participants who have no expectation of returning to work, this reflects on the severity and serious vocational consequences of accidents in this group - in 17% of cases, the AP is unable to work again or is required to change his job.

At the time of the telephone interview, many APs (79% of the total sample) still had, as might be expected, residual physical effects. Figure 5.8 illustrates the range and incidence of these, as volunteered during the interview and subsequently post-coded into meaningful categories.

**Figure 5.8** Construction accident group – residual physical effects (n=74)

![Figure 5.8](image.png)

Key issues for this group relate to lower limb pain and mobility, with restrictions still present in more than 20% of those cases reporting residual effects.

### 5.4.1.2 Economic consequences

In this section of the telephone survey, participants were asked what level of pay they had received while absent from work, what other sources of funds they were able to draw on, and the nature of any other costs which they incurred as a direct result of the illness or accident.

**Earnings**

Of the 94 participants in the accident group, of those 89 who had lost time off work, 31 had received full pay during their entire absence. The majority of cases, however, suffered direct financial losses as a result of their absence from work, shown in Table 5.1 below:

**Table 5.1** Construction accidents – pay received during absence from work (n=94)

<table>
<thead>
<tr>
<th>Description</th>
<th>Number (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received full pay (for duration of absence)</td>
<td>31 (33%)</td>
</tr>
<tr>
<td>Did not receive full pay (for duration of absence)</td>
<td>58 (62%)</td>
</tr>
<tr>
<td>n/a – no lost time</td>
<td>5 (5%)</td>
</tr>
</tbody>
</table>
Of the 58 individuals who did not receive full pay, 43 received no pay from their employers. Under these circumstances, the AP might expect to receive support from the state. In fact, of these 43 APs who received no pay from their employers, 13 (15% of those cases who lost time from work in the construction accident group) received no additional support whatsoever.

The key point to emerge from the data is therefore that in the construction accident group, the financial consequences of losing time from work are severe for most workers. In summary, key figures are:

- 65% of individuals who lose time in the construction accident group did not receive full pay during their absence
- 48% of those losing time received no pay from their employers
- 15% of those with no pay received no further financial support

Other sources of financial support

Overwhelmingly, additional financial support was provided by the state. In no case did the case’s trade union help financially, and in only 3 cases from the 58 where full pay had not been received had the participant claimed on a valid insurance policy or care plan. State support in this sample was invariably through Statutory Sick Pay (SSP), and was therefore at a level well below the normal salary of the interviewee - SSP typically provides between £60 and £80 per week. In some cases, SSP was received together with a reduced salary from the employer.

Additional costs incurred

Over half of the cases interviewed in this group (51%) had incurred additional costs as a result of the accident. These included costs of prescriptions, non-prescription medication, transport and several other categories, summarised in Figure 5.9, below.

As can be seen, medical and transport costs are the most prevalent. The category “other” includes such items as the loss of the costs of pre-booked holidays which could not be taken, and memberships of clubs where no attendance was possible during the injury.
Economic effects on others

In some cases, the economic effects of the accident would spread beyond the individual to members of their family and friends. In the construction accident group, a total of 23 cases (24%) were affected in this way, with lost time by others ranging from a minimum of one day to a maximum of 8 weeks.

Most commonly affected in this group were partners (14 cases or 61% of valid cases), followed by the mother (5 cases or 22% of valid cases). These data do not include time spent caring where there was no economic loss, it should be pointed out, as may be found where the partner had no employment.

5.4.1.3 Social Consequences

In the construction accident group, the effects of the accident on the individual’s social life, including personal care, were marked. Figure 5.10 shows percentages of interviewees reporting adverse effects on areas of their lives.

Figure 5.10  Construction accident group – social effects (n=94)

Not surprisingly, given the severity of many of the cases interviewed, the effects of the accident on social issues had been severe, with all key areas affected in more than 50% of interviewees. Worst hit were mobility, leisure and recreation, and personal care, with cases affected approaching 80%. In this group, the issues surrounding money management – paying bills – were also badly affected, reflecting the difficulties experienced by many participants who received reduced or no pay during their absence.

Family and child-related activities had also been affected in this group. Excluding those who live alone, Figure 5.11 shows which activities were still not possible at the time of the interview.
“Other”, in these data, includes sports coaching, various hobby activity and holidays.

Support for the interviewees in this group had been provided by a range of people, with partners and parents dominating the frequency counts, as shown in Table 5.2 below.

<table>
<thead>
<tr>
<th>Support providers</th>
<th>Partner</th>
<th>Parents</th>
<th>Siblings</th>
<th>Children</th>
<th>Friends</th>
<th>Other individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>64</td>
<td>40</td>
<td>16</td>
<td>32</td>
<td>20</td>
<td>9</td>
</tr>
</tbody>
</table>

5.4.1.4 Psychological consequences

During the course of the telephone survey, it quickly emerged that the psychological effects of the accidents in this group could be very serious. On a number of occasions, interviewees would find it difficult to discuss their accident without becoming upset, though none declined to help provide information in this section where time was available. Two parts of the interview schedule bear on this issue: whether there were lasting emotional effects from the accident together with details of these (see questions E3 and E4 in Appendix 1), and the Trauma Screening Questionnaire (TSQ). Originally, the TSQ had been envisaged purely as a screening tool to aid the research team's approach to the various cases and home interviews; in practice the TSQ came to be seen as a valuable source of psychological data in its own right and was administered to a total of 84 cases in this group. In a small number of cases, insufficient time or concerns about the quality and/or accuracy of the responses (due to language problems, for example) resulted in the exclusion of the cases from the results.

Considering firstly the existence of emotional effects at the time of the telephone interview, it is important to bear in mind that these interviews were carried out predominantly between 9 and 16 weeks after the adverse event.
Table 5.3 below shows the frequency of responses to this question.

<table>
<thead>
<tr>
<th>Is the accident still affecting you emotionally?</th>
<th>n=92</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>55 (60%)</td>
</tr>
<tr>
<td>No</td>
<td>37 (40%)</td>
</tr>
</tbody>
</table>

Despite the elapsed time since the accident the majority of individuals were still expecting residual emotional effects. Not all participants were able to describe these effects in detail, nor was it appropriate for interviewers to seek further details in some circumstances. However, at an anecdotal level, a review of the responses revealed a wide range of emotional effects, the dominant ones being depression and anger/frustration.

The results of the TSQ are shown in Figure 5.12.

![Figure 5.12](image)

Taking the threshold for concern on Brewin's TSQ index as 6 (that is, the total of re-experience and arousal scores as 6 or above), it may be seen that 27% of cases reported symptoms indicative of Post Traumatic Stress Disorder (PTSD). Once again, it should be underlined that these data were collected no earlier than 6-8 weeks after the event and in many cases rather later than that.

5.4.2 Construction illness

5.4.2.1 Vocational consequences

Absence and return to work

In the construction illness group, the pattern of vocational effects is shown in Figure 5.13 which follows the interview structure set out earlier in Figure 5.5.
Overall, in the sample of 36 construction illness cases, only one case was still off work at the
time of the telephone interview, and had been off work at that point for one year.

The pattern in construction illness is thus distinct to that in accidents. Most cases in this group
had not taken any time off work. For the 13 cases who had returned to work after a period of
absence, the mean time off was just over 3 weeks. In the single case who was still off work, the
individual was unable to estimate how much longer he would need before returning.

Figure 5.13  Construction illness group – vocational consequences (n=36)
The patterns presented in these results is one of chronic conditions rather than acute, with the most prevalent illness being Hand Arm Vibration Syndrome (HAVS). The effect of the illnesses, despite the relatively small amounts of time lost when compared to other groups, is nevertheless significant. In terms of working life, only one third of cases, approximately, had experienced no change. In all others, the participant had either changed jobs due to the illness or was experiencing ill effects at work as a result.

Figure 5.14 below summaries the vocational outcomes at the time of the interview.

![Figure 5.14](image_url)

In this group, 88% of the APs reported continuing or residual effects, as shown in Figure 5.15, below.

![Figure 5.15](image_url)

(As in other figures, categories in the figure above may be empty as the same format is used across all groups)
5.4.2.2 Economic consequences

Earnings and other sources of funds

Details of pay received during time off work are shown in Table 5.4. 15 cases in this group had lost time from work as a result of their illnesses. Of these, one serious case with mesothelioma had retired on medical grounds at the time of the interview. Of the 14 remaining cases, 11 had received full pay during their absence (which the data shows was of considerably shorter duration than in the accident group) and 3 had not. Of these 3, one had received 50% of his normal salary for one month before returning to work, and two had received no pay.

| Received full pay | 11 (31%) |
| Did not receive full pay | 3 (8%) |
| n/a – no lost time/retired | 22 (61%) |

Other sources of financial support

Only 3 cases in this group had not received full pay during their absence - a number too small to draw any valid information from. However, of these 3 cases, it may be noted that 2 had received SSP only during their absence, and 1 no financial support whatsoever.

Additional costs incurred

Additional costs were incurred in this group in 16 cases (44%). The types of costs are shown in Figure 5.16 below.

Figure 5.16 Construction illness group - additional costs incurred (n=16)
Economic effects on others

In the construction illness group, only 1 case reported lost time by carers, where a worker’s partner had needed to take two weeks from work. Once again, the figures in this section relate only to where carer’s had been absent from work rather than total time spent caring.

5.4.2.3 Social consequences

In the illness group, social consequences were also marked. As can be seen in Figure 5.17, below, personal care and leisure activities had been affected in more than 50% of cases. A typical effect of the dominant illness in this group, HAVS, is the loss of fine motor skills; many of the interviewees were frequently in need of help in fastening buttons, for example.

Figure 5.17 Construction illness group - social effects (n=36)

For those not living alone, Figure 5.18 below shows which activities were still not possible at the time of the interview.

Figure 5.18 Construction illness group - social restrictions (n=14)
Support had been provided as shown in Table 5.5 below.

**Table 5.5**  
Construction illness group - support providers (n=36)

<table>
<thead>
<tr>
<th>Support provided by</th>
<th>Partner</th>
<th>Parents</th>
<th>Siblings</th>
<th>Children</th>
<th>Friends</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>(frequencies)</td>
<td>26</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

**5.4.2.4 Psychological consequences**

Emotional effects were still being experienced by illness cases in this group at a frequency of greater than 60% - despite the long-standing nature of many of the conditions for the most part. Table 5.6, below, illustrates this point.

**Table 5.6**  
Construction illness group - residual emotional effects (n=35)

<table>
<thead>
<tr>
<th>Is the accident still affecting you emotionally?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>22 (63%)</td>
</tr>
<tr>
<td>No</td>
<td>13 (37%)</td>
</tr>
</tbody>
</table>

At an anecdotal level, anger and frustration dominated the reported effects, reflecting the difficulties experienced by workers with HAVS – namely, that the condition is not outwardly visible, that the effects are nevertheless debilitating and disabling to fine motor skills, and that peer and employer pressure sometimes forces the sufferer to try to ignore the condition and work as normal.

The TSQ was not administered within this group.
5.5 HEALTHCARE SECTOR RESULTS

5.5.1 Healthcare Accidents

5.5.1.1 Vocational Consequence

Absence and return to work

43 telephone interviews were carried out with workers in the healthcare sector who had suffered accidents at work. Of these, 17 were still off work at the time of the interview; full details of the vocational effect in these cases are shown overleaf in Figure 5.19

*Figure 5.19* Healthcare accident group - vocational consequences (n=43)
Of the individuals still off work at the time of the interview, the average time off was just under 12 weeks, and they were expecting a further mean absence of 5 weeks before returning to work.

Some 22 cases had returned to work at the time of the telephone interview. The mean time taken off as a result of the accidents in this group was 3 weeks. Of these, all had returned to the same job but many reported that their ability to do their job was affected by the accident.

Summarising this group, it can be seen that less than half the sample had not returned to work at the time of the interview, and that with one exception, all of these participants expected to return, mostly to their original job. The mean time off work for this subset was 12 weeks, and the mean expectation for further time of was 5 weeks. In the one case where the AP would return to a different job, the job change was attributed to the effects of the accident.

Those who had returned had all returned to their original job, but a majority of these were finding that the accident was still adversely affecting their work. Of the four cases where no time had been lost, half of those were also finding an adverse effect at work from their accident. In this group, those who had already returned to work at the time of the telephone survey were the less severely affected cases, and had been absent for an average period of 3 weeks. Overall outcomes are shown in Figure 5.20.

Figure 5.20  Healthcare accident group - vocational outcomes (n=43)

The figure overleaf summarises residual physical effects reported by APs in this group at the time of the telephone interview, with 78% of the sample reporting residual effects.
5.5.1.2 Economic consequences

Earnings and other sources of funds

Of the 43 participants in the accident group, 39 had lost time from work as a result of their accident. The pattern of lost earnings for these cases is shown in Table 5.7 below:

<table>
<thead>
<tr>
<th>Table 5.7 Healthcare accident group – pay received (n=39)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received full pay (for the duration of absence)</td>
</tr>
<tr>
<td>Did not receive full pay (for the duration of absence)</td>
</tr>
<tr>
<td>n/a – no lost time</td>
</tr>
</tbody>
</table>

Inspection of the data reveals that of the 13 cases where full pay was not received for the full duration of absence, a significant proportion received no pay from their employers whatsoever.

Key figures in these data are:

- 33% of individuals who lost time in the healthcare accident group did not receive full pay during their absence
- 23% of those losing time received no pay

Other sources of financial support

Of the 13 cases where full pay was not received, 9 had received other financial support, which was, as in other groups, exclusively from the state in the form of SSP, and 4 cases received no other financial support from other sources.

Additional costs incurred
Additional costs were incurred in this group in 27 cases or 63%. The types of costs are shown in Figure 5.22.

**Figure 5.22** Healthcare accident group - additional costs (n=27)

![Figure 5.22](image)

**Economic effects on others**

In the healthcare accident group, 9 cases (21%) reported lost time by others. Support was mostly provided by the partner of the affected person.

**5.5.1.3 Social Consequences**

Accidents in the healthcare sector, though generally less severe than those in the construction sector, had caused marked effects on daily life in this sample. As can be seen in Figure 5.23, in over 80% of the cases studied, personal care, household care, leisure and mobility had all been adversely affected.

**Figure 5.23** Healthcare accident group - social effects (n=43)

![Figure 5.23](image)
The effects on personal life extended to family-related and child-related activities. In many cases, some of these had not returned to normal since the accident. Further details are shown in Figure 5.24 for those who live with their families.

**Figure 5.24** Healthcare accident group - social effects (n=18)

Finally, Table 5.8 below shows the profile of support providers in the sample, with partners and children of the affected person dominating the responses.

**Table 5.8** Healthcare accident group - support providers (n=43)

<table>
<thead>
<tr>
<th>Support provided by (frequencies)</th>
<th>Partner</th>
<th>Parents</th>
<th>Siblings</th>
<th>Children</th>
<th>Friends</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>24</td>
<td>18</td>
<td>2</td>
<td>26</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

5.5.1.4 Psychological consequences

Those involved in accidents in the healthcare sector experienced lasting emotional effects at a frequency of more than 50%, as shown below in Table 5.9.

**Table 5.9** Healthcare accident group - residual emotional effects (n=42)

<table>
<thead>
<tr>
<th>Is the accident still affecting you emotionally?</th>
<th>Yes</th>
<th>24 (57%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>18 (43%)</td>
</tr>
</tbody>
</table>

TSQ results for this group are shown in Figure 5.25 (the questionnaire was administered to 39 of the 43 cases).
Overall, in this sample, 31% of participants showed scores at or above the threshold of 6, indicative of symptoms of PTSD.
5.5.2 Healthcare illness

5.5.2.1 Vocational Consequences

Absence and return to work

A total of 64 illness cases were interviewed in the healthcare sector. Figure 5.26, overleaf, shows vocational outcomes for the data set, following the interview structure described earlier.

Figure 5.26 Healthcare illness group - vocational consequences (n=64)
The mean time lost from work by those still off in this sample was 33 weeks, with time off ranging from 14 weeks to 65 weeks. Three APs in this subset were unable to estimate how long they would need in recovery before going back to work, but of the others, their mean estimate for further time of was 11 weeks.

Four of these cases expected to return to work, three of whom expected to have to do a different job than their original, all due to the effects of their illnesses. Two individuals did not expect to return at all, also due to their illnesses, and two did not yet know how their future employment would be affected.

Of those who had lost time but returned to work, the mean time of absence was just under 13 weeks – a relatively high figure, but somewhat skewed by 8 cases where interviewees had lost more than 20 weeks work. Within the subset, a high percentage (33% of the total sample of 64) felt that illness was still affecting their work and 4 individuals (6% of total sample) had changed jobs because of their illness. Of those who had not lost any time off work, nearly half the cases (14% of the total sample) also felt their work had been affected.

Figure 5.27 summarises the outcomes for this sample at the time of the interview.

**Figure 5.27  Healthcare illness group - vocational outcomes (n=64)**

Residual and continuing physical effects in the sample were reported by 85% of the sample.
5.5.2.2 Economic consequences

Earnings and other sources of funds

In total, 45 cases in this group had lost time from work as a result of their illnesses. Of these, 34 had received full pay during their absence and 11 had not.

<table>
<thead>
<tr>
<th>Received full pay</th>
<th>Did not receive full pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>34 (76%)</td>
<td>11 (24%)</td>
</tr>
</tbody>
</table>

Key figures in these data are:

- 24% of individuals who lose time in the healthcare illness group did not receive full pay during their absence
- 4% of those losing time received no pay

Other sources of financial support

Of the 2 cases where no pay was received, both cases received support from the state in the form of SSP.

Additional costs incurred

Additional costs were incurred in this group in 43 cases or 67%. The breakdown of additional costs is shown in the figure below.
Economic effects on others

In the healthcare illness group, there were 6 cases (9%) where lost time for others was reported. Support was mostly provided in this sample by the partner of the affected person.

5.5.2.3 Social Consequences

As in the accident group, the effects of illnesses in the healthcare sector can cause a severe deterioration in daily life. Most aspects of daily life had been affected in this sample (Figure 5.27)

For those living with their families, the figure below shows activities still not possible at the time of the interview. Effects are significant, and in many cases are viewed as likely to be permanent due to the chronic qualities of illnesses such as RSI and latex allergies.
Table 5.11 below illustrates the sources of support for this subset.

**Table 5.11** Healthcare illness group - support providers (n=64)

<table>
<thead>
<tr>
<th></th>
<th>Partner</th>
<th>Parents</th>
<th>Siblings</th>
<th>Children</th>
<th>Friends</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support provided by (frequencies)</td>
<td>41</td>
<td>16</td>
<td>3</td>
<td>19</td>
<td>0</td>
<td>14</td>
</tr>
</tbody>
</table>

**5.5.2.4 Psychological consequences**

Illness cases in the healthcare sector experienced lasting emotional effects at a frequency of more than 50%, as shown below in Table 5.12.

**Table 5.12** Healthcare illness group - residual emotional effects (n=64)

<table>
<thead>
<tr>
<th>Is the accident still affecting you emotionally?</th>
<th>39 (61%)</th>
<th>25 (39%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In this group, where details were provided by the individual, depression was the most frequently reported residual effect, and anxiety about work, finances and healthcare were also represented highly.
6 CASE SUMMARIES

6.1 INTRODUCTION TO THE CASE SUMMARIES AND ASSOCIATED OVERVIEWS.

The following four sections of the report are devoted to the core findings of the study, the results of the home interviews and follow-up interviews. As discussed in the introductory sections of the report, the cases described are associated with two widely different working populations and working environments: the construction sector and the healthcare sector. Within each sector the cases also reflect a range of different accidents and workplace related illnesses. For clarity, the results obtained for each of the four groups of cases are therefore presented and discussed independently in the following sequence:

- Construction sector accidents (20 cases)
- Construction sector work-related illnesses (20 cases)
- Healthcare sector accidents (20 cases)
- Healthcare sector work-related illnesses (20 cases)

The focus of the work reported here is on identifying the full impact that serious injury or illness can have on an individual and their family. The consequences of serious injury or illness are not easily quantifiable, often complex in nature, frequently interwoven and often cumulative in effect. For all these reasons, we have chosen to present the main results of the interviews in a series of case summaries, each of which covers the general impact of the injury or illness as perceived by the relevant individual.

In order to respect confidentiality these case summaries do not include the more sensitive or personal aspects of the case that may, for example, reflect on other members of the family. Details of family interviews are also not covered for the same reasons. However, these aspects are covered in the general commentary that precedes the case summaries.

Each of the four sections is therefore structured as follows:

- A summary table that provides a brief overview of the 20 cases and the main physical and emotional effects of the injury or illness that were identified at the first home interview. It also identifies the main information sources associated with each case.

- A commentary on the 20 cases under the following headings: vocational consequences, economic consequences, social consequences, behavioural consequences and psychological consequences. Again, as discussed in the earlier methodology section of the report, these cases are not fully representative of the whole range of major accidents or workplace related illnesses and the numbers interviewed in any one category are small. Accordingly the overview does not claim to provide an accurate quantitative picture of the prevalence of these consequences within a sector, sub-group or category of accident or illness, but rather to identify the main patterns and relative scale of the effects that may be experienced. Reducing the discussion of these issues to a series of numbers can also often disguise their real impact; the overviews have therefore been deliberately peppered with illustrations to provide greater insight into what the repercussions of these accidents and illnesses are at an individual and family level. It should be noted that these illustrations are not verbatim reports but reconstructions based contemporaneous notes taken at the home interviews. Throughout these
overviews the individuals involved in the accident or illness is referred to as the *affected person* or AP.

- Summaries of each case: each case summary integrates the main results of the first home interview and any subsequent follow up interview. Again, for reasons of confidentiality, the information collected in the family interviews are not included in the case summary but summarised in the general commentary. To avoid repetition, information from follow-up interviews is only included when it reinforces or extends findings from the first interview. It should also be noted that, as described in the earlier methodology section of the report, follow-up interviews were only carried out in a subset of cases. Where available, this information is distinguished in italics. For ethical considerations, we have withheld all quantitative results relating to individual cases such as scores on psychological instruments, all demographic data, and any specific items, such as a detailed description of the accident or illness, which would allow the identification of a participant in the study.

Lastly, comparisons between the sectors and between the consequences of accidents and work-related illness are covered separately in the discussion section of the report.
6.2 CONSTRUCTION ACCIDENT GROUP - OVERVIEW
### Table 6.1

#### Construction accident group – summary table

(residual effects present at the time of the home interview)

<table>
<thead>
<tr>
<th>Case no.</th>
<th>Gender</th>
<th>Nature of illness or accident</th>
<th>Family member interview</th>
<th>Follow-up Interview</th>
<th>Residual Physical effects</th>
<th>Residual emotional effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>m</td>
<td>Fell from tower platform; multiple fractures of hands, wrists, ribs, shoulders.</td>
<td>Partner</td>
<td>Yes</td>
<td>Restricted movement, pain and side effects from medication.</td>
<td>Anxious and emotional. Cannot remember the accident.</td>
</tr>
<tr>
<td>2</td>
<td>m</td>
<td>Fall resulting in fractures pubic rami and fractured pelvis.</td>
<td>Partner</td>
<td>Yes</td>
<td>Limp, numbness and pain in thigh.</td>
<td>Anxiety about the future and being injured again. Incident dwells on his mind.</td>
</tr>
<tr>
<td>3</td>
<td>m</td>
<td>Scaffolding collapsed; severe concussion and broken ribs and wrist.</td>
<td>Partner</td>
<td>Yes</td>
<td>Pain in ribs, inability to lift heavier objects</td>
<td>Depression, disturbed sleep, nightmares and flashbacks</td>
</tr>
<tr>
<td>4</td>
<td>m</td>
<td>Fall on site resulting in two fractured bones in leg.</td>
<td>No</td>
<td></td>
<td>Pain in leg and difficulty walking.</td>
<td>Anger with employer and financial anxiety.</td>
</tr>
<tr>
<td>5</td>
<td>m</td>
<td>Fall from ladder; broken leg and multiple fracture in ankle.</td>
<td>Partner</td>
<td>No</td>
<td>Pain, restricted movement and muscle spasms. Side effects from medication.</td>
<td>Panic attacks, possibly from medication.</td>
</tr>
<tr>
<td>6</td>
<td>m</td>
<td>Fell from ladder after electrocution; fractured vertebrae, burns and bruises.</td>
<td>Partner</td>
<td>No</td>
<td>Unable to lift or bend.</td>
<td>Anxiety about work and finances. Fear of electricity.</td>
</tr>
<tr>
<td>7</td>
<td>m</td>
<td>Accident with rip saw on site; lost index finger and other torn ligaments.</td>
<td>No</td>
<td></td>
<td>Pain and mobility in hand. Lack of strength.</td>
<td>Irritable and angry.</td>
</tr>
<tr>
<td>8</td>
<td>m</td>
<td>Fell from stepladder on site; multiple fractures of leg</td>
<td>Partner</td>
<td>Yes</td>
<td>Limping, pain in back.</td>
<td>Financial anxiety.</td>
</tr>
<tr>
<td>9</td>
<td>m</td>
<td>Fell from scaffold; multiple fractures in both heels.</td>
<td>Partner</td>
<td>Yes</td>
<td>Limping, pain and restricted mobility.</td>
<td>Frustration with physical problems.</td>
</tr>
<tr>
<td>10</td>
<td>m</td>
<td>Cut metal fell on leg; multiple fractures.</td>
<td>Partner</td>
<td>Yes</td>
<td>Pain and restricted mobility.</td>
<td>Frustration and depression.</td>
</tr>
<tr>
<td>11</td>
<td>m</td>
<td>Falling stonework crushed leg; multiple fractures followed by infection.</td>
<td>No</td>
<td></td>
<td>Limping, restricted mobility.</td>
<td>Some depression.</td>
</tr>
<tr>
<td>Case no.</td>
<td>Gender</td>
<td>Nature of illness or accident</td>
<td>Family member interview</td>
<td>Follow-up Interview</td>
<td>Residual Physical effects</td>
<td>Residual emotional effects</td>
</tr>
<tr>
<td>---------</td>
<td>--------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>---------------------</td>
<td>--------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>12</td>
<td>m</td>
<td>Fell backwards down a hole on site; serious soft tissue damage to knee, shoulder, concussion.</td>
<td>Partner</td>
<td>No</td>
<td>Pain and restricted mobility.</td>
<td>Frustration with physical restrictions. Unhappy.</td>
</tr>
<tr>
<td>13</td>
<td>m</td>
<td>Fell from vehicle on site; multiple fractures of arm.</td>
<td></td>
<td>No</td>
<td>Cannot use right hand; no lifting.</td>
<td>None.</td>
</tr>
<tr>
<td>14</td>
<td>m</td>
<td>Crushed against wall by roller on site; multiple fractures and cuts to leg.</td>
<td></td>
<td>Yes</td>
<td>Pain in leg; restricted mobility.</td>
<td>Depression and anxiety for the future.</td>
</tr>
<tr>
<td>15</td>
<td>m</td>
<td>Saw fell from vehicle and cut tendon.</td>
<td></td>
<td>No</td>
<td>Pain and lack of strength in arm.</td>
<td>Angry about the event.</td>
</tr>
<tr>
<td>16</td>
<td>m</td>
<td>Saw dragged hand into path; loss of two fingers followed by RSD</td>
<td>Partner</td>
<td>Yes</td>
<td>Restricted strength and mobility; pain in chest.</td>
<td>Nightmares and disturbed sleep.</td>
</tr>
<tr>
<td>17</td>
<td>m</td>
<td>Fell and impaled by scaffold pole; crushed pelvic area, severe cuts to both sides of body.</td>
<td>Friend/carer</td>
<td>No</td>
<td>Unable to move and dependent on others for all activities.</td>
<td>Severe depression and anxiety.</td>
</tr>
<tr>
<td>18</td>
<td>m</td>
<td>Fell on site; fractured back.</td>
<td>Partner, Daughter</td>
<td>Yes</td>
<td>Back pain and restricted mobility.</td>
<td>Depression, anxiety and flashbacks.</td>
</tr>
<tr>
<td>19</td>
<td>m</td>
<td>Trapped foot on site; broken ankle bones.</td>
<td>Partner</td>
<td>No</td>
<td>Pain and difficulty walking.</td>
<td>Depression, financial anxiety and insomnia.</td>
</tr>
<tr>
<td>20</td>
<td>m</td>
<td>Fell from vehicle on site; multiple rib fractures.</td>
<td>Partner</td>
<td>No</td>
<td>Pain and restricted mobility.</td>
<td>None.</td>
</tr>
</tbody>
</table>
6.2.2 Construction accident group: an overview of the cases

A total of 20 individuals involved in serious healthcare sector accidents were interviewed at home; a further 14 family members (associated with 13 cases) were also interviewed at this time or shortly after this interview. In general, the interviews were conducted within 4 months of the accident, though in two cases this extended to 9 and 14 months respectively. The mean time of these interviews after the accident was 4 months. A further follow-up interview (either a telephone interview or home interview) with the affected person was carried out in a subset of 9 cases after a mean elapsed time of 7 months since the home interview.

Demographics

The age and sex distribution of the 20 cases are shown in Table 6.2 and the distribution by residential status in Table 6.3.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>25-34</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>35-49</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>50-64</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>65 &amp; over</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residential status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lives alone</td>
<td>3</td>
</tr>
<tr>
<td>Lives with partner</td>
<td>6</td>
</tr>
<tr>
<td>Lives with partner and children</td>
<td>7</td>
</tr>
<tr>
<td>Lives with parents</td>
<td>2</td>
</tr>
<tr>
<td>Lives with friends</td>
<td>2</td>
</tr>
</tbody>
</table>

All 20 cases involving construction accidents were male; the dominant age group was 50 years and over. Most APs lived with someone else, usually either their partner or their partner and children. There were a small number of cases where APs lived on their own.

6.2.2.1 Vocational consequences

Work outcome

The pattern of return to work and resettlement at the time of the home interview (and the follow-up interview where available) is summarised in Table 6.4.
Table 6.4  Pattern of return to work and resettlement

<table>
<thead>
<tr>
<th>Work status</th>
<th>Home interview</th>
<th>No.</th>
<th>Follow-up interview</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Returned to work</td>
<td>Returned to work via light duties</td>
<td>5</td>
<td>Still on light duties</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Returned to normal duties</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No follow-up</td>
<td>2</td>
</tr>
<tr>
<td>Back to same job but job redesigned</td>
<td>1</td>
<td></td>
<td>No follow-up</td>
<td>1</td>
</tr>
<tr>
<td>Still off work</td>
<td>Expect to return to same job</td>
<td>6</td>
<td>Went straight back to same job</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Returned to work via light duties</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No follow-up</td>
<td>3</td>
</tr>
<tr>
<td>Don’t expect to return to same job</td>
<td>3</td>
<td></td>
<td>Returned to work via light duties</td>
<td>2</td>
</tr>
<tr>
<td>because of accident</td>
<td></td>
<td></td>
<td>No follow-up</td>
<td>1</td>
</tr>
<tr>
<td>Don’t expect to return to same job</td>
<td>1</td>
<td></td>
<td>No follow-up</td>
<td>1</td>
</tr>
<tr>
<td>because of dispute with employer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choosing to move to another job</td>
<td>1</td>
<td></td>
<td>No follow-up</td>
<td>1</td>
</tr>
<tr>
<td>Don’t know if they will return to</td>
<td>2</td>
<td></td>
<td>Returned to work via light duties</td>
<td>1</td>
</tr>
<tr>
<td>work or not</td>
<td></td>
<td></td>
<td>No follow-up</td>
<td>1</td>
</tr>
<tr>
<td>No longer working</td>
<td>Had taken normal retirement</td>
<td>1</td>
<td>No follow-up</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20</td>
<td></td>
<td></td>
<td>20</td>
</tr>
</tbody>
</table>

The main patterns to emerge from these data are as follows:

- Most APs were still off work at the time of the home interview.
- Of those who had returned to work only 1 had returned to his old job (which had been redesigned to reduce the risk of a similar accident); the rest had returned to light duties.
- Most APs who were still off work expected to return to work at the time of the home interview although all but one of these anticipated that the way they did their job or the way they approached their work would be affected by the accident. Evidence from the follow-up interviews confirms that these expectations were generally realistic.
- The return to work pattern typically involves a period of time on so-called “light duties” with restrictions placed on certain activities; sometimes this involved reduced salary or loss of overtime.

I broke my leg so I’m still not able to lift heavy objects and move around as easily as I could before the accident. I’m officially back to work on light duties but I’m still receiving full pay. There’s no way that I would have been able to come back now and do as much as I used to. I hope to be back to normal at work in about 5 weeks.

Male construction worker

- Of those who did not expect to return to the same job at the time of the home interview or were unsure, 1 was in dispute with his employer, one had retired and 1 was electing to change jobs. Of the remainder, 3 felt the accident might prevent them from returning to their old job and 2 were unsure if they would return to work or not. In the
follow-up interviews it was found that 2 of the former group did in fact return to work, as did 1 of the latter. This demonstrates that APs can sometimes overestimate the impact that an accident can have on their future work prospects.

Length of time off work

The following table lists the actual or anticipated length of time off work for each of the 20 cases. It should be noted that a range of injuries was captured in this sample, which is reflected in the wide variation in length of time taken off.

Table 6.5  Construction accidents - length of time off work

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Length of time off work (weeks)*</th>
<th>Actual</th>
<th>Expected</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>36</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>14</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>At time of home interview had one week off. At time of follow-up he reported he taken some further odd days off work as a result of the accident</td>
</tr>
<tr>
<td>4</td>
<td>-</td>
<td>15</td>
<td>-</td>
<td>Changing jobs because of dispute</td>
</tr>
<tr>
<td>5</td>
<td>-</td>
<td>28</td>
<td>-</td>
<td>Expect to return to the same job</td>
</tr>
<tr>
<td>6</td>
<td>-</td>
<td>Don’t know</td>
<td>-</td>
<td>Interviewed at 12 weeks - not sure if he will be able to return to work</td>
</tr>
<tr>
<td>7</td>
<td>10</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>28</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>11</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>20</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>-</td>
<td>28</td>
<td>-</td>
<td>May choose to move to another job</td>
</tr>
<tr>
<td>12</td>
<td>-</td>
<td>13</td>
<td>-</td>
<td>Expect to return to same job</td>
</tr>
<tr>
<td>13</td>
<td>-</td>
<td>6</td>
<td>-</td>
<td>Expect to return to same job</td>
</tr>
<tr>
<td>14</td>
<td>28</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>2</td>
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<td>44</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>-</td>
<td>Don’t know</td>
<td>-</td>
<td>Interviewed at 8 weeks - not sure if he will be able to return to work</td>
</tr>
<tr>
<td>18</td>
<td>24</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>16</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

*Established at home interview or follow-up interview

Support at work

APs were asked if they had received support or any kind of help from their employer or from those connected to their job, including support from their union.

The main findings are detailed below:

- Half of the cases reported receiving support from one of the following: employing organisation, manager or supervisor, colleagues and trade union, but the rest felt they had received no support of any kind. In general, it was found that the latter group were
not surprised they had received no support and accepted that this was characteristic of
the construction industry.

• In a small number of cases, contact had been made through Human Resource
departments. The majority of individuals, however, worked for small companies and
felt that their supervisor was their main point of contact. Supervisors had contacted
several cases when they were off work, but many cases had not heard from their
supervisor and expressed disappointment.

I’ve not heard anything from my employer, manager or colleagues since the accident. I couldn’t
believe it. My injuries needed an operation you’d think they would have taken it seriously. I’m
leaving soon to work for another company as a result of what’s happened.
**Male construction worker**

• Colleagues visited over half of those who had received some form of support.
Interviewers formed the impression that those who had had no form of contact with
colleagues felt isolated from their job.

Since the accident I’ve had quite a few visits from the guys I work with. They had a collection
for me at Christmas time. I really appreciated it and it meant I could get my partner something
for Christmas to say thank you for looking after me.
**Male construction worker**

• None of the 20 cases in this group had received any contact or care from an
Occupational Health department, though it is acknowledged that most small firms
would not have an Occupational Health section.

• Only a small number of cases had received advice from their trade union – typically
with regard to claiming compensation. In one case, an individual had contacted his
union but had been disappointed by its response, reporting that he had received no help
or useful advice.

• At the follow-up interview, despite having returned to work on light duties, a small
number of cases felt they had been forgotten about by their employers, and were
receiving far less support than during their period of sickness absence. Some helpful
managers were, however, highlighted by a few cases. One case described experiencing
extra tension with colleagues on return to work after five months as a result of a
workload disagreement.

I had been in touch with my manager and colleagues when we first met, and I think I said my
employer had been good to me. Just after that interview they stopped full pay and haven’t
seemed to care about what happens to me.
**Male construction worker**

**Responsibility for the accident**

APs were asked who, if anyone, they felt was responsible for their accident. The overall pattern
of results is shown in Table 6.6.

<table>
<thead>
<tr>
<th>Table 6.6</th>
<th>Perceived responsibility for the accident</th>
</tr>
</thead>
</table>

69
<table>
<thead>
<tr>
<th>Whose responsibility?</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>No-one</td>
<td>3</td>
</tr>
<tr>
<td>Themselves</td>
<td>5</td>
</tr>
<tr>
<td>Employers</td>
<td>7</td>
</tr>
<tr>
<td>Manager/supervisor</td>
<td>3</td>
</tr>
<tr>
<td>Colleague/co-worker</td>
<td>2</td>
</tr>
<tr>
<td>Main contractor</td>
<td>2</td>
</tr>
<tr>
<td>Equipment manufacturer</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24</strong>*</td>
</tr>
</tbody>
</table>

* Numbers exceeds 20 because responsibility was sometimes assigned to more than one party – typically a combination of themselves and their employer or manager.

The results of the interviews suggest that:

- The majority of APs attributed the responsibility for the accident to someone other than themselves, most commonly their employing organisation or individual manager.

> I blame my employer for the accident, the equipment on site wasn’t good quality. I knew that and should have made more of a fuss or said that I wouldn’t work.

*Male construction worker*

Data on compensation, covered later in this overview, show that:

- Although most APs were seeking compensation, attributing responsibility to their employer or manager did not always result in compensation being sought. Even when some APs felt that they had contributed to the accident or that no-one was to blame they were also actively seeking compensation from their employer.

### 6.2.2.2 Economic consequences

#### Loss of pay and increased outgoings

Details of individual losses and additional outgoings are provided in the case summaries. Some general points do, however, emerge:

- Only 1 person was on full pay for the duration of their absence from work (this was for a relatively short period of two weeks). The most common patterns were for individuals to receive full pay for a restricted period of time and then to be moved on to reduced pay, to be on reduced pay or statutory sick pay from the beginning of the period of absence or to be solely reliant on state benefits.

- Most people had incurred additional expense as a result of the accident, most frequently additional transport costs or medical costs, predominantly prescription costs. Nearly half of the cases had also incurred other costs such as specialist equipment or changes to the house to accommodate their new physical needs.

> I broke bones in my foot four months ago and it’s costing me a fortune, I’m using all of my savings. As I’m in the house more now all my bills have gone up, I’ve even had to buy new clothes to go over my casts. The costs so far come to at least £550.

*Male construction worker*
I paid about £100 for a medical certificate the insurance company needed.

*Male construction worker*

- Just over half the cases reported that another person had lost some time off work as a result of the accident.

*Compensation and legal implications*

- At the time of the home interview, most individuals in this group (14 cases or 70%) were seeking compensation or taking legal action against their employer as a result of their injuries, including some who had instigated action as a result of a breakdown in relations with their employer.

I damaged both my legs at work but my employer thinks that their insurer will settle the case if they are liable. I haven’t had to pay for my lawyer, he will take part of my compensation as his fee. That’s fine with me as it means he’ll work harder on my behalf I hope. He seems quite good. I’ve no complaints.

*Male construction worker*

- All cases claiming compensation recognised that potentially this could be a long and difficult process. Experiences of the process were varied: some felt their experience had been largely negative because their injuries were not taken sufficiently seriously, because of the complexity of the process or because they felt they were unfairly being held to blame for the accident. Others felt the process had some positive aspects such as forging a good relationship with their lawyer. The remainder were at too early a stage in the process to comment.

The experience of starting a claim has been really good for me as it’s helped me to realise that the accident wasn’t my fault and that I deserve to get something back from my employer because I think a co-worker was to blame for what had happened.

*Male construction worker*

- At the time of the follow-up interviews all those originally seeking compensation were still pursuing their cases; none of these cases had reached settlement.

### 6.2.2.3 Social consequences

*Activities of daily living*

The case summaries clearly demonstrate that these accidents often have pervasive and damaging effects on personal and family life, typically restricting most normal and routine activities. In some cases this impact continues for a long period of time, leading to feelings of personal frustration and, where mobility is seriously affected, feelings of social isolation. Some of the common patterns to emerge include the following:

- In the aftermath of the accident, almost all individuals were unable to carry out their day-to-day personal activities such as bathing, washing and dressing as normal and often required help from others; as a consequence some individuals temporarily lost interest in their appearance. In many cases one or more personal care activities were still restricted at the time of the home interview. At the time of the follow-up
interviews over half of the cases in this subset were reporting that personal care activities were still restricted or unlikely to return to normal. In the main, these restrictions were due to continuing problems with mobility.

I couldn’t put/get dressed sometimes as my back was so sore and my partner had to help me. I couldn’t shave either to begin with. I can now which helps me feel a bit more normal although I’ll be off work another few months.

Male construction worker

- Many individuals had at some point been unable to carry out or help with normal household tasks such as cooking, shopping and cleaning for some time after the accident. These activities were often still restricted at the time of the home interview. At the time of the follow-up interviews almost half of those interviewed in the subset reported that light household activities were still restricted or unlikely to return to normal.

I find it hard to hold pots and pans in the kitchen so I can’t really cook anymore and don’t think I will again in the future. I don’t know what I’d do without my partner.

Male construction worker

- The more physically demanding activities such as house maintenance, gardening and do-it-yourself were particularly affected. This may be due in part to the group being exclusively male. At the time of the follow-up interviews nearly half of those interviewed reported that these activities were still restricted or unlikely to return to normal.

- Nearly all individuals had had to give up their normal leisure and recreational activities, particularly where these were physically demanding such as playing football or gym work. Again, in most cases, these restrictions were still in place at the time of the home interview. Individuals often expressed feelings of frustration about these restrictions, particularly when there was a significant social aspect involved. At the time of the follow-up interviews many cases in the subset reported that these activities were still restricted or unlikely to return to normal.

I can’t go to the gym or play golf anymore. The fractures in my leg and ankle mean that even walking is hard so there’s no chance of playing sport like I normally do. It’s frustrating and I know I’ve probably put on weight.

Male construction worker

- The nature of the injuries was such that mobility was seriously affected in most cases. Typically, both walking and driving had been temporarily restricted, and in many cases remained restricted at the time of the home interview. At the time of the follow-up interviews a third of the cases in this subset were reporting that mobility was still restricted or unlikely to return to normal.

- Mobility problems had also meant that many individuals were unable to visit family and friends or entertain at home as normal. Most felt that the former had been affected with many still reporting that things had not got back to normal at the time of the home interview. At the time of the follow-up interviews most people in the subset interviewed had sufficiently adjusted to their physical difficulties for these activities to have generally returned to normal.
The case summaries also reveal that these effects typically occur in combination. Individuals were often reliant on others to maintain personal standards, were unable to reciprocate with help in the house and had lost the ability to fulfil their normal domestic role (for example, in a male population, failure to be able to carry out activities such as maintenance and DIY may be particularly significant). Physical impairment and mobility problems had also meant that they were often unable to seek respite in their preferred hobby or leisure activity. All of these problems were compounded by the social isolation that result from prolonged periods of poor or restricted mobility.

- Despite the ill-effects of the accidents, several cases reported a more positive side-effect which had led them to take stock of their priorities and the way they spent their free time.

| I have to spend more time washing and getting dressed. That’s because of the pain from my broken arm, but I do enjoy not rushing so much. My accident made me realise visiting friends and having them round were important so I do them more and enjoy it. |
| Male construction worker |

| We get involved in more socialising than before my accident. That was three months ago and my leg is healing so I can get around a bit more now. It has made us realise we should do as much with our time as possible and family is most important. |
| Male construction worker |

| I live with my fiancée and since I crushed my arm at work a couple of months ago we’ve been doing more together. We’ve been on more day trips and socialise more, partly because we realise how important our relationship is and I want to have fun since I’ve been stuck recovering for so long. |
| Male construction worker |

**Family activities**

Many of the restrictions discussed above have also had a significant impact on the general family life of those who live with a partner and/or children. For example:

- Just over half of the APs reported changes in family activities. Several cases reported that all family activities were restricted at the home interview and in the subset of cases that were followed-up, none felt family activities had returned to normal. Of those cases who reported normal family activities at the time of the home interview, all had experienced some restrictions on their normal family activities in the immediate aftermath of the accident.

- The most commonly reported areas affected were family leisure and sports activities. This was due to the residual mobility problems that many cases suffered following their accident. Furthermore, 3 cases specifically commented on difficulties with playing or lifting grandchildren or children.

| I fell three metres off a ladder, and damaged my foot, toes and wrist. I can’t do the sports I love, rock climbing and cycling, with my girlfriend. |
| Male construction worker |
I couldn’t play football or take my son’s football coaching for his club after fracturing my foot. That lasted almost three months.

Male construction worker

Provision of support and impact on relationships

APs were asked who had provided them with support and help since the accident. They were also asked if they felt any of their personal relationships had been affected by the impact of the accident. The results show that:

- Those living with partners were heavily reliant on them for support and care. In practice all of those interviewed who were living with a partner identified the partner as their primary source of physical and emotional support. General emotional help was frequently referred to, as were practical examples of help such as the partner accompanying the AP to medical appointments or taking on the responsibility for driving.

- In a small number of cases individuals had forged much closer relationships with their partners, though in others the enforced proximity and the changed personal dynamics had resulted in deterioration in the relationship. Key factors in this deterioration were often financial issues such as money, debts and overspending.

The arguments are normally about money - debts and how much money we’re spending. I was off work for about 4 months and only got 25% of my normal wage so we’ve really had to cut back.

Male construction worker

- The two next most common groups providing support and care were friends and parents. An improvement in relationships was reported in a small number of cases with no detrimental effects being identified.

My Mum, Dad and Grandma have looked after me since the accident. They’ve taken me back to the hospital when I needed to go and have looked after me. I feel closer to my Mum; she seems more concerned about me and doesn’t nag me as much.

Male construction worker

- Older children also provided support when they were living at home or in the vicinity; relationships with children were generally not affected.

- Trade unions were identified as an explicit source of support in a small number of cases, although one of these cases had found the interaction unhelpful.

- Half of the cases reported that they had received positive support from the medical services. Social services were also identified as a form of support in some cases, but often the interaction was described as ‘unhelpful’.

The NHS physiotherapy I had was brilliant. Really encouraging and they gave me advice about how to look after myself.

Male construction worker
I tried to call social services to find out the benefits that were available to me because I was still off work. I didn’t get anywhere, the system was confusing and when I finally spoke to someone they were unhelpful and didn’t tell me where I could find out more information. I was passed round 5 offices. The forms I eventually had to complete were ridiculously complicated.

Male construction worker

- At the follow-up interviews, the need for support in this subset had clearly lessened though where still required it’s form had not significantly changed from the home interview. Some relationships had also clearly improved at this stage.

6.2.2.4 Behavioural consequences

Impact on own behaviour

APs were asked if they had noticed any changes in their own behaviour since the accident. The results from the home interview are shown in Table 6.7. These results are presented in detail since in this area there is no equivalent data set in the telephone survey.

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>No change</th>
<th>Increase</th>
<th>Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping</td>
<td>3</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Eating</td>
<td>6</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Ability to concentrate</td>
<td>13</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Ability to take decisions</td>
<td>13</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Ability to remember things</td>
<td>12</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Avoidance of certain situations</td>
<td>12</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td>8</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Use of prescription drugs</td>
<td>5</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Use of non-prescription drugs</td>
<td>11</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Use of illegal drugs</td>
<td>20</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Losing temper/aggression</td>
<td>10</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Desire to leave house</td>
<td>4</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Desire to socialise</td>
<td>7</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Losing patience</td>
<td>12</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Sexual activity</td>
<td>12</td>
<td>0</td>
<td>8</td>
</tr>
</tbody>
</table>

The most common patterns identified were:

- Patterns of sleeping were affected in the majority of cases; in most of these cases APs reported they were able to sleep less well. This was often related to both the physical discomfort following the accident and to anxiety about the accident and its impact on finance and the future.

My leg is so sore that I can’t lie comfortably at night and get to sleep. It’s meant my partner often sleeps in another room so she can get a good sleep. That worries me – that we’re becoming less close. It feels like I spend every night awake – worrying most of the time about whether I’ll get back to work and whether we’ll have to sell the house.

Male construction worker

- Many cases reported changes in normal eating patterns.
After the accident I ate more than normal. I was worried about work and money and it really was a case of eating to feel better. I’m much better now so haven’t been doing that.

*Male construction worker*

When I was off work I definitely ate more. I couldn’t do anything so what was the point in trying to stay healthy. It sounds stupid now.

*Male construction worker*

- There were reported increases in loss of temper and/or loss of patience in over half of the cases. In discussions, this was linked by several cases to their frustration with the long recovery period and to their inability to carry out normal activities.

- Cognitive functions such as the ability to concentrate, the ability to take decisions or remember things were adversely affected in some cases. Other APs, however, had noticed an improvement in their ability to take decisions, partly because of a re-evaluation of priorities that had followed the accident.

*Male construction worker*

I hate admitting it to my partner but I am less sure of myself since the accident although it was over six months ago. I don’t think I’m as decisive as I used to be.

*Male construction worker*

I’m better at concentrating since my accident. It’s made me realise that I won’t be around forever and I don’t want to waste time in life dithering around. I don’t want to dwell on feeling bitter about having been in an accident.

*Male construction worker*

When I was off work it was hard to balance all the bills and I had tough financial decisions to make as they affected my partner. I almost feel better qualified now to make decisions.

*Male construction worker*

- Most APs reported an increased desire to leave the house or to socialise. This was typically a consequence of the mobility problems and enforced social isolation. APs linked these feelings to frustration with their injuries and confinement to the house when they were usually active people accustomed to working outside every day.

- Many APs reported an increase in the use of prescription drugs and/or by an increase in non-prescription drugs. No-one reported an increased use of illegal drugs.

- More APs reported a decrease in alcohol consumption than an increase in consumption. The former was generally a direct consequence of reduced mobility and restrictions on their social life.

*Male construction worker*

I was unable to drink after my accident because I was so ill. It was a while until I could manage to go into a pub.

*Male construction worker*

It feels like ages that I’ve been stuck in the house. I’ve broken my leg in two places so it’s taking ages to heal. A few friends have been round but I miss playing cards and socialising. I
I just want to get out and about a bit more on my crutches - I’m used to being outside on a site all day during the week at work.

Male construction worker

I think being stuck inside after an accident is really hard when you’re used to being outside on a site all day. It makes you want to be outside even more than most people would probably feel. I get annoyed about it as the collapse of the scaffolding wasn’t my fault.

Male construction worker

- A pattern of reduced sexual activity was reported in a relatively large number of cases; again this pattern was largely attributed to the physical consequences of the accident.

The most frequently reported changes at the follow-up interview were:

- All APs in this subset continued to report that their behaviours were still affected by the accident, the negative impacts identified above continuing at the time of the follow-up. The most frequently reported additional changes being further decreases in sleeping, and increased ill-temper and impatience. A small number of cases reported increases in alcohol consumption since the home interviews.

Impact on others behaviours

APs were also asked if they had noticed any changes in the behaviour of the people that they lived with. In half of the cases a change was reported, the main findings being shown below:

- Several APs felt that their partners had shown an increase in loss of temper and/or loss of patience.

My partner has been sleeping less and drinking more, although now she’s getting back to normal. I was off work for 4 months and she had to change her whole routine around looking after me as I wasn’t mobile and was in hospital for a while. She loses her temper more with the kids, they make things worse by being naughty.

Male construction worker

- Cognitive functions were variously described as having improved or declined for their partners. Increases were linked to having more responsibility for decision-making during the incapacity of the AP, while decreases were linked to accident-related stresses and worries about the future and the recovery of the AP.

- Where APs were living with children and reported behavioural changes, the changes involved disruptive behaviour at home or at school. This was reported in 6 out of 7 cases. In one case, the infant son of an AP had also become scared of hospitals as a result of having visited the AP when he was in hospital.

I’ve noticed changes in both of my children. My son and daughter have both become more difficult – at home and at school. It could be an attention seeking thing as since my accident my partner has been busy looking after me.

Male construction worker
6.2.2.5 Psychological consequences

The emotional consequences of the accidents, as described in the case summaries, demonstrate that these accidents can potentially have serious and long-lasting psychological effects. The results of the psychological measures administered at the interviews strongly reinforce this conclusion. These results are summarised in Table 6.8.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Scores</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma Screening Questionnaire*</td>
<td>5.2</td>
<td>8</td>
</tr>
<tr>
<td>(administered at telephone survey)</td>
<td></td>
<td>5 cases scored 8 or over at telephone interview</td>
</tr>
<tr>
<td>Impact of Events Scale Total*</td>
<td>32.3</td>
<td>12</td>
</tr>
<tr>
<td>Goldberg Anxiety</td>
<td>5.9</td>
<td>14</td>
</tr>
<tr>
<td>Goldberg Depression</td>
<td>4.5</td>
<td>18</td>
</tr>
</tbody>
</table>

* scores are only available for 19 of the 20 cases

Whilst the case summaries need to be read in their entirety to appreciate the full extent of these effects on the individual and family, some general points can be made:

- Despite the relatively lengthy period since the accidents, a significant number of APs were showing symptoms relating to Post Traumatic Stress Disorder (PTSD) at the time of the telephone interview (as measured by the Trauma Screening Questionnaire or TSQ). These preliminary findings were confirmed by the results of the Impact of Events Scale or IES completed during the home interview. At this point, nearly two thirds of the cases showed PTSD-type symptoms. Although these findings would suggest the need for some formal assessment, intervention or support, in practice, none of the 20 cases had received any form of psychological support since the accident.

- Most APs were also clearly experiencing symptoms of both anxiety and depression in the aftermath of the accident; in approximately half the cases the scores on the Goldberg scales indicate that these conditions were potentially serious. Despite the severity of their symptoms. Only a very small number of cases had discussed these issues with their doctor and several commented that they felt embarrassed or reluctant to discuss their emotional problems.

- It is difficult to generalise about the nature of the emotional effects that were reported because they often reflected the particular nature of the accident or specific experiences with employers. However, it was clear that some individuals were very apprehensive about returning to their work environment, and that others were concerned about their financial situation and what the future might hold. Many were also frustrated by their inability to carry out their normal activities and were aware of the impact this was having on their family.

I often try not to think about the accident because it puts me in a bad mood. I know that I’ve got lots to still deal with before I get better. It’s the tenseness that means I can’t sleep. It gives me headaches too. I often have dreams about the accident, more like nightmares really.

Male construction worker
Family impact

Family members of 13 cases were also interviewed at or close to the time of the home interview. Where possible, these interviews focused on those involved in the primary care and support role. In 10 cases the partner was interviewed (in one of these cases the adult daughter was also interviewed), and the remaining 3 interviews involved a girlfriend who lived close to the affected person and provided his main support, a mother of a 19 year-old and, lastly, a friend who acted as the main carer and with whom the affected person (who had no immediate family) had been living because of the extensive nature of his injuries. The interviews focused on the actual and perceived impact of the accident on them personally and on their normal lifestyle.

These interviews demonstrate that:

- Family members were often required to take time off work both in the immediate aftermath of the accident when the affected person may be hospitalised or require hands-on care at home and subsequently to provide transport to and from appointments (7 cases).

- Family members often lost pay and/or incurred additional costs as a result of the accident (8 cases). One family member had used holiday time to reduce the financial impact on the family.

- Most normal family and social activities were disrupted because of the accident (11 cases).

- Nearly all family members felt there had been a significant impact on their own behaviour, for example, problems with sleeping, changes in eating habits or increased impatience (11 cases).
I have been sleeping less and eating more since his accident, due to worry about him, his recovery and the money problems of him not working. I can’t help the comfort eating when I’m worried. I know I’m less patient than normal and have been trying to get out of the house a bit. Going out more has meant I’ve been drinking a bit more than usual, though.

*Partner of male construction worker*

- Family members often felt that relationships had been affected by the accident; some reported stronger relationships within the family network (3 cases), though more felt relationships had suffered as a consequence of the accident (7 cases).

Since his accident I think our relationship has been under a lot of strain because his injuries were so serious and he has been off work for over 3 months and I think our relationship has worsened. I get on better with my children though. They’ve given me a lot of support and helped me looking after their Dad.

*Partner of male construction worker*

- Some partners reported they had noticed negative behavioural changes (such as an increase in aggression or disruptive behaviour) in their partner or other family members (four cases). In some cases, the carers had observed changes in their partners which had not been reported by the partners themselves.

I don’t think my behaviour has changed as a result of the accident although since the accident my partner has been sleeping less, probably because of the pain in his leg. My little boy has been disruptive at nursery school and is more aggressive since the accident. I think these changes are due to the changes at home and to his normal routine. It’s been so different from normal as my partner is always in the house.

*Partner of a male construction worker*

- Some family members had clearly been seriously affected emotionally by the accident and reported experiencing feelings and symptoms characteristic of anxiety and depression (nine cases).

I was seriously shaken by his accident and having to look after him when he was unwell. Not to mention how he has been affected by the accident – nightmares and shouting out when he’s asleep. I still feel panicky and anxious from time to time although the accident happened around 9 months ago.

*Partner of male construction worker*
6.3 CONSTRUCTION ACCIDENT GROUP - CASE STUDIES
6.3.1 Case No: 1 - male construction worker

The home interview was carried out 3 months after the event and the follow-up interview after a further 8 months.

Incident and injuries

Case 1 fell 5m from scaffolding on a building site, resulting in multiple injuries: fractures in both wrists, fractures in other bones in the right hand and also the collar bone, shoulder and five ribs. The injuries further included several dislocated fingers, facial grazing and concussion. Additional symptoms at the time of the interview were dizziness and emotional problems.

Vocational consequences

Case 1 had been unable to work for three months at the time of the home interview, and had no expectation of being able to return to work in the immediate future. His impairments as a result of the accident had left him unable to lift or drive. He believed that he would be permanently unable to continue working in his existing job. He had received some visits from his foreman in support. He felt that his employer was responsible for the accident.

At the time of the follow-up interview he had returned to the same job after 9 months off work but found heavy lifting and using his right hand very difficult. He strongly felt that the accident would not have occurred had he been given the appropriate training for the type of work he was carrying out at the time of his fall.

Financial consequences

To the date of the home interview, Case 1 had received full pay of £2000-£2500 per month. Case 1 is self-employed, however, and after this point received nothing from the company he had been contracted to. He reported that he would be forced to sell assets, beginning with his family car, in order to support himself and his family. Additional costs of over £300 had been incurred in the form of prescriptions, special equipment, transport and communication.

The family had also suffered financial loss as a result of the need for care, with Case 1 having lost earnings of £2500 over a three-month period. Case 1 had received an insurance award of £3000. He is seeking compensation from his employers.

For the remaining 6 months off work he had received £110 per week from social services. The follow-up interview also highlighted the continued loss of earnings for his partner, due to caring for him, that totalled a further £2500. Additional costs included a further £100 for prescription charges and £200 for petrol and car parking costs.

Social consequences

The seriousness of the accident had left Case 1 with severely impaired activities. He had been unable to walk or drive, visit friends and family alone, or play with grandchildren. Support had been provided primarily by his partner, who had become a 24-hour carer, and by his three adult children. The situation had resulted in a worsening of the relationships and conflicts within the extended family from the twin demands of caring for Case 1 and caring for the grandchildren.
At the time of the follow-up interview both bathing and cooking were activities that he thought would never return to normal. Dressing, DIY, playing pool and driving were all still restricted. Other elements of everyday life had returned to normal, though it was still very hard for him to be able to lift up his grandchildren or play with them as he had done before the accident.

His partner, brother and adult children had continued to give him a high level of emotional and practical help.

**Behavioural consequences**

Since the accident, Case 1 reported a decrease in sleeping, eating and mental abilities, together with an increase in ill-temper and impatience. Behavioural changes in his partner were significant and included decreases in sleeping, eating, concentration, memory and decision making, and the desire to socialise. These were accompanied by increases in the use of prescription medication, the avoidance of certain situations and a desire to leave the house.

Decreases in sleeping, eating, concentration, memory, avoidance of certain situations and alcohol consumption were reported at the time of follow-up interview. Case 1 reported increases in the use of prescription medication, losing his temper and impatience.

Case 1 reported continued changes in his partner’s behaviour during the follow-up interview including decreases in sleeping, eating, the ability to take decisions and remember things, alcohol consumption and desire to leave the house and socialise.

**Psychological consequences**

Case 1 was frequently tearful when discussing the accident and particularly upset by his inability to recall the event.

Though Case 1 has discussed his dizziness with his doctor, he was unable to bring himself to discuss his emotional problems and had received no appropriate advice or medication.

At the follow-up interview Case 1 reported that he still frequently becomes upset by the accident.
6.3.2 Case No: 2- male construction worker

The home interview was carried out 3.5 months after the event and the follow-up after a further 8 months.

Incident and injuries

Case 2 was involved in a fall from height resulting in a fractured pelvis. At the time of the home interview he was still suffering from pain and numbness in his thigh and was walking with a limp.

Vocational consequences

Case 2 was back at work at the time of the home interview, having had three and a half months off work. He had returned to light duties for two weeks before resuming his normal job.

Case 2 felt that he was responsible for the accident.

Case 2 reported that he had not received any support from his employers, supervisors or colleagues other than the allocation of temporary light duties on return to work.

At the time of the follow-up interview Case 2 had lost no further time. He reported an increase in safety-consciousness in his work.

Financial consequences

During his time off work Case 2 received no money from his employer and was reliant on state benefits of £66 per week. His normal salary level was below £500 per month. The only additional costs that were reported were £50 for shoes required as a result of the injuries.

His mother and father had each lost approximately one and a half weeks off work.

Case 2 was seeking compensation for his injuries but finding this a difficult experience as he did not think the legal profession was taking the severity of his injury as seriously as they should. He was of the view that others had received more compensation for lesser injuries.

At the time of the follow-up interview, no compensation had been received and Case 2 was continuing to feel negative about the extended delay.

Social consequences

As a result of the accident Case 2 experienced temporary problems with personal care activities such as bathing and dressing and also driving. At the time of the home interview he was still experiencing problems with walking and normal social activities such as visiting the gym, friends and the pub were still restricted. He felt that he was unlikely to be able to play football (one of his main recreational activities) again.
Support had mainly been provided by his mother and father, who took him back and forth to hospital, and by his grandmother, who had acted as the main carer on a day-to-day basis. He had noticed an improvement in his relationship with his mother who ‘doesn’t moan at him as much’.

At the time of the follow-up interview, Case 2 reported that he was still restricted in sport but that all other activities had returned to normal.

**Behavioural consequences**

Case 2 had experienced initial problems in sleeping because of discomfort, but at the time of the home interview this had improved. Due to mobility restrictions, there had been an increased desire to leave the house and socialise but in practice mobility problems had resulted in less social activities and less alcohol consumption. Other behavioural changes that were reported included an increase in eating, and the ability to concentrate and take decisions.

Case 2 had not noticed any change in the behaviour of family members.

At the time of the follow-up interview, eating and sleeping were still affected and there was a continuing desire to leave the house and socialise. Alcohol consumption had increased, as had impatience.

**Psychological consequences**

Case 2 felt the accident was still affecting him emotionally at the time of the home interview. He felt he still was apt to dwell on the accident and felt it was a ‘burden on his mind’, particularly with regard to it’s effect on future activities. He had not raised these problems with his GP.
6.3.3 Case No: 3- male construction worker

The personal interview was carried out 4 months after the event and the follow-up interview after a further 7 months.

**Incident and injuries**

Case 3 was working on a building site when scaffolding collapsed and smashed a glass plate into his body. Following the accident consciousness was lost for several hours. He suffered from multiple fractured ribs, a fractured wrist and severe concussion. Additional symptoms when first interviewed were re-experiencing the accident through flashbacks and nightmares.

**Vocational consequences**

Case 3 had been off work for one week at the time of the home interview and had returned to light duties at work. This was linked to a concern that he may have to return to his home country if he were not in continuous employment. He had received no contact or support from his employer. He felt the manufacturers of the scaffolding were responsible for his accident.

_He was working in the same job at the time of the follow-up interview and had found his foreman helpful in checking on his progress at work and his ability to return to normal duties. He had taken several further days off work due to feeling depressed as a result of the accident. Lifting heavy objects was still difficult and Case 3 reported nausea or even physical sickness most mornings before work._

**Financial consequences**

Full pay (normally in the range of £500-£1000 per month) had been received for the 1 week absence from work though it had only been paid after several requests to management staff. Additional costs at the time of the home interview amounted to £20 for prescription costs and £10 for taxis following the accident. Case 3 was hoping to collect compensation for the accident on the basis that his company had agreed in principle to make a compensation payment. A friend who cared for case 3 also lost four days from work, unpaid.

_At the time of the follow-up interview he had lost approximately £200 of earnings from days off work due to feeling depressed and had paid £100 in prescription charges. He was still pursuing a compensation claim and had received no payment. His company had become more reticent about making a payment._

**Social consequences**

Personal care, household activities and playing football were all still restricted at the time of the home interview. Social interaction and mobility had been affected at the time of the accident but had since returned to normal. Support had mainly been provided by a friend who helped with all activities of daily living following the accident. Physiotherapy from the NHS had been very useful.

_Case 3 felt that any heavy activities or those which involved lifting were unlikely to return to normal at the follow-up interview. Playing football was still restricted but all other activities_
had returned to normal. His friend had continued to care for him and helped arrange medical appointments. The physiotherapy had continued and been of great help with his ribs.

**Behavioural consequences**

Case 3 reported a decrease in sleeping and eating since the accident and an increase in the use of medication and in losing his temper.

No changes were noted in the behaviour of others.

A decrease in sleeping was also reported at the follow-up interview, as was an increase in avoidance of certain situations and the use of prescription and non-prescription medication. All other behaviours were felt to be normal.

**Psychological consequences**

Since the accident he had suffered from flashbacks and nightmares and felt down most of the time. He had not discussed the emotional impact of the accident with his GP.

At follow-up he reported the same symptoms though reported they were less severe.
6.3.4 Case No: 4 - male construction worker

The home interview was carried out 3 months after the event.

**Incident and injuries**

Case 4 suffered a fall on a construction site resulting in fractures to both fibula and tibia. At the time of the home interview he was still limping and suffering pain in affected leg.

**Vocational consequences**

Case 4 had been off work for approximately 3 months at the time of the home interview and expected to be off work for a further two weeks before taking up work with another employer. He had been dismissed by his original employer following a dispute about compensation. He anticipated that it might be painful readjusting to work and that he was likely to be more cautious in the future. He had received support from his trade union, which provided advice on his legal position.

Case 4 felt that his employer was responsible for the incident, as they did not supply adequate equipment, but also believed that he himself was partly responsible.

**Financial consequences**

During his time off work Case 4 received full pay of £2000 - £2500 for one month, reduced to £150 per week for the following two weeks and then to £100 per week. For the three weeks prior to the home interview (since his dispute with his employer) Case 4 had received no pay. His parents had provided some additional financial help by paying the mortgage during his time off work. Total direct net losses in earnings amount to approximately £4500.

Additional costs of £200 had been incurred in taxis back and forth to hospital and shops.

No one else has lost time off from work as a result of the illness. No support other than financial had been received from his employers or colleagues.

Case 4 was seeking compensation from his employer. This was proving difficult since the employer originally said that the company’s insurers would cover the claim, he subsequently informed case 4 that this would not be the case. When Case 4 decided to pursue his claim, following advice from a solicitor, the employer stopped sick pay and laid him off.

**Social consequences**

Almost all activities of daily living had been temporarily affected by the accident. At the time of the home interview, all personal care activities and all household activities had been restricted but were now back to normal with the exception of walking, which was still difficult.

Normal family and leisure activities such as sport and socialising with friends and family had also been affected but were now back to normal.
Case 4 had not noticed any changes in the nature of the relationships with his family as a result of the accident and had been supported primarily by his partner, who had helped with personal care and had done all housework, cooking and shopping.

**Behavioural consequences**

Case 4 had noticed a tendency to sleep more following the accident and an increased desire to leave the house and socialise as a result of the restriction on his mobility. He was aware that his partner was tired and frustrated and that there had been an increased responsibility on her part to remember things and take decisions. There had also been an increase in disruptive behaviour at home by their fourteen year-old son.

**Psychological consequences**

At the time of the home interview, Case 4 felt that the accident and its aftermath were still affecting him emotionally. In particular, he was upset about his dispute with his previous employer and continued to feel very angry towards him. He had not discussed any emotional problems with his GP.
6.3.5 Case No: 5 - male construction worker

The home interview was carried out 3 months after the event.

Incident and injuries

Case 5 fell from a ladder, suffering a broken leg (both fibula and tibia) and shattered ankle. At the time of the home interview he was also experiencing hot sweats, hallucinations and panic attacks, which were reported as side effects of his medication.

Vocational consequences

At the time of the home interview Case 5 had been off work for three months and anticipated being unable to return to work for a further four months. He had received no support from his employers, colleagues or union.

He anticipated being able to return to his old job, but commented that his doctor was of a different opinion. He also felt that his outlook on his job would be different and that he would slow down.

Case 5 felt that no-one was responsible for his accident.

Financial consequences

Whilst off work Case 5 received full pay at his normal rate of £1000-£1500 per month for the first six weeks. This was subsequently reduced, and at the time of the home interview he was receiving £71 per week statutory sick pay. He had also received a payout from an accident insurance policy of £3000 whilst in hospital and £240 per month during his convalescence. Whilst off work he had lost the use of a company van and also some holiday pay entitlement. Additional costs incurred included costs of prescriptions (estimated as £200-250), car parking (£28 per week) and alterations to the house (estimated cost of changes to banisters of £80). Equipment such as wheelchair, commode etc. were on loan from the Red Cross.

Case 5 was seeking compensation from his employer. His experience of claiming at this time was significantly better that an earlier experience, which took some eight years to progress.

As a result of the accident, his partner had also lost two weeks off work (no information on costs was available) and, in addition, his daughter and a friend each also lost three days whilst he was in hospital.

Social consequences

The accident had seriously disrupted life in general. Almost all activities of daily living had been affected by the accident and at the time of the home interview, all personal care activities and all household activities were still restricted.
All normal leisure activities such as playing golf and going to the gym had been abandoned. Similar restrictions also applied to general family activities, visits to friends and family and other forms of social interaction.

Case 5 had a sizeable support network which included his partner, who provided the primary support (financial, emotional and physical), his parents-in-law, who provided emotional and financial support, and his daughter. Friends had also been there for him when needed and had taken him on trips out.

Case 5 considered that his relationships with both his partner and daughter had improved since the accident. They have become more attentive and he is now much closer to his daughter who has been especially supportive and caring.

**Behavioural consequences**

Following the accident Case 5 had experienced some problems with sleeping and had been aware of eating more. Restrictions on mobility had led to an increased desire to leave the house and socialise, but in practice, curbs on his mobility had led to a decrease in alcohol consumption. He was also aware that some cognitive functions such as memory had decreased.

He had also noticed that his partner had been sleeping less well and was eating more since his accident. His daughter had become more caring and positive with him.

**Psychological consequences**

At the time of the home interview Case 5 was suffering some severe side effects from the medication he was taking including hallucinations and panic attacks. He had not discussed emotional issues with his GP.
6.3.6 Case No: 6 - male construction worker

The home interview was carried out 3 months after the event.

**Incident and injuries**

Case 6 fell from a ladder while working on a lamp-post after receiving a severe electric shock. The accident resulted in fractured vertebrae, burnt fingers and bruised ribs.

**Vocational consequences**

Case 6 had been off work for 3 months at the time of the home interview and was unsure as to when or whether he would be able to return to the same job. He had not received support of any kind from his employer during his time off work and felt that his manager was responsible for the accident.

**Financial consequences**

During his time off work he had received £120 per week for the first 5 weeks followed by £171 per week in the 10 weeks immediately prior to the home interview. Beyond this, no further financial support had been received and additional costs amounted to approximately £70 for transport to hospital. In addition, his partner had lost 8 days work, which she had taken as annual leave.

His normal salary was in the range £1500 - £2000 per month.

Case 6 was unsure at this point whether to make a claim for compensation and at the time of the home interview was awaiting both a report from his doctor detailing the likelihood of his return to work and further advice from his solicitor.

**Social consequences**

The seriousness of the accident has left Case 6 with impaired activities of daily living with restrictions in personal care, manual household activities, mobility and visiting friends and family. Household tasks such as cooking were unaffected, as was entertaining. All family activities were still affected.

Support from his partner and son was very helpful and focused on practical help with personal care and strenuous household activities such as DIY and gardening. His relationships with family members had not been affected by the accident.
**Behavioural consequences**

Since the accident, Case 6 reported an increase in avoiding certain situations. No other changes in personal behaviour were reported and no changes in behaviour were reported for his partner, mother-in-law or son.

**Psychological consequences**

Residual psychological effects were characterised as worries about working with electricity in the future and worries about returning to work; he was also concerned about the financial implications of the accident. The emotional impact of the accident had not been discussed with his GP.
6.3.7 Case No: 7 - male construction worker

The home interview was carried out 2.5 months after the event.

**Incident and injuries**

Case 7 was injured using a rip saw on a building site. He lost his index finger at the knuckle and damaged the ligaments in his little finger. At the time of the home interview he was still suffering pain and lack of strength and mobility in his fingers.

**Vocational consequences**

Case 7 was back at his original job at the time of the home interview having had ten weeks off work. However, he was no longer working on his own and had been effectively been put on lighter duties.

Case 7 felt that responsibility for the accident was his and was not seeking compensation from his employers. He had received support from his employers in the form of visits to his home on two occasions.

**Financial consequences**

Case 7 received no pay from his employer whilst off work and was reliant on state benefits of £54.40 per week supplemented by housing benefit of £100 per week. His normal salary is in the range £1000-£1500 per month, so that significant losses had been incurred. At the time of the home interview he had returned to light duties on reduced pay.

Additional costs were incurred for transport back and forth to hospital.

His mother had sixteen hours off work to take him to hospital and help him with benefit claims. She did not incur any loss of wages.

**Social consequences**

Following the accident Case 7 experienced temporary problems with personal care activities such as bathing and dressing. He also experienced problems with household activities such as cooking and DIY; driving had also been a problem but was now back to normal.

His mother had been the major source of support, providing transport and helping with benefits. Friends also helped by taking him out to the pub.

Whilst relationships with his immediate family (mother, father, brothers and sister) have improved, since the accident he had separated from his girlfriend.
**Behavioural consequences**

Following the accident, Case 7 felt that he lost his patience and his temper more. He also had difficulty in sleeping and felt that his ability to remember things had suffered. He also believed that he had increased his alcohol consumption.

**Psychological consequences**

At the time of the home interview, Case 7 felt that the accident was still affecting him emotionally. In particular, he experienced an increased loss of temper and a worsening of his views of other people. He had not discussed these issues with his GP.
6.3.8 Case No: 8 – male construction worker

The home interview was carried out 4.5 months after the event and the follow-up interview after a further 11 months.

Incident and injuries

Case 8 fell from a stepladder while working on a building site, fracturing his leg in two places. As well as directly impairing Case 8’s mobility, the injury has resulted in back pain from limping.

Vocational consequences

Case 8 had been unable to work for a period of 4 months at the time of the home interview, and expected to be absent for a further two months. He intended to return to the same job, but was unsure at that point of his ability to work as well as would be necessary.

He has maintained good relationships with his employer and co-workers, though he has not received any particular support from either. Case 8 felt that the main contractor on the site was responsible for the accident and was seeking compensation as a result.

At the time of the follow-up interview, Case 8 had returned to his normal job after a period of light duties. His build-up of debts as a result of his lost time had left him bitter, and he had begun to work with a solicitor on his claim.

Financial consequences

Case 8 had received no pay from his employer since the accident and had received only income support from the state during his 4 months absence. Average monthly salary had been £2000-£2500 prior to the accident. This had resulted in financial losses to the family of £9300 to the time of the home interview, with a further £3800 losses expected until he returned to work.

Case 8 had incurred additional costs of approximately £100 in transport to and from hospital.

At the time of the follow-up interview, additional costs of £50 for parking and £50 for additional utilities costs had been incurred.

Social consequences

The injury to Case 8 had resulted in temporary restrictions to bathing and other personal care, though he had begun to make a recovery at the time of the home interview. Still restricted at this point were walking, use of public transport and his ability to visit friends and family.

Support has been provided by his partner, who is not employed and has been able to devote time to caring, and by his adult sons. Case 8’s father has been helping the family with money problems. He reports no changes in relationships with others, but his partner was clearly worried about the injury itself and the financial consequences for the family.
At the follow-up interview, all activities had returned to normal with the exception of walking, where Case 8 still had a limp.

**Behavioural consequences**

Case 8 had experienced relatively few behavioural changes, though had noticed an increase in eating and the desire to leave the house, together with a decrease in sleeping.

*Sleeping was still adversely affected at the time of the follow-up interview.*

**Psychological consequences**

Case 8 was anxious about money at the time of the home interview. The emotional impact of the accident had not been discussed with his GP.

*At the time of the follow-up interview, Case 8 expressed continuing frustration with the event, and was experiencing difficulty sleeping.*
6.3.9 Case No: 9 - male construction worker

The home interview was carried out 3 months after the event and the follow-up interview after a further 11 months.

**Incident and injuries**

Case 9 missed his footing when climbing from a ladder to scaffolding and fell 15 feet. This resulted in a fractured left heel and multiple fractures to the right heel.

**Vocational consequences**

At the time of the home interview Case 9 had returned to work having been absent for 11 weeks as a result of his injuries. He had returned to light duties and was still unable to lift heavy objects. No support had been provided by his employing organisation since the accident.

Case 9 felt that the accident would not have happened if he had not been asked to carry too heavy a load up a ladder. He felt that both he and his supervisor were responsible for the accident.

*Between the home interview and the follow-up interview, Case 9 had moved onto a new job in the same line of work with a new employer.*

**Financial consequences**

Case 9 received full pay of £1000 - £1500 for the first month of absence from work and two thirds of his normal wage, after negotiating with his employer. Additional costs incurred included £30 for prescription charges, £200 in transport costs and £10 for a wheelchair ramp. No compensation claim was planned at the home interview stage.

His partner also lost 1 week from work to care for him immediately after the accident.

*At the follow-up interview, he reported that additional income from his new job amounted to £500 per month.*

**Social consequences**

All activities of daily living were adversely affected following the accident although interest in personal appearance and cooking did not change from normal levels. Visiting friends had originally been problematic but had returned to normal when the home interview was carried out. All family activities other than eating out were still restricted.

His partner, mother and father-in-law had provided practical help with personal care and in responsibilities such as child care and DIY. He was very pleased with the level of care he had received at hospital but felt that Social Services had been very unhelpful on the telephone when he had enquired about what financial help might be available as a result of the accident.
His relationships with his partner and child had both improved since the accident.

Activities of daily living, other than driving, had all returned to normal when the follow-up interview was carried out. Family activities had also returned to normal.

**Behavioural consequences**

A decrease in alcohol consumption was accompanied by increases in eating, decision-making, avoiding certain situations, medication use and desire to leave the house. Any behavioural changes in his partner were described positively, as a reflection of their increased closeness since the accident, though Case 9’s young son had a more disturbed sleep pattern since the accident and was now scared of hospitals.

*Increases in avoiding certain situations and non-prescription drug use were again reported in the follow-up interview, while all other behaviours were deemed by Case 9 to be at a normal level.*

**Psychological consequences**

Case 9 had experienced ongoing frustration at restrictions on his activities. The emotional impact of the accident had not been discussed with his GP.

Case 9 felt it was hard to move past the feelings of stress and worry about the future that the accident raised.
6.3.10 Case No: 10 – male construction worker

The home interview was carried out 4 months after the event and the follow-up interview after a further six months.

**Incident and injuries**

Case 10 was cutting metal into sections when waste metal fell and broke his right ankle in two places. At the time of the home interview this had led to feelings of frustration and depression.

**Vocational consequences**

Case 10 had been unable to work for four months at the time of the home interview and expected to be off work for a further 5 weeks. He viewed his employer as a good one and had been called by his manager since the accident to check on his progress. Some of his colleagues had visited him and his trade union had also been in contact. He felt that responsibility for the accident lay firmly in the hands of the main contractor that operated his work site since they had not given him the information needed to carry out his tasks safely at the time of the accident.

*Since the home interview and his return to work (after a total absence of 5 months) he felt that colleagues had taken over much of his work, which had led to some tension. His employer, however, had organised a collection for him at Christmas time.*

**Financial consequences**

Case 10 had not received any pay from his employer while absent from work and had been living on statutory sick pay since the accident. No additional financial support had been provided from any source. This had placed severe financial strain on Case 10 and he had used redundancy payments saved from a previous job to help during his absence. His normal monthly income would be in the range £1000 - £1500. Additional costs incurred included £250 transport costs, £45 for trousers to fit over the plaster cast and £200 for additional utility costs resulting from being at home while off work.

Case 10 was seeking compensation from his employer but finding the process complex and difficult. He was unaware, for example, that he needed to keep detailed records of costs incurred as a result of the accident.

*During the period following the home interview he continued to receive SSP until his return to work. Further additional costs included £20 for painkillers and £10 for transport costs. At the time of the follow-up interview, he was still waiting to hear if the company’s insurers would accept liability for the accident.*

**Social consequences**

Walking was still restricted at the time of the home interview, though all other activities of daily living had returned to normal. Support from his partner had been vital in his recovery. She had helped with transport, household activities and provided emotional support through the difficult
family time that followed the accident. Nevertheless, case 10 reported that the relationship had been under strain due to his enforced stay in the home.

Services were generally deemed very good. His trade union was very helpful in assisting with making a claim for compensation and had arranged for Case 10 to contact a lawyer. Physiotherapy had been very useful, though his GP had been of little assistance. Social services had been very unhelpful when dealing with requests for information about benefits.

At the time of the follow-up interview Case 10 judged himself as unlikely to return to normal in the following activities: heavy household tasks such as DIY, dog walking and driving. His relationship with his partner had returned to normal, having worsened at the time of the accident due to stress, and she had continued to provide help with driving and household tasks.

**Behavioural consequences**

Since the accident, Case 10 reported decreases in sleeping, and the ability to make decisions and to remember things. Increases were reported in eating, use of non-prescription medication, losing his temper, impatience and a desire to leave the house.

Other behavioural changes were reported at the follow-up interview and included a decrease in alcohol consumption, increases in avoidance of certain situations, increased use of all types of medication and a continued increase in losing his temper and impatience.

**Psychological consequences**

Feelings of frustration with his physical condition and feeling down were both reported at the time of the home interview, and Case 10 had discussed the emotional impact of the accident with his GP (no treatment was prescribed).

At the follow-up interview, feelings of frustration with his employer were an ongoing issue.
6.3.11 Case No: 11 - male construction worker

The home interview was carried out 5 months after the event.

Incident and injuries

Case 11 was crushed by falling stones as he was rebuilding a gate. This resulted in a fractured tibia and severe crush injuries to his inner thigh. In turn, the injuries led to a serious leg infection which threatened the leg and could have resulted in amputation. At the time of the home interview Case 11 was still limping, experiencing restricted mobility and had permanent scarring; he had also been told that there was a likelihood of arthritis developing in the affected leg.

Vocational consequences

At the time of the home interview, Case 11 had been off work for twenty weeks and expected to be off work for a further eight. He is self-employed and was considering whether to look for work with a different employer when he recovered. Case felt that both he and his manager were responsible for the accident. He had received no support from his employers, trade union or colleagues.

Financial consequences

Case 11 is self-employed and has therefore received no financial support from the company he was contracted to at the time of the accident. Since the accident he has been reliant on state benefits of £54 per week, though it had taken approximately six weeks to get any money through. He had received little help or support in claiming benefits and found the experience of difficult, overly time-consuming and complex for the sum involved. Money had been the main problem since the accident.

He has incurred additional costs obtaining certificates and other medical forms from his doctor (estimated at £27) and in travel costs getting to and from hospital (estimated at £25).

Case 11 is seeking compensation from the firm he was contracted to at the time of the accident. He is currently in the early stages of this and in discussions with solicitors. He has found the experience very negative as the company is trying to assign complete responsibility for the accident to him, which he finds difficult to deal with - he felt some of the responsibility for the accident lies with the person who was managing the work.

No one else has lost time off from work as a result of the accident.

Social consequences

Most normal daily activities were affected by the accident as a result of restricted mobility and the fact that he was on crutches for three months. These included personal care activities such as bathing and dressing and household activities such as cooking, shopping, house keeping and maintenance. Driving, using public transport and visiting family and friends and other forms of
socialising were also restricted, the latter because of both mobility problems and lack of money. At the time of the home interview, Case 11 was still experiencing problems with walking and still needing crutches for longer distances. He was still restricted socially and unable to pursue his normal leisure activities of fishing and golf. He feels that his ability to play golf is unlikely to return to normal.

Although living alone, Case 11 has relied on a strong network of support since his accident. His mother and father have both provided practical support and help with mobility problems and looking after the house. His brothers (three) and sister (one) have all given him financial help and friends have helped both with his restricted mobility and in filling forms etc. He has also received good medical support.

Since the accident he is aware of improved relationships with his brothers and sister and also with close friends who have been supportive.

**Behavioural consequences**

Since the accident Case 11 feels he has been eating and sleeping more. He also reported that some of his cognitive functions such as his ability to take decisions and remember things have improved, and he also feels that he is more patient. He is conscious of generally being more careful and avoiding certain situations. Lack of mobility and money has led to an increase in his desire to leave the house and socialise, but in practice this is still restricted and, as a consequence, his alcohol consumption has decreased. He is also aware of the fact that he has become better at handling money because of living on a limited budget.

**Psychological consequences**

At the time of the home interview Case 11 did not feel he was still affected emotionally by the accident. He had not discussed the emotional impact of the accident with his GP.
6.3.12 Case No: 12 - male construction worker

The home interview was carried out 3 months after the event.

Incident and injuries

Case 12 fell 1.6m backwards into a trench on a building site, a heavy fitting falling on top of him at the same time. He sustained cartilage damage to his knee, requiring surgery, as well as damaging his shoulder and head.

Vocational consequences

Case 12 had been unable to work for a period of 12 weeks at the time of the home interview. He expected to return to the same job in the next few days, however, and hoped that the injury would have no permanent effect on his ability to work. At the time of the interview, for example, he was unable to lift heavier objects or move around quickly.

Case 12 has reported a worsening of his relationships with both his employer and his colleagues since the injury. As well as describing a lack of trust on both sides of the relationship, Case 12 reports that no support or care has been received from his employers, supervisors or co-workers. He will be leaving this employer within a short time and beginning work for a different company.

Case 12 felt that the main contractor was responsible for his accident.

Financial consequences

Case 12 received full pay from his employer for the initial 3 weeks of absence, and Statutory Sick Pay thereafter, resulting in direct losses of over £2000 to that point. His usual monthly salary was £1000-£1500. Minor losses of approximately £100 have been incurred in paying for exercise needed and sports training lost. Case 12 is engaged in seeking compensation with the aid of a solicitor.

Case 12's father had also lost 2 days from work, and at the time of the interview Case 12 expected his girlfriend to take one week away from her studies. Additionally, Case 12 has been unable to contribute to the family’s household budget for 2 months.

Social consequences

Case 12 has experienced impairment in daily activities such as bathing and dressing, shopping and household tasks, but has now largely recovered. Sports activities, including football and swimming, were still restricted, however. Family activities had returned to normal by the time of the interview, though the Case 12 had missed a family holiday while injured.

Support had been provided by Case 12's girlfriend and by his parents, with some days lost by each in caring and transporting to and from hospital. He reported a worsening of his
relationship with his girlfriend during the time of the injury, with a higher frequency of disagreements and arguments.

**Behavioural consequences**

Since the accident, Case 12 has reported a decrease in sleeping, eating and cognitive functions, together with an increase in aggression, impatience, alcohol consumption and the use of prescription and non-prescription drugs.

**Psychological consequences**

Case 12 did not report any lasting emotional effects from the injury, except for a continuing frustration with his inability to play sports. He had not discussed the emotional impact of the accident with his GP.
6.3.13 Case No: 13 - male construction worker

The home interview was carried out just over 2 months after the event.

Incident and injuries

Case 13 slipped on the interior of a company van, falling out of the van and suffering multiple fractures to his right arm. At the time of the home interview he was still unable to use his right arm fully and unable to do any lifting.

Vocational consequences

At the time of the home interview Case 13 had been off work for five weeks and expected to return to work approximately one week later. He anticipated returning to his old job, but to be put on light duties as a result of his physical restrictions.

Case 13 had not received any direct support from his employers or colleagues since the accident.

Financial consequences

During his time off work Case 13 had received approximately 25% of his regular salary of £2000 - £2500 per month. He had not received any other financial support. He anticipated being on a lower salary on returning to work as a result of being on light duties.

Case 13 incurred additional costs obtaining relevant medical forms for insurance (estimated at £104), extra public transport costs (estimated at £40) and additional domestic help (estimated at £150).

His partner lost one week off work as a result of the accident, providing care and transport (estimated cost of £140).

Case 13 is seeking financial compensation as a result of the accident; on the whole he felt that this has been a positive experience because it has resulted in him feeling more in control.

Social consequences

The injuries received in the accident affected most aspects of his normal life; activities of personal care such as bathing and dressing were affected but are now back to normal. However, most household activities such as shopping, housekeeping, maintenance and gardening etc. were still restricted at the time of the home interview. Driving and social activities had also been restricted but had now returned to normal. Socialising with his partner had returned to normal after a period of restriction, but sport and recreational activities were still restricted.

Case 13 has had a network of support since his accident; his partner provided all aspects of support to begin with and, at the time of the home interview, was still providing general care.
His mother provided domestic help, his brother provided transport to hospital and his father visited.

**Behavioural consequences**

Since the accident Case 13 reported an increase in sleeping and also an increase in loss of temper. A loss of mobility also resulted in an increased desire to leave the house and to socialise.

Case 13 reported that, although his partner had been eating less since the accident, there had been an improvement in their relationship. No changes were reported in any of the other relationships.

**Psychological consequences**

Although Case 13 expressed frustration at the time of the telephone interview, he did not feel he was still suffering emotionally from the accident at the time of the home interview. He had not discussed the emotional impact of the accident with his GP.
6.3.14 Case No: 14 - male construction worker

The home interview was carried out 4 months after the accident and the follow-up interview after a further 5 months.

Incident and injuries

Case 14 was trapped against a wall by a roller on a building site. Injuries incurred were multiple fractures to the left leg and crushing to both legs that resulted in an operation to remove leg muscles. At the time of the home interview anti-depressants had been described as a result of the accident and as a consequence of the injuries sustained.

Vocational consequences

Case 14 had been off work for four and a half months at the time of the home interview and expected to be off for a further 6 months. His manager had been very supportive and had called every week to monitor his progress. Managers and colleagues had also been in touch since the accident. He rated all aspects of his employer as very good.

Case 14 believes that a co-worker on the site was responsible for his accident.

At the time of the follow-up interview, Case 14 had been back at work for 7 weeks and had been off work for a total of 28 weeks. He felt that it was frustrating to be carrying out light duties as he couldn’t supervise people or carry out the work he was trained to do. Far less support had been forthcoming from his employer since the period of the home interview. Relationships with work colleagues were no longer as strong as they were before the accident.

Financial consequences

A collection had been made at the worksite following the accident and he had received full pay when the home interview was carried out. Additional costs at that stage included £100 for medical supplies and almost £2000 in transport costs relating to his family visiting him during his hospitalisation and medical and physiotherapy appointments. Average monthly salary was £2500-£3000.

No-one else had lost time as a result of the accident.

He was considering claiming compensation for the accident.

At the follow-up interview, Case 14 reported that immediately after the home interview his pay had been stopped until his return to work. As a result he began to claim SSP, which he continued to claim until his return. Further additional costs related to hospital appointments but had been minimal compared to costs incurred at the time of the home interview.

Since the home interview Case 14 had entered the compensation process and was satisfied with the service provided by his solicitor. At the stage of the follow-up interview he was awaiting further medical reports requested by his solicitor and was hoping to receive an interim payment from his employer within a year.
**Social consequences**

Activities of daily living had been seriously impaired when the home interview was carried out and many were reported as still being restricted, including personal care and household care. His main leisure activities - walking with his family and meeting friends for a drink - were also still restricted due to problems with mobility. All family activities were also still restricted.

The accident had resulted in practical help with daily life from his partner, though he felt that he argued with her more as a result of being in the house all the time. He felt closer to his extended family as a result of their regular calls to check on his progress.

*Personal care and household care were still restricted at the time of the follow-up interview and he felt that activities requiring full mobility such as walking, golf and cricket would never be possible to the extent they had been in the past. Family leisure activities and holidays were still restricted.*

**Behavioural consequences**

Decreases in sleeping, eating, alcohol consumption and the desire to socialise were reported at the home interview. Increases were reported in avoidance of certain situations, and use of prescription medication.

He reported decreases in sleeping for his partner, increases in a desire to socialise and increased ill-temper and impatience. He reported increases in disruptive behaviour at school and at home from his daughter.

*At the time of the follow-up interview increases in sleeping, alcohol consumption and losing his patience were reported by Case 14. He reported the same behavioural changes in his partner as he had made in the home interview.*

**Psychological consequences**

Case 14 has discussed feelings of depression and sleeping troubles with his GP who prescribed anti-depressants.

*Case 14 continued to report anxiety at the time of the follow-up interview.*
6.3.15 Case No: 15 – male construction worker

The home interview was carried out 13 months after the event.

**Incident and injuries**

Case 15 lifted a heavy item onto a vehicle and tore his shoulder muscle. After examination by a specialist, this damage was confirmed. It was also confirmed that no treatment for the condition was possible. Case 15 also suffers from white finger and some depression.

**Vocational consequences**

Case 15’s injury caused him to lose 2 weeks from work, and in the longer term has prevented him from any lifting whatsoever. He was able to drive, however, and continued to work for the same employer in that capacity until his retirement. Case 15 received support from his managers in rearranging the work tasks around his impairment and very helpful support from his trade union in claiming compensation.

No-one else lost time from work as a result of the injury.

Case 15 felt that his employer and supervisor were responsible for the accident.

**Financial consequences**

Case 15 received full pay from his employer (in the range of £1000 - £1500) during his 2 weeks absence. He incurred additional costs of £1000 for prescriptions, approximately £10 for transport and £70 for new power tools for DIY.

**Social consequences**

Many aspects of Case 15’s daily life had been affected by his accident, though it should be pointed out that in addition to his injury, he also has white finger from vibration tool usage and some carpal tunnel syndrome. The accident, however, had left him with irreparable damage to his shoulder, and any lifting is now impossible. This has affected bathing and washing, where he finds it difficult to lift himself in and out of the bath, cooking due to the weight of pans, as well as gardening, housekeeping and DIY. His leisure activities had been curtailed, and because driving was very hard, this has also affected his family activities, where picking up grandchildren is now difficult. Case 15 sees these changes as irreversible. Case 15 has received support from his partner, both practical and emotional, from his union, and from the medical profession. He reported no changes in relationships.
**Behavioural consequences**

Case 15 had experienced decreases in sleeping, cognitive functions and alcohol consumption as a result of the injury, accompanied by increases in medication usage, ill-temper and impatience, the desire to leave the house and the desire to socialise.

He reports that his partner has become more bad-tempered and impatient, but has noticed an increase in her ability to remember things, concentrate and take decisions.

**Psychological consequences**

At the time of the interview, Case 15 was still experiencing adverse emotional effects in terms of frustration and anger at his lack of ability to carry out activities as before. He had discussed the emotional impact of the accident with his GP, but did not feel that he received a sympathetic hearing. Though he was prescribed anti-depressants, he had ceased to use them after some months as they seemed ineffective and had unwelcome side-effects.
6.3.16 Case No: 16 - male construction worker

The home interview was carried out 9 months after the event and the follow-up interview after a further 3 months.

*Incident and injuries*

Case 16 was using a circular saw when it became stuck in a piece of wood and his fingers were dragged into the path of the saw. This resulted in ripped tendons in 2 fingers and amputations of parts the fingers. Another finger can no longer be bent. Reflex Sympathetic Dystrophy is now present in the right hand.

*Vocational consequences*

Case 16 had been off work for 40 weeks at the time of the home interview as a result of the accident and expected to return to work in 8 weeks to undertake light duties. His employer had kept in touch during his absence. His manager and colleagues had visited him while in hospital and his friends from work had visited him at home. He feels the accident was “just one of those things”.

Case 16’s partner lost five weeks from work in order to care for him.

*He was off work for a total of 48 weeks and at the time of the follow-up interview was back at work and carrying out light duties in the yard of his work site. He also noted there had been less support from his employer since the home interview.*

*Financial consequences*

Since the accident, Case 16 had received state benefits for the 3 months prior to the home interview. His normal earnings would be in the range £1000 - £1500. He estimated that he had lost £1000 per month as a result of loss of earnings and was finding it hard to find the money to pay bills.

Additional costs centre on transport costs although a special discount card from the bus office had allowed cheaper bus travel.

He was claiming compensation for the accident and hoped to receive a payment from his employer within 6 months of the home interview. The claim was being made through his insurance company who are awaiting a decision on liability from his employer’s insurers.

*Little progress had been made with the compensation claim at the time of the follow-up interview. No decision had been made as to whether any payment would be made. Since returning to work full pay had resumed.*
Social consequences

Manual household tasks and leisure activities deemed unlikely to return fully in the future. Personal care activities, mobility and social interaction had been restricted in the past but had returned to normal by the time the home interview was carried out. All family activities had also returned to normal, after temporary restriction. His partner cared for him during the 10 months he had been off work and his adult daughter, who lives in the area, had helped with transport. Treatment received at the local hospital was judged to have been excellent. Information about benefits from social services, however, was very poor and case 16 blamed an inefficient system that had passed him round 4 or 5 offices, and the complexities of the forms that Case 16 had been required to complete.

Renewed difficulties with washing, cooking, gardening and DIY were reported at the time of the follow-up interview. All other activities of daily living had either returned to normal or had not been affected by the accident.

Behavioural consequences

An increase in sleeping and use of prescription medication had been noted at the time of the home interview. There were no other changes in behaviour reported for his own behaviour or that of his partner.

Though sleeping had increased after the accident, at the time of the follow-up interview it had decreased as had sleeping, eating, and avoidance of certain situations. No changes were reported in his partner.

Psychological consequences

At the time of the home interview he reported feeling better than he had done at the time of the accident, although he still suffered from nightmares and shouting out during his sleep. He did not discuss the emotional impact of the accident with his GP.

No continuation of these effects was reported at the follow-up interview.
6.3.17 Case No: 17 – male construction worker

The home interview was carried out 2.5 months after the event.

**Incident and injuries**

Case 17 fell and was impaled by a scaffold pole and crushed between scaffolding and a skip lorry. He suffered severe cuts to both sides of his body and a crushed pelvis.

**Vocational consequences**

At the time of the accident Case 17 was working as a skilled labourer for a building firm, through an agency. He was unemployed at the time of the home interview, having not worked for ten weeks and was unable to make an assessment of how long it might be before he was able to work again. He reported that he felt too upset by the accident to return to the same kind of work.

Case 17 felt that a co-worker was responsible for the accident.

**Financial consequences**

Since the accident Case 17 has received no money from his employer and has been reliant on state benefits. His carer is providing free accommodation and meeting all domestic bills. Case 17’s normal earnings had been in the range £1000 - £1500 per month.

At the time of the home interview Case 17 had incurred additional transport costs for parking and travel to hospital (estimated at £80) and additional utility costs from being at home (estimated at £40).

Case 17 is currently seeking compensation from the building company. He has found this a positive experience, since he now realises that responsibility for the accident does not lie with him and can appreciate what happened in a wider context.

His main carer has also lost one week off work as a result of the accident and anticipates losing a further week from work as part of his continuing care role.

**Social consequences**

The injuries received in the accident have affected every part of his life; all aspects of personal care, household care and his main recreational and leisure activities have been affected and were still restricted at the time of the home interview.

He considered himself to be completely dependent on the care of others for help with everything.
Since the accident he has been living with a friend who has acted as his main carer and provided the main source of help and support. Although his sister has not provided direct support, Case 17 considered that his relationship with his sister has improved since the accident.

**Behavioural consequences**

Since the accident Case 17 has found that he has been eating and sleeping less well, he also felt that he has been losing his patience more and avoiding certain situations. His cognitive functions have also been adversely affected, with a noticeable decrease in his ability to concentrate, take decisions and remember things. He was aware of an increased desire to leave the house (as a result of restricted mobility) but also a reduction in his desire to socialise; his alcohol consumption has also decreased.

Case 17 had not noticed any changes in the behaviour of his carer.

**Psychological consequences**

At the time of the home interview Case 17 felt he was still suffering symptoms of depression and severe stress as a result of the accident, including panic attacks. He felt that the emotional impact of the accident had been ‘huge’, but did not discuss this with his GP. He still felt traumatised and too scared to return to the same work.
6.3.18 Case No: 18 - male construction worker

The home interview was carried out 3 months after the event and the follow-up interview after a further 5 months.

Incident and injuries

Case 18 fell onsite and fractured his back. Additional symptoms include flashbacks of the accident.

Vocational consequences

Case 18 had been off work for 13 weeks at the time of the home interview and expected to be off for a further eight weeks. During his time off work he was visited at home by his supervisor. He felt the accident was “just one of those things”.

At the time of the follow-up interview he had returned to work after having been off for 24 weeks in total. He had started working for a different company, in the same type of work, carrying out light duties since he was unable to lift heavy objects as a result of the accident. He was satisfied with his new employers who were happy to let him call upon colleagues to help with heavy work. His colleagues were always willing to help him when required.

Financial consequences

He had received two weeks full pay (in the range £1000 - £1500 per month) after the accident before going on to claim SSP. Additional costs included approximately £70 on prescription charges, £50 on transport costs and £20 on increased utility bills as a result of spending more time in the house.

He was not intending to claim any compensation as a result of the accident at the time of the home interview, and no-one else had lost time as a result of the accident.

For the remainder of the time Case 18 was off work, following his home interview, he received statutory sick pay. He had also received £150 per month in industrial injuries benefit, starting the month before the follow-up interview. He had paid a further £50 in prescription charges.

At the time of the follow-up interview, case 18 had decided to make a claim for compensation, and had started the process by contacting a solicitor who had advised him that his case had a good chance of success.

Social consequences

Personal care activities had returned to normal at the time of the home interview but most household activities, mobility and social interaction were still adversely affected. Family activities had not changed.
Practical support was provided by his partner, daughter and friend and included helping with shopping, transport to appointments and gardening, though his relationships with his partner and daughter were strained at the time of the home interview. Social services were unhelpful when advice was requested with regard to claiming benefits.

*Personal care activities (which had become more difficult since the home interview), socialising with friends and mobility activities were reported as being unlikely to return to normal at the time of the follow-up interview. Heavy household tasks were still restricted. Family activities had all returned to normal. His relationship with his partner was reported as normal although they had experienced some disagreements as a result of the accident.*

**Behavioural consequences**

Eating, use of prescription medication, losing his temper and a desire to leave the house were all reported to have increased by Case 18 at the time of his home interview. His ability to remember things had decreased.

An increase in anxiety was reported for his partner along with a decrease in a desire to leave the house.

*At the follow-up interview Case 18 reported increases in sleeping, avoiding situations, use of all medication and losing his temper and patience, since the home interview. He was eating and drinking less alcohol in an effort to lose the weight he had put on since the accident. A further decrease in his desire to leave the house was also reported.*

**Psychological consequences**

At the time of the interview, Case 18 was still experiencing flashbacks of the accident, and he felt that he was scared of certain situations at work and had lost self-confidence. He did not discuss the emotional impact of the accident with his GP.

*By the time of the follow-up, there had been no improvement reported in his emotional state.*
6.3.19 Case No: 19 - male construction worker

Case 19 was interviewed 4.5 months after the event.

**Incident and injuries**

Case 19 slipped on unsecured scaffolding on a building site, falling and breaking his leg in two places, requiring surgery. Other symptoms at the time of the interview were anxiety and depression.

**Vocational consequences**

Case 19 was absent from work for 16 weeks before returning to light duties with the same employer. He received helpful support from colleagues who visited several times during his absence, but felt that his employing organisation and immediate supervisor were not helpful and gave no support.

Case 19 is engaged in claiming compensation from his employer, whom he feels was responsible for the accident, and has received some help in this from his trade union. No-one else lost time as a result of the accident.

**Financial consequences**

During the first three months of his four-month absence, Case 19 received 25% of his full salary of £1000 - £1500 per month, and none during the final month, when he subsisted on statutory sick pay only. The direct loss of earnings due to the accident amounts to approximately £4000.

Apart from SSP, Case 19 has received no other financial support during this period. In addition, Case 19 has incurred prescription costs of £20, transport costs of £30, alteration costs of £30 as he moved his bedroom to the ground floor of his house, and £10 for equipment. Total additional costs were therefore £90 at the time of the interview.

Case 19 is engaged in claiming compensation.

**Social consequences**

Several daily activities were still affected at the time of the interview: Dressing, was still difficult, gardening and DIY were affected, as well as driving, walking and using public transport. Case 19 had experienced problems with bathing and washing and also restrictions on his social life, but these had returned to normal at the time of the interview.

Family leisure, sport and days out were still restricted and the accident had also impacted upon child care activity, with Case 19 still experiencing difficulties with playing with his children, picking them up from school and taking them to and from other activities. Case 19 had been supported emotionally and practically by his partner and by his brother. Work colleagues had held a collection for him, which helped financially, and support from the trade union had helped him with claiming compensation.
Case 19 reported a worsening of his relationship with his partner, with increased disagreements over debts and spending. He also felt that his young children, aged 5 and 7, had been adversely affected by the financial pressure, and had behaved worse than normal as a result.

**Behavioural consequences**

Case 19 was sleeping less at the time of the interview, and reported a decrease in cognitive abilities including concentration, memory and decision-making. Impatience and aggression had increased, as had eating and alcohol consumption, and the desire to leave the house. Case 19 also reported that his partner was sleeping less, drinking more and was also more aggressive and impatient since the accident.

He had also noticed behavioural changes in both children. Case 19’s son and daughter had become more ill-tempered and impatient, and were more disruptive in the home.

**Psychological consequences**

Case 19 was still experiencing emotional problems at the time of the interview, but did not discuss these with his GP. He was very worried about the financial problems of the family and suffering problems with sleeping as a result. He also expressed anxiety about the worsening family situation and felt this to be a source of stress.
6.3.20 Case No: 20 - male construction worker

Case 20 was interviewed 2 months after the event.

Incident and injuries

Case 20 slipped from the back of a van whilst loading materials on site and suffered 3 broken ribs. At the time of the home interview Case 20 was still experiencing pain and lack of mobility; any physical exercise or exertion was still causing pain.

Vocational consequences

Case 20 had had two weeks off from work and then returned to the same job. The job has now been redesigned and a new system of work introduced to reduce risk, though Case 20 commented that, although they were supposed to use new system of work, it didn’t always happen in reality.

Case 20 felt his employer was responsible for the accident, as there were insufficient staff to cope with the demands of the work at that time. Case 20 felt that his employer had given him no support, and felt particularly aggrieved because of the loss of pay. He also felt he had received no support from his trade union. His sole support from work had been his immediate manager, who had taken him to hospital and called after the accident.

Financial consequences

During the period of time off work Case 20 received £50 per week from his employer. There was no additional income from any source. His normal monthly income would be £500 - £1000.

The only additional cost incurred as a result of the accident was cost of travelling on public transport as a result of not being able to drive himself or his family (estimated as £30 - £50).

No one else has lost time off from work as a result of the accident.

Case 20 is not seeking compensation as a result of the accident. He did not consider his injuries were serious enough to warrant a claim against his employer.

Social consequences

Most normal daily activities had been temporarily affected by the accident. These included personal care activities such as bathing and dressing and household activities such as cooking, shopping, house maintenance and gardening. Visiting family and friends and other forms of socialising were also restricted. At the time of the home interview, Case 20 was still experiencing problems with walking and driving and was not able to pursue his normal leisure activity of bodybuilding. He was feeling particularly frustrated about the latter.
He also considered that most activities that involved doing things with the family had been affected, including playing with the children and taking children to and from various activities.

Case 20 received considerable support from his partner whilst off work but recognised that they had argued a lot more because ‘they were stuck together all the time’. His daughters helped cheer him up, as did friends when they visited. Although his relationship with his daughters had remained good, he was also aware that he became annoyed with them at times when they were badly behaved even though they knew he was ill. His doctor also provided good advice on how to cope with restricted mobility.

**Behavioural consequences**

During the period following the accident Case 20 considered he slept less (because of discomfort), ate more and drank more alcohol; he was also aware of losing his patience and temper more than usual. He experienced an increased desire to socialise and leave the house as a result of enforced immobility.

Case 20 also noticed a similar pattern of behavioural change in his partner. She also found difficulty in sleeping and seemed to lose her patience and temper more than usual. All three daughters had also become more disruptive in their behaviour at home.

**Psychological consequences**

At the time of the home interview Case 20 expressed some anger at himself and at his employer for what he felt was pressure to get the job done and to return to work early. However, he did not feel he was still affected emotionally by the accident. He had not discussed the emotional impact of the accident with his GP.
6.4 CONSTRUCTION ILLNESS GROUP - OVERVIEW
### 6.4.1 Construction illnesses group - summary table

#### Table 6.9  Construction illnesses – summary table
(residual effects present at the time of the home interview)

<table>
<thead>
<tr>
<th>Case number</th>
<th>Gender</th>
<th>Nature of illness or accident</th>
<th>Family member</th>
<th>Follow-up Interview</th>
<th>Residual Physical effects</th>
<th>Residual emotional effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>m</td>
<td>Vibration white finger</td>
<td>Partner</td>
<td>No</td>
<td>Numbness in hands and upper limbs.</td>
<td>Unhappy about restrictions on activities.</td>
</tr>
<tr>
<td>22</td>
<td>m</td>
<td>Mesothelioma; asbestos-related</td>
<td>Partner</td>
<td>No</td>
<td>Increasing tiredness and pain.</td>
<td>Severe anxiety about the future and onset of further symptoms.</td>
</tr>
<tr>
<td>23</td>
<td>m</td>
<td>Vibration white finger; both hands affected</td>
<td>Partner</td>
<td>Yes</td>
<td>Worsening coldness and numbness.</td>
<td>Frustration and anxiety. Worried about becoming disabled.</td>
</tr>
<tr>
<td>24</td>
<td>m</td>
<td>HAVS stage 2; carpal tunnel syndrome in both wrists</td>
<td>Yes</td>
<td>Pain in arms, wrists and neck.</td>
<td>Frustration and depression; insomnia.</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>m</td>
<td>HAVS stage 2</td>
<td>Partner</td>
<td>Yes</td>
<td>Tingling, loss of sense in hands.</td>
<td>Anxiety; fear of the condition worsening.</td>
</tr>
<tr>
<td>26</td>
<td>m</td>
<td>HAVS stages 1 and 2; both hands affected</td>
<td>Partner</td>
<td>Yes</td>
<td>Pain and numbness in hands.</td>
<td>Anxiety, depression, insomnia and increased use of alcohol.</td>
</tr>
<tr>
<td>27</td>
<td>m</td>
<td>Paint led to burns to eyes, forehead, neck and wrists.</td>
<td>No</td>
<td>None.</td>
<td>Anxiety; depression and frustration with physical problems.</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>m</td>
<td>Vibration white finger; both hands affected, also neck and shoulder.</td>
<td>No</td>
<td>Pain, cold and numbness in hands.</td>
<td>Severe anxiety and depression.</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>m</td>
<td>Stonemason; chronic silicosis.</td>
<td>Partner</td>
<td>No</td>
<td>Breathing difficulties and tiredness.</td>
<td>Depression, anxiety, panic attacks; attempted suicide.</td>
</tr>
<tr>
<td>30</td>
<td>f</td>
<td>RSI in wrists, elbows and shoulders; both hands affected.</td>
<td>No</td>
<td>Severe pain in hands, arms and neck.</td>
<td>None.</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>m</td>
<td>HAVS in hands and shoulders.</td>
<td>Partner</td>
<td>No</td>
<td>Numbness and locking of fingers.</td>
<td>None.</td>
</tr>
<tr>
<td>32</td>
<td>m</td>
<td>Mesothelioma, asbestos-</td>
<td>Partner,</td>
<td>No</td>
<td>Pain and tiredness.</td>
<td>Severe depression and anxiety.</td>
</tr>
<tr>
<td>Case number</td>
<td>Gender</td>
<td>Nature of illness or accident</td>
<td>Family member interview</td>
<td>Follow-up Interview</td>
<td>Residual Physical effects</td>
<td>Residual emotional effects</td>
</tr>
<tr>
<td>-------------</td>
<td>--------</td>
<td>-----------------------------------------------</td>
<td>-------------------------</td>
<td>---------------------</td>
<td>---------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>33</td>
<td>m</td>
<td>Lead poisoning, severe tiredness and lethargy.</td>
<td>Partner</td>
<td>No</td>
<td>Lethargy and tiredness.</td>
<td>Severe depression and anxiety; angry with employers and co-workers.</td>
</tr>
<tr>
<td>34</td>
<td>m</td>
<td>White finger, stage 2; cramps, locking.</td>
<td>No</td>
<td>Tingling, cramps and coldness.</td>
<td>Anxiety, depression and frustration with restrictions on work and earning ability.</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>m</td>
<td>HAVS in hands and arms.</td>
<td>Partner</td>
<td>Yes</td>
<td>Pain and numbness; disturbed sleep.</td>
<td>Anxiety, anger and frustration.</td>
</tr>
<tr>
<td>36</td>
<td>f</td>
<td>Tinosynovitus, pain in arm</td>
<td>Yes</td>
<td>Pain and restricted mobility.</td>
<td>Anxiety, depression and frustration; feelings of loneliness.</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>m</td>
<td>Contact dermatitis on hands and arms</td>
<td>No</td>
<td>Sore and itchy skin.</td>
<td>Anxious and self-conscious.</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>m</td>
<td>Scabies, flea infestation</td>
<td>Partner</td>
<td>Yes</td>
<td>Itching and soreness.</td>
<td>None.</td>
</tr>
<tr>
<td>39</td>
<td>f</td>
<td>RSI in hands, arms, neck.</td>
<td>No</td>
<td>Minor pain in neck and hands.</td>
<td>Some anxiety and frustration.</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>m</td>
<td>Glutaraldehyde industrial asthma.</td>
<td>Partner</td>
<td>Yes</td>
<td>Some dermatitis and asthma.</td>
<td>Anxiety and insomnia.</td>
</tr>
</tbody>
</table>
6.4.2 Construction illness group– an overview of the cases

A total of 20 individuals suffering from serious reportable illnesses who work in the construction sector were interviewed at home; a further 12 family members (associated with 11 cases) were also interviewed at this time or shortly after this interview. The mean time of these interviews after the illness report date was 13 months. A follow-up interview (either a telephone interview or home interview) with the affected person was carried out in a subset of 8 cases. The mean time of the follow-up interview after the home interview was 5 months.

The distribution of the 20 cases by the nature of the illness is shown in Table 6.10

<table>
<thead>
<tr>
<th>Nature of illness</th>
<th>Number of APs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand &amp; Arm Vibration Syndrome (HAVS)*</td>
<td>9</td>
</tr>
<tr>
<td>Repetitive Strain Injury (RSI)</td>
<td>3</td>
</tr>
<tr>
<td>Paint allergy/Contact dermatitis/Industrial Asthma</td>
<td>3</td>
</tr>
<tr>
<td>Lead poisoning</td>
<td>1</td>
</tr>
<tr>
<td>Flea infestation &amp; scabies</td>
<td>1</td>
</tr>
<tr>
<td>Chronic illness (mesothelioma (2) &amp; silicosis (1))</td>
<td>3</td>
</tr>
</tbody>
</table>

* Includes all cases of Vibration White Finger (VWF)

In a number of these cases the affected person had been exhibiting symptoms of the illness for a long period of time prior to it’s formal diagnosis and report to HSE. Where available, the case summaries indicate the length of time over which symptoms have been developing.

Demographics

The age and sex distribution of the 20 cases are shown in Table 6.11 and the distribution by residential status in Table 6.12.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-34</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>35-49</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>50-64</td>
<td>8</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residential status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lives alone</td>
<td>4</td>
</tr>
<tr>
<td>Lives with partner</td>
<td>5</td>
</tr>
<tr>
<td>Lives with partner and children</td>
<td>9</td>
</tr>
<tr>
<td>Lives with parents</td>
<td>2</td>
</tr>
</tbody>
</table>

Of the 20 cases of reported illnesses in the construction sector; 17 were male and 3 female; all three females were office-based and were suffering from Repetitive Strain Injury. Most APs were in the older age groups with 17 (85%) over 35. The majority of APs lived with someone else, typically either their partner or their partner and children. There were a number of cases where APs lived on their own.
6.4.2.1 Vocational consequences

Work outcome

The pattern of return to work and resettlement at the time of the home interview (and the follow-up interview where available) is summarised in Table 6.13.

Table 6.13 Pattern of return to work and resettlement

<table>
<thead>
<tr>
<th>Work status</th>
<th>Home interview</th>
<th>No.</th>
<th>Follow-up interview</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No time lost</td>
<td>Changed employer and job</td>
<td>2</td>
<td>Still in new job</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(HAVS – to eliminate exposure)</td>
<td></td>
<td>No follow-up</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Changed role (HAVS – to reduce exposure)</td>
<td>4</td>
<td>Had been off work 5 weeks &amp; expected to be for a further 14 weeks</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No follow-up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In same job but left to manage exposure (HAVS)</td>
<td>3</td>
<td>Still in same job</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Moved onto light duties</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>In same job but left to manage exposure (silicosis)</td>
<td>1</td>
<td>No follow-up</td>
<td>1</td>
</tr>
<tr>
<td>Returned to work</td>
<td>Back to same job but way job is done has changed (RSI)</td>
<td>3</td>
<td>Still in same job</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No follow-up</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Back to same job but way job is done has changed (Scabies)</td>
<td>1</td>
<td>Still in same job</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Back to same job but way job is done has changed (Industrial asthma)</td>
<td>1</td>
<td>Still in same job</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Back to different job with same employer (Silicosis)</td>
<td>1</td>
<td>No follow-up</td>
<td>1</td>
</tr>
<tr>
<td>Still off work</td>
<td>Seasonal worker in-between jobs</td>
<td>1</td>
<td>No follow-up</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(paint allergy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Does not expect to return to work</td>
<td>1</td>
<td>No follow-up</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(mesotheloma)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No longer working</td>
<td>Taken early retirement</td>
<td>1</td>
<td>No follow-up</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Dismissed</td>
<td>1</td>
<td>No follow-up</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>20</td>
<td></td>
<td>20</td>
</tr>
</tbody>
</table>

The main patterns to emerge are as follows:

- Half of the cases in this group had not taken any time off work as a result of the illness:

- APs suffering from HAVS did not take any time off work (9 out of the 10 cases who had not lost any time off work at the time of the home interview were suffering from these conditions, the remaining case was suffering from contact dermatitis). Of the 5 cases of HAVS that were followed up, 4 had lost no further time off work but 1 AP was absent at the time of the interview and expected to be off work for approximately 19 weeks in total.

- The majority of those suffering from HAVS (6 of the 9 cases) had either changed their role at work to try and reduce or eliminate their exposure to vibrating tools or had changed both employer and role. In 3 cases APs had been left to effectively manage their own exposure in collaboration with colleagues. At the follow-up
Interview one of these cases had been moved on to light duties. It should be noted that returning to work in this group can present major problems. Where there is a restricted skill set, as in the majority of these cases, very few alternative positions are available to an affected person, and the difficulties experienced can be compounded by the structure of the industry itself, where there may be no Occupational Health department available to provide advice on working practice or additional training. In practice, many APs simply return to a damaging situation and try to continue as best they can.

• Of the six cases who had returned to work, 5 had returned to the same job but with modifications. One case had returned to a different job as a result of the illness. These 6 cases are broken down as follows:

  - The 3 APs suffering from RSI had all been away from their jobs for between 1 and 16 weeks. All had returned to work at the time of the home interview. One had returned on reduced hours but was in an acrimonious dispute with her employer. Two APs had returned to the same job but had tried to reduce the symptoms of RSI by varying their work content or changing their posture. The single RSI case that was interviewed at follow-up had not taken any further time off work.

  - Both the AP with industrial asthma and the AP with scabies had also returned to their original jobs, though both reported they were now much more cautious in the way they carried out their work. The asthma case that was interviewed at follow up had not taken any further time off work; the AP with scabies had lost a further week from work.

  - The AP with silicosis had subsequently returned to a different role (with less exposure but also less responsibility) as a direct consequence of his illness.

• Of the 2 cases that were still off work at the time of the home interview, one was a seasonal worker and was waiting for the job to resume and the other case was suffering from mesothelioma and had no expectation of being able to return to work

• Of the 2 cases no longer working, 1 AP with mesothelioma had taken early retirement on ill-health grounds and the other, who had suffered from lead poisoning, had been dismissed.

**Length of time off work**

The following table lists the actual or anticipated length of time off work for each of the 20 cases. It should be noted that a range of illnesses was captured in this sample, which is reflected in the wide variation in impacts.
Table 6.14  Construction illness – length of time off work

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Type of illness</th>
<th>Length of time off work (weeks)</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>HAVS</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>HAVS</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>HAVS</td>
<td>19</td>
<td>Suffering from mesothelioma &amp; has taken early retirement</td>
</tr>
<tr>
<td>24</td>
<td>HAVS</td>
<td>None</td>
<td>At time of home interview had not lost any time but expected to be off work for up to 19 weeks at follow-up</td>
</tr>
<tr>
<td>25</td>
<td>HAVS</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>HAVS</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Paint allergy</td>
<td>11</td>
<td>Seasonal worker with same firm – was trying to pick-up work between main jobs</td>
</tr>
<tr>
<td>28</td>
<td>HAVS</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Silicosis</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>RSI</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>HAVS</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Mesothelioma</td>
<td></td>
<td>Suffering from mesothelioma - at time of home interview had been off work for 52 weeks and did not expect to return to work</td>
</tr>
<tr>
<td>33</td>
<td>Lead poisoning</td>
<td></td>
<td>Had been dismissed &amp; was taking legal action against employer</td>
</tr>
<tr>
<td>34</td>
<td>HAVS</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>HAVS</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>RSI</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Dermatitis</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Scabies</td>
<td>2 and 1</td>
<td>At home interview had taken 2 weeks off and at time of follow-up had taken a further week off</td>
</tr>
<tr>
<td>39</td>
<td>RSI</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Industrial Asthma</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

*Established at home interview or follow-up interview

Support at work

This section summarises the support received from colleagues, trade unions, managers or employing organisations.

The main findings are:

- In more than half the cases, employers or managers were not explicitly identified as a source of support and many APs commented on the poor quality of contact and support.

- Where help was received from managers, employers or supervisors, examples included changing the work schedule to minimise use of vibrating tools and visiting the AP while absent. In a small number of cases, there were instances of paying for private medical treatment, providing transport to medical appointments and providing financial advice.
My employer and manager have been really good and sent me to see an Occupational Health expert who tested me for HAVS. Everyone has been really helpful and I now have a more office-based job so my condition shouldn’t become any worse.

*Male construction worker, HAVS*

- Colleagues provided a point of contact with work and positive support in a number of cases. However, some APs reported that they experienced a form of victimisation or negative behaviour from their colleagues on their return to work, typically associated with their taking up a new or modified role to reduce exposure to a particular situation.

My job has changed so I don’t have to use power tools anymore. I have a more managerial-type role and visit sites. Colleagues don’t think it’s fair and think I’m work-shy. I’ve had a hard time, they don’t like me going out with them anymore and sometimes I feel a bit intimidated.

*Male construction worker, HAVS*

- Formal support, in terms of contact with an Occupational Health or Human Resource department was reported in only a small number of cases

- When they were involved, trade unions typically provided advice on sick pay or when and how to apply for compensation.

- At the follow-up interview there had been very little change in the pattern of support from employers, supervisors and colleagues. Of those who noted changes in the nature and level of support at the follow-up interview, 3 APs reported positive support from their employer and manager while 2 APs reported a decline in levels of support.

*Responsibility for the illness*

APs were asked to assign responsibility for their illness with results shown below.

**Table 6.15 Perceived responsibility for illness**

<table>
<thead>
<tr>
<th>Whose responsibility?</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>No-one</td>
<td>3</td>
</tr>
<tr>
<td>Themselves</td>
<td>4</td>
</tr>
<tr>
<td>Employers</td>
<td>12</td>
</tr>
<tr>
<td>Manager/supervisor</td>
<td>1</td>
</tr>
<tr>
<td>Colleague/co-worker</td>
<td></td>
</tr>
<tr>
<td>Main contractor</td>
<td>1</td>
</tr>
<tr>
<td>Equipment manufacturer</td>
<td>1</td>
</tr>
<tr>
<td>Industry-wide problem</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>25*</td>
</tr>
</tbody>
</table>

* Numbers exceeds 20 because responsibility was sometimes assigned to more than one party - typically a combination of themselves and their employer or manager.

Some general findings from the interviews are as follows:

- Although a number of APs held themselves partly responsible for their own condition or felt no-one was to blame, the majority attributed the responsibility for their condition to someone other than themselves, most commonly their employing organisation or the general nature of the industry they worked in.
All cases of HAVS and all cases of RSI felt that their employer or the industry as a whole was responsible for their condition.

I should have complained about there not being adequate ventilation where I worked. My employer should have risk assessed where we were working and the jobs we did. If they had done this I might not be ill now.

Male construction worker

Data on compensation, covered later in this overview, show that:

- Of those attributing responsibility to their employer or to the industry in general, most were claiming compensation.

- Of the 3 APs suffering from chronic illness such as mesothelioma and silicosis, 2 held their employer responsible and 1 felt no one was to blame; all 3 were seeking compensation.

### 6.4.2.2 Economic consequences

#### Loss of pay and increased outgoings

Details of individual losses and additional outgoings are provided in the case summaries. Some general findings are shown below.

- Of the 9 cases of HAVS, none of whom had taken any time off work, 4 subsequently experienced a reduced salary from either a loss of overtime or a change of job.

I’ve lost out on about £5000 per year due to my illness. I asked my employer to be put on light duties as I work for the Roads Department. They have, but they’ve shot me in the back as they’re saying I can’t drive the gritting lorries during the winter so I’ll miss out on a lot of overtime and unsocial hours payments.

Male construction worker, HAVS

- All 3 cases of RSI had taken time off work - 2 cases were on full pay and 1 case was on reduced pay supplemented by state benefits.

- Both cases of mesothelioma were no longer working - 1 had retired on full pension and one was still receiving full salary whilst on sick leave.

- Many APs had incurred additional transport costs, typically on visits to hospital, and also additional medical costs in the form of prescription charges.

- A number of cases had incurred substantial costs in the form of private medical care or complementary medicine.

- Other people had lost time off work in only a small number of cases.

The prescriptions come to £26 a month. I’ve also tried a private physiotherapist due to the ridiculous NHS waiting list time I was given and seen a consultant neurologist and orthopaedic surgeon. I had to pay to see both of them. I was in such pain that I needed appointments quickly. I haven’t been able to leave the house at some points so I’ve had to put my home-help onto my car insurance, which has cost a bit more.
**Female administrative worker, RSI**

*Compensation and legal implications*

The number of cases seeking compensation or engaged in other legal action is shown in Table 6.16.

**Table 6.16 Number of cases taking legal action**

<table>
<thead>
<tr>
<th>Nature of illness</th>
<th>Total no. of cases</th>
<th>No. seeking compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand &amp; Arm Vibration Syndrome</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>(HAVS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repetitive Strain Injury</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Paint allergy/Contact dermatitis/Industrial Asthma</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Lead poisoning</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Flea infestation &amp; scabies</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Chronic illness (mesothelioma (2) &amp; silicosis (1))</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>20</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

- At the time of the home interview, just over half of the APs were seeking compensation for their illnesses. One was taking legal action against their employer for unfair dismissal and one was undecided as to whether to take any action. Because of the lengthy time delay between the onset of the condition and the time of the home interview, many cases had been progressing for some years. None had been settled at the time of home interview.

| My employer told me I might be paid off, then offered me another job that they knew would be unsuitable for me. I felt the personnel department were targeting me personally as none of the other people who had been diagnosed had been moved from their jobs. My lawyer says my employment tribunal case has a good chance – it was unfair and I hope that I’ll receive compensation for what has happened to me. I’m also involved in claiming compensation for my physical condition. I’ve been offered £2000 as part of a group settlement with some of the other workers, though we won’t settle for such a small amount. |

*Male construction worker, HAVS*

| My union has helped me with my claim. They sent me to a lawyer and I’ve been seen by 4 doctors for different opinions about my condition. I’ve declined an out-of-court settlement for £5000 and have been sent another court date because my last one was cancelled. I’ve not been that happy with my lawyer, I don’t feel as if he has been 100% behind my case. |

*Male construction worker, RSI*

- Where comments were made about the experience of pursuing a compensation or legal claim they were generally negative, usually because of the time involved and the complexity of the process. APs suffering from conditions such as mesothelioma expressed particular concerns about the uncertainty of the process. These individuals were particularly vulnerable and found most aspects of the experience distressing.
Skin infections from working have affected my whole family so I originally thought I would claim against my employer but they won’t admit liability. As a result the case could take five years to settle. They’ve paid for some medical treatment for me, though. Doesn’t that mean they’ve already admitted liability? I can’t cope with more stress so have decided not to claim compensation.

Male construction worker

At the time of the follow-up interviews, of the 5 APs in this subset who had been seeking compensation, 4 were still pursuing their claim and 1 had been advised to settle out-of-court. One AP who had been considering seeking compensation at the time of the home interview had decided not to pursue a claim because of the complexity of her employment history.

6.4.2.3 Social consequences

Activities of daily living

The case summaries cover a range of different conditions, making it difficult to draw general conclusions about the impact they have on specific activities of daily living. However, case summaries show that overall, for many APs, their condition has had a significant impact on their daily lives. In many cases, the condition has been progressive with APs reporting that some activities remain affected many years after their initial onset and are often unlikely to return to normal. The following findings from the case summaries provide some insight into the impact these conditions can have on the quality of life:

- Both APs suffering from mesothelioma reported that the condition had dramatically affected their daily life. At the time of the interviews they were each experiencing problems with any activities that required sustained physical effort. For example, they were no longer able to help with the garden or with looking after the house, and both reported tiredness, lack of energy and problems with mobility, all of which led to further restrictions on their normal life. Both cases had experienced serious emotional problems as a result of the illness, summed up by one individual as feeling unable “to get on with life or do anything”.

- Conditions such as VWF or HAVS can have an impact on normal life far beyond that perhaps expected by those unfamiliar with these conditions. Dressing becomes difficult because of loss of sensitivity and the associated difficulty in manipulating buttons or fastenings. Normal household tasks such as cleaning and DIY become frustrating because of loss in dexterity and any sports or hobbies that rely on obtaining purchase or a good grip (such as golf or climbing) become impossible. Driving, especially driving for long periods, becomes difficult because of numbness in the fingers or hands. All of the 9 cases of HAVS reported one or more of these effects and many reported a significant impact on most aspects of their personal life. In nearly all these cases, these restrictions had led to feelings of frustration and anxiety about the future.

I don’t do cooking and avoid boiling the kettle since the white finger got worse over the last few years. It takes my fingers about ten seconds to feel the temperature of things and I could burn myself.

Male construction worker

I couldn’t do up my own shirts because I can’t do the small buttons any more. My wife has to help me get dressed. The white finger is far worse during the winter as it’s colder then.
Of the 3 cases of RSI that were interviewed, 2 APs reported a serious and continued impact on their normal activities, with personal care, household activities, leisure and social activities all adversely affected. Both of these cases also reported that the condition had led to significant emotional problems.

All of the 3 APs who had suffered from allergic reactions (paint allergy, contact dermatitis, industrial asthma with associated skin allergy) had experienced an impact on their personal and social life. In particular, both APs who had suffered from allergic skin responses had found the effect the condition had had on their personal appearance difficult to deal with, leading to feelings of discomfort and embarrassment when out in public.

I don’t go out and socialise at all any more because I get blurred vision and I don’t always know when I’m going to get it. My face is often puffy and it’s embarrassing. People don’t know it’s because I’m allergic to paint at work. I’ve been like this since the allergy started.

Considering the entire sample of 20 cases, the following points may be highlighted:

Many of the cases in this group were or had been unable to carry out their day-to-day personal activities. In some cases one or more personal care activities was still restricted at the time of the home interview or was deemed unlikely to return to normal. At the time of the follow-up interviews, some cases in this subset continued to report that personal care activities were still restricted or unlikely to return to normal.

Many individuals could no longer carry out or help with normal household tasks such as cooking, shopping and cleaning for some time after the illness. These activities were often still restricted at the time of the home interview or were felt to be unlikely to return to normal. At the time of the follow-up interviews, half the cases interviewed in the subset reported that light household activities were still restricted or unlikely to return to normal.

Heavy household tasks were particularly affected with many cases reporting restrictions on one or more of these activities. In most of these cases, at the time of the home interview these activities were still restricted or deemed unlikely to return to normal. At the time of the follow-up half of the cases in this subset reported that these activities were still restricted or unlikely to return to normal.

Many cases had had to give up their normal leisure and recreational activities, particularly when these were physically demanding. In most of these cases the restrictions were still in place at the time of the home interview or deemed unlikely to return to normal. At the time of the follow-up interviews some cases in the subset reported that these activities were still restricted or unlikely to return to normal.

Mobility was seriously affected, typically because of restrictions on driving, and was felt in some cases to be unlikely to return to normal. At the time of the follow-up interviews half of those originally reporting mobility difficulties in this subset were still affected by them.
• A relatively small number of people were reporting restrictions on their social life at the time of the home interview. At the follow-up interview a small group of cases in this subset were still experiencing difficulties, largely due to problems with driving.

Family activities

Many of the restrictions discussed above have also affected the family life of those who live with a partner and/or children, as shown below.

• The home interviews show that a range of family activities was reported as having been affected. In addition, some APs reported a more pervasive impact on the family, through, for example, excessive drinking on the part of an AP, or to the embarrassment to children caused by an unsightly skin condition.

When I was drinking to forget about losing my job and the HAVS it affected all the kids activities such as school runs and helping with homework. It must have been really tough on my daughter. I feel awful about it.
Male construction worker, HAVS

• HAVS can cause problems with driving. This can often mean that many normal family activities are disrupted. As discussed above, these conditions can also make it difficult to pursue preferred sport or leisure activities, again having an impact on shared aspects of family life. In the subset of these cases that were followed-up, driving was still reported as a major problem.

I used to drive to Blackpool on holiday but can’t drive for long periods because of the white finger. It’s much harder to get the train and I don’t want my wife to have to carry all the cases just because I can’t grip things properly.
Male construction worker

• A condition such as VWF can often affect family life in a more subtle fashion due to the difficulties experienced with fine motor skills. For example, one AP with the condition was upset that he could no longer get his baby daughter ready for bed because he was unable to deal with the fastenings on the baby clothes.

• Some APs were also frustrated that they were no longer able to help within their wider family network as they used to. This included activities such as helping parents and older family members with gardening and DIY, and helping to look after children for other family members.

• Lastly, illnesses such as mesothelioma have the capacity to affect all aspects of normal family life, as indicated in the relevant case summaries. Life becomes more and more restricted with the progression of the illness. Both APs suffering from this condition also referred to the difficulties of getting travel insurance, further undermining their ability to maintain their normal family pattern.

Provision of support and impact on relationships

As in all sample groups, APs were asked who had provided them with support and help since the illness. They were also asked if they felt any of their personal relationships had been affected by the impact of the illness. The results show that:
Those living with partners typically relied on them for both emotional and practical support. All but one of the APs in this group identified their partners as their principal source of support.

The case summaries indicate that there was a range of other family members and friends involved in supporting the AP, but to a lesser extent than was evident in the construction accident group.

Trade unions were identified as a source of support in 5 cases, but in 3 of these they were described as unhelpful.

In a small number of cases, APs explicitly mentioned the support provided by their local church.

Going to church is a very positive experience and has helped enormously with my battle with lung cancer.

Male construction worker

Nearly half the cases reported receiving positive support from the medical services, but a further quarter of the sample had been dissatisfied with the standard of the medical care.

Only 2 cases reported contact with social services and in both cases they reported that social services had been unhelpful.

Although most APs did not feel that their relationships had been affected, some changes were reported. In 3 cases, individuals had forged much closer relationships with their partners, though in others (4 cases) the enforced proximity and the changed personal dynamics had resulted in a deterioration in the relationship.

At the follow-up interviews, the general pattern of support had remained the same for those in this subset, with partners still the main source of support.

6.4.2.4 Behavioural consequences

Impact on own behaviour

APs were asked if they had noticed any changes in their own behaviour since the accident. The results from the home interview are shown in Table 6.17, overleaf. These results are presented in detail since in this area there is no equivalent data set in the telephone survey.
Table 6.17  Behavioural consequences

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>No change</th>
<th>Increase</th>
<th>Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping</td>
<td>3</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Eating</td>
<td>13</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Ability to concentrate</td>
<td>8</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Ability to take decisions</td>
<td>14</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Ability to remember things</td>
<td>14</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Avoidance of certain situations</td>
<td>6</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td>13</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Use of prescription drugs</td>
<td>10</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Use of non-prescription drugs</td>
<td>6</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Use of illegal drugs</td>
<td>19</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Losing temper/aggression</td>
<td>4</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>Desire to leave house</td>
<td>11</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Desire to socialise</td>
<td>12</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Losing patience</td>
<td>6</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Sexual activity</td>
<td>15</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

The most common patterns identified were:

- Patterns of sleeping were affected in the majority of cases. In most of these cases APs reported they were able to sleep less well. This was frequently attributed to anxiety about their health and/or their future.

- Some cases reported a change in eating behaviour or a loss of appetite:

The RSI means I can’t grip things properly. I’ve been so bad in the past that I couldn’t prepare food. I couldn’t even put things that a friend had prepared into the microwave. Holding cutlery becomes almost impossible too.

**Female administrative worker**

The treatment for the asbestosis has involved chemotherapy and radiotherapy. I don’t feel like eating anything afterwards. My appetite has definitely decreased though I’m trying to treat myself with a naturalistic approach. It’s been hard to change my diet.

**Male construction worker**

I don’t eat as much as I did before the white finger was diagnosed. I don’t feel like it as I’m stressed about not being able to stay in my job in the future.

**Male construction worker**

- A particularly noticeable finding was the relatively large number of cases reporting an increase in loss of temper and/or loss of patience.

- Cognitive functions, most notably an inability to concentrate, were often adversely affected. Often these behaviours were reported in combination with disturbed sleep.

The HAVS is always nagging at the back of your mind, both how it feels and the way it affects work when it may be getting worse. It affects the way you think and decide things.

**Male construction worker**

- More APs reported a decrease in desire to leave the house than an increase. This partly explains reported decreases in alcohol consumption; where increases in alcohol consumption were reported, however, cases often spoke of an increase in stress levels
and the difficulties experienced in coping with their illnesses and the resultant effects on quality of life.

<table>
<thead>
<tr>
<th>It’s harder to get around as driving hurts my arms and wrists so I go out less. This means I see friends less. I probably don’t drink as much on my own.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female administrative worker</td>
</tr>
</tbody>
</table>

- Most APs reported an increase in the use of non-prescription drugs and/or an increase in the use of prescription drugs. One person reported an increased use of illegal drugs.
- A pattern of reduced sexual activity was reported in some cases. APs were usually unwilling to give more information in relation to this behaviour although a small number of cases linked the decrease to illness-related anxieties.
- In many cases APs reported combinations of behavioural change that, in their totality, indicate major changes in the quality of their life.

<table>
<thead>
<tr>
<th>I stay in bed more, even though I sleep more poorly and I know that I lose my patience and temper more than before. I have little desire to leave the house. I can’t remember things as well as I used to.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male construction worker</td>
</tr>
</tbody>
</table>

- At the time of the follow-up interview, just over half of the subset had experienced further behavioural declines, including further decreases in sleep and increases in ill-temper and impatience. Some behavioural improvements were also noted in this subset: one AP had started drinking less alcohol since the home interview due to ongoing health concerns, while 3 APs reported behavioural improvements such as an increase in sleep, a return to normal eating patterns and a reduction in ill-temper and impatience.

**Impact on others behaviours**

APs were also asked if the the behaviours of others had been affected. The main findings were:

- A number of APs felt that their family members had shown an increase in loss of temper and loss of patience at the time of the home interview. Several APs linked this to their own poor temper since the onset of their illness.
- A small number of participants were aware that their partners were making more decisions than they had before the onset of the illness.

<table>
<thead>
<tr>
<th>The changes in my partner have been similar to my own: she’s been less patient and loses her temper more often. I think she makes more decisions these days, probably because I’m not as sure of things as I used to be.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male construction worker</td>
</tr>
</tbody>
</table>

- The APs who lived with children and who had noticed behavioural changes (4 out of 9 cases), thought that changes to their behaviour were negative, including attention problems at school and disturbed sleep at home.
6.4.2.5 Psychological consequences

The case summaries, together with the results of the psychological measures administered at the interviews, demonstrate the seriousness of the emotional effects in this sector. These results are summarised in Table 6.18.

**Table 6.18** Summary of results from psychological measure

<table>
<thead>
<tr>
<th>Measure</th>
<th>Scores</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Number score over threshold</td>
</tr>
<tr>
<td>Goldberg Anxiety</td>
<td>6.1</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9 cases scoring 7 or over at home interview</td>
</tr>
<tr>
<td>Goldberg Depression</td>
<td>3.8</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10 cases scoring 4 or over at home interview</td>
</tr>
</tbody>
</table>

As can be appreciated more fully from the case summaries themselves, most APs had experienced significant emotional effects as a consequence of their illnesses. Nearly all, regardless of the nature of their condition, scored above the threshold on either Goldberg’s anxiety or depression scale.

The following summarises the main points identified:

- In cases such as mesothelioma and silicosis the emotional effects were particularly severe and had led to long periods of anxiety, particularly about the future, and/or symptoms of depression. All cases had discussed these problems with their doctor.

- In cases of HAVS, all but one felt that they were still affected emotionally by the condition. These concerns were sometimes expressed as generalised feelings of anger, depression or anxiety about the future, sometimes centred on the frustration felt because of the physical impairment and restrictions imposed by their condition. Only 2 of these cases had discussed their feelings with their doctor.

  I don’t normally like talking about it – what’s the point, it won’t change anything. It doesn’t mean I’ve gone nuts, that’s not what I mean. I sometimes feel down and because of that I get annoyed with others and take it out on them. It’s normally my fiancée. I’m lucky I have her to talk to and she’s put up with a lot since the illness a few months ago. Mainly, though, when I feel down it’s because I’ve been earning so little because I’m on light duties. It’s not my fault, the illness, but I’m the one paying for it.

  *Male construction worker*

- All 3 cases of RSI reported a range of psychological symptoms including anxiety, depression, frustration and helplessness. In 2 of these cases (where the AP lived alone) these feelings were exacerbated by feelings of loneliness and social isolation. In 2 out of the 3 cases, the AP had discussed their problems with either a doctor or a psychologist.

  I’ve known my GP for years and he’s been good. I think he didn’t know that much about RSI before I got it. He’s given me a lot of practical advice and realises I’m under emotional strain. The biggest help was that I was just allowed to talk about how it made me feel. The appointments are too short though.

  *Female administrative worker, RSI*

- In cases of allergic reactions, concerns focused on anxieties and uncertainties about the future and, in particular, the extent to which they may be permanently sensitised
with consequent work and personal implications. In 2 out of the 3 cases, the AP had not discussed these problems with their doctor.

**Family impact**

Of the 20 cases discussed above, 4 APs lived alone. Of the remaining 16 cases, family members of 11 cases were also interviewed at or close to the time of the home interview. These interviews focused on those involved in the primary care and support role. In 11 cases the partner was interviewed and in one of these cases the adult daughter was also interviewed. The interviews focused on the actual and perceived impact of the illness on the carer and on their normal lifestyle.

It is difficult to generalise across all cases because of they cover a wide spectrum of conditions, but some general points may be made.

- Few family members were required to take time off work to care for or support the affected individuals. In contrast to the construction accident group, this reflects the fact that many individuals did not lose time from work. The conditions in the present group, though chronic and painful, do not require the same level of day-to-day care as those experienced in the accident group.

- The additional costs incurred by family tended to be relatively minimal.

The extra costs I’ve had are buying natural remedies for pain and insomnia to try and help [my partner]. I’ve spent more money on petrol for visiting the hospital when he’s been in having treatment.  
*Partner of male construction worker with HAVS*

- In most cases some personal and family activities had been affected by the illness or condition. Most notably, serious and long-term chronic illnesses such as mesothelioma and silicosis had had a fundamental impact on family life. One partner described how “every activity is now overshadowed by sadness.”

All of my own activities have been limited by the illness and we’re no longer able to visit friends and family or go out like we used to. He can’t manage, it’s so tiring for him. I’d really like to go on holiday, to get a break from it all.  
*Partner of male construction worker*

- Some family members felt relationships had been affected by the illness with some cases reporting stronger relationships within the family network (2 cases), though more felt that relationships had suffered as a consequence of the illness (5 cases). Some couples had recently experienced, or were still experiencing, significant problems in their relationship at the time of the interviews.

I think I’m closer to my children and partner since he’s had this illness. They seem to be more open about showing they care for me. We’ve all been involved in supporting my partner with his illness although we do argue more than we used to, because of the stress I suppose.  
*Partner of male construction worker*
I’ve had a really hard time with the change in my partner’s behaviour since this illness led to changes at his work. It’s affected me and my daughter and during the worst of it, when he was drinking, I left the house and stayed in a hotel for a couple of nights. I think our relationship is OK now that the really awful phase seems to have passed.

Partner of male construction worker

- Even when family members did not feel that their own personal life had been significantly affected, all but one of those that were interviewed felt there had been an adverse impact on their own behaviour. Problems with increased impatience, loss of sleep or poor concentration were all mentioned.

I’ve been eating more and have definitely felt more bad-tempered and impatient. I’ve been sleeping less, so I’m always tired and I know I can’t concentrate as much as normal. I’ve noticed my daughter seems nervous and worried about her dad.

Partner of male construction worker

I think both my partner and I have become more bad tempered and impatient since his illness was diagnosed. He doesn’t think he has but I notice a difference, no wonder when the illness is so serious, it’s a result of him worrying about the future all of the time.

Partner of male construction worker

- In 2 cases, partners reported that they had noticed negative behaviours in their partners where these had not been reported by the APs themselves.
- Half of the partners interviewed had been affected emotionally by the illnesses of their partners. In 3 cases out of 6, these effects had been marked.

My partner has been so frustrating recently, I know he’s not well but it’s really getting to me. It would be good to talk to someone outside our situation but getting hold of a counsellor would be too much hassle.

Partner of a male construction worker
6.5 CONSTRUCTION ILLNESS GROUP – CASE STUDIES
6.5.1 Case No: 21 - male construction worker

The personal interview was carried out 8.5 months after the report of the illness.

**Illness**

At the time of the home interview Case 21 had been suffering from vibration white finger (VWF) for approximately nine months; this was detected at a routine company medical. His fingers become numb, cold and white; there is a loss of sensation and hand function; he also experiences pain, particularly in cold weather.

**Vocational consequences**

Case 21 has not taken any time off work as a result of the illness. He is currently working as a site supervisor (as a result of injuries received in a non-related traffic accident); this job is more office based and hence he has reduced exposure to power tools. However, the VWF has also reduced his ability to carry out weekend overtime work since this also involves the use of power tools.

Case 21 did not feel that anyone had needed to provide any explicit physical or emotional support as a result of the illness and he had received no support from his employers or colleagues. The trade union had, however, provided some guidance (in the form of leaflets) that had prompted him to seek financial compensation.

Case 21 felt his employer (who provided the tools) was responsible for his condition and is seeking financial compensation.

**Financial consequences**

A change in role since the illness has resulted in a decrease in monthly net income from £2000 - £2500 to £1000 - £1500. There has also been a loss of income as a result of the VWF because of loss of overtime at weekends.

No one else has lost time off from work as a result of the illness.

Case 21 is seeking compensation for the VWF, but is currently only in the early stages of this process and unable to comment on the likely outcome.

**Social consequences**

The illness has had a significant impact on most aspects of his life. Aspects of personal care such as bathing and dressing remain difficult (for example, he burns fingers because of lack of sensitivity and finds fastening buttons difficult); all routine household activities such as cleaning, maintenance and DIY tasks have similarly become difficult because of a loss in dexterity. Favoured leisure activities such as mountain biking, golf and particularly rock climbing have become impossible because of loss of grip. Driving for long periods has also become difficult and he has to make frequent stops, increasing the time of journeys.
The VWF has also affected basic family activities such as getting the baby ready for bed, because of difficulties in dealing with fastenings on baby clothes; Case 21 also expressed regret that he would now be unable to teach his children to drive.

Case 21 had not noticed any changes in the nature of the relationships with his family as a result of the illness.

**Behavioural consequences**

Case 21 felt that he was sleeping less well since the onset of the illness and that he was aware of avoiding certain situations (where he would be exposed to power tools). He has not noticed any particular changes in the behaviour of his partner.

**Psychological consequences**

At the time of the home interview, Case 21 considered the illness was still affecting him emotionally. In particular, he was clearly unhappy about the impact the illness has had on his leisure and sporting activities and is obviously missing rock climbing with his brother and friends. He has not discussed any emotional issues with his GP.
6.5.2  Case No: 22 - male construction worker

The home interview was carried out 18 months after the onset of symptoms.

**Illness**

Case 22 is suffering from mesothelioma, asbestos related. The condition began to exhibit symptoms in November 2003 and was diagnosed some 5 months later. He gets tired easily and is experiencing pain when moving right arm.

**Vocational consequences**

Case 22 took early retirement (on grounds of ill-health) approximately two months after formal diagnosis. Case 22 felt that no particular person was responsible for the illness but views it as a reflection of the lack of knowledge at the time and is seeking compensation from his employer.

He has received strong support from work colleagues and also from his trade union.

**Financial consequences**

Case 22 had worked forty years for the same company at a final salary level of £2000 - £2500 per month, and retired on a full pension. At the time of the home interview he was also in receipt of industrial injuries benefit (£120 per month) and disability living allowance (£99 per month). He has also received payment from an insurance policy, no details of which were provided.

There have also been some direct financial losses incurred as a result of taking early retirement. He has lost the use of a company car (no estimated value), petrol allowance (estimated at £2000 per year), private health insurance (estimated at £1000 per year) and professional fees (estimated at £110 per year).

At the time of interview, additional costs had been incurred in the form of extra transport costs of £150 (travelling to hospital etc.) and in car parking at the hospital, estimated at £100.

Case 22 is seeking compensation from his employer, having been told he is not entitled to claim via the relevant government scheme. Currently in discussions with insurers, he has been told if it has to go to court it may take up to 5 years.

No one else has lost time off work as a result of the illness.

**Social consequences**

The severity of the illness and the resulting tiredness has led to a restriction on most physical activities. House maintenance, gardening and DIY are now all restricted and walking has become difficult; generally speaking he has to do everything more slowly in order to conserve energy.
Case 22 has received strong support from his immediate family. His partner provided emotional and practical support, his sisters have taken over the care of his elderly mother and his sons have also been there when needed. The nurse specialist at the hospital was also identified as a valuable source of support.

He reported that his partner is “desperate” for a holiday but his understanding is that he can not get travel insurance because of his condition.

Overall, he feels his relationships with his immediate family are strong, and that they have not been affected by the illness. However, he commented that this is because they do not discuss the illness. In general he feels that people, including work colleagues, do not understand the illness or shy away from talking about it.

**Behavioural consequences**

The illness had had a major impact on Case 22. He stays in bed more, even though he sleeps more poorly, and he recognises that he loses both his patience and temper more than before. He has little desire to leave the house and socialise. Cognitive functions, such as ability to concentrate and remember things, have also deteriorated. He has not noticed any significant changes of behaviour in his partner.

**Psychological consequences**

At the time of the home interview, Case 22 expressed feelings of depression and an inability ‘to get on with life or do anything’. He had discussed the emotional impact of the illness with his doctor but declined to join a support group with similar patients because they are all substantially worse than him and their condition frightened him.
6.5.3 Case No: 23 - male construction worker

The home interview was carried out 8 months after the report date of the illness, and the follow-up interview after a further 8 months.

Illness

At the time of the home interview Case 23 had been suffering from the symptoms of vibration white finger (VWF) for between three to four years. His fingers go numb, cold and white and are often clenched in a fist first thing in the morning. He also suffers from pins and needles in his hands.

Vocational consequences

Case 23 has not taken any time off work as a result of the illness. He has, however, changed roles and currently works as a charge hand. Previously he used jackhammers three to four hours per day but now he only uses them for about twenty minutes (helpful colleagues allow him to do other jobs). He felt that nobody was responsible for the condition but felt that it is the responsibility of the construction industry to develop safer tools in the future. No-one else had lost time as a result of the illness.

At the follow-up interview, Case 23 had been off work for 5 weeks and did not expect to return for a further 14 weeks.

Financial consequences

His earnings of £1500 - £2000 per month (including both basic pay and overtime payments) have not been affected by the illness. There have been additional costs associated with journeys to the hospital and car parking (estimated at £30).

Case 23 is seeking compensation for the VWF with the support of his trade union. The experience has been difficult to date because of the uncertainty of when the process will be resolved, the number of visits to various doctors and the fact that the lawyers have not been particularly helpful. No-one else lost time off work.

At the time of the follow-up interview, Case 23 was receiving full pay and had not incurred direct financial losses or additional costs. His claim for compensation was continuing, though he had no direct involvement in the process, which was being handled on his behalf by a lawyer.

Social consequences

The illness has had a significant impact on most aspects of his life. Aspects of personal care such as bathing and dressing remain difficult and all routine household activities such as cooking, maintenance, gardening and DIY tasks have become restricted or much slower because of a loss in dexterity. Driving is also difficult and typically he has to drive using only one hand. His main leisure activities of golf and darts have also been affected with the ability to play darts unlikely to return to normal.
Case 23 has been strongly supported by his partner and son and the trade union has provided help in claiming compensation. The medical services have been helpful but no-one explained the nature of the problem and its prognosis - he has had to discover this information for himself. His employers, supervisors and colleagues have all been helpful in ensuring he can stay at work in a modified role. However, Case 23 considers that the illness has put a strain on the relationship between himself and his partner.

At the time of the follow-up interview, personal care, household activities and driving were still restricted, due to a loss in dexterity. Playing golf was unlikely to return to normal. There had been no changes in support received or relationships.

**Behavioural consequences**

The illness has had a significant impact on Case 23. His sleep has been affected and he recognises that he loses both his patience and temper more than before. He is aware of drinking more and has less interest in socialising outside the house. He also is aware of avoiding certain situations, particularly the use of power tools. Cognitive functions, such as ability to concentrate and take decisions have also deteriorated.

He did not feel able to comment on any changes in the behaviour of his partner (who was present at the interview).

At the time of the follow-up interview, Case 23 reported drinking less alcohol, and sleeping less as a direct result of the stress and pain at night. Stress and residual pain were also the reasons for his continued lack of interest in socialising.

**Psychological consequences**

At the time of the home interview Case 23 expressed frustration at not knowing what will happen as the illness progresses and also fear that when he retires he will be a ‘cripple’. He had not discussed emotional issues with his GP.

At the follow-up interview, he reported feeling bitter about the lack of help provided by the medical profession.
6.5.4  Case No: 24 - male construction worker

The home interview was carried 11 months after the report of the illness, and the follow-up interview after a further 4 months.

Illness

Case 24 has been diagnosed with Hand Arm Vibration Syndrome, stage 2, and nerve damage in both wrists. They are the result of prolonged use of vibrating tools. He may also have arthritis in his elbows and spondulitis in his neck as a result of vibrating tool use. The pain from his arms severely disturbs his sleep and he reported frustration and stress linked to the above conditions.

Vocational consequences

Case 24 had not taken any time off work as a result of his illnesses at the time of interview, though he was worried about losing his job. He was still using vibrating tools, against the advice of doctors, having used them 5 days a week for 15 years. He had received no support from his employing organisation or manager but had received legal help from his union. Case 24 felt that his employer was responsible for his illness.

At the time of the follow-up interview Case 24 had been moved onto light duties. His views of his employing organisation and manager were very poor and he thought poorly of his colleagues since he felt that he had received no support from them.

Financial consequences

There had been no direct financial implications of the illness as no time had been lost from work. However, additional costs had been incurred and amounted to approximately £200 in travelling costs to visit doctors. The majority of these costs had been reimbursed through his solicitors. Case 24’s normal net monthly income was in the range £1500 - £2000.

His union had assisted in making a compensation claim and he had seen 4 doctors in connection to the claim at the time of the home interview. An out-of-court settlement of £5000 was declined by Case 24 and a court date for his case had been received but it had subsequently been deferred.

No-one else had lost time as a consequence of Case 24’s illness.

The financial situation of Case 24 had not changed at the time of the follow-up interview. He was continuing to pursue his claim and to champion the cases of others from his union who were similarly affected by HAVS.

His union and lawyers were reported as being less helpful although he had received a new date for the case being heard in court.
**Social consequences**

Household activities, bowls and snooker were the activities deemed unlikely to return to normal at the time of the home interview. Driving, visiting people and going on family holidays were all still restricted due to the painful nature of driving. Even getting the train to go on holiday was difficult as it was hard for Case 24 to carry heavy suitcases and bags.

He had received helpful advice from his partner in relation to the compensation claim and felt their relationship was the same as ever. He did feel, however, that since the onset of his illness his partner had seen a different, less happy, side of him.

*Cooking and shopping were the activities at the follow-up interview that Case 24 felt were still difficult to carry out. Driving was also cited as an activity that was unlikely to return to normal.*

**Behavioural consequences**

Increases in sleeping, using medication and a decrease in eating were reported at the home interview. The increase in sleep, however, was in relation to the duration of time spent trying to fall asleep/remain asleep, as sleep was now very disturbed and only possible having taken painkillers. No behavioural changes were noted in his partner.

*At the follow-up interview his sleep had decreased to 4 – 4.5 hours per night. This was linked to pain from the illness and worries about his compensation claim. An increase in avoiding certain situations was also recorded.*

**Psychological consequences**

In the home interview, Case 24 felt frustrated with the slowness of the compensation claim and worried about the damage that taking painkillers might be doing to his body. He had discussed emotional issues with his GP and had been prescribed medication.

*Sleep disturbance was an important concern at the stage of the follow-up interview, as was feeling down and worried about the progression of the compensation claim.*
6.5.5 Case No: 25 - male construction worker

The home interview was carried out 18 months after the report date of the illness and the follow-up interview after a further four months.

Illness

Case 25 was diagnosed with stage 2 Hand Arm Vibration Syndrome at the end of 2002. It is related to prolonged use of vibrating tools and symptoms have been developing slowly over the last decade.

Vocational consequences

Case 25 had not lost any time off work as a result of the illness. He is now more wary of working with vibrating tools and his employer has said it is his own decision as to whether he uses them or not. His colleagues had discussed his illness and situation with him but they had no knowledge of the condition. His union helped him to organise a lawyer for claiming compensation. He felt his employers had let him down as they had offered him no support. Case 25 felt the manufacturers of vibrating tools are responsible for his illness as they carry no safety warnings.

There had been no change in the vocational situation of Case 25 at the follow-up interview.

Financial consequences

The earnings of Case 25 have not been affected by the illness. However, he felt angry that he had not been eligible to claim disability allowance because he had been judged by a doctor to be 12% disabled, 3% less than the necessary 15%. At the time of the home interview he had paid £50 for someone to wash the car and house windows, as he could not feel his fingers when they were wet and/or cold, and can be painful. He is claiming compensation and although the claim was started 2 years ago it is still in the early stages of the process.

At the time of the follow-up interview he felt that claiming compensation was a very negative experience with no one who cares about what is happening or to arbitrate the process. He was disappointed by the solicitor that the union had recommended as his case was approaching the 3 year limit for resolution and his solicitor had made very little progress after having his case for more than 2 years.

Social consequences

Household activities and visiting friends were both still restricted at the time of the home interview. Driving was also still difficult and, as a result, visiting friends and family had become difficult too. There had been no change in family activities. He had received support from his partner who helped him with dressing and had put up with him when he was in a bad temper. He was disappointed with the treatment he had received from social services which had made him feel like a “scrounger” when he applied for benefits.

His relationship with his partner had remained unchanged since the onset of the illness. Case 25 felt he took out his bad temper, resulting from his illness, on his sons by shouting at them.
Household activities were still affected at the time of the follow-up interview. Manual dexterity was affected and doing up buttons on clothing was still difficult. Long distance driving was uncomfortable and made his arms and wrists sore.

**Behavioural consequences**

At the time of the home interview Case 25 felt he had lost his temper and patience more frequently than he used to. He avoided situations that might be uncomfortable or painful, such as unnecessary driving, and as a result was less willing than he used to be to go out and socialise.

He had given up smoking around the time of the follow-up interview and as a result felt it impossible to separate behavioural changes that had occurred as a result of the illness from those connected to giving up smoking. He had not noticed any further changes in his partner but thought his sons avoided him more than they did before the illness.

**Psychological consequences**

Case 25 felt down about his illness at the time of the home interview and felt the more he found out about the illness the worse his condition felt, but had not discussed emotional issues with his GP.
6.5.6 Case No: 26 - male construction worker

The home interview was carried out 9 months after the report date of the illness and the follow-up interview after a further 4 months.

Illness

Case 26 has Hand Arm Vibration syndrome with stages 1 and 2 affecting different hands. Residual emotional effects include anxiety, depression and insomnia.

Vocational consequences

Case 26 had never taken time off work as a result of his illness. He was asked to apply for other jobs by his employer and was the only one diagnosed with HAVS to have been so requested. Case 26 feels that this was a result of his position as a union shop steward. He feels that he should not have been made to compete for other jobs available within his employing organisation, though he had been made to do so – eventually finding a job as a school attendance officer 6 months before the home interview. He has also taken an additional job at weekends as an airport courier to make up the shortfall in wages.

Case 26 felt that his employer was responsible for the illness.

He had received no support from his employers, and felt that both the personnel department and his manager had treated him aggressively.

At the time of the follow-up interview he had been trying to gain higher, more relevant qualifications relating to his new job in order to gain promotion and an associated rise in salary. He had, however, been denied access to the course, despite a recommendation from his manager. His new manager had been extremely supportive with his career plans and also supportive emotionally. A new, better paid courier job had also allowed him to spend more time with his family at weekends.

No-one else had taken time off work as a result of the illness.

Financial consequences

Case 26’s new job paid £500 per month less than his original work with the roads department, where he earned £1500 - £2000 per month. As a result of his lower salary his pension contributions have declined. Additional costs amounted to £50 for prescription charges.

Case 26 is claiming compensation from his employer for the illness and had refused an out-of-court settlement of £2000 at the time of the home interview. His union lawyer had been very helpful. He was also engaged in legal action against his employers as he felt that he had been singled out from his colleagues, was given no training and had to compete within the organisation for another position. An employment tribunal was pending.

At the time of the follow-up interview, Case 26’s financial situation had not altered and his solicitor had advised him to accept an out-of-court settlement for compensation.
Social consequences

Dressing, DIY and gardening were still restricted at the time of the home interview due to the difficulties with dexterity issues. He had no time for hobbies as a result of his holding down two jobs. Family activities were normal at the time of the interview but had been through a period of disturbance when he had first been asked to apply for other jobs as he had begun drinking heavily.

He had received support and practical advice from his partner and sisters and had been encouraged in his situation by his GP. Though he had been through a period of heavy drinking since the illness, accompanied by a sever decline in his relationships, since he had stopped drinking heavily, relationships had returned to normal.

At the time of the follow-up interview his social life had improved and he was spending more time with his daughter at weekends. He had received helpful advice from his new manager who has been involved in tribunals in the past.

Behavioural consequences

Activities of daily living were severely affected by the illness of Case 26 and it’s associated psychological effects. Decreases in sleeping, eating, and cognitive abilities all contributed to anxiety and depression. Increases in the use of medication and losing his temper were linked to the illness. Alcohol consumption had become very heavy when he had been most stressed.

He felt that his partner had behaved unreasonably at times when he had been under stress and that his daughter had been more disruptive at home during his drinking period.

At the follow-up interview he reported an increase in sleeping and an improvement in cognitive functions such as memory. Decreases were reported in losing his temper and impatience, and he had been using less prescription medication. No changes in his family’s behaviour were reported.

Psychological consequences

Case 26 reported feeling down and anxious most of the time and had suffered from interrupted sleep, leaving him feeling tired all day. He had discussed his situation with his GP, who had prescribed sleeping tablets and anti-depressants.

At the follow-up interview Case 26 reported feeling in better psychological health than at the time of the home interview. He appeared to have come to terms with his condition, was enjoying his new job and was spending more time with his family.
6.5.7 Case No: 27 - male construction worker

The home interview was carried out 8 months after the illness.

*Illness*

Case 27 suffered an extreme reaction to the paint he was working with. This led to rashes on forehead, neck and wrists, swelling of eyelids and, after several days' exposure, to burning and flaking of the skin.

*Vocational consequences*

At the time of the home interview Case 27 had taken three weeks off work as a result of the paint sensitivity and had been subsequently laid off from his usual seasonal work. Although he expected to be able to return to the same company, he is now unable to work with paint because of the acquired sensitivity. Finding a different type of work in the period between his planned seasonal jobs would also be difficult as he is trained as a painter and this is his only skill.

His employers had referred him to the company doctor who provided useful advice, and occupational health had provided transport to appointments.

Case 27 felt that nobody was responsible for his sensitivity to the paint.

*Financial consequences*

During his time off work, Case 27 was in receipt of 50% of his normal pay of £1500 - £2000 per month. Additional costs incurred as a result of the illness had been prescription costs (estimated at £20) and extra transport costs (estimated at £10).

Because of change of role when he returns to work he anticipated losing approximately £400 per month in income.

No one else has lost time off work as a result of the illness.

Case 27 is not seeking any compensation from his employer as he feels he would not be reemployed if he put in a claim.

*Social consequences*

Many aspects of his normal life were affected during the period of sensitivity. These included personal care activities such as bathing and dressing and routine household activities such as cooking and shopping.

He felt uncomfortable going out in public when his skin was inflamed and so many social and normal leisure activities, such as fishing and going to the pub, were also restricted. He has also been told that he may now be sensitised to other things such as washing powders. His girlfriend provided practical help with applying creams etc.
Case 27 had not noticed any changes in the nature of the relationships with his girlfriend as a result of the illness.

**Behavioural consequences**

Case 27 was aware of some behavioural changes as a result of the illness. Sleeping was more difficult and he was conscious of losing his temper and of impatience with others. He had less desire to leave the house and socialise, leading to a reduction in alcohol consumption. He also noticed a decrease in his ability to concentrate. Lastly, he was aware of avoiding those situations that may have led to a flare-up of the condition.

**Psychological consequences**

At the time of interview, Case 27 did not feel that the illness was still affecting him emotionally, though at the time of the earlier telephone interview he had expressed anxiety about future work prospects.

He had not discussed any emotional issues with his GP.
6.5.8 Case No: 28 - male construction worker

The home interview was carried out 8 months after the report date of the illness.

Illness

At the time of interview, Case 28 had been suffering from symptoms of vibration white finger for approximately three years, with the condition formally identified more recently. Hands, neck and shoulders have been affected by the condition. This has resulted in numbness, pain and loss of feeling in his hands and forearms; neck and shoulders are also painful.

Vocational consequences

Case 28 has not taken any time off work as a result of the illness but has moved jobs within the same company. He now works as a technical monitoring officer, no longer working with vibrating power tools. He is unable to carry out weekend overtime work as previously.

He received some help from Occupational Health who have organised appointments with relevant specialists. His employers had paid these additional medical costs. Although some managers have been supportive and understanding, he has experienced some workplace bullying from colleagues as a result of his new job.

Case 28 felt that the construction industry in general was responsible for his condition.

Financial consequences

Case 28 lost overtime payments and is now unable to help out his extended family financially. At the time of the home interview there had also been personal medical costs of £1200 for a chiropractor, additional petrol costs for hospital visits (estimated at £30), and additional costs of £20-£30 for equipment to help with the condition.

No one else has lost time off from work as a result of the illness.

Case 28 is seeking compensation for the VWF but is finding the process lengthy and difficult with problems with insurers (more than one employer is involved) and repeated visits to different doctors.

Social consequences

The illness has had a significant impact on most aspects of his life. Aspects of personal care such as bathing and dressing are difficult because of numbness in fingers and hands as are most routine household activities such as cooking (because he can’t feel the difference between hot and cold), shopping, housekeeping, maintenance and DIY. Driving for long periods has also become difficult because of numbness in his hands, lengthening journey times because of the need to stop. The VWF has also meant he is unable to help members of his family as he used to.

Plans for a move to Norfolk with his partner to renovate a cottage (described as a ‘shared dream’) have had to be abandoned due to the illness.
Case 28 has received most help from his partner who has continued to provide practical support and help in researching information for his compensation claim.

Case 28 has not noticed any changes in the nature of the relationships with his family as a result of the illness.

**Behavioural consequences**

Case 28 has noticed some significant changes in his behaviours since the onset of the illness. He is sleeping and eating less well and finding that he is losing patience and his temper more frequently. He also feels that he is less able to concentrate and make decisions than he used to be. He tends to avoid certain situations more than before (in particular those involving use of power tools). He has noticed a similar pattern in his partner, whom he feels is also displaying less patience and increased loss of temper. Other behavioural changes noticed in his partner include eating more and increased ability to take decisions.

**Psychological consequences**

At the time of the home interview, Case 28 expressed feelings of anxiety, depression and frustration with the physical problems he is experiencing as a result of the illness. He had not discussed the emotional impact of his illness with his GP.
6.5.9 Case No: 29 - male construction worker

The home interview was carried out 15 months after the illness report date.

**Illness**

Case 29 suffers from chronic silicosis. Beginning with breathing difficulties when lying down, the condition now causes difficulties with walking longer distances and in walking upstairs. Case 29 also suffers from anxiety attacks.

**Vocational consequences**

After experiencing breathing difficulties and subsequent diagnosis, Case 29 had six weeks off work before returning to the same employer but to a different job. His current job involves less exposure to dust but also less responsibility (he was previously employed as a supervisor). He considers his current job to be less satisfying and more boring than his previous role. Overall, he perceives the illness as having a very negative impact on his career.

Some work colleagues have been supportive but he has also experienced some unpleasantness at work form other colleagues.

Case 29 expressed a desire to change career but felt this would not be possible until his partner is able to return to work and his youngest child starts school.

Case 29 felt that both himself (for not complaining about inadequate ventilation) and his employer (for not addressing the risks) were responsible for his illness.

**Financial consequences**

During his period of time off work Case 29 received Statutory Sick pay (SSP), together with a £300 lump sum payment. He has also been in receipt of Industrial Injuries Benefit (£96 per month) for approximately two years. His salary at work has remained the same despite the change of role.

Additional costs associated with the illness include transport costs for regular hospital visits (£20), baby sitters (£20) and prescription costs (unquantified).

Case 29 is seeking compensation from employers. The case has been pursued for over 2 years and is currently in dispute awaiting a court hearing. The dispute is causing considerable upset and anxiety.

No one else has lost time off from work as a result of the illness.

**Social consequences**

The main physical impact of the illness is a restriction on his ability to walk or run for any distance, which Case 29 considers is likely to be permanent. As a result he is now unable to continue with hill walking as a pastime. However, in practice he has tried not to let the illness significantly affect any of his other normal individual or family activities.
He feels that he has become more loving and closer to his children as a result of the illness, although he has noticed that there has been a tendency for him and his partner to argue more frequently.

**Behavioural consequences**

Since the onset of the illness, Case 29 had noticed some significant changes in his own behaviours. He has been sleeping and eating less (particularly when suffering from anxiety attacks) and has found difficulties in concentrating. He has been losing his temper more and has had noticeably less patience. He has not noticed any particular changes in the behaviour of his partner or children.

**Psychological consequences**

At the time of the home interview, Case 29 reported that he still felt very down, anxious and depressed. In particular, he felt worried about the future and whether he would still be there to see his children grow up. He had discussed these problems with his GP and at the time of the interview was taking beta-blockers to deal with anxiety attacks and sleeping tablets for associated sleeping difficulties. He also reported that he had become more risk averse and more conscious of everything to do with the children.
6.5.10 Case No: 30 - female administrative worker

The home interview was carried out 7 months after the illness report date.

Illness

At the time of the home interview, Case 30 had been suffering from symptoms of Repetitive Strain injury (RSI) for approximately eleven months. The RSI has affected hands, arms, neck and shoulders. At the time of the interview Case 30 was suffering considerable and constant pain in her hands, arms and neck and had lost functional grip and effective use of her hands.

Vocational consequences

Case 30 was off work for sixteen weeks as a result of the RSI. She returned to same job but on reduced hours (from 37 to 20 hours per week). Although she felt she was unable to carry out most tasks normally, her employer insisted she return to full duties. At the time of the home interview Case 30 was in the process of being made redundant.

She considered that her employer had provided no support and had been both unhelpful and spiteful since her illness.

She felt her employer was responsible for her condition.

Financial

Case 30 received full pay in the range £500 - £1000 for the first two months off work and 50% of pay for subsequent two months. She also claimed and received £15 per week Disability Living Allowance and had received financial support from her personal mortgage insurance.

Case 30 has incurred additional medical costs for prescriptions, bus fares to and from medical appointments, costs of carers, home help and gardener because she lives alone, additional car insurance for her carer and cost of additional medical support including chiropractor, acupuncture, private physiotherapy and visits to neurology and orthopaedic specialists. At the time of the home interview these additional costs were estimated in total at approximately £5000.

Case 30 had returned to work part-time instead of full-time and as a result has a reduced income.

Case 30 is seeking compensation from her employer and is also involved in a complex legal action for a broken contract of employment and grievance against her employer as a result of her treatment following the onset of her illness. She sees this as a cause of additional stress.

No one else has lost time off from work as a result of the illness
**Social consequences**

Case 30 feels that her entire life has been affected by her illness. She considers that all aspects of personal care, all household activities, all leisure and recreational activities will be permanently affected. Her mobility and her social life are unlikely ever to return to normal.

Case 30 has no family and immediate neighbours are elderly and unable to provide support. She has employed a carer and home help to provide the necessary support.

She has also received some informal support from the local vet and his staff in looking after her animals, which she had been unable to care for properly.

**Behavioural consequences**

At the time of the home interview, Case 30 considered she was eating more and sleeping less than before the illness. She was also aware of an impact on her cognitive functions: she was less able to concentrate, take decisions and remember things. She was also aware of avoiding certain situations, and had less desire to leave the house and socialise.

**Psychological consequences**

At both the telephone and home interview, Case 30 reported symptoms of extreme psychological distress, including suicidal thoughts and reported suicide attempts, depression, loneliness and panic attacks. She lives alone and has no immediate family or close friends for support.
6.5.11 Case No: 31 - male construction worker

The home interview was carried out 20 months after the illness report date.

**Illness**

Case 31 has used vibrating tools for many years in his work. In 1998 he was diagnosed with HAVS in hands and shoulders, which resulted in numbness in hands and locking of fingers. Fine motor skills were especially affected. The illness had persisted for four years at the time of the interviews.

**Vocational consequences**

Case 31 had lost no time from work as a result of the illness, though his ability to work without discomfort was affected. Since contracting the condition, he has changed jobs to a more indoor-based position with less use of vibrating tools.

Case 31 feels that both his employing organisation and his immediate managers have been helpful and supportive. He feels that the condition is an inevitable consequence of the type of work he has done, and that therefore nobody is responsible.

**Financial consequences**

Since case 31 had lost no time from work, his earnings of £2000 - £2500 per month had been unaffected. There had been no financial consequences resulting from his change in job, which is with the same employer. Medical costs of £300 had also been covered by his employer.

Case 31 was not seeking compensation as a result of his illness. No-one else lost time from work.

**Social consequences**

Relatively few social effects have been reported, with the illness still causing restrictions only in manual work at home such as gardening and DIY. There has been no lasting change in family or leisure activities.

Support has been provided by the Case 31’s, colleagues at work who have also suffered from HAVS, and by medical staff. No changes in relationships as a result of the condition have been reported.

**Behavioural consequences**

Since the illness, the only behavioural change noticed by the Case 31 had been a decrease in sleeping.
Psychological consequences

Case 31 discussed the emotional impact of the illness with his GP, who established that he was coping with the situation. Case 31 reported no lasting emotional effects from the condition.
6.5.12 Case No: 32 - male construction worker

The home interview was carried out 8 months after the illness report date.

**Illness**

Case 32 is suffering from mesothelioma, asbestos-related. Although the cancer had been in remission, it had returned, and at the time of the home interview Case 32 was about to embark on a new course of chemotherapy. He was physically weak and became tired very easily.

**Vocational consequences**

Case 32 had been off work for a year at the time of the home interview and had no expectations of being able to return to work. He felt that past and current employers were responsible for his illness.

**Financial consequences**

Up to the date of the home interview Case 32 had received full pay. He was also in receipt of Industrial Injuries Benefit and Disability Living Allowance.

Additional costs have been incurred in the form of extra transport costs (estimated at £500) and spending on complementary medicine of approximately £3750. He has experienced difficulty in getting travel insurance at an acceptable price.

Case 32 is seeking compensation from his employers with the support of his trade union. There is uncertainty as to when this will be resolved and he is worried that he may pass away before it reaches a conclusion.

At the time of the interview, his partner had lost two weeks from work with no pay, and had hence suffered losses of approximately £500-£750. His daughter had lost two days without financial penalty.

**Social consequences**

The severity of the illness has adversely affected many aspects of daily living, including most household activities that require physical effort such as gardening and DIY. Mobility has been affected and this has led to restrictions in social activities such as seeing and visiting family and friends. Most family activities involving socialising and going out have also been affected. Case 32 has found that his religious faith and his contact with the church a significant support and aid to recovery.

Case 32 has had an extensive network of support since his illness. Primary care and support have been provided by his partner and adult children. This has led to closer relationships between them all. He has also received considerable and valued support from his employer, supervisor, colleagues and friends from church who have kept in close contact with the family since his illness. He has also received support and advice from his trade union.
**Behavioural consequences**

Since the onset of the illness, Case 32 has experienced problems with most cognitive functions, including a decrease in the ability to concentrate, take decisions and remember things. He noticed that his partner had problems sleeping, was eating more and tended to be less patient.

**Psychological consequences**

Case 32 experienced serious emotional problems since the diagnosis of his illness, including long bouts of anxiety and depression and had at one time contemplated suicide. He discussed these problems with his GP and at the time of the home interview was taking anti-depressants. He was also taking various forms of alternative medicine to supplement orthodox treatments.
6.5.13  Case No: 33 - male construction worker

The home interview was carried out 5 months after the illness.

Illness

Case 33 suffered from lead poisoning, resulting in severe tiredness and lethargy. The condition was diagnosed approximately six months prior to the home interview. He also suffered from high blood pressure, which he considered to be linked to the lead poisoning.

Vocational consequences

Case 33 was unemployed at the time of the home interview, having been dismissed by his employer. Following diagnosis, he was moved to a new job within the company at his own request. Three weeks later he was sacked, and informed over the telephone. He is pursuing a legal case for unfair dismissal.

Case 33 felt he had been badly supported by his original employers who had taken very few steps to prevent the condition (they were not supplied with the correct overalls, masks or gloves) and had not provided any help since the condition was diagnosed. Others have also contracted the condition and similar work has now stopped. He felt he received no support from his manager or colleagues, and had had little contact with the latter since leaving the job.

Case 33 felt that the main contractor on the site was responsible for his condition and that incorrect or insufficient PPE was made available. The work concerned seemed to affect many others adversely and has now been stopped.

Financial consequences

Case 33 did not lose time from work as a result of the illness. His original salary was £2000 - £2500 per month and some 25% less than that in the job he had been moved to prior to his dismissal. He is currently unemployed and living off state benefits of £220 per month (job seekers allowance). He had not incurred any additional costs as a result of the illness.

At the time of the home interview, Case 33 was seeking legal redress for unfair dismissal. The case had been proceeding for seven weeks and there was no indication of a resolution date at that time. Case 33 hopes to settle out of court before the date of the tribunal. He has no indication of the potential sum involved.

No one else has lost time off from work as a result of the illness

Social consequences

As a result of the tiredness and lethargy, Case 33 has experienced restrictions on all aspects of his leisure activities, such as golf and watching friends play rugby, since the illness. He also felt his mobility (both walking and driving) were still restricted, as was visiting friends, family and general socialising. His family leisure activities had been similarly affected, including seeing his grown-up children.
Case 33 had received both practical and emotional support from his partner. He felt his children had provided him with strong emotional support. He had also received advice and support from his GP, including help with his legal claim.

**Behavioural consequences**

At the time of the home interview, Case 33 considered that he was sleeping and eating less than before the illness and that he was losing his temper and patience more than usual. There was a reported decrease in cognitive functions, with a decreased ability to concentrate and remember things. As a result of decreased mobility there was an increased desire to leave the house and socialise. He felt his partner and daughter had been very accommodating to these changes in his behaviour and he had not noticed any changes in their behaviour.

No relationship changes were reported.

**Psychological consequences**

At the time of the home interview Case 33 felt the illness was still affecting him emotionally. He reported feelings of stress and insecurity about the future, anxiety about unemployment and feelings of frustration at being let down by his employer and colleagues on the site. He had not discussed any of these feelings with his GP.
6.5.14 Case No: 34 - male construction worker

The home interview was carried out 10 months after the illness report date.

**Illness**

At the time of the home interview, Case 34 had been suffering from symptoms of Vibration White Finger (VWF) for approximately two and a half years. He was experiencing numbness, cramps and locking of fingers, with his fingers also becoming cold very easily.

**Vocational consequences**

Case 34 did not take any time off work from his original employer as a result of the illness. However, he subsequently left this employer as a result of their poor safety practices. He currently works as driver and no longer uses vibrating tools.

Case 34 felt that his employers and managers (whom he felt had failed to look after their staff) were responsible for his condition.

**Financial consequences**

Case 34 did not lose any time off work with his original employer, except for visits to a doctor with an estimated loss of £100. He was, however, unable to do any overtime because of his condition, which resulted in an estimated loss of £4000 over the course of the year. He also earns less in his new job, estimated at £80 less per week, because he is restricted to driving.

Case 34 has incurred additional costs for painkillers (no estimate), buying an automatic car (estimated at an additional £1000), and extra gloves (estimated at £18)

Case 34 is not claiming compensation because of his condition. He expressed a view that he would not know where to go to or how to find out about claiming.

No one else has lost time off from work as a result of the illness.

**Social consequences**

At the time of the home interview, Case 34 was still experiencing problems with dressing and various household activities such as house maintenance, gardening and DIY. He considered these unlikely to return to normal. His normal leisure pursuits (drawing and boxing) were also now difficult or impossible because of pain or lack of sensitivity and grip in hands. His driving was still affected and he considered it unlikely to return to normal.

Case 34 considered he had received little or no support from anyone. His family also work in construction and he felt that they had offered very little support or sympathy because they felt they were all in the same position and equally vulnerable.

Case 34 felt he had been badly supported by his original employers who had taken very few steps to prevent the condition occurring (in terms of PPE and rest periods) and had flouted
safety regulations. He felt he had received no support from his manager and that his colleagues were too frightened to make a fuss, as they were afraid of losing their job. There were no trade unions within the organisation. He felt the medical services had been helpful but that social services had been very poor.

Case 34 also felt that his relationships in general had deteriorated because of his feelings of anger and frustration, particularly when in his original job.

*Behavioural consequences*

At the time of the home interview, Case 34 felt he was sleeping less well and experiencing a greater loss of temper and loss of patience. He was also aware of avoiding certain situations. He felt less inclined to leave the house and socialise, which was not normal for him.

*Psychological consequences*

At the time of both the telephone and home interview, Case 34 expressed feelings of frustration at his inability to continue with his favourite hobby of drawing. He also expressed feelings of lethargy and loss of motivation to do things, and of being worried financially because of his reduced income.

He had not discussed his symptoms with his GP.
6.5.15 Case No: 35 - male construction worker

The home interview was carried out 7 months after the illness report date and the follow-up interview after a further 7 months.

**Illness**

Case 35 was diagnosed with Hand Arm Vibration Syndrome in 2000 and reported numbness and pain in hands, arms and neck at the home interview. He also reported related sleep problems and feelings of frustration and anger about his condition.

**Vocational consequences**

Case 35 had no time off work. He works differently as a result of his illness and limits his exposure to vibrating tools. Even though his employer had sent him for a private medical consultation to measure the extent of the illness and had allowed him time off for appointments, he feels his employer is poor and has offered him no support. His colleagues helped him at work by allowing him to use vibrating tools less, though he feels this is unfair as it is increasing their exposure and therefore their likelihood of developing HAVS. He felt his employer was responsible for the condition, as they had not warned their staff of the dangers of using vibrating tools.

At the time of the follow-up interview he had still had no time off work and was still using vibrating tools.

**Financial consequences**

Case 35 had received a £50 payment from his union as a result of developing HAVS and reported no direct losses at the time of the home interview. His normal monthly earnings were in the range £1500 - £2000. He had incurred some extra costs for transport. Case 35 is making a claim for compensation but the claim was in its early stages. The solicitor had been very helpful and Case 35 was awaiting medical assessments in connection with the claim.

At the time of the follow-up interview there had been no changes in the financial position of Case 35. He had incurred costs of £30 for prescription charges and £150 for alterations to be made to the house. He was finding the claim process a positive one and felt confident about the success of his claim as his solicitor was handling many similar cases.

No-one else had lost time off work as a result of the illness of Case 35.

**Social consequences**

Bathing, washing, cooking and shopping were still restricted at the time of the home interview. He enjoyed shooting but can’t take part, as he is unable to pull a trigger safely. All activities are worse when the weather is cold and family sports activities are still restricted. His partner had been very supportive and had helped him to find natural remedies to alleviate his symptoms. Neighbours had helped with washing the car and gardening. He felt the level of medical care received was poor as his condition had not been followed-up after assessment.
The activities adversely affected at the home interview were deemed unlikely to return to normal at the follow-up interview. Household activities were still restricted. He was aware that his partner was worried, as she knew his condition would not improve and was getting tired of the problems linked to the illness. He had established a closer friendship with his neighbour who had been helping him with gardening. No relationship changes were reported.

**Behavioural consequences**

At the time of the home interview Case 35 reported a decrease in sleeping and increases in eating, taking medication and losing his temper. These changes were all a result of his illness and the perceived stresses it placed on him. He had noticed that his partner was sleeping less, taking more painkillers due to headaches and seemed less able to make decisions. Case 35 thought these changes were also related to stress induced by the illness.

At the follow-up interview, additional changes had been an increase in impatience and a normalisation of his previously increased eating.

**Psychological consequences**

Case 35 was angry and frustrated with his condition and the restrictions that it places on his life. He did not discuss any emotional issues with his GP.

At the follow-up interview, he was worried that the illness would continue to worsen.
6.5.16 Case No: 36 - female administrative worker

The home interview was carried out nine months after the illness and the follow-up interview after a further 2 months.

Illness

Case 36 suffers from Tinosynovitus in her arm. Symptoms are linked to computer and mouse use. Residual emotional effects included anxiety, depression, loneliness and frustration.

Vocational consequences

Case 36 had been off work for 6 weeks but had returned to the same job at the time of the home interview. She had changed the way she worked by taking more breaks and including more variety in her tasks. This meant she was typing less, which had helped her condition. Personnel had been supportive and had allowed time off work. Her manager had also been helpful by changing the work rota. She felt that her employer was responsible for her condition and felt that they should have warned her of the likelihood of developing the illness.

At the time of the follow-up interview there had been no change in her vocational position. Her manager was still allowing her to include a variety of work in her schedule.

Financial consequences

She received full pay of £1500 - £2000 per month when off work and incurred no direct losses as a result of the illness. Additional costs incurred were £300 for taxis to work and for visit family members (as driving was painful), £20 for labour-saving household gadgets and £800 for private medical appointments and prescription charges. At the time of the home interview she was undecided as to whether she would pursue a compensation claim against her employer. A friend had taken one day off work to drive Case 36 to medical appointments.

At the follow-up interview she explained she would not be pursuing a compensation claim as she had had too many similar jobs in the past which would make a claim very complicated. Further costs included £250 for natural remedies, £100 for taxis and £200 for help in the garden. These were all due to her illness.

Social consequences

Personal care, household activities and driving were all unlikely to return to normal at the time of the home interview, due to the painful nature of manual activities and work. Walking and social interaction were limited due to her illness and it’s emotional effects. Interest in personal appearance had been affected, and she commented that she often couldn’t be bothered with how she looked.

A friend helped with lifts to work and to social events, and members from her church group made sure they included her in their activities.

At the follow-up interview gardening and driving were highlighted as being especially restricted. Relationships had not changed since the home interview.
Behavioural consequences

Decreases in sleeping, cognitive functions and alcohol consumption were linked to feeling depressed as a result of the illness. She felt she avoided situations that could be painful or where she could become overly tired. Losing her temper had become more frequent as had medication use to alleviate symptoms. As she was now less mobile, she felt an increasing desire to get out of the house more often.

In addition to the behavioural changes reported at the home interview, Case 35 felt a continued decrease in sleeping, cognitive functions and avoidance of situations at the time of the follow-up interview. These behavioural changes were all linked to the illness, as were further increases in losing her temper or impatience.

Psychological consequences

At the home interview Case 36 reported frequent feelings of depression, as well as feelings of helplessness, but she did not want to take the anti-depressants offered by her GP. She also felt lonely, as she was unable to get out as much as she could before the illness.

At the follow-up interview, Case 36 reported feeling a little more positive than at the home interview.
6.5.17 Case No: 37 - male construction worker

The home interview was carried out 40 months after the illness was first reported.

**Illness**

Case 37 suffers from contact dermatitis when exposed to cement. This leads to soreness and itchiness on hands and arms. The dermatitis started some years before the home interview and still flares up following any new exposure.

**Vocational consequences**

Case 37 had not taken any time off work as a result of the illness. He tried to reduce his exposure to cement but whilst this worked in the short term, in practice he can’t really avoid it in his job. He also tried to wear gloves when handling cement. He had experienced bad feeling from colleagues who have called him “soft”. This had also resulted in him being labelled a troublemaker, and as a result he had not been offered overtime.

Case 37 felt he himself was responsible for recurrences of the condition as he recognises that he doesn’t take adequate steps to avoid exposure.

**Financial consequences**

Case 37 has not lost any time off work or associated pay as a result of the dermatitis, though he had lost overtime payments. His monthly net pay was in the range £500 - £1000. At the time of the home interview he had incurred additional costs for prescriptions (estimated at £40), special creams for the condition (estimated at £20) and for special gloves (estimated at £30).

He was not seeking compensation for his condition, as he did not consider his employer to be responsible. He has, however, felt under felt under pressure from the trade union to put in a claim.

No one else has lost time off from work as a result of the illness

**Social consequences**

The illness has mainly impacted on personal care activities, with bathing and washing and his interest in his personal appearance all still affected at the time of the home interview.

His mother has provided him with care and support. He felt his trade union had not been helpful in that they had no information available on his condition and that his doctor had also not been particularly helpful in providing alternative treatment when original medication was not effective.

His employers have been helpful but he feels there is nothing else that they can do.
He felt that the illness had brought him and his mother closer. He also feels that he has a better relationship with one particular colleague who has been helpful - this had been especially important because of the attitudes of other workers.

**Behavioural consequences**

Since the onset of the illness, Case 37 considers that he is sleeping less well and is losing his temper and his patience more. He is also aware of drinking more and avoiding certain situations.

He has not noticed any change in other people’s behaviour since the illness.

**Psychological consequences**

Case 37 is still worried about his condition and the fact that continued exposure may mean he won’t be able to get rid of condition. He is also self-conscious when suffering an attack. He reported that the bad feeling towards him at work has been very stressful.

He had not discussed his emotional issues with his GP.
6.5.18 Case No: 38 - male construction worker

The home interview was carried out 12 months after the illness and the follow-up interview after a further 5 months.

Illness

Case 38 suffered an infection from working in an office infested with fleas and scabies. In January 2004 he was diagnosed with dermagraphism, as a result of the infection, which may persist for up to 6 years.

Vocational consequences

Case 38 had returned to work and his job at the time of the home interview but had been off for 2 weeks in the past due to his illness. He felt he was more cautious when working as a result of the illness. His employer and manager had both been helpful and accommodating. He felt that nobody was responsible for his illness, but he was annoyed that the first doctor he had seen had been unable to diagnose his condition.

At the follow-up interview he had had a further 1 week off work and his employer had continued to be helpful in letting him have time off work as required for medical appointments. They had also offered to pay for prescription charges.

Financial consequences

He received full pay at the rate of £2000 - £2500 per month when he was off work. Extra costs incurred amounted to £500 for trips to hospital appointments and prescription charges and £20 for cleaning expenses arising from the nature of the illness. Despite agreeing to pay prescription charges, his employer was not admitting liability for what had happened. Case 38 had decided not to claim compensation from his employer.

No one else had lost time off work in connection with the illness.

There were no changes to the financial position of Case 28 at the time of the follow-up interview. He had received full pay for the additional week off.

Social consequences

There had been no change to his normal activities of daily living at the time of the home interview, other than worry about his appearance. This was partly due to the unsightly scarring on his legs, as a result of scratching while asleep. No other daily activities were affected, although he felt most comfortable wearing shorts, even in winter time, as they minimised the itching sensation experienced. His partner was very helpful in ensuring he remained clean after returning from work and helped prevent the spread of infection into the family home.

No relationship changes had occurred.
At the time of the follow-up interview no changes in activities of daily living or relationships were reported. However, he reported that his children complained about him still scratching his legs all the time. This caused distress and embarrassment.

**Behavioural consequences**

The incessant itching experienced as a symptom of the illness made Case 38 lose his temper more frequently than normal. It also meant he could not sleep properly and was worried about scratching his legs whilst asleep. He used medication to reduce the itching and symptoms of the illness and avoided situations that would make him feel itchy, too hot or uncomfortable.

The decrease in sleeping had continued at the time of the follow-up interview, as had losing his temper and patience and avoiding certain situations. He had begun to feel less confident when making decisions about his illness and treatment.

**Psychological consequences**

Case 38 found getting changed in the garage every day before going into the house after work very stressful and upsetting. He was extremely relieved when his condition of dermagraphism was diagnosed by a specialist as it made the illness feel more manageable. He had discussed the emotional impact of the infection with his GP.

At the time of the home interview, Case 38 became distressed when describing the conditions of the illness.
6.5.19 Case No: 39 - female administrator

The home interview was carried out 15 months after the illness report date.

**Illness**

Case 39 has been diagnosed with persistent RSI in both hands, back and neck, which has caused her pain and difficulties in movement over a one-year period. She had seen her GP on several occasions before a referral to a specialist diagnosed RSI.

**Vocational consequences**

Case 39 had lost 1 week off work as a result of the condition and had been advised to change her posture and take more frequent breaks by the organisation’s Health and Safety officer. This had resulted in some improvement to the condition, though Case 39 found it difficult to adhere to the new working practices.

Case 39 felt both herself and her employers were responsible for the condition.

**Financial consequences**

Aside from minor transport costs incurred from visits to hospital, Case 39 had suffered no financial losses. Her normal monthly net income is in the range £1000 - £1500.

No-one else has lost time as a consequence of her condition. Case 39 is claiming compensation as a result of the illness.

**Social consequences**

While the condition was acute, Case 39 was restricted in driving ability and sports. Both activities were back to normal at the time of the interview. No other adverse effects had been reported. Support was provided by the Case 39's father and brother, and by a medical specialist.

**Behavioural consequences**

Case 39 has experienced a decrease in the ability to concentrate since the onset of the condition, and an increase in impatience and aggression. This is coupled with a decrease in the desire to socialise and leave the house. There had been an increase in use of non-prescription drugs.

**Psychological consequences**

Case 39 he reported that the emotional burden had reduced by the time of the interview, but that she had suffered from worry and frustration, and anxiety about her ability to care for her father both now and into the future. She had not discussed any emotional issues with her GP.
6.5.20 Case No: 40 - male construction worker

The home interview was carried out 24 months after the illness and the follow-up interview after a further 6 months.

**Illness**

Case 40 developed industrial asthma and skin irritations from working with undiluted chemicals. He also reported feelings of stress and worries about his health. Residual emotional effects were anxiety and insomnia.

**Vocational consequences**

Case 40 had been off work for 2 weeks before returning to the same job at the time of the home interview, but reported that he was physically able to do less as a result of his asthma. His colleagues had been sympathetic, as they had experienced similar ailments. He rated the organisation he was working for as poor, both before and after the onset of the illness. He felt responsibility for the illness lay with his employer. The company he worked for had not provided him with any support.

*There had been no changes to his vocational situation at the time of the follow-up interview.*

**Financial consequences**

He received no pay when off work due to being self-employed. His normal earnings would be expected to be £1500 - £2000 per month. Insurance for mortgage repayments takes several months of absence before payments are made, so no help had been received in that regard. Extra costs were £30 for prescription charges, £250 for new bed linen and a special vacuum cleaner to reduce the amount of household dust, and £150 for acupuncture sessions. The main financial difficulty was not receiving any wages when off work. He had decided not to claim for compensation.

No-one else had lost time as a result of the illness.

*At the follow-up interview he had spent a further £300 on acupuncture sessions.*

**Social consequences**

Gardening, DIY, swimming and walking were all still restricted at the time of the home interview due to case 40’s shortness of breath when taking part in physical activities. Playing bowls and driving had been restricted but had since returned to normal. His partner had helped with all the extra cleaning to reduce the level of dust in the house and had provided emotional strength. He felt they had become closer as a result of coping with the pressures and stress linked to the illness. He had received good advice from his brother and it had helped talking things through with him.

*Walking, and family leisure and sports activities, were still restricted at the time of the follow-up interview due to shortness of breath. Overall, however, he was feeling better and he felt that everyone in the family was more relaxed and there was less tension in the house.*
**Behavioural consequences**

Since the onset of the illness he felt he had less concentration and didn’t like to drink alcohol in case it lessened the effectiveness of his medication. He felt the medication made him sleep more and he avoided situations that he might find stressful. He lost his temper and patience more frequently than normal on account of feeling unwell at times.

His partner had been under strain since the illness began and had also lost her temper and patience more frequently.

*At the follow-up interview Case 40 reported avoiding fewer situations and losing his temper and patience less frequently, on account of feeling better than at the time of the home interview. Feeling better also accounted for the increase in sleeping and improved cognitive functions. A continued use of medication was recorded. His partner’s behaviours had also improved.*

**Psychological consequences**

At the home interview he reported feeling better after discussing his illness with his GP, although it did not resolve any medical issues. He was worried about his health and family in the future. He occasionally worried that the asthma might return.
### 6.6.1 Healthcare accident group: summary table

<table>
<thead>
<tr>
<th>AP No.</th>
<th>Age</th>
<th>Nature of illness or accident</th>
<th>Family member interview</th>
<th>Follow-up Interview</th>
<th>Residual Physical effects</th>
<th>Residual emotional effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>29</td>
<td>Multiple fracture of right ankle.</td>
<td>Partner</td>
<td>Yes Interview</td>
<td>Pain and restricted mobility.</td>
<td>Frustration; some anxiety.</td>
</tr>
<tr>
<td>42</td>
<td>42</td>
<td>Dislocated shoulder requiring operation</td>
<td>Partner</td>
<td>No</td>
<td>Pain and restricted mobility; lack of strength.</td>
<td>Anxiety and depression; feelings of vulnerability.</td>
</tr>
<tr>
<td>43</td>
<td>44</td>
<td>Attacked by patient; broken coccyx and bruising</td>
<td>Yes</td>
<td></td>
<td>Pain.</td>
<td>Anxiety, fear of work situation; tearful and sensitive.</td>
</tr>
<tr>
<td>44</td>
<td>52</td>
<td>Fall in hospital move; tears in connective tissue.</td>
<td>No</td>
<td></td>
<td>Pain from torn tissues.</td>
<td>Depression.</td>
</tr>
<tr>
<td>45</td>
<td>52</td>
<td>Fall in residential home: fractures to left elbow.</td>
<td>Partner</td>
<td>Yes Interview</td>
<td>Pain and restricted movement of the arm.</td>
<td>Some depression and frustration.</td>
</tr>
<tr>
<td>46</td>
<td>56</td>
<td>Fall in NHS hospital; fracture to left wrist, trapped nerve, chipped bone &amp; dislocated little finger displaced shoulder, nerve damage to R hand</td>
<td>Yes</td>
<td></td>
<td>Pain and swelling.</td>
<td>None.</td>
</tr>
<tr>
<td>47</td>
<td>28</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>42</td>
<td>Fall in hospital; broken elbow.</td>
<td>No</td>
<td></td>
<td>Restricted movement.</td>
<td>None.</td>
</tr>
<tr>
<td>49</td>
<td>55</td>
<td>Attacked by client; fractured bones in left arm, bruised and damaged retina, emotional effects and insomnia</td>
<td>Yes</td>
<td></td>
<td>Pain, loss of use of left hand.</td>
<td>Anxiety, depression, anger, bitterness, insomnia.</td>
</tr>
<tr>
<td>50</td>
<td>52</td>
<td>Fall while caring; multiple fractures in left ankle.</td>
<td>Yes</td>
<td></td>
<td>Pain, limping and restricted mobility.</td>
<td>Severe anxiety, depression and disturbed sleep.</td>
</tr>
<tr>
<td>51</td>
<td>57</td>
<td>Fall in hospital; damage to breast, ribs and back.</td>
<td>No</td>
<td></td>
<td>Pain and restricted movement affecting daily activities.</td>
<td>Anxiety and worry for the future; flashbacks.</td>
</tr>
<tr>
<td>AP No.</td>
<td>Age</td>
<td>Nature of illness or accident</td>
<td>Family member interviewed</td>
<td>Follow-up Interview</td>
<td>Residual Physical effects</td>
<td>Residual emotional effects</td>
</tr>
<tr>
<td>--------</td>
<td>-----</td>
<td>------------------------------------------------------</td>
<td>---------------------------</td>
<td>--------------------</td>
<td>--------------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>52</td>
<td>60</td>
<td>Slip in hospital lift; fractured ankle.</td>
<td>No</td>
<td>None</td>
<td>Mild residual pain.</td>
<td>None.</td>
</tr>
<tr>
<td>53</td>
<td>57</td>
<td>Fall in hospital; back and abdominal damage.</td>
<td>Partner</td>
<td>No</td>
<td>Internal pain and difficulty moving.</td>
<td>Anxiety, depression and loss of confidence.</td>
</tr>
<tr>
<td>54</td>
<td>52</td>
<td>Fall in hospital; dislocated shoulder</td>
<td>Partner</td>
<td>No</td>
<td>Pain in shoulder and back.</td>
<td>Anxiety about work and compensation.</td>
</tr>
<tr>
<td>55</td>
<td>56</td>
<td>Fall in care home; multiple fractures and bruising followed by infection.</td>
<td>Yes</td>
<td>Pain and restricted mobility.</td>
<td>Anxiety and depression; frustration and loss of confidence with colleagues.</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>57</td>
<td>Fall in delivery suite; fractures to right wrist</td>
<td>Partner</td>
<td>Yes</td>
<td>Pain in wrist and arm; mobility problems.</td>
<td>Anxiety and anger; financial worries.</td>
</tr>
<tr>
<td>57</td>
<td>26</td>
<td>Fall in hospital; multiple fractures to left foot</td>
<td>Partner</td>
<td>No</td>
<td>Impaired mobility and pain; inability to return to sports.</td>
<td>Frustration and anxiety.</td>
</tr>
<tr>
<td>58</td>
<td>41</td>
<td>Fall in hospital; dislocated knee followed by arthritis.</td>
<td>Partner</td>
<td>No</td>
<td>Pain and restricted mobility; sleep problems.</td>
<td>Anxiety and depression.</td>
</tr>
<tr>
<td>59</td>
<td>30</td>
<td>Fell down stairs in A&amp;E; multiple fractures in right foot.</td>
<td>Partner</td>
<td>Yes</td>
<td>Pain and restricted mobility.</td>
<td>Frustrated and angry.</td>
</tr>
<tr>
<td>60</td>
<td>40</td>
<td>Fall in hospital; fractured humerus, two operations</td>
<td>No</td>
<td>Restricted movement in arm affecting daily activity.</td>
<td>Anxiety for the future.</td>
<td></td>
</tr>
</tbody>
</table>
6.6.2 Healthcare accidents group: an overview of the case summaries

A total of 20 individuals involved in serious health sector incidents were interviewed at home. Of the 20 cases, 18 involved an accident and 2 involved a personal attack by a patient or client. A further 9 family members (associated with 9 cases) were also interviewed at this time or shortly afterwards, the mean time of these interviews after the accident being 5.5 months, though this figure is biased somewhat by three cases interviewed 10 – 14 months after the event in an attempt to capture a fully representative range of cases. In 9 cases, a follow-up interview (either a telephone interview or home interview) with the affected person was carried out. The mean time of the follow-up interview after the first home interview was 6.4 months.

6.6.2.1 Demographics

The age and sex distribution of the 20 cases are shown in Table 6.20 and the distribution by residential status in Table 6.21.

### Table 6.20 Distribution of cases by age and sex

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>25-34</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>35-49</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>50-64</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>65 &amp; over</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>3</td>
<td>17</td>
</tr>
</tbody>
</table>

### Table 6.21 Distribution of cases by residential status

<table>
<thead>
<tr>
<th>Residential status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lives alone</td>
<td>2</td>
</tr>
<tr>
<td>Lives with partner</td>
<td>8</td>
</tr>
<tr>
<td>Lives with partner and children</td>
<td>9</td>
</tr>
<tr>
<td>Lives with children</td>
<td>1</td>
</tr>
</tbody>
</table>

All but 3 of the 20 cases were female. The dominant age group was 50 years and over. Most APs lived with some one else, typically either their partner or their partner and children. There were a small number of cases where APs lived on their own. Of the 20 cases, 14 were employed by the NHS, the remainder worked outside the NHS.

6.6.2.2 Vocational consequences

**Work outcome**

The pattern of return to work and resettlement at the time of the interviews is summarised in Table 6.22.
Table 6.22  Pattern of return to work and resettlement

<table>
<thead>
<tr>
<th>Work status</th>
<th>Home interview</th>
<th>Follow-up interview</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Outcome</td>
<td>No.</td>
</tr>
<tr>
<td>Returned to work</td>
<td>Back to same job</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Returned to work via light duties</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back to same job but way job is done affected</td>
<td>Still in same job</td>
<td>7</td>
</tr>
<tr>
<td>Back to different job because of accident (same employer)</td>
<td>No follow-up</td>
<td>2</td>
</tr>
<tr>
<td>Still off work</td>
<td>Expect to return to same job</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>No follow-up</td>
<td></td>
</tr>
<tr>
<td>Don’t expect to return to same job (unconnected to accident or incident)</td>
<td>Returned to work to different job</td>
<td>2</td>
</tr>
<tr>
<td>Don’t expect to return to work because of accident</td>
<td>Had returned to work part-time</td>
<td>1</td>
</tr>
<tr>
<td>No longer working</td>
<td>Had resigned from job</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

The main patterns to emerge are as follows:

- Everyone in this group had lost time from work as a result of their accident and most APs had returned to work at the time of the home interview.

- Of those who had returned to work, at the time of the home interview, most had gone back to their old job (11 of the 13 cases). In 2 cases APs had gone back to a different job as a direct result of the accident. In one case this had involved a move to a less physical role and in another a move to part-time work. In the latter case this has meant a significant change of role and an associated reduction in salary.

- Most of those who had returned to work either returned via temporary light duties or, if they had returned directly to their original job, approached their work with considerably more caution. In 2 cases APs explicitly reported they felt they had become physically restricted by the injuries they had sustained. Of the 5 cases who had returned to work and were followed-up, 1 had returned to normal duties and 3 had continued to carry out their original job but with more care. One case was on protracted sick leave having aggravated his injury by going back to work too early.

- Of the 6 cases where APs were still off work, 3 expected to return to work, 2 anticipated a change of job unconnected to the accident and 1 did not expect to be able to return to work because of the severity of her injuries. However, the follow-up interviews demonstrated that individuals can sometimes misjudge the long-term consequences of their injuries. Of the 4 cases that were followed-up, 1 of those who expected to return to her old job was still off work and had no expectation of returning (this was one of the cases involved in a personal attack), 2 had returned to a different job (the remaining case involving a personal attack), and the single AP who had not expected to return to work had actually recovered enough to return to part-time work.
I’ve been off for over 4 months since my attack and I’m nervous about going back. I’m going back to a slightly different job, nothing to do with my accident, and think this will make it easier. I’ll be in a different ward and won’t always be reminded of where the attack happened. 

Female clinical NHS worker

- One AP had tried unsuccessfully to make a complete return to work. On return, she had felt unable to do her job properly and had subsequently resigned. She was unemployed and seeking compensation from her employer at the time of the interview.

Length of time off work

The following table lists the actual or anticipated length of time off work for each of the 20 cases. It should be noted that a range of injuries was captured in this sample, which is reflected in the wide variation in length of time taken off.

Table 6.23 Healthcare accidents – length of time off work

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Length of time off work (weeks)</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual*</td>
<td>Expected</td>
</tr>
<tr>
<td>41</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>26</td>
<td>Expected to return to nursing via temporary administrative role</td>
</tr>
<tr>
<td>43</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>Don’t know</td>
<td>Had been off work a total of 26 weeks at time of home interview; had tried to return to work on 3 occasions</td>
</tr>
<tr>
<td>45</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Don’t know</td>
<td>At time of follow up interview had been off work for 39 weeks-did not expect to be able to return to same job</td>
</tr>
<tr>
<td>50</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>8</td>
<td>Had gone back to work after 1 week and subsequently had to take off another 7 weeks</td>
</tr>
<tr>
<td>60</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

*Established at home interview or follow-up interview

Support at work

At the interviews APs were asked if they had received support, or any kind of help, from their employer and those connected to their job. They were also asked about support from their union.
The main findings are detailed below:

- Most cases reported receiving support from one or more of the following: employing organisation, manager or supervisor, colleagues or Occupational Health department, though approximately one quarter of the cases felt they had received no support of any kind. These cases expressed both surprise and disappointment with the lack of support they had received and had expected more help, in part because the nature of the organisations they worked for.

> I received time off work to recover from my accident which I suppose is a kind of support but they can’t force you back to work can they? I’m disappointed my manager hasn’t been to visit me or been in contact but I know how busy she is. A phone call or something would be good. I think my colleagues are annoyed that I’m still off as they have to do my work.
> Female administrative NHS worker

- In approximately half of the cases, colleagues were the main point of contact with work and source of support. Managers and supervisors were only explicitly identified as a source of support in a small number of cases.

> A couple of people have called who I work with and it’s been brilliant to catch up with what’s happening. It makes thinking about going back less daunting.
> Female clinical NHS worker

- Occupational Health departments received mixed feedback from the small number of cases where they had been involved. In general those who had come into contact with them were surprised that they had not been more effective or more able to offer more useful information.

- Contact with Human Resource departments was reported by a small number of APs during their home interviews and one such department was specifically mentioned by one AP as having made returning to work a straightforward process.

> The HR department have been good and let me know about returning to work and the situation with my pay. My manager has been disappointing because he’s called twice but always just to see when I’m coming back to work. I’d like to hear how things are going at work.
> Female NHS care worker

- Advice provided by trade unions was exclusively in connection with claiming compensation. Several cases mentioned supportive union representatives who were well informed about these issues.

- At the follow-up interview, 4 cases out of a total of 9 reported changes in support. Occupational Health departments had been further consulted by 2 cases, 1 of whom was very disappointed with the advice they were given. In terms of managerial support, one case had continued to receive a high level of support from their manager while another had received no support.

Responsibility for the accident

APs were asked who, if anyone, they felt was responsible for their accident. The overall pattern of results is shown in Table 6.24.
Key findings from the study are highlighted below.

- The majority of APs attributed the responsibility for the accident to someone other than themselves, most frequently their employing organisation or individual manager. In this group, cleaning or maintenance departments were also sometimes referred to specifically where a fall had involved slipping on a recently washed floor.

- In only a small number of cases did APs feel that the main responsibility for the accident or incident lay solely with themselves.

- Most APs who held either their employer or a service department responsible were either actively seeking or considering seeking compensation.

### 6.6.2.3 Economic consequences

#### Loss of pay and increased outgoings

Full details of lost pay and other financial factors are provided in the individual case summaries. The main findings are summarised as follows:

- With very few exceptions, all those working within the NHS had received or were still receiving full pay during their period of time off work. Of the small number of cases in the private sector two were on full pay, two had been on reduced pay or SSP after their accident, though this sometimes followed a brief period of full pay. One AP in this sector had received no pay while absent from work.

- Although they may have received full pay whilst off work, some NHS employees reported that their income was significantly reduced because of loss of overtime or ‘bank’ work.

- Most APs had incurred additional expense as a result of the accident. This was usually reported as additional transport costs, primarily for visits to hospital, and/or medical costs. In terms of additional medical costs these typically involved private physiotherapy, complementary medicine, or prescription charges.

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**I get lifts to appointments from my son when I can. I’ve still spent about £50 on taxis and buses. I have to get a bus to church too as I can no longer drive my car. I could if I could buy an automatic but I’m really low income and can’t afford it. Prescriptions come to around £80.**  
*Female NHS clinical worker*

---

**I fell at work and hurt my back. The only thing that helps is going to see an osteopath. Appointments are £46 a week. Already the bills are running into hundreds of pounds. I’ve no idea how much all the transport comes to. I try to avoid taxis where possible and get the bus.**
Female administrative NHS worker

- A small number of cases had also incurred other costs such as domestic support or changes to the house to accommodate their new physical needs.

- Nearly half the cases reported that another person had lost some time off work as a result of the accident to provide care and support, or help with transport.

Compensation and legal implications

- At the time of the home interview, over half of the APs were either seeking compensation from their employer as a result of their injuries or considering pursuing such a claim. In some cases they had mixed feelings about taking this action because of the potentially damaging impact this might have on their relationships with their employer.

I ripped some tissue in my hand during an office move. The move was very badly planned and there was no risk assessment done. My employer should have planned everything better. That’s why I’m claiming compensation from them.

Female NHS administrative worker

- One AP explicitly reported that she would have been less inclined to seek compensation if her relationship with her employer had been more supportive.

- Whilst most people were at too early a stage in the process to comment on their experience, comments that were made suggested that individuals found the process difficult and uncomfortable.

- Of those not seeking compensation, one AP in a more senior role within the NHS commented that the patients would be disadvantaged by a claim.

I’m not making a claim from my employer for my fall despite being off work for over 5 months, as I think NHS patients in the future would be the losers. It’s public money I’d be getting.

Female NHS administrative worker

- At the time of the follow-up interviews, some situations had changed. One of the cases that had reported that she would not be seeking compensation had subsequently decided to pursue a claim because of the damaging psychological impact of the incident - an attack by a patient. Of those interviewed that had been seeking compensation or considering it at the time of the home interview, 2 cases had decided not to pursue the action. Both of the other cases that had been involved in a claims process affirmed that they were finding the procedure slow and frustrating.
6.6.2.4 Social consequences

Activities of daily living

Examination of the case summaries associated with this group reveals that the injuries frequently caused restrictions in the lives of the APs. While it is difficult to generalise, the main impact that these injuries had on people’s day-to-day activities are highlighted below.

- All but one individual had experienced some restriction on their personal care activities including bathing, washing and dressing since the accident. These effects were particularly serious for those who lived alone – as illustrated by the case of a care worker who had been attacked at work and was forced to seek her neighbour’s help with dressing. In many cases, these activities were still restricted at the time of the home interview. At the follow-up interview several APs in this subset reported their personal care was still restricted.

  Doing my hair was virtually impossible as I couldn’t reach behind due to dislocating my shoulder five month ago. I adapted to the problem but I’ve been struggling again recently as a result of the last operation.
  
  *Female private sector clinical worker*

- All but one individual reported a restriction on light household activities since their accident – a particular concern in a female population in which responsibility for household care is frequently seen as important. Following the accident most cases had to rely on their family and/or friends to help them. At the time of the home interview, most cases were still restricted in these activities. At the follow-up interview several APs in this subset were still facing restrictions.

- The more physically demanding activities such as house maintenance, gardening and do-it-yourself were similarly affected. Most APs had found the heavier household tasks restricted and were still experiencing restrictions at the time of the home interview. At the time of the follow-up interview, a small number of APs in the subset reported that these activities were unlikely to return to normal.

- Most individuals had faced some level of restriction on their leisure and recreation activities since their accident, and at the time of the home interview, many cases were still restricted. And at the time of the follow-up interview a small number of APs, who had been restricted at the time of the home interview, reported these activities were unlikely to return to normal.

- Driving had been affected in all cases but one and was still restricted in many cases at the time of the home interview. This had placed an additional burden on caregivers who were needed to help with transport for medical appointments, for example. In one case, damage to the upper limbs was severe enough to prevent her from driving anything other than an automatic vehicle in the future. Walking had been affected in many cases with lower limb injuries and was still restricted in 12 cases at the time of the home interview. At the time of the follow-up interviews, almost half of the APs in the subset were still facing mobility restrictions.

- At the time of the home interview, many cases reported that mobility problems had led to restrictions on their social life. At the time of the follow-up interviews, those who had improved mobility had returned to normal levels of social interaction while...
those with residual mobility problems continued to report restrictions on their social life.

*Family activities*

Many of the restrictions discussed above had also had a significant impact on general family life. For example:

- Restrictions on family activities were reported by many cases. The most commonly reported effects were restrictions on family leisure and sports activities. At the follow-up interview several cases reported their family sports activities were unlikely to return to normal because of residual movement difficulties.

> We normally go swimming as a family every Tuesday after school and work. We haven’t been able to recently as my partner has been away with his job and I can’t swim because of my shoulder. I won’t let the kids go in on their own so we’ve had to stop going.

*Female clinical NHS worker*

- A small group of APs described their difficulties in caring for their children and the emotional distress this caused them. Examples included not being able to play with them or take them to their daily activities.

> Since the attack I’ve not been able to have my grandchildren round to the house like I used to. I couldn’t pick them up anymore or run after them. I really miss seeing them and looking after them, it makes me feel very sad.

*Female NHS care worker*

*Provision of support and impact on relationships*

APs were asked who had provided them with support and help since the accident and whether they felt that any of their personal relationships had been affected by the accident. The results show that:

- Those living with partners had found them their main source of help and support. They had variously provided emotional and practical help, including assistance in getting dressed, shopping and transport if they could not drive.

> I don’t know how I’d have managed without my partner. He’s done everything for me as well as cheering me up when I felt down. He’s looked after the kids too. We’re far closer than we used to be.

*Female clinical NHS worker*

- One quarter of the APs reported that their adult children or those of secondary-school age had provided support. This included helping with shopping and cooking, and with transport where mobility was restricted.

- After support from within the family, a significant group of APs was helped by friends, including colleagues from work.
My friends, most of whom are colleagues, have visited me since I’ve been off work. Getting out of the house has been hard due to hurting my back. They help me feel normal, and are a link to work as well, otherwise I’d only see my partner and son.

*Female clinical NHS worker*

- Trade unions were not identified as a major source of support and were referred to in only 1 case – who thought their level of support had been poor.

- Physiotherapy was welcomed and valued by the 3 cases who had received it. A further 2 cases had been disappointed by the support they had received from their GP and from medical services in general. Complimentary medicine, (specifically acupuncture and chiropractic) were reported as effective treatments by a small number of APs.

*I’ve seen a physiotherapist at the hospital and she was really good and encouraging as well. I got more help there than from any doctor. My wrist is far more supple due to the exercises they gave me to do.*

*Female clinical NHS worker*

- In several cases APs in this group mentioned their pride in how their children had behaved and how much help and support they had given them. In general, this related to adult children and those of secondary-school age. An improvement in relationships with children, parents and parents-in-law was also reported in a number of cases.

- In general, APs had felt closer to their partners, though negative changes in the relationship were reported in one case.

*I feel like I pick on my partner sometimes. I don’t know why really, it’s venting all my frustrations to do with the accident and being off work. I feel like I’ve become really difficult for him to be around. As a result we don’t get on very well now.*

*Female administrative NHS worker*

### 6.6.2.5 Behavioural consequences

**Impact on own behaviour**

APs were asked if they had noticed any changes in their own behaviour since the accident. The results from the home interview are shown in the table overleaf. These results are presented in detail since in this area there is no equivalent data set in the telephone survey.
<table>
<thead>
<tr>
<th>Behaviour</th>
<th>No change</th>
<th>Increase</th>
<th>Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping</td>
<td>1</td>
<td>0</td>
<td>19</td>
</tr>
<tr>
<td>Eating</td>
<td>10</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Ability to concentrate</td>
<td>9</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Ability to take decisions</td>
<td>13</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Ability to remember things</td>
<td>14</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Avoidance of certain situations</td>
<td>5</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td>18</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Use of prescription drugs</td>
<td>9</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Use of non-prescription drugs</td>
<td>3</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Use of illegal drugs</td>
<td>20</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Losing temper/aggression</td>
<td>8</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Desire to leave house</td>
<td>16</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Desire to socialise</td>
<td>12</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Losing patience</td>
<td>8</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Sexual activity</td>
<td>14</td>
<td>0</td>
<td>6</td>
</tr>
</tbody>
</table>

The most common patterns identified were:

- Sleeping was adversely affected in the majority of cases. This was attributed to physical discomfort and also to worries about their future.

- Nearly half the sample reported a change in their eating habits. Some reported an increase linked to their mobility restrictions, whilst other individuals reported an adverse effect on their appetites.

- Cognitive functions such as concentration, decision-taking and memory were adversely affected in many APs. Some cases suggested during the home interviews that this was due the painful and intrusive nature of their injuries while others connected it to anxiety.

- Only a small number of cases reported that they had increased their alcohol consumption. This was attributed to boredom and being confined to the house in one case.

- An increase in the use of both prescribed and over-the-counter medication was reported for most cases. Several APs reported that they were uncomfortable with taking painkillers over a long period of time.

- Over half the cases reported increases in ill-temper and in impatience.

- Decreases in sexual activity, reported in some cases, were all related to mobility restrictions and pain.
At the follow-up interviews, of the 9 cases in this subset, only 2 reported that all their behaviours had fully returned to normal. Other changes noted were:

- The sleeping patterns of 4 APs had returned to pre-accident levels at the time of the follow-up interviews.
- A further loss of patience since the home interviews was reported by a small group of APs; this was linked to continued frustration with their injuries.
- Since the home interview several APs who had returned to work felt their cognitive functions had improved as a direct result.

When I was off work I didn’t think about anything more than when I would be better, what was on TV and worrying about everything. I’ve a better routine now that I’m back at work and I use my brain. It makes me feel more like myself.

*Male clinical NHS worker*

One case who had been attacked at work reported further negative behavioural changes at the follow-up interview. These included taking more medication and an increase in losing her temper and in impatience. She had also continued to eat and sleep less than normal.

*Impact on the behaviour of others*

APs were also asked if they had noticed any changes in the behaviour of the people that they lived with. Of the 20 cases, over half had noticed that the behaviours of others had been affected. The main findings were:

- A number of APs felt that their partners had shown an increase in loss of temper and impatience. This was attributed to additional stress, worries about the health of their family member and increased domestic workload. At the follow-up interviews several APs in this subset noted that their partners had continued to be more bad tempered and less patient than normal.

> He sleeps less than he used to because I’m so restless from the pain in my shoulder. I think being tired is what makes him so bad tempered during the day.

*Female clinical worker*

- A decrease in sleeping was reported by 6 APs with regard to their partners. This was related to anxieties about the recovery of the affected person and, in some cases, the disturbed sleep of the AP.

> My daughter has been less patient than normal, but she’s stayed in the house more so she could care for me. She has become more responsible since the accident, though.

*Female NHS clinical worker*
6.6.2.6 Psychological consequences

As in the construction sector, the emotional consequences of the accidents clearly demonstrate that they can potentially have serious and long lasting psychological effects. The results of the psychological measures administered at the interviews also underline this conclusion. These results are summarised in Table 6.26.

**Table 6.26** Summary of results from psychological measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Scores</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Number over threshold</td>
</tr>
<tr>
<td>Brewin TSQ* (administered at telephone survey)</td>
<td>4.9</td>
<td>8</td>
</tr>
<tr>
<td>IES Total</td>
<td>25.1</td>
<td>9</td>
</tr>
<tr>
<td>Goldberg Anxiety</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Goldberg Depression</td>
<td>3.7</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 cases scored 8 or over at telephone interview</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 cases scoring 7 or over at home interview</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8 cases scoring 4 or over at home interview</td>
</tr>
</tbody>
</table>

* The TSQ scores are only available for 18 of the 20 cases

A number of general points may be highlighted, as described below.

- As in the construction accident group a significant number of participants were reporting symptoms of Post Traumatic Stress Disorder (PTSD) at the time of the telephone interview (as measured by the Trauma Screening Questionnaire or TSQ). These preliminary findings were also confirmed by the results of the Impact of Events Scale or IES completed during the home interview with nearly half of the cases reporting PTSD type symptoms. Most APs were experiencing symptoms of both anxiety and depression after the event, despite the elapsed time. In some of the cases, scores on the Goldberg scales indicate that these conditions were potentially serious. Despite this, however, only 3 out of the 20 cases had discussed these issues with their doctor.

> I feel isolated as I’ve not seen people as much as I normally do because I can’t drive. I don’t want to discuss feeling down and so worried with my GP as he already must think I’m malingering on account of my visiting him so often.

*Female NHS administrative worker*

- Nearly all the APs reported that they were still emotionally affected as a result of the accident at the time of the home interview. The emotional effects reported often reflected the particular nature of the accident or specific experiences of the AP. The most frequently reported feelings were frustration or anger at the accident, anxiety, depression and ill temper. Some individuals also expressed anxieties about their health and the impact the accident would have on their future.

> Since the accident, when I broke my ankle, I’ve been worrying more. I know it sounds stupid but I think a lot of people who suffer accidents must feel the same. I worry about how much longer I’ll be around for and who will look after my children.

*Female care worker, private sector*

> I worry about working as a nurse in the future as my back and shoulders are still painful, and I’m concerned about the effect of claiming compensation on working in the future.

*Female clinical NHS worker*
• Of the 2 cases that had suffered a personal attack at work, one case was still displaying symptoms of serious emotional trauma.

<table>
<thead>
<tr>
<th>I have nightmares since the attack and felt angry, bitter and depressed about what happened. I’ve been offered sleeping tablets by my GP but don’t want to take them.</th>
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</thead>
<tbody>
<tr>
<td>Female care worker, private sector</td>
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</table>

**Family impact**

Family members of 9 cases (8 partners and 1 son of the affected person) were also interviewed at or close to the time of the home interview. The interviews focused on the actual and perceived impact of the illness on the carer and on their normal lifestyle.

A number of general points may be made:

• Family members were often required to take time off work as a result of the accident. In this group, the time taken off was relatively short - all 4 family members who took time off work were absent for 3 days. Full pay was received by 3 of the 4 family members, the fourth used annual leave entitlement in preference to losing pay.

<table>
<thead>
<tr>
<th>I used my holiday entitlement to cover the 3 days I took off work. I didn’t expect to be given extra time off from my employer to be honest. It meant that I could go with her to appointments for her arm and when she had her operation.</th>
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</thead>
<tbody>
<tr>
<td>Partner of female clinical NHS worker</td>
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• Only 1 family member reported a loss of normal earnings as a result of taking time off work - the partner of an AP who reported losing £700 in overtime payments.

• Additional costs due to the accident were reported by 7 of the 9 family members interviewed. Principally, these costs were associated with transport and additional convenience food as a result of the injured person being at home more than usual.

<table>
<thead>
<tr>
<th>I think I spent more than usual on petrol and parking when she was going to appointments and because she can’t do so many activities on her own. The biggest extra cost has been food as she can’t cook or go to the supermarket like she used to. I’ve just been buying ready-made meals to save on hassle but that’s been another £100 on our normal food bills.</th>
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<tr>
<td>Partner of female administrative NHS worker</td>
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</table>

• Many normal family and social activities had been disrupted because of the accident and all family members reported changes in this area. Most frequently, these changes were to household care tasks, particularly cooking and shopping. Additionally, several people reported they had been unable to participate fully in their hobbies and sports.

• All family members had received support throughout the period of the accident. The support had been both practical and emotional and had been from other family members, neighbours and friends.

<table>
<thead>
<tr>
<th>My parents have helped out a lot since my partner’s accident, particularly with looking after the kids. The kids themselves have helped out far more than usual with household chores which has been good, a team effort.</th>
</tr>
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<tbody>
<tr>
<td>Partner of NHS female clinical worker</td>
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</table>
• Family members rarely felt relationships had been affected by the accident and only 3 reported changes. Though one female partner of an affected person felt their relationship had been more strained since the time of the accident, both other changes were positive.

<table>
<thead>
<tr>
<th>I received support from my sister and friends but my relationship with my partner has been strained at times since his accident. It’s mainly due to him being bad tempered.</th>
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<tbody>
<tr>
<td><em>Female partner of male clinical NHS worker.</em></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>I feel closer to my partner now after the accident and all the worries she has had since about her health and damage the accident might have caused her.</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Male partner of female administrative NHS worker</em></td>
</tr>
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</table>

• Eight of the family members had perceived a change in their own behaviour as a result of the accident although typically they were only short-term. The most common changes were a decrease in sleeping and an increase in losing their patience or ill temper.

<table>
<thead>
<tr>
<th>I’ve noticed I’m sleeping less. I’ve been grumpy and lost my patience and sometimes felt like just getting out of the house. It’s because we’ve been cooped up together in the house more than usual since he’s been off work and the accident</th>
</tr>
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<tbody>
<tr>
<td><em>Partner of male clinical NHS worker</em></td>
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</table>

• There were slight inconsistencies between changes reported by APs and those perceived by family members, most notably in the areas of ill-temper and impatience where family members reported greater impatience and ill temper compared to the APs themselves.

<table>
<thead>
<tr>
<th>I worried about him, and us as a couple, as we’d been arguing more. I was worried about sleeping less as I knew I was tired at work and not doing as good a job as I normally do. But accidents happen; it’s just one of those things.</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Partner of male clinical NHS worker</em></td>
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</table>
6.7 HEALTHCARE ACCIDENT GROUP - CASE STUDIES
6.7.1 Case No: 41 - male clinical NHS worker

The home interview was carried out 5.5 months after the event and the follow-up interview after a further 5 months.

Incident and injuries

Case 41 slipped on a wet floor and fractured his ankle.

Vocational consequences

Case 41 had been off work for 7 weeks at the time of the home interview before returning to his original job. He had become more safety conscious at work than before his accident. He had seen the Occupational Health department but felt they had been of little use. His supervisor had not been in touch since the accident but he had been in contact, socially, with his colleagues who had given him moral support when he was feeling down and bored.

He felt that responsibility of the accident was due to both the individual carelessness of the cleaner who left the floor wet and himself for rushing.

His partner had taken three days off work following the accident.

There had been no change to the vocational situation of Case 41 at the follow-up interview.

Financial consequences

At the time of the accident Case 41 was earning £2500 - £3000, net monthly income and received full pay during his time off. Taxis to appointments totalled £30 and a small wooden ramp at the front door, to avoid the steep steps, cost £20. He bought thank-you gifts for his carers that cost £100 in total.

Case 41 was not engaged in seeking compensation for his injury.

At the time of the follow-up interview he had spent an additional £100 - £200 on transport costs as driving was difficult.

Social consequences

Almost all activities had been restricted after the accident including mobility, manual household work, football and squash. Meeting his family to eat out had stopped since the accident. His partner had helped cheer him up and organise practical details as well as caring for him. His mother had helped around the house following the accident and his father had built the ramp at his front door. Physiotherapy had been very useful and encouraging in getting back to normal. He felt closer to his partner as a result of the accident although he reported taking out his frustration on her since the time of the accident. He also felt closer to his mother as a result of the time they had spent together.
At the time of the follow-up interview all activities of daily living had returned to normal, apart from playing football and squash. He thought he made more of an effort to be patient with his family after their care when he was off work.

**Behavioural consequences**

At the time of the home interview Case 41 had been sleeping less due to the discomfort of the plaster cast on his foot. He had been eating more and drinking more alcohol during his recovery period. Because he was housebound, he found that he wanted to socialise more than normal. He also reported an increase in his use of painkillers and an increase in ill temper and impatience.

He reported that his partner was sleeping more, drinking more alcohol and losing her temper and patience more often than normal, all as a result of the accident. Additionally, she was eating less because of her anxiety following the accident.

At the follow-up interview he reported that all his behaviours had returned to normal, as had those of his partner.

**Psychological consequences**

Case 41 felt frustrated that he had not regained full mobility. He had not discussed the emotional impact of the accident with his GP.

At the follow-up interview he reported feeling much better overall.
6.7.2 Case No: 42 - female clinical private healthcare worker

The home interview was carried out 6 months after the event.

Incident and injuries

Case 42 was supporting a patient when the patient overbalanced and fell, holding onto her arm at the time. Her arm was pulled out of its socket at the shoulder and has required an operation to remedy the situation. Despite the operation and physiotherapy, she felt, at the time of the interview, that the joint was not healing.

Vocational consequences

Case 42 had been absent from work for five months at the time of the interview and was hoping to return after a consultation in a further six weeks. She did not expect to return immediately to nursing and hoped to be able to take on an administrative role for a time.

She had received strong support from her work colleagues, both encouragement and practical help, but very little from her employer. Her relationships with colleagues remain excellent, but she felt markedly less positive than prior to the accident about her employing organisation and about her immediate manager.

Financial consequences

To the time of the interview, Case 42 had been in receipt of full pay of £500 - £1000 per month. However, future pay is not a contractual obligation on the employer’s part, but is discretionary, and Case 42 believed that her pay would be reduced in the future.

Case 42 incurred additional costs of £180 for transport to and from hospital appointments, which would have been much higher had not friends and neighbours helped out.

Case 42 had provisionally decided to institute a claim for compensation against her employer, but was concerned about the effect this will have on her prospects and working environment.

No-one else had lost time from work as a result of the accident.

Social consequences

Though many daily activities had recovered somewhat after the initial accident, at the time of the interview Case 42 was still recovering from a further operation on her shoulder 4 weeks previously. At the time of the home interview, all personal care and household activities were still restricted, including bathing, dressing, cooking, shopping and housekeeping. Also restricted were driving and social interaction. Case 42, in anticipation of a reduction or a loss of pay was carefully monitoring household expenditure.

Family activities were also restricted, as were playing with the children and taking them to and from their activities. Support has been provided by Case 42’s partner, parents-in-law and friends. This has, in turn, led to a strengthening of those relationships.
**Behavioural consequences**

Case 42 has experienced significant changes in behaviour since the accident, with decreases in sleeping, eating, cognitive functions, and socialising. This is coupled with increases in situation avoidance, impatience and ill-temper. She has also increased her use of prescription drugs.

She further reported changes in the behaviour of others in the family. Her partner was sleeping less and shown increases in impatience and ill-temper. All three children, who are aged 8, 9 and 11, have shown decreased sleeping and increased negative behaviour, including impatience, ill-temper and disruptive behaviour at school and at home.

**Psychological consequences**

Case 42 was experiencing feelings of vulnerability and apprehension at the prospect of returning to work at the time of the interview. She had been worrying about her long-term health and the impact of the accident. She had not discussed any emotional issues with her GP.
6.7.3 Case No: 43 - female clinical NHS worker

The home interview was carried out 4 months after the event and the follow-up interview after a further 6 months.

Incident and injuries

Case 43 was attacked by a patient while working on a ward, sustaining bruised shins from where she was kicked and a fractured coccyx from being pushed onto her back.

Vocational consequences

Case 43 had been off work for 4.5 months, and expected to return to work shortly after the interview. She was returning to a different job though this was unrelated to her attack. She felt that her employer thought that she was responsible for what had happened. Her manager had called her on two occasions when she had been off work and she had often been in touch with her colleagues. Her trade union advised her with regard to sick pay. She held her employer responsible for the attack in that the unit was understaffed and the emergency response team were very slow in responding to her call.

No one else had taken time off work in relation to the attack.

*At the follow-up interview she indicated she was now more nervous of patients than she had been before the attack.*

Financial consequences

Her net monthly income was £2000 – £2500 before the illness and while she was off work she received full pay. She did, however, suffer financial losses due to not being able to work overtime. To help with managing these losses, her mortgage company reduced her monthly payments to half the usual amount. She had incurred no extra costs and was not planning on claiming compensation of any kind.

*At the follow-up interview she had spent £20 on prescription charges and £200 on alternative therapies, as she had felt stressed since she had returned to work and was anxious about her personal safety. She had decided to claim compensation and had consulted a lawyer, since the psychological impact of the attack had been more serious than she had expected.*

Social consequences

Her interest in her personal appearance had decreased, as had household activities, walking, driving and social interaction. She needed help with household tasks, which caused some tension within the family, though both her partner and her son had been more considerate and helpful since the attack. All family activities had been affected by her injuries. Her friends had visited her at home and helped keep her company.
At the follow-up interview her interest in her appearance and driving were both still affected and she believed that walking was unlikely to return to normal, as were family sports. She felt the positive changes in her relationships with her partner and son had been sustained.

**Behavioural consequences**

A decrease in sleep was reported, as was an increase in eating, avoiding certain situations and taking medication. She lost her patience and temper more than normal because of worrying about her health and being in pain, and as a result felt less like socialising. There had been no changes in the behaviour of her partner or son.

At the follow-up interview, Case 43 thought that her cognitive functions had improved since returning to work, but still had sleeping problems, avoided certain situations and often lost her temper and patience.

**Psychological consequences**

Case 43 reported feeling bad-tempered, snapping at her family and worried about the pain she had initially from her injuries returning.

At the follow-up interview she reported that she sometimes felt down and worried about the future.
6.7.4 Case No: 44 - female administrative NHS worker

The home interview was carried out 2.5 months after the event.

Incident and injuries

Case 44 fell in hospital during an office move, which she describes as pressured and without a prior risk assessment. She suffered tears in the connective tissue of her hand, resulting in pain and lack of mobility. At the time of the interview she was still waiting for an investigative operation to arrive at a correct diagnosis. Since the injury, she has also suffered from periodic depression.

Vocational consequences

Case 44 had been absent from work for a total of 26 weeks at the time of the interview, though not in a single block. She had tried to return on three occasions and found it impossible to work due to her injury. During the attempts at working again, she was moved to lighter duties such as answering the phone and reception.

She has received support from her employers in terms of time off to allow her hand to recover, but during the period covered by the injury she had noticed a change for the worse in the culture of the hospital due to an organisational change, of which the move resulting in her injury was a part. Case 44 felt that this action was badly planned and had caused the accident, and that the organisation is liable. As a result, Case 44 is seeking compensation.

Attitudes to Case 44 at work have altered since both the accident and the initiation of the claim, with Case 44’s perception of the employer and her colleagues worsening sharply. She has described how she received little care and support, and has been ostracised by team leaders at the hospital since she informed them of the claim.

Case 44 considered that her employers, specifically her senior manager, were responsible for the accident.

Financial consequences

Case 44 has received full pay of £500 - £1000 per month during her absence and has incurred relatively minor costs for transport amounting to approximately £50.

Case 44’s partner has lost a few days work as a result of the accident in taking her to and from her hospital appointments. She expects that there will also be some further loss in the future. Additionally, her daughter has been helping for two hours a day since the accident.

Case 44 is seeking compensation.

Social consequences

Case 44 experienced a temporary restriction in her personal care abilities, including washing and dressing, which has now returned to normal.
Still restricted, however, are all household activities, including housekeeping and gardening, playing with grandchildren and hobbies. Social drinking, eating out and days out were also still restricted at the time of the interview.

Case 44 has received support from her family, especially her partner and her adult daughter. She reports, however, that her relationship with her partner has worsened since the accident and blames herself for this deterioration.

**Behavioural consequences**

Many aspects of Case 44’s personal behaviour have been affected by the accident. She has reported a decrease in sleeping, and also decreases in memory and the desire to socialise. Alcohol consumption has increased, as have the use of prescription and non-prescription drugs, impatience and loss of temper.

Case 44 also reported that her partner was sleeping less, drinking more and more prone to impatience and ill-temper.

**Psychological consequences**

Case 44 has experienced periodic depression, for which she has sought medical advice and been prescribed medication by her GP.
6.7.5 Case No: 45 - female clinical worker (private sector)

The home interview was carried out 4.5 months after the event and the follow-up interview after a further 6 months.

Incident and injuries

Case 45 tripped on carpet and fractured her left shoulder. She suffered from severe pain during recuperation and was still finding some movements difficult at the time of the home interview.

Vocational consequences

Case 45 was back at work when the home interview was carried out after being absent for 7 weeks. She has returned to the same job and was far more cautious at work. Her employer had sent her a get-well card and her manager had called to see how she was getting on while off work, as had her colleagues. Initially she had felt guilty for the inconvenience that the accident was causing people but at the time of the interview thought of it as “one of those things”.

Her partner had taken 15 hours off work to take her to hospital appointments. She did not expect that he would need more time off.

At the follow-up interview she was still working normally and receiving full pay. Her manager had continued to be understanding with regard to her physical limitations. She still occasionally felt guilty about the accident.

Financial consequences

Her net monthly income at the time of the accident was £1000 – £1500. She received no pay when she was off work. Extra costs due to the accident were £12 for car parking at hospital appointments and £20 for petrol costs to and from appointments.

She had no plans to seek compensation.

Further additional costs at the time of the follow-up interview were £200 for private medical appointments and £20 in transport costs for appointments. Since the home interview she had considered claiming compensation but had decided to stay with her original decision not to claim.

Social consequences

Housekeeping, household maintenance and gardening were all still restricted at the time of the home interview. Personal care, leisure and hobbies had returned to normal, as had family activities. In terms of support, her partner had helped her with dressing, physical care and shopping. Her mother-in-law had phoned her to check on her recovery and had provided valuable emotional support. There had been no changes in her relationships.
Any activity that involved heavy lifting was unlikely to return to normal at the time of the follow-up interview. Her partner had continued to give her practical help around the house and in the garden and her colleagues had made her feel far more positive since returning to work.

**Behavioural consequences**

Case 45 has been sleeping less since the accident and avoiding situations that she might find tiring. Being confined to the house had been very frustrating. There were no behavioural changes in those people she was close to.

*At the time of the follow-up interview she was still sleeping poorly but had experienced some improvement since the home interview.*

**Psychological consequences**

Case 45 reported feeling edgy as she had extra work to do to catch up from when she was off work but was now working consciously slower so as to not to over-stretch herself. She reported frustration with her impaired abilities, and with the lengthy time it seemed to be taking her arm to heal. She had not consulted her GP about the emotional impact of the accident.

*At the follow-up interview she felt more positive about the future and was not as worried as she had been at the home interview.*
6.7.6 Case No: 46 - female clinical NHS worker

The home interview was carried out 4 months after the event and the follow-up interview after a further 9 months.

**Incident and injuries**

Case 46 slipped on a wet floor in the hospital and sustained a fractured left wrist, a trapped nerve in her right wrist and dislocated bone in her hand. She underwent a carpal tunnel operation to help relieve the problem with the trapped nerve. She also jarred her back and now suffers from lower back pain.

**Vocational consequences**

Case 46 had returned to work at the time of the home interview and had been off work for a total of 10 weeks. She had been on light duties for 5 weeks on her return to work. Case 46 had become very wary of walking on floors that had just been cleaned. She thinks her manager and the estates department were responsible for the accident since she had reported the leak which caused the event the evening before she slipped and fell. She did not receive any support from her employer. Case 46 was seeking compensation for her injury with the aid of her trade union, but finding the process difficult.

*At the follow-up interview she reported residual pain in her hand after working and had spoken to Occupational Health. There had been no further changes in her vocational situation. She felt the compensation process was very slow and had not heard from her solicitor in some months. She felt that it had been very frustrating to not know what was going on with her case and that claiming compensation had continued to be a negative process.*

**Financial consequences**

At the time of the home interview Case 46 was earning £500 – £1000 as her monthly net income and had received her full pay while off work. Additional cost for petrol and parking costs for visiting hospital for medical appointments amounted to £100.

Her partner took 2 days off work to visit her in hospital and did not expect to have to take more time off.

Her union representative had been very supportive and had given useful advice with regard to claiming compensation.

*There had been no further changes in financial circumstances at the time of the follow-up interview.*

**Social consequences**

Housekeeping, gardening and swimming were all still restricted at the time of the home interview. Family leisure activities were also still affected, as was being a youth leader for a
local children’s group. Her partner had provided emotional support and helped with transport.

Her son had also helped with transport, and she reported that she took great comfort from knowing her church were praying for her and thinking about her. NHS physiotherapy had been very useful. She felt closer to her son who had helped her a lot since the accident.

Case 46 believed that she would never be able to lift items as she could before the accident and was not sure whether housekeeping and gardening would ever return to normal. All family activities, however, had returned to normal.

At the time of the follow-up interview, swimming and her work as a youth leader, which had been adversely affected, had returned to normal.

**Behavioural consequences**

Case 46 was sleeping less when the home interview was carried out, despite taking both prescription and non-prescription medication and she reported that her cognitive abilities were impaired. She felt more like getting out of the house and socialising than normal, as a result of being confined to the home. Her partner had become frustrated with her, as she could not do all the things she normally does.

Case 46 said she had put on weight at the follow-up interview but had started eating less now that she was recovering. She was still sleeping less than usual and was very tired.

**Psychological consequences**

Case 46 did not feel that the accident was still affecting her emotionally, and had not consulted her GP about any emotional issues.

At the follow-up interview she had become angry and frustrated with her continuing impairments.
6.7.7  Case No: 47 - female clinical NHS worker

The home interview was carried out 5.5 months after the event.

**Incident and injuries**

Case 47 slipped on a wet floor in the hospital, dislocating her right shoulder and chipping her clavicle. She has lost some movement in her shoulder and now has nerve damage in her right hand.

**Vocational consequences**

Case 47 was absent from work for 6 weeks before returning to the same job. The injury affects her work and she is forced to compensate with her left side whilst working due to the loss of strength and mobility since the injury.

She received helpful support from her employers, but felt that they were responsible for the accident.

**Financial consequences**

Case 47 received 75% of her full pay of £1500 - £2000 per month while absent, resulting in direct loss of earnings of £650. She received no other financial support, and also incurred prescription costs of £40.

She is considering seeking compensation, particularly since the pain has recently worsened. No-one else lost time off work as a result of the accident.

**Social consequences**

The injury had caused some temporary restrictions in daily activities such as bathing and dressing, but Case 47 had recovered most of this ability by the time of the interview. As a result of her strength and mobility problems, however, shopping was still restricted, as was swimming and other family leisure and sport. Case 47 still experienced some difficulties in caring for her children.

Practical support has been provided by her partner, and childcare help by her parents. No changes in relationships have been reported.

**Behavioural consequences**

Case 47 has experienced a general decrease in strength since the accident, and reports a decrease in sleeping, together with an increased use of both prescription and non-prescription drugs. No behavioural changes have been noticed in either her partner or her children.
Psychological consequences

Case 47 reported no residual emotional effects.
6.7.8 Case No: 48 - female clinical NHS worker

The home interview was carried out 2.5 months after the event.

Incident and injuries

Case 48 slipped on a wet floor outside a shower room in the hospital, landing heavily and fracturing her arm below the elbow. At the time of the interview she still had a stiff arm and some nausea from the injury.

Vocational consequences

Case 48 was absent for 7 weeks before returning to work. She returned to the same job. The injury still affected her work and caused pain with some activities.

Case 48 received no support from her employer, manager, colleagues or trade union, and thinks less of her employer as a result. She blames the employer for the accident, which she believes could have been avoided.

Financial consequences

Case 48 received full pay of £500 - £1000 per month during her absence. The injury also required her partner to take two weeks off work in order to help with transport, and household, childcare and shopping costs. The major cost to the family has been this loss of time, which was valued at £300.

Other costs incurred for painkillers and bandages have been relatively minor.

Case 48 was seeking compensation through a private solicitor.

Social consequences

Case 48 had made a good recovery by the time of the interview, though was still restricted in personal care activities such as washing and bathing. She had experienced temporary difficulties with cooking, shopping and other household tasks, as well as swimming and driving.

Family leisure activities and days out were also affected at first, as was childcare, but these activities had returned to normal by the time of the interview.

Practical support was provided by her partner, her parents-in-law and by her daughter. No changes in relationships were reported.

Behavioural consequences

Case 48 had noticed a decrease in sleeping and eating, and an increase in the use of non-prescription drugs. She had also reported changes in the behaviour of her 11-year old daughter, whom she describes as very shaken by the accident.
Case 48 noticed that in the case of her daughter, there had been a decrease in sleeping and cognitive functions such as concentration, a decrease in socialising and desire to leave the house, and an accompanying avoidance of certain situations. There has also been an increase in impatience and disruptive behaviour at school. Case 48 does not believe, however, that all of these changes are attributable to the accident.

**Psychological consequences**

Case 48 reports no lasting emotional effects from the injury.
6.7.9 Case No: 49 - female clinical worker (private healthcare sector)

The home interview was carried out 3 months after the event and the follow-up interview after a further 7 months.

Incident and injuries

Whilst working in a client’s house case 49 was violently attacked. She was struck in the face and her arm was violently grabbed during the attack, in additional to verbal threats being made against her. Residual injuries included facial swelling, a fractured wrist, permanent thumb ligament damage and eyesight problems.

Vocational consequences

Case 49 had been off 11 for weeks at the time of the home interview and did not know when she might return, although she thought she would return to the same job eventually. She felt that her employer, manager and herself were all responsible for the attack, but particularly her employer, in that they had not provided the information that she needed to work safely with the client who carried out the attack.

At the follow-up interview she had been off work for a total of 39 weeks and at this point did not expect to be able to return to work. She had received no support from her employer.

Financial consequences

At the time of the home interview her net monthly income was £1000 – £1500. She had not been paid during her time off work and was receiving statutory sick pay. Additional costs included £80 for prescription charges and £55 for public transport and taxis.

Case 49 had received a one-off payment of £50 from her union.

Her son took 3 days off work to take her to report the assault and to go shopping, as she couldn’t drive. This was only possible as he is self-employed. Case 49 does not expect her son will need to take more time off work.

She was seeking compensation from her employer as a consequence of the accident, and had a lawyer investigating the case at the time of the home interview.

At the time of the follow-up interview, case 49 had decided not to pursue her claim for compensation, having found the experience negative. She was still receiving SSP. Her son had been paying her household bills for 7 months but she was not sure how much they totalled and was worried, as he could not keep paying for the bills in the future. Further costs included £50 for prescription charges, £100 for taxis and £200 for the cleaner paid for by her son.

Social consequences

Dressing was very difficult since she could not manipulate zips and buttons and her neighbour had to help her put on her bra. All household activities, driving and gardening were
impossible. In order to drive she would need an automatic car and would not be able to afford one. Case 49 reported that her garden was a mess as she was not able to do any work in it and could not afford a gardener. Further, she reported that she could no longer have her grandchildren round to the house, with resulting sadness and depression. Her friends and son have helped with shopping and around the house.

At the follow-up interview going to church and walking were still restricted and driving was not likely to return to normal.

**Behavioural consequences**

She had lost weight at the home interview as a result of eating less since the attack, she slept less and found it more difficult to remember things. Increasingly she avoided certain situations and had increased the medication she took from before the attack.

At the follow-up interview she was taking further medication and losing her temper and patience more frequently than previously. She had continued to sleep poorly and eat less.

**Psychological consequences**

Case 49 had been suffering from sleeping problems such as nightmares and felt angry, depressed and bitter about the attack. She had been prescribed sleeping tablets by her GP.

At the follow-up interview she reported feeling very depressed and increasingly isolated, bitter and frustrated. Her doctor had prescribed anti-depressants.
6.7.10 Case No: 50 - female community worker, private sector

The home interview was carried out 4.5 months after the event and the follow-up interview after a further 6 months.

**Incident and injuries**

Whilst working with a group of children on an outward-bound course, Case 50 fell and fractured her right ankle in 5 places.

**Vocational consequences**

Case 50 had been off work for approximately 6 months at the time of the home interview and expected to return to a different job, though this was unconnected to the accident. She was disappointed with the lack of support provided by her employer, though her immediate manager had visited her at home after the accident and her colleagues visited her while she was in hospital.

Overall, she felt her employing organisation was responsible for the accident, since she felt they had not provided sufficient training.

At the time of the follow-up interview Case 50 had been off work for a further 3 months but had begun working again in a new job similar to her previous one.

**Financial consequences**

Before the accident, Case 50 had a net monthly income of £1500 – £2000. She received full pay for the first two months she was off work. Subsequently her pay stopped and she claimed statutory sick pay. She received a one-off payment of £89 from her union. Hospital bills (amount not specified at interview) from a private hospital were paid for by her insurance policy and transport costs to medical appointments totalled £100. Her family had moved house 2 days before the accident so she had had to pay tradesmen to decorate the house, as she was unable to. This, together with extra food costs for convenience foods, amounted to £3000.

Her partner had taken approximately 3 weeks off work after the accident to care for Case 50; no information was provided with regard to the costs of his absence.

Her trade union advised her about lawyers for making a compensation claim and Case 50 was engaged in seeking compensation for her injuries.

Case 50 had continued to claim statutory sick pay until her return to work. At the follow-up interview additional costs were £500 for private hospital appointments and £30 for transport to medical appointments. She had been finding the compensation process very slow and frustrating, and had experienced some negativity from her employers, which she felt was due to the claim.
Social consequences

All activities of daily living were restricted at the time of the home interview, apart from her interest in personal appearance, which was normal. All family activities had also been affected. She had found not being able to play with her children very difficult. Her partner and children had been good at looking after her and each other since the accident. Staff at the hospital where she had stayed had been especially helpful. The relationship between Case 50 and her partner had changed to become more balanced, since she felt that her partner had taken more responsibility - previously she had made most of the decisions.

At the time of the follow-up interview her mobility was still restricted but all other activities of daily living had returned to normal. Family activities had also returned to normal, although sports could still be difficult because of residual movement difficulties. Relationships with her family members had not changed.

Behavioural consequences

Case 50 had been taking more medication than normal as a direct result of the accident and had been sleeping less because of discomfort and worrying. She felt her cognitive functions were still impaired and lost her temper and patience as a result of not being able to carry out normal activities. This had also led to wanting to get out of the house and visit people more.

Sleeping had returned to normal at the follow-up interview but she felt she had continued to lose her temper and patience more than normal. She was still taking non-prescription medication.

Psychological consequences

Case 50 described how the accident had made her question her own mortality and wonder how much longer she would live for. She also discussed feeling depressed and frustrated with the restrictions on her daily life.

At the follow-up interview Case 50 reported feeling much better, though she said she still felt frustrated with what had happened and was annoyed about the compensation process being complex.
6.7.11 Case No: 51 - female support worker, private sector

The home interview was carried out 3 months after the event.

Incident and injuries

Case 51 tripped over a cable when working under pressure during a staff shortage. She fell against a storage unit and compressed her chest and arm, fracturing several ribs.

6.7.11.1 Vocational consequences

Case 51 had been off work for 9 weeks before returning to her original job. On her return, the injuries made working difficult since she was unable to lift equipment or carry out any activity that was physically demanding due to the pain in her chest. She felt unable to do her job properly at this point, and that she was a burden to those she worked with, and subsequently resigned from her position. She hopes to be able to work again in a few months.

Case 51 received no support, other than financial, from her employer and felt that the maintenance department of the company were responsible for her accident.

Financial consequences

Case 51 received full pay of less than £500 per month during her absence and the company also covered private medical care costs for a chiropractor. Since she has now resigned, the chiropractor’s ongoing fees of £46 per week will be paid by Case 51.

She is seeking compensation with a lawyer’s help.

No-one else has lost time off work as a result of the accident.

Social consequences

At the time of the interview, personal care such as bathing and dressing, household care, leisure and recreation, and social interaction were all still restricted by the injury. Mobility was also restricted and Case 51’s breathing remained painful.

Case 51’s partner had provided practical support, as had her adult children. Though Case 51 found her GP’s attitude dismissive and unhelpful, she had been impressed with the care and effectiveness of her chiropractor.

No changes in relationships were reported.

Behavioural consequences

Case 51 had become risk-averse, and reported a decrease in sleeping and an increase in non-prescription drug use. She was not aware of any changes in the behaviour of others.
Psychological consequences

Case 51 was worried about the future and described how the worries play on her mind. She had experienced flashbacks since the injury.

She had not sought the advice of her GP on any emotional issues.
6.7.12 Case No: 52 - female clinical NHS worker

The home interview was carried out 3.5 months after the event.

Incident and injuries

Case 52 stepped into a lift, which was under repair in the hospital. Though there was no warning sign, the base of the lift was below floor level and caused Case 52 to fall and fracture her ankle.

Vocational consequences

Case 52 lost one week from work before returning to the same job. She began work with light duties for 6 weeks before resuming her job fully. Case 52 has received no particular support from her employers or union; colleagues covered her work while she was absent.

Case 52 considers that her employer was responsible for her accident.

Financial consequences

Case 52 received full pay (at her normal level of £1000 - £1500 per month) whilst absent, and incurred no costs. Required follow-up treatment was carried out at the hospital where she is employed.

She is not engaged in seeking compensation as a consequence of the injury.

No-one else lost time off work as a result of Case 52’s accident.

Social consequences

Though some activities of daily living were still restricted, including keep-fit, many have now returned to normal and Case 52 had no expectation that any permanent effects would persist. Family leisure and sport had also returned to normal by the time of the interview.

Support was provided by her partner.

Behavioural consequences

No behavioural changes were reported.

Psychological consequences

Although Case 52 reported a level of anxiety, this was unrelated to the accident.
6.7.13 Case No: 53 - female administrative NHS worker

The home interview was carried out 5 months after the event.

**Incident and injuries**

Case 53 slipped on a wet floor in an equipment storeroom in hospital. She damaged her lower back and felt that there was further internal damage, though this was never diagnosed. She subsequently suffered from stress and has undergone substantial weight loss since the accident, which she attributes to the internal damage. Case 53 was unable to walk for some time and still felt at the time of the interview, which was several months after the event, that she had not fully recovered.

**Vocational consequences**

Case 53 was absent from work for 5 weeks. On her return to the same department at the hospital her job was altered to a more clerical role, without the lifting involved in her previous position. Nevertheless, case 53 felt resentful that the accident occurred and felt that her employer was responsible, and further that she had received no support from management after the accident.

**Financial consequences**

Case 53 received full pay of £1000 - £1500 per month during her absence. Additional costs incurred were £125 for osteopathy and approximately £40 for painkillers. She has also received an award of £25 from her trade union.

Her partner had lost 2/3 days from work, and her son half a day, taking her to and from hospital appointments.

Though case 53 initially began claiming financial compensation, and may still do so, she felt that management have not accepted liability and have made claiming difficult for her by public statements about her claim.

**Social consequences**

As a result of the accident, many activities of daily living had been affected, some of which Case 53 believes are unlikely to return to normal. These include walking, shopping, housework and gardening. Visiting friends and socialising were also restricted due to mobility problems. Family leisure and sport activities were also restricted at the time of the interview.

Support had been provided by her partner, but Case 53 feels that the service and support she received from both the medical profession and her trade union was poor.

No changes in relationships were reported.
**Behavioural consequences**

Case 53 reported decreases in eating and sleeping, and decreased cognitive functions in terms of memory, ability to concentrate and take decisions. She had also required an increase in the use of non-prescription painkillers.

**Psychological consequences**

Though Case 53 felt that the change in her job had been positive in her life, she had experienced a marked loss of self-confidence since the accident and was still worried about her appearance and weight loss.

She discussed the emotional impact of the accident with her GP but was not referred for counselling or psychological support.
6.7.14 Case No: 54 - female clinical NHS worker

The home interview was carried out 4 months after the event.

**Incident and injuries**

Case 54 slipped and fell on ice in the hospital grounds, dislocating her right shoulder. She experienced intense pain at the time of the accident and subsequently, and at the time of the interview was still struggling with pain and mobility.

**Vocational consequences**

Case 54 was absent from work for 26 weeks but had returned to full-time work at the time of the interview. She had received helpful support from Occupational Health officers and some help from her trade union regarding claiming compensation.

**Financial consequences**

Though Case 54 received full pay of £1500 - £2000 per month while absent, she incurred losses in earnings as a result of the loss of both “bank-hours” pay and unsocial hours pay. Together, these losses are of the order of £400 per month so that total lost earnings during her absence amount to £2400.

Case 54 has also incurred additional costs of £100 for private physiotherapy, approximately £100 for transport in taxis to and from appointments, and small sums for prescriptions.

At the time of the interview, Case 54 was considering seeking financial compensation from her employer, whom she believed to be responsible for her accident. She had consulted a solicitor. She was initially worried that she may have to stop work whilst claiming, but has now been advised otherwise.

No-one else had lost time off work as a result of the accident.

**Social consequences**

At the time of the interview, Case 54’s abilities in personal care were still restricted, with both bathing and dressing still difficult. As a result of the injury, other daily activities were still affected, including shopping, housekeeping, leisure and driving. Family leisure and sport were also affected adversely.

Support had been provided by her partner and by her adult children, together with their respective spouses. Case 54 had experienced a greater degree of closeness to both children during her recovery period.
Behavioural consequences

Case 54 reported an increase in ill-temper and impatience, together with increased use of prescription and non-prescription drugs. Sleeping and her ability to concentrate were adversely affected.

Case 54 reported a number of positive behavioural changes in her partner, including increased patience and helpfulness, and decreased alcohol consumption. Positive behavioural changes were also reported for her daughter.

Psychological consequences

Case 54 expressed worries for her future employment as a clinical NHS worker since her shoulder and back were still painful, and she is also anxious about the effect that claiming compensation will have on her job. She had not consulted her GP about the emotional issues of the accident.
6.7.15 Case No: 55 - female administrative worker, private sector

The home interview was carried out 3 months after the event and the follow-up interview after a further 10 months.

**Incident and injuries**

Case 55 tripped and fell whilst walking outside in the grounds of the facility she managed. As a result of the fall she sustained a fractured elbow and an infection. She has had two subsequent operations.

**Vocational consequences**

Case 55 had been off work for 12 weeks at the time of the home interview and did not expect to be able to return to work. The Human Resources department had been co-operative but she was very disappointed with her manager who had only called her twice - on both occasions was in connection to her anticipated date of return to work. She feels the shortage of resources led to material lying around, which caused the accident, and therefore blames her employer for her injuries.

Case 55 indicated she was considering claiming compensation from her employer as she felt the consequences of the accident had been severe.

*At the follow-up interview she had recovered significantly and had returned to her old job having been off for 7 months. She was working part-time at this point as she still tired easily and it allowed a better working arrangement between her and her deputy.*

**Financial consequences**

Prior to the accident Case 55 had a monthly net income of £2500 – £3000. She received full pay for the first month off work, which decreased to 50% in the following months. She was also claiming statutory sick pay. Additional costs included £350 for transport costs, £500 for a gardener and £100 for comfortable clothing.

*At the follow-up interview the additional costs incurred included a private medical appointment of £150, a further £250 for taxis and other transport costs, and £350 for a gardener. She had decided not to claim compensation from her employer now that she had returned to work.*

No one else took time off work in connection with the accident.

**Social consequences**

All activities of daily living had been affected by the accident, including her favourite hobbies of dog-walking and hill-walking. Playing bridge had returned to normal, as had her interest in her appearance. Her friends had been an invaluable source of support, looking after her while she was in hospital and helping out when she returned home by keeping her company and
bringing round meals. Her bridge circle visited her house so as to avoid her having to travel. She had felt guilty, however, at not being able to attend church.

There had been no change in her relationships.

_Gardening and DIY were deemed unlikely to return to normal at the time of the follow-up interview. Mobility, personal care, shopping and household maintenance were all still restricted. Her friends had continued to support her._

**Behavioural consequences**

Since the accident Case 55 had slept less than normal and eaten more due to being at home more than normal. She felt her cognitive functions had declined as a result of not working and taking medication. Spending more time than normal in the house left her wanting to socialise more and get out of the house. It also made her less patient than normal.

_At the follow-up interview her sleeping and eating had returned to normal. She had returned to work and as a result felt her cognitive functions had improved. She was avoiding situations where she had to walk less often and that felt some normalisation with regard to leaving the house and impatience had taken place._

**Psychological consequences**

Case 55 felt a sense of isolation due to not seeing people as much as usual. She was frustrated, as she had not yet recovered. She had not discussed the emotional effects of the accident with her GP, as she was worried that he thought she was a malingerer on account of her having to visit him so frequently.

_At the follow-up interview she felt less lonely than at the home interview as she was getting back to normal. She felt less depressed but was occasionally frustrated with residual pain._
6.7.16 Case No: 56 - female clinical NHS worker

The home interview was carried out 7 months after the event and the follow-up interview after a further 5 months.

**Incident and injuries**

Case 56 slipped while working in a delivery suite and broke her right wrist. It was an extremely painful injury and was slow to heal.

**Vocational consequences**

Case 56 had been off work for almost 5 months when the home interview was carried out. She had returned to the same job and had become far more careful when working. Personnel had called her at home to check on her recovery, as had her supervisor. Colleagues had visited her when she was off work. She felt the accident was the responsibility of a member of the public.

She was not claiming compensation.

*Her vocational situation had not changed when the follow-up interview was carried out.*

**Financial consequences**

Her net monthly income at the time of the accident was £1500 – £2000 and she received full pay when she was off work. However, she had lost other earnings from not being able to work overtime or to carry out agency work, which amounted to an approximate loss of £500 per month. Transport to appointments had cost £50 and costs of independent transport for her children had also amounted to £50.

No one else had taken time off work in connection with the accident.

*At the follow-up interview she had spent an additional £100 on taxi fares.*

**Social consequences**

Most personal care and household activities were still restricted at the time of the home interview, as were all forms of mobility. Family leisure and sports activities had not been possible since the accident. Her children had helped with shopping and cooking since the accident, had cheered her up when she was feeling down, and had also kept her company by talking and reading to her. She felt proud of how her children had managed whilst she had been severely incapacitated since the accident. She felt closer to her daughter as a result.

*Gardening and DIY were still restricted at the time of the follow-up interview. Family activities had returned to normal and her relationships had undergone no further changes.*
**Behavioural consequences**

Case 56 had been sleeping less since the accident and often felt tired. As a result she thought her cognitive abilities had decreased. She avoided situations linked to mobility or leaving the house, though she missed being able to socialise. She had been taking both prescription and non-prescription medication.

Her daughter had been losing her temper and patience more than normal but had wanted to stay in the house more than usual to look after Case 56. Her son had become more responsible and had started taking more decisions.

*She felt her behaviour had returned to normal by the time of the follow-up interview and that the positive changes in her children had been sustained.*

**Psychological consequences**

Case 56 was worried about having less money than normal and felt angry the accident had happened. She had not talked to her GP about the emotional effects of the accident.

*At the follow-up interview Case 56 was worried she would never regain the original level of use in her wrist.*
6.7.17 Case No: 57 - male clinical NHS worker

The home interview was carried out 5 months after the event.

**Incident and injuries**

Case 57 fell in a poorly lit car park at the hospital when tired after a late shift. He broke his ankle and two bones in his foot and was still in pain and suffering from lack of mobility at the time of the interview. He has suffered since from stress-related headaches and anxiety.

**Vocational consequences**

Case 57 had been absent from work for 7 weeks before returning to his regular job at the hospital. He was still in some pain and finding himself being more careful at work, especially when tired.

He had received some support from his employer, had been contacted by the Occupational Health department, and had also received some encouragement from colleagues. Case 57 felt that both himself (for carelessness) and the hospital (for poor lighting) were responsible for the accident.

**Financial consequences**

Case 57 received full pay of £2500 - £3000 per month while absent from work.

He incurred costs of £120 for a course of acupuncture that successfully treated his stress headaches, and minor costs for painkillers.

He is not claiming compensation. Nobody else lost time off due to the accident.

**Social consequences**

Though back at work at the time of the interview, Case 57 was experiencing restrictions in personal care such as dressing and bathing, and in his ability to carry out household tasks such as cooking and housekeeping. Since he finds these tasks uncongenial, however, he has seen a positive side to those particular restrictions. More serious to him are the pain and lack of mobility, which cause him to avoid sports and driving. Social interaction and days out with his partner had not been affected.

During his period of impairment, Case 57 received practical support from his partner and mother, as well as emotional encouragement from friends. He was helped by physiotherapy and was especially impressed by his course of acupuncture.
Behavioural consequences

At the time of the interview, most behaviours were back to normal for Case 57, with the exception of difficulty in sleeping and lack of patience. He had also noticed a similar lack of patience and difficulty sleeping in his partner.

Psychological consequences

Case 57 was experiencing frustration and anger that the accident had happened, and had noticed a marked increase in stress-related headaches. He had not consulted his GP about any emotional issues relating to the accident.
6.7.18 Case No: 58 - female administrative NHS worker

The home interview was carried out 14 months after the event.

**Incident and injuries**

Case 58 slipped in urine on the floor of an NHS hospital and dislocated her right knee. The injury was followed by the onset of arthritis in the same joint causing additional pain and mobility problems. Since the accident, case 58 has had emotional problems and anxieties about her future.

**Vocational consequences**

Case 58 was absent from work for a total of 25 weeks. On her return, and as a result of the injury and its consequences, she had changed her role to a part-time one with less responsibility. It is not yet clear how the injury and the resultant illness will affect Case 58’s long-term employment situation and prospects.

She felt well-supported by her employers. She felt that her employers were responsible for the accident, but she is unwilling to compensation as she feels that NHS patients would ultimately be disadvantaged by this action.

**Financial consequences**

Case 58 received full pay of £2000 - £2500 per month from her employer during her absence. However, in her new position, which she has had to accept due to the injuries, she will earn £6000 less per annum.

In addition, Case 58 has incurred costs of £100 for physiotherapy, £70 for a wheelchair and some transport costs when visiting hospitals. Her partner lost 2 days from work to take her to appointments.

**Social consequences**

Case 58 was still experiencing restricted mobility at the time of the interview and was unable to either walk or drive comfortably. She believes that her ability to walk will never return to normal and that this lack of mobility affects most household activities, including housekeeping, shopping and gardening. Social and leisure activities with the family are not affected.

Support has been provided by her partner, who lost some days driving Case 58 to appointments, and by friends. No changes in relationships have been reported.
**Behavioural consequences**

Case 58 was experiencing a decrease in sleeping and in cognitive functions at the time of the home interview. Eating, use of both prescription and non-prescription drugs have all increased, as has impatience and ill-temper.

**Psychological consequences**

Case 58 described feelings of depression and a sense of despair since the accident. She continued to experience problems with sleeping. She had not discussed the emotional impact of the accident with her GP.
6.7.19 Case No: 59 - male clinical NHS worker

The home interview was carried out 10 months after the event and the follow-up interview after a further 4 months.

Incident and injuries

Whilst working in a trust hospital Case 59 tripped walking downstairs and fractured several bones in his right foot.

Vocational consequences

Case 59 had been off work for 1 week following his accident before returning to his original job, though he was able to return to lighter duties initially. Since returning to work he is far more careful. His employer had been very supportive and Occupational Health had contacted him to arrange an appointment. His supervisor had also been in touch about changing the schedule of Case 59, and his colleagues are helping him by covering some of his work when he is on shift.

He felt that he himself was responsible for what happened and had no intention of claiming compensation from his employer as a result.

He had taken another 7 weeks off work at the stage of the follow-up interview since he had gone back to work too early, aggravating his injury. At this point he felt that Occupational Health had not been of any help and that the HR department had made no effort with him. His colleagues had continued to be very helpful in covering his work when he was off.

Financial consequences

At the time of the home interview Case 59 had a net monthly income of over £3000 and had received full pay when he was off work. He had been using taxis as he has unable to drive and these amounted to £210. While he had been off work he had spent £50 on videos, books and magazines to keep himself occupied.

No one else has taken time off to care for him or in connection to his accident.

At the time of the follow-up interview he had spent £150 on taxis and £150 on gifts for people who had looked after him and helped out at work.

Social consequences

Personal care, household activities and mobility were all still affected when the home interview was carried out. His favourite hobbies, canoeing and football were impossible because of his injury. His partner had been particularly helpful with transport, as had his sister.

There had been no changes in his relationships.
Mobility, football and canoeing were all still affected at the follow-up interview because of his residual physical impairment. All other activities of daily living had returned to normal. Since the home interview his relationship with his partner had become strained, though she continued to be very patient and he felt closer to his partner as a result of the whole experience. His sister had provided continued practical assistance.

**Behavioural consequences**

Case 59 had been sleeping less and felt less able to make decisions. He had been less patient and more bad tempered than normal as a result of the accident and avoided unnecessary travel because of difficulties with walking.

His partner had been sleeping less and lost her patience more frequently than normal.

*At the time of the follow-up interview, Case 59 thought he was sleeping more and that the rest of his behaviours had returned to normal.*

**Psychological consequences**

Case 59 was very annoyed with himself for causing the accident, and was frustrated that he was missing out on doing things as a result. He had not discussed the emotional impact of the accident with his GP.
6.7.20 Case No: 60 - female clinical NHS worker

The home interview was carried out 14 months after the event.

*Incident and injuries*

Case 60 slipped and fell on hospital site, fracturing her upper humerus. Despite an operation to set the bone and intensive physiotherapy, she remained in pain at the time of the interview, lacked strength and mobility in the arm, and was anxious for her future.

*Vocational consequences*

Case 60 had been absent for a total of 5 months until her return to work at the same hospital. Initially she was placed on light duties in an administrative role, but has now returned to nursing. She still experiences pain in her arm during the course of her work.

She received no support from her employing organisation and minimal contact with managers. Case 60 felt that her employer was responsible for the accident and had begun to seek compensation at the time of the interview.

*Financial consequences*

Case 60 received full pay of £1000 - £1500 per month for the first two months of absence, followed by 50% pay for the next three months. Her total loss of earnings amounted to £1875. In addition, she incurred costs of £300 for private physiotherapy and approximately £20 for transport to and from appointments.

During this period, she was able to borrow money from her parents to cover household expenses.

No-one else had lost time from work as a result of the accident.

*Social consequences*

After a period of restricted abilities, Case 60 was back to normal with personal care at the time of the interview, and was able to wash and dress without difficulty. Still restricted, however, were all household activities, including housekeeping and cooking, and driving. Family leisure and social activities were back to normal after a period of difficulty, but child-related activities involving driving, such as taking her daughter to school, were still restricted.

Emotional support had been provided by her 16 year old daughter, her mother, and by friends. The relationships of Case 60 with both her daughter and her mother have been strengthened by the experience, as they have spent more time together and have come to understand each other more.
Behavioural consequences

Case 60 has reported increases in eating since the injury, as well as impatience and ill-temper, and her use of non-prescription drugs. She also finds herself avoiding certain situations. Sleeping has decreased, as has her ability to concentrate.

Case 60 describes a positive change in her daughter’s behaviour in that she has become more patient and helpful whilst looking after her mother.

Psychological consequences

Case 60 was worried about the future at the time of the interview, and especially worried that a further operation may prove necessary, and the potential loss of pay that this may entail.

She had not consulted her GP about the emotional impact of the accident.
6.8 HEALTHCARE ILLNESS GROUP - OVERVIEW
### 6.8.1 Healthcare illnesses: summary table

Table 6.27 Healthcare illnesses summary table  
(residual effects present at the time of the home interview)

<table>
<thead>
<tr>
<th>AP No.</th>
<th>Gender</th>
<th>Nature of illness or accident</th>
<th>Family member interview</th>
<th>Follow-up interview</th>
<th>Residual Physical effects</th>
<th>Residual emotional effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>f</td>
<td>RSI; pain &amp; swelling in arm, wrist &amp; elbow.</td>
<td>No</td>
<td></td>
<td>Pain and swelling in wrist and elbow; difficulty sleeping.</td>
<td>None.</td>
</tr>
<tr>
<td>62</td>
<td>f</td>
<td>Carpal tunnel; numbness and pain in arms, fingers, hands.</td>
<td>Yes</td>
<td></td>
<td>Pain and numbness in wrists; poor grip.</td>
<td>None.</td>
</tr>
<tr>
<td>63</td>
<td>f</td>
<td>Latex allergy; skin rash on wrists and palms.</td>
<td>Yes</td>
<td></td>
<td>Allergic reactions; skin rash and painful itching.</td>
<td>Panic attacks, anxiety and tension.</td>
</tr>
<tr>
<td>64</td>
<td>f</td>
<td>Needlestick injury from hepatitis C patient.</td>
<td>Yes</td>
<td></td>
<td>None.</td>
<td>Anxiety and worry for the future; guilty feelings and nightmares.</td>
</tr>
<tr>
<td>65</td>
<td>f</td>
<td>RSI; pain elbow and hand.</td>
<td>Yes</td>
<td></td>
<td>Some pain in elbow and hand.</td>
<td>Anxiety and worry about professional future.</td>
</tr>
<tr>
<td>66</td>
<td>f</td>
<td>Latex allergy; dermatitis &amp; asthma.</td>
<td>Yes</td>
<td></td>
<td>Asthma and painful dermatitis.</td>
<td>None.</td>
</tr>
<tr>
<td>67</td>
<td>f</td>
<td>Latex allergy; rash on hands, wheezing, anaphylactic shock.</td>
<td>Yes</td>
<td></td>
<td>Continuing attacks and need to carry adrenaline.</td>
<td>Anxiety and worry about latex in the environment.</td>
</tr>
<tr>
<td>68</td>
<td>f</td>
<td>Latex allergy; itchy skin &amp; nettle rash, anaphylactic shock.</td>
<td>Yes</td>
<td></td>
<td>Continuing risk of attacks; need to carry adrenaline.</td>
<td>Anxiety and depression; constant worry about latex.</td>
</tr>
<tr>
<td>69</td>
<td>f</td>
<td>RSI in elbow.</td>
<td>Partner</td>
<td>No</td>
<td>None.</td>
<td>None since trust implemented latex-free policy.</td>
</tr>
<tr>
<td>70</td>
<td>f</td>
<td>Allergy; anaphylactic shock, skin rash, wheezing</td>
<td>Yes</td>
<td></td>
<td>None.</td>
<td>Worry about future attacks.</td>
</tr>
<tr>
<td>71</td>
<td>f</td>
<td>RSI; pain in wrist, thumb, arm and shoulder.</td>
<td>Yes</td>
<td></td>
<td>Pain and lack of strength.</td>
<td>Frustration and depression.</td>
</tr>
<tr>
<td>72</td>
<td>f</td>
<td>Latex allergy; affects hands, face, new food allergies also.</td>
<td>No</td>
<td></td>
<td>Rashes and itchiness.</td>
<td>Worry about further attacks.</td>
</tr>
<tr>
<td>73</td>
<td>m</td>
<td>Industrial rhinitis from formaldehyde; sore inner nose/throat, 99% loss of smell, dry throat, insomnia.</td>
<td>Yes</td>
<td></td>
<td>Soreness and dryness in throat and nose; no sense of smell. Insomnia.</td>
<td>Anxiety and frustration.</td>
</tr>
<tr>
<td>AP No.</td>
<td>Gender</td>
<td>Nature of illness or accident</td>
<td>Family member interview</td>
<td>Follow-up Interview</td>
<td>Residual Physical effects</td>
<td>Residual emotional effects</td>
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<tr>
<td>74</td>
<td>m</td>
<td>Paramedic contracted meningococcal septicaemia; hospitalised.</td>
<td>Partner</td>
<td>No</td>
<td>Constant feeling of hotness, neuralgia and limb pain; headaches and tiredness.</td>
<td>Anxiety, memory loss, frustration.</td>
</tr>
<tr>
<td>75</td>
<td>f</td>
<td>RSI; disabling pain in arm neck &amp; shoulder.</td>
<td>No</td>
<td>No</td>
<td>Pain, lack of mobility and strength; insomnia.</td>
<td>Drained and anxious.</td>
</tr>
<tr>
<td>76</td>
<td>m</td>
<td>Industrial allergy; dry itchy skin on hands &amp; arms, eczema on upper trunk.</td>
<td>No</td>
<td>No</td>
<td>Dry, itchy skin; occasional breathlessness.</td>
<td>Self-conscious and frustrated.</td>
</tr>
<tr>
<td>77</td>
<td>f</td>
<td>RSI; lost use of right hand.</td>
<td>Yes</td>
<td>No</td>
<td>Continuing pain and loss of mobility in right hand.</td>
<td>Anxiety, depression.</td>
</tr>
<tr>
<td>78</td>
<td>f</td>
<td>Latex allergy; asthma, redness, flushing, mild anaphylaxis, tiredness, sickness, tachycardia.</td>
<td>Yes</td>
<td>No</td>
<td>Continuing attacks, tiredness.</td>
<td>Fear of attacks, frustration and worry.</td>
</tr>
<tr>
<td>79</td>
<td>f</td>
<td>RSI in left wrist.</td>
<td>Partner</td>
<td>Yes</td>
<td>Stiffness, numbness and pain.</td>
<td>Anxiety.</td>
</tr>
<tr>
<td>80</td>
<td>f</td>
<td>Carpal tunnel syndrome; disabled right hand and arm.</td>
<td>Yes</td>
<td>No</td>
<td>Pain and restricted movement; must wear splint.</td>
<td>Continuing anxiety and some depression.</td>
</tr>
</tbody>
</table>
6.8.2 Healthcare illness group: an overview of the cases

A total of 20 individuals working in the healthcare sector who had suffered serious work-related illnesses were interviewed together with a further 5 family members, associated with 5 separate cases. The mean time of these interviews after the illness report date was 17 months. As in the construction illness sector, the variation in times between the onset of the illness and the home interview reflects the methodological difficulties in obtaining illnesses cases with recent onset. A further follow-up interview (either a telephone interview or home interview) with the affected person was carried out in a subset of 14 cases. The mean time of the follow-up interview after the first home interview was 5 months.

The types of illness experienced by those interviewed are listed in the table below. It should be noted that the illnesses have been allocated according to their primary presentation. One affected person who suffered from a latex allergy had also developed secondary dermatitis. Another whose main illness was dermatitis also was affected by eczema. A third person developed both occupational asthma and dermatitis.

Table 6.28 Types of illness experienced

<table>
<thead>
<tr>
<th>Illness</th>
<th>Number of APs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latex allergy</td>
<td>6</td>
</tr>
<tr>
<td>RSI</td>
<td>9</td>
</tr>
<tr>
<td>Suspected Hepatitis C</td>
<td>1</td>
</tr>
<tr>
<td>Asthma</td>
<td>1</td>
</tr>
<tr>
<td>Dermatitis</td>
<td>1</td>
</tr>
<tr>
<td>Meningococcal septicaemia</td>
<td>1</td>
</tr>
<tr>
<td>Industrial Rhinitis</td>
<td>1</td>
</tr>
</tbody>
</table>

6.8.2.1 Demographics

The age and gender distribution of the 20 cases are shown in Table 6.29 and the distribution by residential status in Table 6.30.

Table 6.29 Age and sex distribution of sample

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>25-34</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>35-49</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>50-64</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 6.30 Residential status of sample

<table>
<thead>
<tr>
<th>Residential status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lives alone</td>
<td>2</td>
</tr>
<tr>
<td>Lives with partner</td>
<td>9</td>
</tr>
<tr>
<td>Lives with partner and children</td>
<td>6</td>
</tr>
<tr>
<td>Lives with children</td>
<td>2</td>
</tr>
<tr>
<td>Lives with parents</td>
<td>1</td>
</tr>
</tbody>
</table>

Of the 20 cases affected by illnesses in the healthcare sector, 17 were female. Most APs lived with others, typically either their partner or their partner and children. Of the 8 APs who
lived with children, 2 were living with adult children and the remainder with children under 18 years old. There were a small number of cases where APs lived on their own.

### 6.8.2.2 Vocational consequences

#### Work outcome

Of the 20 cases, 17 were employed by the NHS. The remainder were employed in the private sector. The pattern of return to work and resettlement at the time of the interviews is summarised in Table 6.31.

<table>
<thead>
<tr>
<th>Work status</th>
<th>Home interview</th>
<th>Follow-up interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>No time lost</td>
<td>Working but job affected (RSI)</td>
<td>Job still affected 1</td>
</tr>
<tr>
<td></td>
<td>Working but job affected (allergy-related illnesses)</td>
<td>Job still affected 1, No follow-up 2</td>
</tr>
<tr>
<td>Returned to work</td>
<td>Returned to different job (RSI)</td>
<td>Still in the same job 1</td>
</tr>
<tr>
<td></td>
<td>Returned to different job (rhinitus)</td>
<td>Still in the same job 1</td>
</tr>
<tr>
<td></td>
<td>Back to same job but job affected (suspected hepatitis C)</td>
<td>Different job due to illness 1</td>
</tr>
<tr>
<td></td>
<td>Back to same job but job affected (RSI)</td>
<td>Job still affected 3, Different job due to illness 1, No follow-up 3</td>
</tr>
<tr>
<td></td>
<td>Back to same job but job affected (latex allergy)</td>
<td>Job still affected 1, No follow-up 1</td>
</tr>
<tr>
<td>Still off work</td>
<td>Don’t expect to return to same job because of illness (RSI)</td>
<td>Still don’t expect to return to same job because of illness 1</td>
</tr>
<tr>
<td></td>
<td>Don’t expect to return to same job because of illness (Asthma &amp; allergies)</td>
<td>Still don’t expect to return to same job because of illness 1</td>
</tr>
<tr>
<td></td>
<td>Don’t know if they will return to work or not 1 latex allergy</td>
<td>Still don’t know if they will return to work or not 1</td>
</tr>
<tr>
<td>No longer working</td>
<td>Taken medical retirement (latex allergy)</td>
<td>No change (latex allergy) 1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

The main patterns to emerge are as follows:

- Most APs were working at the time of the home interview but had lost time in the past due to their illnesses.

- At the time of the home interview, 10 APs had returned to the same job but had altered the content of their job or the way they worked. Those suffering from RSI had introduced more variety into their work routine while those with allergies had
adapted the way they worked. The latter group was forced to plan ahead so that they
could avoid environments where allergens were present.

| I’ve restructured my day to be able to manage to work. The RSI gets worse when I do the
same tasks for a long time so I now take breaks from working on the computer for long
periods and have trained myself to be able to use the mouse with both hands. |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female NHS administrative worker, RSI</td>
</tr>
</tbody>
</table>

- Of the 4 people who had lost no time off work, 1 suffered from RSI and 3 from
allergy-related illnesses. All 4 cases had adapted the way they worked to mitigate the
impact of their illnesses.

Most people with such a serious latex allergy who work in a hospital would have taken time
off work, I suppose, but I’ve always felt I should go in otherwise it’s just more pressure for
my colleagues. Not everyone with a latex allergy can work, though - other people are far
more sensitive than I am.

| Female clinical NHS worker, latex allergy |

- One case affected by RSI was unlikely to be able to return to work as she was unable
to carry out even simple tasks after her right hand became especially painful.
Additionally, one AP affected by allergies and asthma did not expect to be able to
return to work after developing an especially high sensitivity. The AP who was
unsure as to whether she would return to work had been affected by a latex allergy
but expected to be able to find a career where the exposure to the allergen could be
managed.

- A very serious latex allergy that prevented any type of work in the healthcare sector
had led to medical retirement.

- At the follow-up interview most cases had not experienced any change in their
employment situation. One RSI sufferer had left her job and moved to another job
and a case who had suffered a needle-stick injury had also moved jobs.

*Length of time off work*

The following table lists the actual or anticipated length of time off work for each of the 20
cases. It should be noted that a range of illnesses was captured in this sample, which is
reflected in the wide variation in impacts.
<table>
<thead>
<tr>
<th>Case No.</th>
<th>Type of illness</th>
<th>Length of time off work (weeks)</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>RSI</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>RSI</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>Latex allergy</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>Suspected Hepatitis C</td>
<td>3 days</td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>RSI</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>66</td>
<td>Latex allergy</td>
<td>11</td>
<td>At time of follow-up interview had been off work approximately 44 weeks and did not expect to return to work</td>
</tr>
<tr>
<td>67</td>
<td>Latex allergy</td>
<td>60</td>
<td>Retired on medical grounds having been off work for approximately 3 months</td>
</tr>
<tr>
<td>68</td>
<td>Latex allergy</td>
<td>2</td>
<td>At time of follow-up interview had been off work for 28 weeks and did not expect to go back to old job</td>
</tr>
<tr>
<td>69</td>
<td>RSI</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>Latex allergy</td>
<td>A few days</td>
<td></td>
</tr>
<tr>
<td>71</td>
<td>RSI</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>72</td>
<td>Latex allergy</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>73</td>
<td>Rhinitis</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>74</td>
<td>Meningococcal septicaemia</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>75</td>
<td>RSI</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>76</td>
<td>Industrial allergy</td>
<td>None</td>
<td>At time of follow-up interview had been off work approximately 44 weeks and did not expect to return to work</td>
</tr>
<tr>
<td>77</td>
<td>RSI</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>78</td>
<td>Latex allergy</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>79</td>
<td>RSI</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>RSI</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

*Established at first home interview or follow-up interview

**Support at work**

At the interviews APs were asked if they had received support from their employer, trade union or others connected to their job.

The main findings are detailed below:

- A total of 15 cases reported receiving support from one or more of the following: employing organisation, manager or supervisor, colleagues or Occupational Health department.
• 5 cases felt they had received no support of any kind. This had led to feelings of resentment towards their employer, demotivation at work or a lack of enthusiasm for return to work.

<table>
<thead>
<tr>
<th>I went back to work after 2 weeks. I didn’t receive any support which was annoying as working practices need to be reviewed to prevent my condition from worsening and the same thing happening to others.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female clinical NHS worker with RSI</td>
</tr>
</tbody>
</table>

• Positive examples of manager support were given by 5 APs and included keeping in touch with people when absent and suggesting new work patterns.

• Examples of negative interactions with managers were given by a small number of APs. These cases reported that their manager had not provided any emotional support but had focused exclusively on administrative issues.

<table>
<thead>
<tr>
<th>My manager called me when I was off but it sounded like he was annoyed with me for messing up his plans for the department. It left me feeling guilty although I know I shouldn’t be.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female NHS laboratory worker with RSI</td>
</tr>
</tbody>
</table>

• Colleagues were praised by APs in almost half the interviews. Support often took the form of keeping in touch when off work and accommodating the AP’s illness on return. One case, however, reported problems with her colleagues due to their increased workload, a consequence of her RSI and long-term absence from work.

• As was found in the healthcare accident sector, Occupational Health departments received mixed feedback. In general, those who had come into contact with them were surprised that they were not more effective or able to offer useful information, despite the fact that these cases were working within the healthcare sector.

<table>
<thead>
<tr>
<th>I didn’t find Occupational Health much use. I had to go looking for someone in another hospital who had specialist knowledge; they were great, as were the nurse practitioners who treated me. I shouldn’t have had to go looking to find help.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female NHS clinical worker, suspected hepatitis C</td>
</tr>
</tbody>
</table>

• When they were involved, trade unions typically provided advice on sick pay or the practical details of seeking compensation.

• In the subset of cases that were followed up there had been very little change in the pattern of support from employers, managers and colleagues. Several cases noted in their interviews that prolonged support and assistance were required throughout the course of chronic illnesses but felt that the level of support that they had received had declined once their colleagues and employer became accustomed to the illness.

Responsibility for the illness

APs were asked who, if anyone, they felt was responsible for their illness. The overall pattern of results is shown in Table 6.33.
Table 6.33 Perceived responsibility for the illness

<table>
<thead>
<tr>
<th>Whose responsibility?</th>
<th>Number*</th>
</tr>
</thead>
<tbody>
<tr>
<td>No-one</td>
<td>6</td>
</tr>
<tr>
<td>Themselves</td>
<td>3</td>
</tr>
<tr>
<td>Employers</td>
<td>12</td>
</tr>
<tr>
<td>Equipment manufacturer</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>23</strong></td>
</tr>
</tbody>
</table>

* Numbers exceed 20 because responsibility was sometimes assigned to more than one party - typically a combination of themselves and their employer or manager.

The results of the interviews indicate that:

- The largest group of APs felt that their employer was responsible for their illness, though this was often in combination with other parties.

> The Trust tries to save money everywhere and a lack of resources in my department led to having more work than was practical to do. It’s down to the employer not providing enough staff.

*Female NHS laboratory worker, RSI*

- Those who blamed themselves attributed their illness to their failure to look after themselves properly; one case with RSI, for example, blamed herself for not taking more breaks while she was working.

- Those who thought their illness was “just one of things” were still likely to feel bitter about their condition.

> My illness is a natural condition. It’s more frustrating in some ways than when you’ve got someone to blame.

*Female clinical NHS worker, latex allergy*

6.8.2.3 Economic consequences

Loss of pay and increased outgoings

Details of individual financial consequences of the illnesses are provided in the case summaries. Some general points can be made, as shown below.

- Half of the total number of APs received full pay for the duration of their absence from work and some cases received full pay for a limited period before moving onto reduced pay. There were 2 cases who received only reduced pay during their absence from work, and one case who received only Statutory Sick Pay during their time off work.

> I don’t have a partner to share the burden of a reduced income and I don’t have savings that I can dip into while I’m off work. I already have credit card debts so can’t use credit to help with household costs. As a result when my daughter offered to lend me money I’ve had to accept the offer.

*Female administrative NHS worker, RSI*
• A small group of cases had received full pay during their time off work but had lost earnings as a result of their inability to work normal overtime. Several cases also felt they may lose out financially because the illness limits the subsequent likelihood of future promotions.

• A positive outcome was reported by 2 cases where a job change due to the illnesses had resulted in higher earnings.

• Only 1 AP had not incurred additional expenses as a result of their illness. In all other cases additional costs had been incurred, these typically being additional transport costs and medical costs (predominantly prescription costs). Over half of the cases had also incurred further costs including the cost of removal of all latex from their house, domestic help and gardening.

<table>
<thead>
<tr>
<th>I am extremely sensitive to latex. The financial costs related to the illness have been massive. All carpets in the house have had to be removed and replaced with other floor surfaces. All shoes in the house need to be leather. I’ve had to buy a new washing machine, employ a dog walker as I can’t always manage it. We even had to buy new mattresses. We can’t fly anywhere because of all the latex in planes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female clinical NHS worker, latex allergy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I’ve got repetitive strain injury and the costs have really mounted up for me. I’m a widow so pay for myself. I’ve spent around £200 on prescriptions and a private appointment to see a doctor. I’ve spent over £200 on taxis and public transport so I can still see my family. I even have to pay a lady to do my ironing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female administrative NHS worker, RSI</td>
</tr>
</tbody>
</table>

• Just under half the cases reported that another person had lost time off work as a result of the illness. Half of those who had lost time off work to care for the AP had lost income.

Compensation and legal implications

• At the time of the home interview, only 2 cases were actively seeking compensation from their employer as a result of their illness. Both cases (one of latex allergy and one of asthma and dermatitis) felt their lives would never return to normal as a result of their condition. These cases felt that they were entitled to some form of compensation in recognition of this and of their limited abilities to work. One claimant affected by a latex allergy had found the process to be positive as she felt that she had been treated unfairly by her employer.

<table>
<thead>
<tr>
<th>I’m young - and this condition will affect my whole life. I think it’s only fair that I receive some sort of compensation. From now on I’ll be very limited in what sort of work I can do.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female NHS care worker, latex allergy</td>
</tr>
</tbody>
</table>

• The 2 further APs considering claiming compensation were both suffering from RSI and had permanently disabling conditions.

• A further case was involved in a tribunal after her claim for industrial injuries benefit had been refused. She was suffering from a long-term latex allergy that had resulted in her not being able to work.
• One AP had been involved in industrial action, through his union, to try and change protocols for healthcare professionals dealing with the chemical he had been affected by.

• Two cases who were not claiming compensation provided very specific reasons for their decisions:

I was advised by my lawyer to keep working and not bother making a claim as I’m 40 years old and still have many years left to work while a compensation payment wouldn’t be very substantial - certainly not enough to allow me to stop working.

Female administrative worker, latex allergy

By the time I had managed to see a doctor who would agree that my condition was caused by the chemical I normally work with, I had missed the 3 year window for making a claim (since the onset of the illness). Now I have to wait to see if the illness gets worse. If it does, I can make a claim.

Male NHS laboratory worker, chronic illness

• At the time of the follow-up interviews all those originally seeking compensation were still pursuing their cases; none of these cases had reached settlement.

6.8.2.4 Social consequences

Activities of daily living

As in the construction accident group, the case summaries in this section cover a range of different conditions, making it difficult to draw general conclusions about the impact they have on specific activities of daily living. However, case summaries show that overall, for many APs, their condition has had a significant impact on their daily lives. Some individuals found it difficult to care for themselves and had also lost the ability to fulfil their normal domestic role. In a female population, for example, failure to be able to carry out activities such as cooking and housekeeping may be particularly significant to the APs concerned. Some of the common patterns to emerge include the following:

• Personal care was reported as one of the first activities to be affected in this group. More than half the group reported restrictions in personal care such as difficulties with dressing or bathing and washing. RSI sufferers, for example, reported having difficulty using zippers and buttons due to problems with fine motor skills; those with allergy-related illnesses had had to find clothing, including underwear, that did not contain latex. Many women use make-up and most make-up applicators and lipsticks contain latex so alternatives had to be found. At the time of the follow-up interviews, the restrictions reported at the home interview by the APs in this subset had continued.

Dressing is difficult because all fine movements are now hard so I have difficulties with buttons and zips.

Female NHS laboratory worker, RSI

• Most individuals had been unable to carry out normal household tasks such as cooking, shopping and cleaning for a period after the onset of the illness. In just over half the cases these activities were still restricted at the time of the home interview. The high percentage of APs reporting these restrictions may be because women normally carry out these domestic activities. When the follow-up interviews were
carried out 1 AP with RSI felt her ability to carry out light household tasks had further declined. The remaining APs, who had all faced difficulties with household tasks at the home interview, reported no improvements. These findings strongly suggest that these chronic debilitating conditions have a long-term effect on day to day activities.

I can’t cook safely as I can’t smell burning or gas. It means more work for my partner.  
Male NHS laboratory worker, chronic illness

- The more physically demanding activities such as house maintenance, gardening and DIY were also affected. Over half the cases reported temporary restrictions on one or more of these activities and many reported they were still restricted or unlikely to return to normal at the time of the home interview. At the time of the follow-up interviews 2 APs in this subset felt that their ability to carry out heavy household tasks had further declined since their home interview. Those reporting restrictions at the home interview confirmed these restrictions were still in place at the follow-up interview.

I love gardening and haven’t been able to do much since this flared up. The heavy work is impossible. I particularly miss this as I live on my own and it’s my main hobby. Driving is also hard because it’s so painful.  
Female clinical NHS worker, RSI

- Most individuals had had to give up at least 1 of their normal leisure and recreational activities temporarily, largely due to their anxiety about exacerbating an existing condition or coming into contact with allergens. When the home interviews were carried out, just over half the cases still reported a restriction on one or more of their leisure activities, and a number of these cases felt these activities would not return to normal. Of those cases that were followed up, those reporting restrictions at the home interview confirmed these were still in place. Additionally, one case reported a further restriction not identified at the home interview.

I feel self-conscious when I go swimming due to the rash on my body. It’s embarrassing and I’m worried my kids think it’s embarrassing too. I’ve stopped going, at least until it’s a bit better. I think the chlorine might make it worse.  
Male clinical NHS worker with asthma and eczema

- All APs were able to walk normally at the time of the home interview and only 2 cases had faced restrictions during their illness. One of these cases had suffered a life-threatening illness with a long recuperation period, and the other had been affected by a condition that affected breathing and therefore all forms of movement. At the follow-up interview all APs were still able to walk normally.

- Driving restrictions were reported by nearly half the cases at the time of the home interview. This was largely related to pain in the hands and wrists of those affected by RSI. In addition, those suffering from latex allergies were frequently no longer able to drive a car that contained latex in airbags. At the follow-up interviews, a number of those with RSI and latex allergies reported that driving had become more difficult, although in one case they had improved as a result of a successful operation. In the remaining cases, restrictions reported at the home interview were still in place at the time of the follow-up interview.
Driving is so painful I avoid it where I can. Going to the supermarket is hard too, as the trolleys are so heavy. I hate not having the freedom you have when you can drive.

*Female NHS administrative worker, RSI*

- At the home interview just over half the cases had experienced a restriction in visiting friends and family at some point and a quarter of the cases did not expect this to return to normal due to the chronic nature of their illnesses. Social life was most likely to be curtailed in APs not wanting to, or not feeling able to, leave their house - rather than a fall in entertaining people at home. This reflects the general reluctance of allergy sufferers to enter unfamiliar surroundings in case of coming into contact with allergens. At the follow-up interview some APs who had reported restrictions at the home interview were still facing difficulties in carrying out a normal social life, while others who had faced temporary restrictions at the time of the home interview felt they had improved and were able to have a more normal social life.

Eating out is very hard as you never know if the food will have been prepared by someone wearing latex gloves, or whether there could be latex in the kitchen where the food is prepared. Some organisations, such as Tesco and British Airways are great as they guarantee their food is prepared in latex-free environments.

*Female administrative worker, latex allergy*

- Several latex allergy sufferers noted problems that they were having with their dentists and hairdressers who doubted the seriousness of their condition and the danger of contact with latex. This had made visiting a dentist or hairdresser extremely difficult, and in one case had resulted in a serious anaphylactic shock following a visit to a dental surgery.

*Family activities*

Many of the restrictions discussed above have also had a significant impact on the general family life of those who were living with a partner and/or children:

- Over half of the APs in this sector reported changes to their normal family activities. Of the APs who had children all but one reported that they had faced difficulties with child-related activities such as playing, helping with homework and transport.

- At the follow-up interviews, some APs who had earlier reported difficulties were experiencing further problems with child-related activities and others (those with latex allergies) felt that child-related activities were unlikely to return to normal.

Playing with my 2 children is hard because I’ve such bad pain in my hands and arms. It’s difficult as they’re both under 5 years old so don’t understand what’s wrong with me.

*Female administrative worker, RSI*

- Of those APs who reported restrictions on family sport and leisure activities, those cases reporting the most serious effects were again those suffering from latex allergies. Sports equipment and environments tend to contain latex in many, often unexpected, areas. No improvements in these cases were reported at the follow-up interview stage, reflecting the chronic nature of these conditions.

All family activities have been affected and I don’t think they’ll ever return to normal. Even the kids’ friends have to watch what they wear as some types of trainers can trigger a reaction. I can’t go swimming with them any more or even go and watch them play sport.
**Female clinical NHS worker, latex allergy**

**Provision of support and impact on relationships**

APs were asked for details of support since the onset of their illness. They were also asked to comment on their personal relationships where they had been affected by the illness. Key points are:

- Those living with partners were heavily reliant on them for support and care. All cases that were living with partners reported receiving positive support from their partner, who were all cited as the primary caregiver and the main source of emotional support.

- The next largest group providing both practical and emotional support and care were friends, followed by parents and children. In some cases, extended family members helped with transport, shopping and cooking.

My friends have brought me videos to watch as I’ve been off work for about 7 months and get bored spending so much time in the house and on my own. My friends also take me to church. My daughter does my shopping and looks after me. I worry I’m a burden to her.

**Female administrative NHS worker, RSI**

- Examples of types of practical support include accompanying the affected person to medical appointments and helping with household chores. Examples of emotional support from a partner include working from home to keep an AP from feeling lonely when off work, more openly expressing affection towards an AP and talking about their future together in connection with the demands of the illness.

My partner comes to all my appointments with me. Sometimes there’s too much information to take in and I appreciate the moral support, though all the worry and uncertainty have put a big strain on our relationship.

**Female NHS clinical worker, asthma and dermatitis**

- Trade unions were not identified as a major source of support; only 1 case having indicated that they thought they had been useful.

- Many cases reported that they had received positive support from the medical services though 2 cases reported an unhelpful interaction. Physiotherapists, GPs and hospital staff were mentioned as key personnel who had been helpful to APs.

My GP and the physiotherapists I’ve seen have been great, really encouraging and it helped being able to chat to someone outside the family about how I’m getting on.

**Male clinical NHS worker**

- At the follow-up interview support was still being provided by those cited at the home interviews although several APs reported that those who provided them with support became “tired” of their condition at times.

- Of those who reported changes in relationships, most were reported as positive changes. However a small number of cases reported negative changes. This was largely due to altered responsibilities and increased impatience or ill-temper as a result of the strain of living with a chronic illness.
I went to stay with my brother and his family when I was recovering from my operation and it’s given me a chance to get to know them better. We’re much closer than we used to be.

Female NHS clinical worker, RSI

• An improvement in relationships with children was also reported in a number of cases. Two relationships with daughters were reported as having improved, one with an adult daughter who suffered from similar allergies as those developed by her mother, and one with school-age daughter who had looked after her mother during her illness.

6.8.2.5 Behavioural consequences

Impact on own behaviour

APs were asked if they had noticed any changes in their own behaviour since the accident. The results from the home interview are shown in Table 6.34. These results are presented in detail since in this area there is no equivalent data set in the telephone survey.

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>No change</th>
<th>Increase</th>
<th>Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping</td>
<td>9</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Eating</td>
<td>16</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Ability to concentrate</td>
<td>12</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Ability to take decisions</td>
<td>15</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Ability to remember things</td>
<td>13</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Avoidance of certain situations</td>
<td>3</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td>15</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Use of prescription drugs</td>
<td>4</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Use of non-prescription drugs</td>
<td>10</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Use of illegal drugs</td>
<td>20</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Losing temper/aggression</td>
<td>10</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Desire to leave house</td>
<td>12</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Desire to socialise</td>
<td>14</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Losing patience</td>
<td>10</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Sexual activity</td>
<td>15</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

The most common patterns identified were:

• Sleeping had been disrupted in half the cases, both directly due to their illness and/or anxieties related to their illness. Several cases linked sleep problems to feelings of depression.

After I came out of hospital I was sleeping poorly as I was disturbed by my wife who was more restless than normal. That was because she was so worried about me.

Male clinical NHS worker, meningitis

• Eating patterns were affected in some cases.

I can’t taste my food due to my loss of smell so occasionally don’t have an appetite.

Male NHS worker, chronic illness
• One or more cognitive functions such as the ability to concentrate, the ability to take decisions or remember things had been adversely affected in just under half the cases.

**Decision making is harder with a latex allergy as you have to think everything through in more depth and the consequences are more serious.**  
*Female clinical NHS worker, latex allergy*

• A large number of APs had experienced an increase in avoiding certain situations. In the case of those affected by RSI, the APs tried to avoid actions that might cause them pain or exacerbate their condition, such as lifting heavy objects or rigidly adhering to a uniform pattern of work with very little variety. Those with allergies tried to minimise their risk, which resulted in a changed pattern of activity. This usually included a reluctance to visit new places.

**I have to go to a supermarket that is further away from the house as the trolleys at my old supermarket are too heavy for me to push and really make my wrist sore.**  
*Female NHS clinical worker*

• Most APs reported an increase in both prescription and non-prescription medication.

• Some cases reported a decrease in alcohol consumption and none reported an increase. Reductions in alcohol consumption were linked with a need to moderate alcohol intake due to their medication.

• An increase in both losing temper and impatience was recorded for just under half the cases. Many people related this change to feeling frustrated about their illness or physical condition. This finding was a general effect, linked to a wide variety of illnesses; there was no clear connection to a specific condition. One case, however, reported a decrease in impatience and bad temper - a long-standing latex allergy case had felt forced to analyse her behaviour, with positive results for the AP.

**I’ve learnt to live with the allergies associated with gloves and the asthma. I’m more in control and feel more even-tempered now and back to normal.**  
*Female NHS clinical worker*

• Some cases, principally those suffering from latex allergies, had experienced a decrease in the desire to leave the house and the desire to socialise. A small number of cases, who had been off work for long periods of time and missed their previous level of social interaction had, however, experienced an increased desire to leave the house and socialise.

It is difficult to generalise about the degree to which specific changes in behaviours were sustained between the home interview and the follow-up interview because of the variety of cases and behaviours involved. None of the cases reported that their behaviours had returned to pre-illness patterns, and all indicated that their behaviours were still affected as a result of their illness. Of the 14 cases which were followed up in this group, the most frequently cited changes were:

• Further and increased avoidance of certain situations due to the chronic nature of illness. This ranged from avoidance of typing and other manual tasks that exacerbate RSI, to avoiding placing oneself in situations that could involve further contact with allergens. Those who had had an illness with an acute onset avoided situations that were similar to those when they contracted their illness.
• Continued use of medication, again related to the chronic nature of the illnesses of many cases. Several cases had noted an increase in medication usage since the home interview.

• A small number of APs who were still off work linked a further decline in cognitive functions to their continued absence from work.

Because I’m not working I feel I don’t have to concentrate on things or make decisions like I used to. I’m not sure if this is because I haven’t had to for a couple of months, since I’ve been off work, or if it’s an effect of the allergies.

Female NHS worker, latex allergy

Impact on others’ behaviours

As in other groups, APs were asked if they had noticed any changes in the behaviour of the people that they lived with. Approximately one third of cases had noticed that the behaviours of others had been affected. The main findings were:

• A number of APs felt that their partners had shown an increase in loss of temper and loss of patience - although several were keen to emphasise that their partners had also been very supportive throughout the illness.

• A small number of participants were aware that their partners were sleeping less as a result of their illness. This was related to both anxieties about the illness and the disturbed sleep pattern of their partners.

• At the home interview, changes in children’s behaviour were described by 3 cases and related to 6 children. This included increased loss of temper, anxiety about the illness of the participant and increased disruptive behaviour. At the time of the follow-up interview the behaviour of one child had returned to normal.

He had nightmares when the condition first started but he’s much better now that he understands what is happening to me and that I’m not going to die. He had trouble working at school when the allergy became serious but it’s just part of everyday life now.

Female clinical NHS worker, latex allergy

• The only further change reported at the follow-up interview was a concern from a partner that the condition of a participant had worsened at night when asleep and that this in turn was affecting her own sleep.

6.8.2.6 Psychological consequences

The case summaries illustrate the full emotional consequences of the illnesses and show that there is a wide range of psychological effects associated with this group.

The results of the psychological measures administered at are summarised in Table 6.35.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Home interviews</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean score</td>
<td>Number over</td>
<td></td>
</tr>
</tbody>
</table>

Table 6.35 Summary of the results from psychological measures

254
<table>
<thead>
<tr>
<th>threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goldberg Anxiety</td>
</tr>
<tr>
<td>Goldberg Depression</td>
</tr>
</tbody>
</table>

Whilst the case summaries need to be read in their entirety to appreciate the full extent of these effects on the individuals and their families, some general points can be made:

- A significant number of APs reported feeling frustrated with their condition and their inability to carry out tasks that they were able to achieve before the onset of their illness. Several APs linked their frustration to the persistence of their condition.

> I get frustrated that I can’t grip things the way I want to or use my hands like I used to. It affects everything and even cooking is difficult. I get down about it occasionally but normally I’m OK as I’ve got my son to help me out when I need anything.

*Female NHS administrator, RSI*

- Some APs were clearly experiencing symptoms of both anxiety and depression in the aftermath of the illness - in a significant number of cases the scores on the Goldberg scales indicate the potentially serious nature of these conditions. Despite this, however, only 5 out of the 20 cases had discussed these issues with their doctor.

> I get worried about going out to new places and hate it. It’s not fair, and so frustrating that this has happened to me. I can’t see that it will change in the future. It gets me down. I hope that it will get better in the future.

*Female care worker, latex allergy*

- Many APs commented on feeling worried about a particular aspect of their life. Table 6.36 summarises the type of worries discussed during home interviews. Worries about the future were linked to chronic conditions such as RSI and latex allergies. Financial worries were mentioned by comparatively few APs, reflecting the more favourable pay regimes in this sector.

**Table 6.36 Summary of anxiety and worry expressed during home interviews**

<table>
<thead>
<tr>
<th>Type of anxiety/ worry</th>
<th>No. of cases*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>5</td>
</tr>
<tr>
<td>Career</td>
<td>4</td>
</tr>
<tr>
<td>Future</td>
<td>7</td>
</tr>
<tr>
<td>Work-related</td>
<td>2</td>
</tr>
<tr>
<td>Burden on caregiver</td>
<td>2</td>
</tr>
<tr>
<td>Financial</td>
<td>2</td>
</tr>
</tbody>
</table>

* Some cases had more than 1 area of concern, while other cases did not mention any anxieties or concerns

- Those affected by latex allergies described during their personal and follow-up interviews they experienced situation-based anxieties about coming into contact with latex. This had led, in several cases, to worries about going to new places and/or leaving the house unaccompanied.

> I’m always aware that my condition is life threatening. I worry about where I might have to go and how different places could trigger an attack. I can’t help but be really worried about the future and what might happen.

*Female clinical NHS worker, latex allergy*
• A small number of APs reported symptoms similar to those of Post Traumatic Stress Disorder (PTSD) at the time of the home interview. There was no formal assessment of these in this group since the instruments used to assess PTSD symptoms were not administered to illness groups in this study. However, the cases in question (for example the case of meningococcal septicaemia and a case of a latex allergy which resulted in a severe anaphylactic shock) were characterised by the acute and traumatic onset of the conditions. The psychological symptoms were still in evidence at the time of the home interview – a relatively long period of time since the onset of the illness.

The attacks are awful when they first start and you think you’re going to die, it’s really scary. It’s hard not to think about it all the time and even when you don’t want to. I feel very depressed about it sometimes and it and try to avoid anything that could make my allergy worse or even just remind me of what’s happened.

Female NHS care worker, latex allergy

• None of the cases had received any form of psychological intervention at the stage of the home and follow-up interviews.

Family impact

Family members of 5 cases were also interviewed at or close to the time of the home interview. As in other groups, where possible these interviews focused on those involved in a primary care and support role. In 4 cases the partner was interviewed and the remaining interview was carried out with the adult daughter and main caregiver of an affected person who lived alone. The interviews focused on the actual and perceived impact of the illness on themselves personally and on their normal lifestyle. In this sample, the consequences of the illness on the 5 family members generally reflected the seriousness of the illness. Four cases affected by RSI were interviewed, as well as 1 case of meningococcal septicaemia. Main points emerging from the interviews were as follows:

• The family members of 2 cases took approximately 1 week off work to care for their relatives who had RSI. One had received full pay and the other took annual leave in order to avoid financial penalties. The female partner of a case who had contracted meningococcal septicaemia took 6 months off work, on reduced pay, to care for her husband as a result of the seriousness of his illness. The remaining 2 family members had not taken any time off work.

I have taken about a week off work and used my annual leave to cover the days. I had to, as my employer wouldn’t give me time off as the medical appointments were not mine. I didn’t have to go to the appointments but knew she would appreciate the moral support and it helped to have me driving as I know it’s painful.

Partner of female clinical NHS worker

• The normal family and social activities of several APs were disrupted because of the illness. Those common to all family members interviewed were family leisure and sports activities.

My own daily activities have not been affected by her illness but family activities have been affected as she is unable to join us and look after the children like she used to. Picking up the children from school and taking them to their after school activities is difficult now since she can’t help me any more.

Daughter of female NHS administrative worker
There has been very little impact on my everyday life but I do more heavy work around the house and garden now she’s not able to any more. Hobbies have been affected that we used to do together, such as dancing.

*Partner of female administrative NHS worker*

- Two of the five family members interviewed reported noticing a behavioural change in themselves. In one case, this involved a reduction in the ability to make decisions as a result of chronic stress and in the other an increased loss of patience.

- Two family members felt their relationship with their partners had been strengthened as a result of the illness. This was felt to be due to the need to share decision and responsibilities and to jointly face up to the difficulties which emerged as a result of the illness.

I think we both feel closer to each other after everything we’ve been through since the illness. You appreciate each other more and don’t take anything for granted.

*Partner of male clinical worker*

- One family member had been seriously affected emotionally by the illness.

My partner was ill for a long time after he came out of hospital and I felt depressed during his illness. I’ve worried a lot about my health as well as his, not to mention money worries, and about how we would manage in the future. His illness has been the worst period in my life that I can remember.

*Partner of male clinical worker*
6.9 HEALTHCARE ILLNESS GROUP – CASE STUDIES
6.9.1 Case No: 61 - female administrative NHS worker

The home interview was carried out 10 months after the illness report date.

**Illness**

Case 61 has had painful RSI over an 18 month period, with swellings and lumps on her wrist. The pain has lessened in recent months, though sleeping is still affected.

**Vocational consequences**

Case 61 had lost no time from work, but has needed to restructure her working practice to cope with the illness. She had been able to relieve the condition somewhat by using her left hand for mouse work and taking breaks between extended computer tasks.

Her employer had provided practical support in sending her to an Occupational Health specialist and suggesting changes in working practice.

Case 61 felt that her employer was in part responsible for the illness, because her workload had been far higher than usual. She also feels that she herself is responsible, to a degree, for working too intensively.

**Financial consequences**

Case 61 lost no time and has suffered no loss of earnings, which are in the range £500 - £1000 per month. In addition, her employer had covered the costs of prescriptions, splints and transport where needed. Domestic help in the garden had cost Case 61 £100 to date.

Case 61 is not seeking compensation for her illness. No-one else has lost any time off work as a result.

**Social consequences**

All household activities including housework, cooking, shopping, DIY, house maintenance and gardening have been adversely affected by the condition. The key leisure activity of Case 61, curling, has been adversely affected, as have family leisure activities.

Support has been provided by her GP and the consultants at the hospital. No changes in relationships were reported.

**Behavioural consequences**

Case 61 has experienced a decrease in sleeping and an increase in ill-temper and impatience. She now avoids some situations more, and has increased her use of both prescribed and non-prescribed drugs.
Psychological consequences

Case 61 reports no lasting emotional effects but has expressed frustration at her inability to carry out tasks that were previously within her ability. She did not discuss any emotional impacts with her GP.
6.9.2 Case No: 62 - female clinical worker, private sector

The home interview was carried out 32 months after the illness report date and the follow-up interview after a further 6 months.

Illness

Case 62 developed Carpal Tunnel Syndrome in both hands as a result of the nature of her work, and has been suffering from the condition for over three years. The illness has required an operation, which has been of help, but Case 62 still has poor strength and grip together with wrist pain in certain movements.

Vocational consequences

Case 62 has lost 10 weeks from work over the period since 2001. The illness was a serious difficulty in her work because of the danger of dropping instruments or chemicals into patients’ mouths, or onto a non-sterile surface. For a time, Case 62 moved onto reception as a result of this, but since the operation she has returned to her normal job. For computer work, she now has better, more ergonomically designed equipment, following a risk assessment at her employers.

She has received some practical support from colleagues at work. She felt that nobody was responsible for her condition, but that it was simply the result of carrying out repetitive work. She is not planning to seek compensation as a result of her illness.

No changes in her vocational situation were reported at the time of the follow-up interview.

Financial consequences

Case 62 received full pay of £500 - £1000 per month during her absence and incurred no additional costs beyond approximately £100 for transport to and from hospital appointments.

Case 62’s partner needed to take two weeks off from his work to support her, which he covered by using annual leave.

No changes in the financial situation were reported at the time of the follow-up interview.

Social consequences

Case 62 has experienced temporary restrictions in most aspects of daily life, including personal care, household care, leisure, social interaction and mobility. At the time of the home interview, all of these had returned to normal, though she explained that her grip was still badly affected and that she was unable to carry out any activity which requires firm grip or heavy lifting. Family leisure, days out and churchgoing were all back to normal.

Support has been provided by her partner. She reports no changes in relationships due to the illness.
At the follow-up interview, six months later, Case 62 was experiencing renewed difficulties with gardening and still suffering with gripping problems. She frequently drops and breaks items.

**Behavioural consequences**

Behavioural changes have been relatively few in this case. Sleeping had decreased at the time of the home interview, and both the use of non-prescription painkillers and the desire to leave the house had increased. Case 62 was not aware of any changes in the behaviour of family members.

*There had been no changes to these patterns at the time of the follow-up interview.*

**Psychological consequences**

Case 62 reports no residual emotional effects. She had not discussed any emotional issues with her GP.
6.9.3 Case No: 63 - female clinical NHS worker

The home interview was carried out 6 months after the illness report date and the follow-up interview after a further 5 months.

Illness

Case 63 has suffered from a latex allergy for over 4 years, the condition reaching a peak in autumn 2000. The physical symptoms include a rash on the hands and wrists, intense itching and a painful sensitivity to water. Because of the ubiquitous nature of the allergen, Case 63 suffers frequent panics in situations where latex may be found. The allergy has now extended to lanolin and wool alcohols. The condition has been treated with topical and oral steroids.

Vocational consequences

Case 63 has lost no time from work as a result of the illness. She has been forced, however, to take extreme care in her job to avoid latex – a task made difficult by the hospital environment she works in, where latex catheters, gloves and rubber-based bandages are very common. Case 63 has found that using polythene or vinyl gloves helps to avoid reactions, but has to depend on colleagues to carry out many tasks where latex could be involved.

Case 63 has received practical support from her employers and managers, including the provision of vinyl gloves, and has been encouraged to spend some of her time on formulating a policy for sufferers and researching latex-free products. Economic considerations at her employing organisation, however, have meant that low-cost gloves have been sourced, which are more likely to contain or be contaminated by latex.

Case 63 felt that because of her condition and the environment she works in, her future employment is uncertain. She does not hold her employers responsible for the condition.

At the follow-up interview, Case 63 was still exercising extreme care at work.

Financial consequences

Case 63 has lost no pay (usual earnings are £500 - £1000 per month) as a result of the condition, but has incurred some minor costs in gloves for household tasks, latex-free condoms, and driving gloves.

Case 63 was not seeking compensation from her employer.

No changes in financial issues were reported at the follow-up interview.

Social consequences

Case 63 has experienced restrictions in some areas of personal and household care as a result of the condition, and will have to be permanently alert for the presence of allergens in her clothing and foods.
Case 63’s condition is such that she must exercise care in all aspects of daily living, with even the presence of balloons at grandchildren’s parties being a serious problem.

Days out and family sport and leisure were affected adversely, and she was forced to be careful with children’s Wellingtons and shoes, and with visits to doctors and dentists.

Practical support has been most usefully provided by the Latex Allergy Support Group, and by members of her family. Her daughter, who has provided moral support and who also suffers from allergies, has been drawn closer to Case 63 as a result. This is the only change in relationships reported. Case 63 felt that the medical advice she received from her consultant was of very little help.

At the follow-up interview, Case 63 reported that shopping was particularly difficult because of her sensitivity, and had deteriorated in the five months between home and follow-up interviews. Driving had also become more difficult over this period.

**Behavioural consequences**

Case 63 had experienced a number of behavioural changes as a result of the illness. In particular, cognitive functions such as concentration and decision-making were adversely affected, as were sleeping, and socialising. There had been an increase in ill-temper and impatience, and, unsurprisingly, an increase in risk-aversion.

At the follow-up interview, these behaviours had not changed, with the exception of situation avoidance, which had become still more dominant.

**Psychological consequences**

Case 63 reports being constantly on the edge and in fear of latex. Even discussing the issues brought about a dry mouth and a tingling sensation during the interview, and panic attacks are not uncommon.

She has not discussed the emotional impact of the illness with her GP.
6.9.4 Case No: 64 - female clinical NHS worker

The home interview was carried out 6 months after the illness report date and the follow-up interview after a further 5 months.

Incident and illness

Case 64 suffered a needlestick injury during her work as a surgeon, which has resulted in an extended and debilitating treatment for a potential infection of hepatitis C. She had been treated with interferon and other antiviral agents for 6 months. Treatments have necessitated constant monitoring of white cell counts and additional medication to stimulate bone marrow. Overall, the sufferer has felt tired, nauseous, anaemic and anxious, and has suffered from persistent shaking.

Vocational consequences

Case 64 lost 3 days from work as a result of the illness. More serious than this, however, had been the effect on her professional abilities. Whilst there is any doubt about her possible infection (which will take 6 months to a year to finally be sure of), she is unable to carry out surgical work.

She had found Occupational Health of very little help in this instance, but was able to find a consultant (through her work colleagues) with wide experience of treating Hepatitis and HIV. Her own superior was less helpful, but did arrange locum cover for her surgical duties.

Case 64 is not seeking compensation from her employers, and felt that she was responsible for the incident.

At the time of the follow-up interview, Case 64 had moved to paediatrics and no longer wished to be involved in surgery as a career. Both the risk factor and the attitudes of her surgical colleagues had been a factor in this decision. Though the risk of these injuries is recognised and the consequences potentially serious for the individual, Case 64 had experienced that a stigma was attached to the disease and so had largely kept the injury and subsequent illness to herself.

Financial consequences

Case 64 has lost no earnings (normal range £2000 - £2500 per month) as a result of the illness. She has incurred minor prescription charges, but recognises that, were she not in the medical profession, these charges would have amounted to over £1000.

No-one else had lost any time off work as a result of the illness.

There were no further financial changes at the time of the follow-up interview.
6.9.4.1 **Social consequences**

Case 64 experienced temporary restrictions in household care and in walking as a result of the illness and the side effects of the treatments. Most of these had returned to normal by the time of the home interview.

Case 64 lives alone, but had found that she was spending more time with friends and family who visited more since the illness.

Emotional support had been provided, in particular, by Case 64’s mother, father, sister and friends. Though her boyfriend had been supportive at first, the relationship became very stressful during the difficult period following the injury and has since ended. The other relationships mentioned had become closer during the illness.

Special help had been provided to Case 64 by both her consultant and a nurse practitioner, who were familiar with cases of this type and were able to spend time listening to her worries, as well as co-ordinating her treatment.

*By the time of the follow-up interview, no changes had taken place in her social and daily life.*

**Behavioural consequences**

Case 64 was experiencing increases in impatience and ill-temper, together with some increase in situation avoidance and the ability to take decisions at the time of the home interview. Sleeping had decreased, as had the ability to concentrate and remember things. Additionally, Case 64 had less desire to socialise and leave the house.

*Four months later, at the follow-up interview, Case 64 was still finding it difficult to concentrate and was still risk averse, but other behaviours had returned to normal.*

**Psychological consequences**

At the time of the home interview, Case 64 expressed worries about her future health and career – worries that were compounded by nightmares, disturbed sleep and flashbacks. She did not discuss emotional issues with her GP.
6.9.5 Case No: 65 - female NHS health advisor

The home interview was carried out 25 months after the illness report date and the follow-up interview after a further 3 months.

Illness

Case 65 has suffered from work-related RSI from lifting heavy files daily over a long period of time. She is now unable to lift heavier objects and in occasional pain in any event.

Vocational consequences

Case 65 was absent from work for 2 weeks with the illness. She returned to the same job, but received no support from her employers or managers when working practices needed to be reviewed to alleviate the condition.

Case 65 felt that her previous employer was responsible for the illness, but also herself for not being more assertive in the face of what she perceived as management indifference. Case 64 felt vulnerable because of her lack of qualifications and in danger of losing her job.

This situation effectively removed Case 65’s enthusiasm for and commitment to the company, and as a result of this, at the time of the follow-up interview, she had subsequently changed her job and her employer.

Financial consequences

Case 65 received full pay whilst absent, and incurred no additional costs.

No-one else lost time off work as a result of the illness.

Her change in job had resulted in an increased salary: originally in the range £500 - £1000, she now earns £1000 - £1500.

Social consequences

The condition has caused one apparently irreparable change to Case 65 in that she is now unable to lift heavier objects. This affects many aspects of daily living such as shopping, gardening and house maintenance. At the time of the interviews, however, all of these activities, with the exception of shopping, had returned to normal. Family leisure and sport activities, socialising and taking children out had also been temporarily affected, but had returned to normal since her change of job.

The immediate family of Case 65 had provided practical and emotional support, and she also felt that she had been helped by the medical services, whose investigations confirmed that the condition was due to lifting. No changes in relationships have been reported.

No further changes in daily living had occurred by the time of the follow-up interview.
Behavioural consequences

Case 65 has adapted to the restrictions imposed by the illness, and the only behavioural change is her need to avoid lifting. She has reported no behavioural changes in her family.

*No further changes in behaviour were reported during the follow-up interview.*

Psychological consequences

Case 65 has described her anxiety and stress when the condition first appeared and she was experiencing difficulties with her previous employer, but reported no emotional problems at the time of the interviews. She had discussed emotional issues with her GP.
6.9.6 Case No: 66 - female clinical NHS worker

The home interview was carried out 3 months after the illness report date and the follow-up interview after a further 4 months.

**Illness**

Case 66 has suffered from occupational asthma over the past 10 years, since the introduction of latex gloves in 1993. In the past year the condition has widened to include severe dermatitis on her hands, causing painful and unsightly fissures and preventing movement of the thumb. The conditions are treated with topical steroids, inhalers, special gloves and moisturising creams. Case 66 also feels frustrated and under stress.

**Vocational consequences**

At the time of the home interview, Case 66 had been absent from work for five months. She is unable to use latex gloves, and has found no particular benefit in using other types such as nitrile or non-powdered. Case 66 has been offered office-based work by her employer, which she has declined for reasons of preference and because an increase in typing and computer work would also be detrimental to her hands. Subsequently, she was offered a demotion to another position at a salary £9000 per annum less, which she has also declined.

She has received some support from the occupation health section, and strong support and camaraderie from her colleagues, but nothing helpful from her employing organisation or immediate managers. As a result, her opinion of her employers has worsened. Case 66 is in the early stages of a claim for compensation, which she has been advised will take 2-3 years, and in which she has been helped by her local union representative. She considers her employer to be responsible for her condition.

During the follow-up interview some four months later, relations between Case 66 and her employer had worsened further, with Case 66 feeling frustrated that no resolution had been arrived at, that no support or interest had been shown and a general feeling of being “messed around”.

**Financial consequences**

Case 66 was reluctant to divulge financial information during interviews, but has commented that receiving full pay would have helped her to cope with the illness. She has incurred additional costs of approximately £135 for transport and special creams, shampoos etc., and further estimates that the costs of prescriptions over the past 9 years has amounted to £750.

In supporting Case 66, her partner had lost 5 days work, which he has been able to cope with since he is self-employed and can be flexible about his own hours. It was anticipated that a further 1-2 weeks of his support time would be needed over the next months.

By the time of the follow-up interview, her partner had lost a further 5 weeks work; no details of the financial implications of this were disclosed.
**Social consequences**

Most activities of daily life have been affected by the illness and were still restricted at the time of the interview. These include bathing, dressing, cooking, all household activities, DIY, decorating, and social interaction. Case 66 had by this point recovered sufficiently to drive again.

The social life of Case 66 is especially affected by her sensitivity to many common products and pollutants: tobacco smoke, pet dander, scented candles and air fresheners. This makes it difficult to visit pubs and restaurants, or friends and relatives. She believes that this aspect of her life will never recover.

Case 66 has received emotional and practical support from her partner, who accompanies her to all appointments. She does feel, however, that the illness and uncertainty about the future have placed a strain on the relationship and that they argue more than before.

*At the follow-up interview, there had been no changes in the restriction reported.*

**Behavioural consequences**

The main behavioural changes experienced by Case 66 were the increased use of prescription and non-prescription drugs, and increased sleeping. She also reported a decrease in her ability to remember things. Additionally, she felt that her partner had also become frustrated and annoyed with her employer and the ongoing situation.

*At the follow-up interview she reported experiencing an increase in impatience.*

**Psychological consequences**

Case 66 describes herself as someone who loves her job and is very frustrated that she is unable to do it, either now or in the future. She felt bored at home, and worried about the future and also about the compensation claim. In losing her work, she felt her own identity has been compromised and that she was also losing part of herself.

She had not discussed the emotional impact of the illness with her GP.
6.9.7 Case No: 67 - female clinical NHS worker

The home interview was carried out 32 months after the illness report date and the follow-up interview after a further 4 months.

**Illness**

A severe latex allergy was diagnosed by a dermatologist following exposure to latex gloves. Wheezing began after working in an environment with latex gloves for several months. This led to a workplace risk assessment and subsequent medical suspension when the condition made working impossible.

**Vocational consequences**

Case 67 had been given medical retirement at the time of the home interview and did not expect to ever be able to return to work since she is unable to work in an environment where there is any latex present. While she was still employed she received no support from her employer, although her immediate supervisor kept in touch with her when she was off work. She was new to the job so did not have contact with her co-workers. Her nursing union had provided her with excellent help and advice, in particular with information about legal issues and emotional support. She felt that nobody was responsible for what had happened and thought it was just one of those things.

*At the time of the follow-up interview there had been no further changes.*

**Financial consequences**

Whilst working, the net monthly income of Case 67 was £1500 – £2000. Her retirement pension (due to her ill health) is close to the same value. Additional payments include £155 per month of disability allowance, although she has been denied her claim for industrial injuries benefit. She was appealing against this decision through a tribunal but was not claiming any compensation from her employer. Additional costs reported by Case 67 amounted to approximately £29000; included in this is £1000 for the removal of latex carpets and household objects and £8000 for a camper van so the family can still go on holiday, together with medication costs.

Her partner had taken 6 weeks off work by the time of the interview to care for her at home following attacks and when she has been very ill in hospital. A number of neighbours had also taken time of work to look after her when her partner was away working, both during and after attacks. Case 67 has approximately one attack per month and when she does her partner takes off 2 days from work. It was expected that he will need to take several more months off work in the future.

*There had been no change to the financial situation of Case 67 at the follow-up interview.*
Social consequences

Many activities of daily living were unlikely to return to normal because of the sensitivity of the latex allergy. For example, she could no longer go to a supermarket because the belts for shopping at checkouts are all made of latex, and had to order all food over the internet and have it delivered. Cooking, DIY, use of public transport and visiting friends are also unlikely to return to normal. Family activities were all unlikely to return to normal.

Her partner has arranged his work and life around caring for Case 67 and she felt much closer to him since the allergy had developed. Friends and neighbours had been extremely supportive and very helpful in looking after her 3 children, as well as Case 67 herself, when she was unwell. They have taken the children to school and various other activities. She feels closer to her daughter as well.

At the time of the follow-up interview Case 67 had continued to be very restricted in shopping, cooking and household maintenance and thought they would never return to normal. Visiting the dentist and hairdresser was also very difficult as both use latex. Whenever she is replacing a household appliance she has to contact the manufacturer to check that it does not contain latex. All family activities are unlikely to return to normal.

Behavioural consequences

Case 67 reported an increase in avoiding situations where latex might be present and was less keen to leave the house, at the home interview. She ate less, and drank less alcohol than she used to, and lost her temper and patience more regularly. Her partner was more attentive, though she reported that her daughter lost her temper more than she used to and wanted to be out of the house. Her son had found it hard to work at school for a while because he couldn’t concentrate, and was also suffering from nightmares. He has since returned to normal.

At the follow-up interview she noted an increase in avoiding conflict, and socialising. There had been a further decrease in cognitive functions.

Psychological consequences

Case 67 was worried about her allergy in the future, and reported frequent emotional episodes. She had not talked to her GP about the emotional impact of her illness.

At the follow-up interview she felt frustrated and angry about her illness.
6.9.8 Case No: 68 - female clinical NHS worker

The home interview was carried out 3 months after the illness report date and the follow-up interview after a further 5 months.

Illness

Case 68 had been working for 5 months in healthcare before spending a week in the nursery where she developed an allergy to latex and bananas. This left her too unwell to attend work and feeling very tired. Her allergies triggered attacks which left her in bed for several days at a time.

Vocational consequences

Case 68 was still off work at the time of the home interview and had been off for 2 months. She expected to be able to go back to work eventually. Her colleagues had provided emotional support. She felt that her employer was responsible for her condition.

At the follow-up interview she had been off work for a total of 7 months and did not expect to be able to return to her old job.

Financial consequences

Her net monthly income was £500 – £1000 and she received full pay while off work. She had, however, lost her pension contributions (no details provided). Additional costs were £80 for prescription charges, though the full costs of coping with the illness included sums for removing latex products from the house; these were not detailed at the interview.

Case 68 was claiming compensation and had found it a positive experience.

Her boyfriend had taken 2 days off work to visit her in hospital and to look after her. He expects to be off work for another couple of days a month in the future to look after Case 68.

At the follow-up interview she had been in contact with her lawyer and the claim was progressing. No other elements of her financial situation had changed.

Social consequences

All activities of daily living had been affected by the illness although dressing had returned to normal. She missed cycling, going to the gym and socialising with her friends. Her boyfriend and family were all very worried about case 68 but her relationships with them had not changed.

Shopping was unlikely to ever return to normal, at the time of the follow-up interview, and going to the gym was still restricted. She never travelled on her own because of the risk of a dangerous attack.
**Behavioural consequences**

Case 68’s sleep patterns had varied since the illness and her eating pattern had increased. Her cognitive functions had decreased, as had her alcohol consumption and desire to leave the house and socialise. The illness meant that she had to take a lot of medication, and she also reported that she lost her temper more than she used to. Her relationships had not changed, although Case 68 was aware that her mother was worried about her.

*Case 68 noted a continued decrease in cognitive function at the follow-up interview, which she attributed to a lack of stimulation while off work. She continued to avoid situations where there may be risks for her and had increased her use of prescription medication.*

**Psychological consequences**

Case 68 felt anxious about going out alone or to a new place. She had not talked to her GP about the emotional impact of her illness.

*At the follow-up interview she continued to experience anxiety and frustration.*
6.9.9 Case No: 69 - female administrative NHS worker

The home interview was carried out 23 months after the illness report date.

**Illness**

Case 69 suffered from RSI, which first manifested after a lengthy filing session, and experienced severe and persistent pain for over one year. The condition caused even minor movement to be extremely painful. Physiotherapy has provided no relief, and painful steroid injections only temporary relief.

**Vocational consequences**

Case 69 was absent for 3 weeks before returning to the same job. Management have suggested changes in working practice to spread the difficult tasks over a longer period, but this has proven difficult to sustain in practice. Case 69 felt that management have not been helpful since the illness and had received no support from her employers, nor any others at her workplace.

Case 69 felt that her managers were responsible for the condition because of the arrangements of the filing system at the time of the illness.

**Financial consequences**

Case 69 received full pay of £1000 - £1500 per month during her absence and so incurred no loss of earnings. She was recommended a course of acupuncture by her GP at a cost of £135.

Case 69 is not seeking compensation as a result of her condition.

No-one else had lost any time off work in caring for her.

**Social consequences**

Case 69 experienced temporary difficulties with all household activities and her particular hobby, gardening. She believes that her difficulties with heavy work will permanently affect her leisure interests.

Her partner and mother provided support. No relationship changes were reported.

**Behavioural consequences**

At work, Case 69 has experienced a decrease in the ability to concentrate and take decisions. She avoids certain situations, and has increased her use of non-prescribed drugs.
Psychological consequences

Case 69 reports no residual emotional effects and had not discussed any emotional issues with her GP.
6.9.10 Case No: 70 - female clinical NHS worker

The home interview was carried out 17 months after the illness report date and the follow-up interview after a further 4 months.

**Illness**

Case 70 suffered from an allergic reaction to latex, and subsequently to other allergens, which began in 1995 with asthma attacks and skin rashes. She suffered a full anaphylactic shock in 1997 and has been forced to carry an adrenaline pen and other medication since then. Since the trust that employs her is now latex-free, her condition has improved on a day-to-day basis, but is still a danger to her.

**Vocational consequences**

Case 70 has lost no more than a few days from work, and has received valuable support from her employers, managers and colleagues. In practical terms, she feels that she has to exercise constant vigilance at work in case of latex; her sensitivity is such that food prepared by others who were wearing latex gloves would provoke a reaction.

The NHS trust she works in is now latex-free, which has removed some of this pressure. She believes that her condition is a natural allergy exacerbated by high exposure to latex and that it is a consequence of the job. She has no plans to seek compensation.

*No changes in her employment or vocational issues were reported at the follow-up interview, except that she had a new line manager who was very understanding and supportive.*

**Financial consequences**

Case 70 has lost no earnings, normally in the range £1000 - £1500 per month, as a result of her few days off. She has incurred additional costs, however. Insurance premiums, including her endowment and travel policies, are between 20% and 50% higher than previously, and she spends £36 a year approximately on prescriptions.

No-one else has lost time from work as a result of her illness.

*No changes in finances were reported at the time of the follow-up interview.*

**Social consequences**

The condition is such that many activities of daily life are permanently affected. Any environment where rubber may be present is a source of worry and potential danger – this includes shopping centres, where rubberised material on staircases are present, children’s parties and restaurants where balloons are used and, a particular worry for case 70, cars where airbags may be made from latex and where their deployment would almost certainly cause an anaphylactic reaction.
The condition has adversely affected household care and gardening since the sufferer cannot wear rubber gloves. Visits to friends, families and restaurants were still restricted at the time of the interview, and Case 70 believed that family leisure and sport will never return to normal because of the presence of rubber in locker keys, balls, sports clothing and so on.

The condition requires vigilance even when being treated by doctors. In a recent visit to a clinic, despite prior conversations and the warnings on her notes, the doctor would have implanted a latex-covered device using latex gloves had not Case 70 noticed the errors.

Support has been provided primarily by Case 70’s partner and by neighbours. Case 70 reported no changes in relationships.

*No changes were reported in the follow-up interview, and the general feeling of Case 70 was that this was a condition which would always be with her and would require constant management.*

**Behavioural consequences**

The care needed in preventing adverse reactions affects many aspects of behaviour, though in general Case 70 was managing well. Case 70 reported an increase in risk aversion and an increase in the use of prescription medication.

No changes in others’ behaviour have been reported, but Case 70 has described how her children worry when a reaction occurs.

*At the time of the follow-up interview a further increase in the use of prescription medication was reported.*

**Psychological consequences**

Case 70 has a potentially life-threatening condition and is acutely aware of it. Her worries are situation-based and she is concerned in all unfamiliar situations and constantly fearful for the future.

She has not discussed any emotional issues with her GP.
6.9.11 Case No: 71 - female clinical NHS worker

The home interview was carried out 11 months after the illness report date and the follow-up interview after a further 4 months.

Illness

Case 71 suffered from RSI over a two year period. Beginning with a dull ache in the wrist, the condition worsened to pain in the wrist, hand and arm, and included periods of numbness in the fingers. The restrictions imposed by the condition also resulted in depression, which required additional treatment.

Vocational consequences

Case 71 was absent from work for 6 weeks before returning to the hospital. She did not return to the same job and has now changed her job to laboratory technician, which has less repetitive elements than her previous work, and is easier for Case 71 to cope with.

Case 71 felt that the employing organisation was responsible for the condition, and argues that economic constraints prevent the employer from allocating sufficient resource to the work, effectively forcing workers to carry out a high volume of repetitive tasks, with serious consequences for their health.

She received no support from her managers, but Occupational Health was of some help in the job change.

She is not engaged in seeking compensation from her employer.

There had been no changes in her employment or other vocational changes when the follow-up interview was conducted.

Financial consequences

Case 71 received full pay of £500 - £1000 per month during her absence, but lost £100 per month from other work which she used to undertake, and which she is now unable to carry out. Over a six month period, this has amounted to £600. The parents of Case 71 have provided some financial support.

In addition, she has incurred prescription charges of £6 per month.

No-one else had lost time off work as a result of her condition.

No financial changes were reported during the follow-up interview.

Social consequences

At the time of the interviews, a number of daily activities were affected. Dressing was difficult when zips are used because of the particular movements required. Household tasks
such as housekeeping, house maintenance and DIY were adversely affected, and cooking would always be difficult because of the need to lift pans of boiling water, heavy lids and so on.

Case 71 believes that these activities are unlikely to return to normal.

There had been no change in family activities. Practical support was provided by parents and children. No changes in relationships were reported.

**Behavioural consequences**

Key changes in behaviour had been the increased use of prescription and non-prescription medication. There has also been an increase in ill-temper and in the avoidance of repetitive actions. Case 71 also reported a decrease in the ability to concentrate.

*At the time of the follow-up interview, the avoidance of repetitive tasks had intensified.*

**Psychological consequences**

The emotional impact of the illness and the resultant changes in work have been such that Case 71 needed temporary help and was prescribed a course of anti-depressants by her GP. Case 71 feels frustrated in relying on others for everyday tasks and for help at work.
6.9.12 Case No: 72 - female clinical NHS worker

The home interview was carried out 23 months after the illness report date.

Illness

Case 72 suffered from dermatitis as a result of an allergy to latex. This has since developed to include allergies to certain foods such as avocado, banana and kiwi, and also some perfumes and topical medicines.

Vocational consequences

Case 72 has lost no time from work, but the illness has necessitated changes in her working practice and has ultimately placed her career as a nurse in jeopardy. The condition has effectively removed many options for her career, such as work in intensive care. The NHS trust where she works has now removed latex gloves and replaced them with vinyl, but as a nurse, there is always a possibility of coming into contact with latex. Case 72 has now changed her job to a more managerial role.

Case 72 feels that responsibility for the illness resides with standard industry practice and materials.

Case 72 feels that her employer and colleagues have been supportive. Her trade union has not been involved in the illness.

Financial consequences

Case 72 has not suffered from any lost earnings (normally in the range £500 - £1000 per month) as a result of the illness and has only incurred the minor cost of needing non-latex condoms.

Since her change of job her earnings have increased to £1500 - £2000 per month.

She is not seeking compensation as a result of her condition.

Her partner lost 2 days of work in taking her to hospital.

Social consequences

Most daily activities are unaffected in this case, with the exception of cooking, where case 72 must avoid certain foods, and holidays, where allergens may be present in foods and travel. Eating out and days out are also affected. She believes that these effects will be permanent.

Case 72 is required to carry an adrenaline pen and has had to instruct her partner in it’s use, as well as making her colleagues aware of her needs. Her partner has provided most support during the illness, both emotionally and practically. No changes in relationships have been reported.
**Behavioural consequences**

The illness has caused relatively few behavioural changes. Case 72 is careful to avoid certain situations and foods, and has a higher use of prescription drugs than previously. Other activities of daily living are unaffected.

**Psychological consequences**

Case 72 reported that worry about the condition is always with her. She had not consulted her GP about any emotional issues.
6.9.13 Case No: 73 - male clinical NHS worker

The home interview was carried out 18 months after the illness report date and the follow-up interview after a further 3 months.

**Illness**

Case 73 has suffered from industrial rhinitis over a 5 year period as a result of exposure to formaldehyde. The condition has left him with soreness and dryness in ear, nose and throat and rendered him anosmic. Case 73 is anxious about the longer-term effects of the condition as it can develop into cancer, and there are significant emotional effects as a result.

**Vocational consequences**

Case 73 has lost a total of 2 weeks from work for hospital appointments and as a result of secondary infections. He has, however, been forced by the illness to move departments within the hospital to a section for which he has no training, which has had adverse effects on his morale and his promotion prospects.

Case 73 has found it difficult to claim compensation for this illness. He feels that the illness is the clear result of over-exposure to formaldehyde, but that this was not immediately accepted by his employers for a number of reasons. He was initially referred to the ENT section of the hospital where he was employed and neither they nor his GP would confirm that the origin of the condition was formaldehyde. This was not finally accepted until Case 73 visited an external consultant, who instructed him to stop working with the reagent and set up a care programme involving frequent check-ups for malignancy. By this time, Case 73 had missed the three-year window for claiming compensation. Case 73 must now await an unwelcome worsening of the condition if he is to make a successful claim.

Case 73 felt his employers were responsible for the illness.

Case 73 felt that the seriousness of the issue was not recognised by his employer until his trade union took industrial action about the matter. Though colleagues and trade union representatives were supportive, he felt that management were not.

*There were no further changes in his vocational situation at the time of the follow-up interview.*

**Financial consequences**

Case 73 received full pay during his absence. As a result of his moving department, however, Case 73 felt that his promotion prospects had been adversely affected. In addition, regular prescription costs have amounted to approximately £500 over the past 5 years, and transport to hospitals £50.

No-one else has lost time off work as a result of the condition.

*There were no additional financial issues raised in the follow-up interview.*
**Social consequences**

The main effects of the condition are anosmia and shortness of breath, and these have caused a number of changes in daily activity.

Leisure and recreation are adversely affected by Case 73’s breathing difficulties, and as a result of the anosmia, he is unable to cook safely, fearing that he cannot detect gas or other fumes. Visiting friends and family is more stressful than previously as the condition leads to dryness and soreness in warm environments.

Case 73’s particular hobby has also been affected by his illness, since it makes it difficult to raise his voice, which is necessary in this particular activity. He feels that he is less skilled and less regarded in this activity than previously.

Support has been provided by the Case 73’s partner, who is especially helpful during the choking episodes caused by the condition, and also provides emotional support. Friends, Case 73’s sister and members of a hobby group have also been helpful. Case 73 reports no changes in relationships.

*At the time of the follow-up interview, no further changes in daily life were reported.*

**Behavioural consequences**

Both sleeping and eating have decreased since the illness, and Case 73 reports that he never achieves a full, uninterrupted night’s sleep due to the condition. Also decreased are the desire to socialise and leave the house, alcohol consumption and memory. There had been an increase in the avoidance of some situations, and also in the use of prescription drugs.

Case 73 reported that his partner had also experienced disturbed sleep as a result of his breathing problems, and had increased her alcohol consumption.

*At the time of the follow-up interview, one further change had been experienced by Case 73, namely a rise in impatience. His partner was also increasingly worried about his breathing patterns during the night.*

**Psychological consequences**

Case 73 had experienced some anxiety at the time of the home interview. In addition, Case 73 points out that he has lost an entire sense, with many resulting frustrations and repercussions. He had discussed this with his consultant and his GP, who was helpful in setting the risks in context and did not prescribe any medication.

*At the follow-up interview this was compounded by the fear of contracting cancer of the throat.*
6.9.14 Case No: 74 - male clinical NHS worker

The home interview was carried out 25 months after the illness report date.

Illness

Case 74 contracted the life-threatening disease meningococcal septicaemia from a patient. He was hospitalised and under intensive care for a time and was not expected to make a recovery. The condition has left Case 74 with neuralgia, heat intolerance and anxiety.

Vocational consequences

Case 74 was absent from work for a total of 15 months. After this period he engaged in a phased return to work, which he found difficult. Though his employer expected and wanted him to take a medical retirement, Case 74 is enthusiastic about his work and was determined to return. He now works again in his normal role, and has a useful insight into how patients with similar conditions to his own will feel.

With the exception of some unhelpfulness from his employers regarding his return to work, he felt that he received good support from his employers, managers and colleagues, and is especially grateful for the care shown by his co-workers.

Case 74 has not made a claim for compensation, but was helped by his union and the solicitor recommended by the union in forcing the employer to review their protocols for dealing with meningitis.

Financial consequences

Case 74 received full pay for the first six months of his absence, followed by half pay for six months and then no pay for the final three months. The total cost of his loss of earnings was £7500. Additional costs have been prescriptions of approximately £200 and transport of £50.

Case 74’s partner also lost six months from work, partly to care for Case 74 and partly as a result of her own reaction to the event. She received 30% of her salary during this period, which resulted in losses to the family of a further £2100, added to which are unspecified losses of annual bonus and profit-sharing. Case 74’s son also took 8 weeks off work to act as a carer, with costs to him of £2000.

Social consequences

Case 74 experienced significant restrictions in all activities of daily life as a result of the illness, including personal care, household activity, leisure and recreation, mobility, social interaction and money management. Family activities such as days out, holidays and sport were also adversely affected. Over the 15 month absence, Case 74 had been able to rebuild his strength and at the time of the interview had recovered all activities with the exception of shopping which he still finds difficult and thinks unlikely to recover.
Case 74 was cared for full-time by his partner for six months. He also received help from his son, his colleagues and the medical profession, where his GP and physiotherapists were particularly helpful for both Case 74 and his partner.

Case 74 has seen a positive effect on relationships during his illness, with increased closeness between himself and his partner, his sons, his son’s partner and also his friends.

**Behavioural consequences**

Case 74 has experienced a decrease in sleeping and cognitive functions as a result of the illness. He had found it necessary to rely on his partner to remember what was said in consultations, and to keep appointments. He had increased his use of prescription medication and had noticed an increase in ill-temper, impatience and the desire to leave the house and socialise.

In the behaviour of his partner, Case 74 reported a similar pattern: decreased sleep and ability to concentrate or take decisions, together with increased use of prescription drugs and ill-temper. Both Case 74 and his partner had discussed the emotional effects of the illness with their GP and had been prescribed medication to help with this.

Case 74 has an adult son at home and had noticed that he too was sleeping less and had become more impatient and aggressive, and more keen to leave the house and socialise.

**Psychological consequences**

Case 74 had not been expected to live more than 24 hours after being diagnosed with the illness, and this had left both he and his partner with residual emotional effects, which required treatment by their GP.
6.9.15 Case No: 75 - female administrative worker, private sector

The home interview was carried out 3 months after the illness report date.

**Illness**

Case 75 supervises an administrative team and developed RSI after a long filing session. The condition worsened, due to the need to cover for other team members, and caused severe pain in hands and arms, such that she feels disabled. Treatment with steroid injections has provided temporary relief, but Case 75 still experiences severe pain even with minor activities.

**Vocational consequences**

Case 75 was absent for 7 weeks before returning to the same job. She had, at the time of the interview, ceased working long shifts at night and was generally unable to work for as long as she had been before contracting the illness.

Case 75 felt that the employer had been unhelpful in this matter, even though several of her colleagues have similar issues. Her opinion of both the employing organisation and her immediate superiors has declined as a result. Case 75 is considering legal action, in partnership with colleagues, against their employer and was seeking advice from the Citizens Advice Bureau.

She felt that her employer was responsible for her condition.

**Financial consequences**

Case 75 received 50% of her normal salary (of £1500 - £2000 per month) during her time off, resulting in direct loss of earnings of £1750. In addition, she is now unable to work overtime, resulting in ongoing losses of £500 per month.

Additional costs have been incurred for prescriptions (£50 in total), and for domestic help and convenience foods (£650 in total over a two month period).

Her partner lost 4 days off work as a result of the illness but received full pay.

**Social consequences**

Case 75 was experiencing, at the time of the interview, restrictions in many activities of daily living, including cooking, shopping, housekeeping, house maintenance, swimming, driving and entertaining friends and family. She also had difficulties in dressing. Family leisure and sport activities were not affected, but both playing with children and taking them to and from other activities were still affected adversely.

Support had been provided by her partner in looking after children when the illness becomes acute. Case 75 expects that this pattern will continue. No changes in relationships were reported.
Behavioural consequences

Case 75 reported that sleep had decreased due to the pain of the condition, as had the ability to concentrate. She was also using more prescription and non-prescription medication. In her family, she had noticed that both her partner and her 2-year old daughter were sleeping less, and an increase in impatience in her son’s behaviour.

Psychological consequences

Case 75 was frustrated about her condition and it’s effect on her manual strength and dexterity. She reported feeling drained, and was worried about the family finances in view of her loss of earnings. She had not discussed the emotional impact of her illness with her GP.
6.9.16 Case No: 76 - male clinical NHS worker

The home interview was carried out 20 months after the illness report date.

**Illness**

Case 76 contracted asthma and eczema as a result of using glutaraldehyde in the hospital where he is employed. Over a six month period, the skin on his hands became dry and itchy, subsequently spreading to his face and upper trunk.

**Vocational consequences**

Case 76 has lost no time as a result of the illness. Working practices at the NHS trust concerned have now changed and a new antimicrobial agent is being used in theatres and for washing. Case 76 feels that his employer and manager have been supportive, as have his colleagues.

Case 76 felt his employers were responsible for the condition as they failed to provide alternative products. He is not seeking compensation from his employers.

**Financial consequences**

No loss of earnings had been experienced by Case 76, his normal earnings being in the range £1000 - £1500 per month. As a result of the illness, however, he found it necessary to use special soaps, detergents and shampoos, which cost approximately £20 per month.

Case 76 is also required to pay for anti-histamine prescriptions every month, with associated costs.

No-one else lost time off work as a result of this illness.

**Social consequences**

Daily activities are relatively unaffected by the condition, though perfume-free cosmetic and cleaning materials are needed. Case 76 felt self-conscious during swimming, and family sport and leisure activities were affected accordingly.

Both emotional and practical support had been provided by his partner, together with colleagues and his GP. No changes in relationships have been reported.

**Behavioural consequences**

Case 76 reported an increase in the use of both prescription and non-prescription drugs, and an increase in ill-temper and impatience.

Though his partner had been supportive, Case 76 has noticed an increase in impatience on her part. No changes had been reported in his son’s behaviour.
Psychological consequences

Case 76 is still self-conscious about his skin condition and frustrated that it hasn’t yet cleared up. He had not discussed any emotional issues with his GP.
6.9.17 Case No: 77 - female administrative NHS worker

The home interview was carried out 10 months after the illness report date and the follow-up interview after a further 4 months.

**Illness**

The introduction of a new, more intensive administration system meant increased use of a computer mouse. This led to the development of repetitive strain injury (RSI) in the right hand and wrist.

**Vocational consequences**

Case 77 had been off work for seven months at the time of the home interview. She felt that the RSI had developed as a result of a new system of working that had increased the amount of typing she had to do as well as the overall workload. It was too painful for her to go back to work as even small movements caused discomfort. Her manager had been very accommodating and had changed her work schedule to try and mitigate the impact of the new system of working. Her colleagues had also been helpful and listened to her concerns and taken on some of her workload.

She felt that her employer was responsible for the condition as a result of the introduction of new working practices.

At the time of the home interview, Case 77 was undecided about whether to claim compensation from her employer.

*At the follow-up interview she mentioned that the HR department had been in contact and the Occupational Health department had discussed possible medical retirement in the future. Case 77 was still off work at this point. At the follow-up interview, Case 77 had decided to seek compensation and was being assisted by a lawyer in seeking an out-of-court settlement. She was, however, concerned that this may affect her request for medical retirement.*

**Financial consequences**

Before the illness had begun her net monthly income was £1000 – £1500. She had received full pay for 6 months and 50% of her normal wage in month 7. Additional costs included £100 for prescription charges, £10 for taxi and petrol costs to medical appointments, £30 for additional utility bill costs owing to spending more time at home and £100 in extra food costs as she no longer received a free lunch when at work.

*Further costs at the follow-up interview included £50 for prescription charges, £50 for transport costs and £100 on extra food costs. Her daughter had given her £300 and she had a credit card to help out financially as she was still receiving 50% of her normal wage.*

No one else had taken time off work.
**Social consequences**

Personal care, household activities, driving, playing with her grandchildren and bowls were all still affected at the time of the home interview. All family activities were adversely affected. Her daughter cared for her every day, cleaned for her and helped out with shopping and friends took her to church and brought her videos to watch. Her church group had helped her with their friendship. Her relationships with her friends and family had not changed but she was worried that she was a burden to her daughter.

It should be noted that Case 77 had recently lost her partner and was dealing with the effects of her bereavement.

*At the follow-up interview she thought it was unlikely that playing bowls, driving and household activities would ever return to normal. She was still receiving support from her church group and her daughter.*

**Behavioural consequences**

The illness had caused a decrease in sleeping, eating and cognitive functions at the time of the home interview. Case 77 also thought she lost her temper and patience more frequently and took more medication.

*At the follow-up interview she noted a further decrease in concentration and avoidance of situations that might aggravate her condition. Use of both prescription and non-prescription medication had increased.*

**Psychological consequences**

Case 77 described feeling lonely with not working, and reported feelings depression and anxiety. She had consulted her GP, who prescribed her anti-depressants which Case 77 took for three weeks before deciding that they had not helped.

*At the follow-up interview she still felt depressed and worried about being a burden to her daughter.*
6.9.18 Case No: 78 - female administrative worker, private sector

The home interview was carried out approximately 4 years after the onset of the illness and the follow-up interview after a further 10 months.

**Illness**

Case 78 developed a severe latex allergy from visiting GPs surgeries, where latex gloves were used. She suffers from anaphylaxis during an attack. Additional symptoms include tiredness and feeling sick, as well as a racing heart. Asthma and flushing have since developed.

**Vocational consequences**

Case 78 was working in her normal job at the time of the home interview. She had been off for 1 month in the past as a result of her illness. She had contacted all the GPs and hospitals she visited through work to make sure they used powder-free latex gloves. She received no support from her employer.

She strongly believed that the responsibilities for her condition lie with the manufacturers of latex gloves, and with the NHS for not listening to the advice of the HSE on powder-free gloves. She also commented on the fact that there was no regulator to enforce the use of powder-free gloves.

*There had been no changes to the vocational situation of Case 78 at the follow-up interview.*

**Financial consequences**

When the illness began, the net monthly income of Case 77 was £1500 – £2000. This had not changed at the time of her home interview, and when she had been off work she had received full pay. She felt her future earnings might be limited by her illness, as before she could change jobs, she would have to carry out a risk assessment. She felt this could limit future career development since an important part of her job is being flexible and mobile.

At the interview she was planning on claiming industrial injuries benefit. She had decided not to make a compensation claim as her lawyer had advised that she was better to keep working as she was only 38 and had many years left to work if possible.

Extra costs connected to the illness were £50 for prescription charges and £2000 for substituting latex products in the house, for example removing latex-backed carpets and replacing with laminate flooring.

No-one else had lost time as a result of the illness.

*There had been no changes in the financial position of Case 78 at the follow-up interview.*
Social consequences

Dressing was still restricted at the time of the home interview and she will always have to use latex-free make-up applicators and lipsticks. Shopping was difficult in case she encountered balloons. Exercise in a gym was impossible but she could cycle if she wore gloves. Eating out was difficult in case food had been prepared by someone wearing powdered-latex gloves.

Family activities were impaired by her condition and she had to check that hotels were latex-free before making a booking.

She had been finding it difficult to help her children with their homework because erasers are latex-based, but other family activities had remained as normal. Her partner had taken care of her where they visited as a family, though her family seemed more distant since the onset of the illness. The Latex Allergy Support Group (LASG) had been very important in sharing experiences. Her GP, dentist and family planning services had all been quite unhelpful.

Case 78 felt her relationship with her partner had suffered as a result of the illness. She had been spending a lot of time helping the LASG and had found that non-sufferers did not really understand what it felt like to have the condition.

At the follow-up interview it was clear that socialising and shopping would never return to normal. Eating out with her family was also unlikely to return to normal, as was playing with her children.

Behavioural consequences

Case 78 avoided situations where she would be likely to come into contact with latex. She also had been taking prescription medication and been losing her temper more than she used to. There had been no changes in the behaviour of her family members.

At the follow-up interview she noted a decrease in alcohol consumption and prescription medication. She continued to avoid situations where her health may be placed at risk.

Psychological consequences

Case 78 had felt scared about the future at times, though she had not talked to her GP about the emotional impact of the accident at the time of the interviews. She wanted to try and help others as she felt that the illness is preventable and that many people should never develop the allergy in the first instance. There were no other psychological effects reported.
6.9.19 Case No: 79 - female clinical NHS worker

The home interview was carried out 4 months after the illness report date and the follow-up interview after a further 7 months.

**Illness**

Repetitive strain injury (RSI) of the left wrist was diagnosed after visiting the doctor in January and April 2003. The condition resulted from repetitive wrist movements in her work.

**Vocational consequences**

Case 79 was back at work, at the same job, at the time of the home interview after being off for 11 weeks. Since returning to work she had tried to make sure there was more variety in her daily tasks since her hand was very painful and claw-like at times.

She felt that her employer had provided her with good support, but that, while the HR department had been helpful, the Occupational Health department had been poor, offering her no useful advice. Her relationship with her colleagues had become difficult as they felt they had more duties as a result of Case 79 changing her daily work methods. Her nursing union had provided her with advice and put her in touch with other people in her area suffering from the same condition.

She felt that her condition is the responsibility of her employer as they have pressured everyone to work harder despite a lack of resources.

*At the follow-up interview she had found the HR department were still supportive and her manager quite helpful despite being increasingly irritated at how much time Case 79 had had to take off work.*

**Financial consequences**

At the time of the interview, Case 79 had a monthly net income of £1500 – £2000 and had received full pay when she was off work. Additional costs included £100 for prescription charges, £200 for private medical appointments and £300 for an ironing lady.

She was not planning to seek compensation from her employer.

Her partner had taken 1 week off work to look after her and to take her to medical appointments, and had used annual leave to cover the costs of this.

*At the follow-up interview she had paid a further £50 for prescription medication, £200 for her ironing lady and £200 for taxis to visit her family.*

**Social consequences**

At the home interview Case 79 thought cooking and household activities were unlikely to return to normal. Dressing, looking after her grandchildren, driving and social interaction
were all still restricted. Her partner had helped in the house more frequently since her illness began and kept her company by working from home when he could. Her daughter had helped her with shopping and cooking, and her grandchildren had kept her spirits up.

At the follow-up interview Case 79 judged that all household activities and driving were unlikely to return to normal and dressing was still restricted. Family activities were normal and her partner was still supportive. She felt closer to him as a result of the illness.

**Behavioural consequences**

Case 79 had been sleeping less, drinking less alcohol and avoiding situations that would worsen her condition or would be painful. She was taking more medication and was still in pain. Other key changes had been an increase in ill-temper and impatience. Her partner had been eating more since she had been forced to cook because of the necessity to use convenience foods. He had also been sleeping less.

At the follow-up interview there had been a further decrease in her sleeping and increases in both her medication use and losing her temper. There had been no further changes in her behaviour.

**Psychological consequences**

Case 79 had not talked to her GP about the emotional effects of the illness, though she worried about her health and about the long-term damage from continuing to work. She had found that these worries had made sleeping more difficult.

At the time of the follow-up interview, Case 79 continued to be anxious about her condition and it’s effects.
6.9.20 Case No: 80 - female clinical NHS worker

The home interview was carried out 15 months after the illness report date and the follow-up interview after a further 6 months.

Illness

Case 80 had persistent pain in the arms for a number of years, which was subsequently diagnosed as carpal tunnel syndrome. She was unable to handle instruments reliably due to the pain and numbness in her hands. After an operation, the problem has lessened somewhat, though Case 80 is required to wear a splint, and has also suffered from anxiety.

Vocational consequences

Case 80 was aware of the illness for some years before taking positive action. Eventually, her inability to perform her work forced her to seek a proper diagnosis and appropriate treatment. An operation was required, but unfortunately the waiting list was 18 months, and during that time, Case 80 would have been unable to work. She had therefore elected to pay for a private operation, and after a 10 week absence, had returned to her usual job. The work still causes her pain, but she is trying to alter her duties somewhat in order to reduce any repetitive tasks.

Case 80 received good support from her employers. Occupational Health was helpful, and her immediate manager was encouraging in suggesting new ways to organise the work.

She felt that nobody was responsible for the condition, but felt that it was a consequence of the nature of the work itself. She was not engaged in seeking compensation at the time of the interview.

At the time of the follow-up interview, she was in less pain and was happier with her work, which now had a higher administrative element to it. She continued to receive support from her managers.

Financial consequences

Case 80 received full pay of £1500 - £2000 for her first month of absence and 50% pay for the next two. Overall, direct loss of earnings was in the region of £1750.

Additional costs were also incurred by Case 80, the most significant of which was the cost of the private operation of £1300. Other costs were £200 transport, £200 for prescriptions and small sums for household equipment.

No-one else had lost time off work as a result of the illness.

At the time of the follow-up interview, Case 80 had incurred further private medical costs of £400.
Social consequences

At the time of the home interview, most activities of daily life were either still affected by the illness or had recently recovered. Still affected were dressing, cooking, shopping, gardening, DIY and driving. Those recovering were bathing and visiting friends and family. Driving was particularly difficult due to the numbness in her hands.

Support had been provided by Case 80’s brother and his family, who looked after her completely after the operation. Case 80 felt that the relationships between herself and her brother’s family had improved as a result of this.

At the time of the follow-up interview, there had been a worsening of some activities, and Case 80 did not believe that she would ever return to normal activity in gardening, which is her chosen leisure activity, or household care, though driving had improved over the same period.

Behavioural consequences

The main behavioural changes reported by Case 80 at the time of the first interview were an increase in ill-temper and impatience and an increase in both prescribed and over-the-counter medications.

Six months later, at the follow-up interview, her use of non-prescription medications had increased still further.

Psychological consequences

Case 80 reports that she had felt very anxious about the illness, and worried that it may become worse. She discussed the emotional impact of the illness with her GP, who was reassuring and helpful.

At the follow-up interview, while still concerned for the future, she reported worrying less and was regaining her confidence.
7 DISCUSSION

7.1 GENERAL STRUCTURE OF THE DISCUSSION

The study has generated a complex set of information, involving a sizeable telephone survey, a more extended home interview survey of a subset of those interviewed in the telephone survey and related, but smaller, data sets associated with follow-up interviews and interviews with family members.

The objective of this discussion is to integrate the major findings across all these datasets in order to identify both key implications for practice and areas that clearly require further research. In general, the structure of the discussion reflects that adopted in the earlier overview sections. Different types of consequence are discussed in turn; within this the main findings associated with each sector (construction and health sector) and each category (accident and illness) are then considered. Where quantitative data can usefully be presented from the telephone survey this is done first; a more qualitative commentary based on the case studies is then included where this illuminates the points being made. Relevant comparisons between the sectors or within the sectors are also included where appropriate. It should be noted that individuals in the construction sector are predominantly male and those in the healthcare sector predominantly female. Any considerations of differences between gender are therefore confounded with sector differences.

Finally, this discussion is necessarily limited to key areas; it does not attempt to summarise all the findings of the study or to repeat many of the points that have already been covered adequately in the main body of the report.

7.2 METHODOLOGICAL ISSUES

Before discussing the main findings of the study, it is worthwhile reviewing some of the main methodological features of the study design, including its strengths and recognised boundaries. Any consideration of the observations and conclusions drawn from the study needs to be seen within this wider context.

The literature search carried out prior to the study confirmed the lack of UK-based research into the social, psychological and other consequences of work-related accidents and illness. Accordingly this is a landmark study and the first to systematically highlight the extent and severity of these effects. Whilst the methodological difficulties discussed below may have limited the power of the study to provide reliable estimates of the prevalence and magnitude of the effects, the study provides compelling evidence that these events have a seriously detrimental impact on the lives of many individuals and their families. Moreover, the results of the study provide a strong indication of the problems that need to be anticipated and managed by employers and professionals who have responsibility for the identification, support and resettlement of those injured or otherwise impaired at the workplace.

In terms of the scope of the study, a number of key points need to be made. Firstly, the primary home interview sample – in terms of both selected sectors and sample size – was pre-defined by the HSE. Construction and health care sectors are clearly widely different both in terms of working populations and working environments. Within each sector, the two categories of work-related accidents and work related illness are similarly diverse in nature.
and internally cover a wide range of different events and conditions. There was also a need to ensure that the range of cases included within the home interviews reflected, as far as possible, the main types of major accidents and serious illness encountered within the two selected sectors. These constraints have meant that the detailed database of 80 case summaries represent a wide range of events, conditions and outcomes with individual numbers of cases for any one category comparatively small. Because of the known differences between cases, and the inability to control for these differences within a relatively small dataset, the scope for statistical comparisons is minimal. For these reasons we have generally limited any quantitative analysis to the larger, but inevitably less rich, telephone survey. Occasionally, where the opportunity does exist to pool data and examine differences within the home interview sample, this has been done.

Secondly, considerable time was spent in satisfying the ethical requirements of the study. In particular, this required managing the essentially ‘opt-out’ design of the accident cases so that individuals were clear that they could elect to withdraw from the study at any time, and were under no duress to co-operate. This was handled very successfully, with no withdrawals and no known complaints. As described in the methodology, illness cases were recruited using an entirely different approach that was fundamentally ‘opt-in’. It could therefore be argued that those who took the decision to volunteer for the study were more self-selected and therefore more likely to be fundamentally unrepresentative of the relevant population. Although there was anecdotal evidence that some of the those who responded viewed themselves as particularly badly affected, or indeed were more vocal or eloquent, many others had clearly simply responded to the invitation that had been passed to them via their employer. Therefore, while it would be reasonable to assume that active self-selection may have confounded certain effects, it would be unreasonable to assume that it had biased all the results for this group given the number and range of variables that were included in the study.

Thirdly, turning to the longitudinal element of the study, although the original objective was to introduce a strong longitudinal element to the study design, in practice this aspect of the study became progressively undermined as the research progressed. These issues are discussed within the methodological section of the report but it is worthwhile recapitulating some of the main points to establish the context for the following discussion. The difficulties which arose in relation to identifying a sample of illness cases meant that we were often contacting cases where symptoms, formal diagnosis and reporting to HSE had occurred many months or even years prior to our first contact. This meant that any orthodox longitudinal approach became inappropriate. Follow-up interviews were, however, carried out with a subset of these cases in both construction and health care sectors either where cases were relatively new or, in the case of long-established conditions, to establish whether the severity of impact of a chronic condition on the individual and family tended to remain consistent over time or was subject to significant change. In terms of accidents, although the initial reporting of cases was more straightforward, for procedural reasons no cases were released by HSE until a minimum of six weeks after initial reporting. The complex ethical process that was required meant that although the telephone interview could take place shortly after this, the home interview was typically only possible after a minimum elapsed time of nine to ten weeks. This time period was often longer, as particular cases were retrospectively culled from the database to meet sampling requirements for a certain type of accident or illness. Again, this compromised the potential for an effective longitudinal study, particularly since the acute or immediate aftermath of the accident was missed - this is perhaps the major limitation of the study. However, in order to capture some longitudinal effects, a subset of these cases was interviewed again, typically between six and nine months after the first home interview. In summary, therefore, the study provides some insight into the longitudinal impact of the accidents and serves to reinforce the chronic and persistent impact of some work-related illnesses.
Finally, it is important to remember that all the consequences and effects discussed in this report are based on self-reporting. In particular, none of the details of physical impairment were independently or objectively verified.
7.3 VOCATIONAL CONSEQUENCES

7.3.1 Work outcomes

The results of the telephone survey can be used to make an overall assessment of the extent to which both the accidents and illness impact on return to work outcomes.

In the construction sector, taking the accident group first, most people who had taken time off work had either returned to work or, if still off, expected to return to work. Of the remainder, one person had retired normally, a further three (3%) did not expect to return to work as a result of the accident and a further four (4%) were unsure if they would return. Amongst those who had returned to work, three people had returned to a different job as a result of the accident (3%) and 11 people (12%) considered the accident had affected the way they did their work. Of those people who were still off work but expected to return to work, 10 people (11% of the whole sample) did not expect to return to the same job as a result of the accident. This gives overall figures of 14% who had not, or did not expect, to return to the same job and a further 12% who felt that the way they did their original job was subsequently affected. Adding these to the 3% who did not expect to be able to return to work gives a total figure of 29% of the total sample. In this sample, approximately one third of cases were also still off work but expected to return to their original job. In view of the fact these cases had already required an extensive period of time off work, it seems reasonable to assume that a proportion of this group would also find that the way in which they did their job would be subsequently affected. Using a similar proportion to that already identified in the group who had already returned to their own job to estimate this figure (this is likely to be a conservative estimate since we are dealing with more serious accidents), and adding this to the 29% referred to above gives an estimate of 40% of cases whose working life may be materially affected by the accident (again is a conservative figure since it excludes the 4 cases who were unsure if they would return to work). This figure also needs to be seen in the context of the responses received to the question on residual physical effects: 79% of the total sample reported that they were still suffering from residual physical effects of the accident at the time of the telephone interview.

Information from the home interviews confirms the serious impact of these accidents on work outcomes. Although the general trend is for eventual return to work, most people return either temporarily, or in some cases permanently, to a different or modified job (typically described as light duties), sometimes on reduced salary. It should also be borne in mind that the study shows that these individuals are often under significant financial pressure to return to work and have few alternative job prospects.

Turning to the pattern in relation to work-related illness in the construction sector (typically HAVS or RSI) the comparable figures are as follows. Of the 36 cases in this sample, most people had either not had time off work or had returned to work. One person had taken early retirement on ill-health grounds and one person was still off and did not know if they would go back to the same job. This is a much smaller sample (representing a wide range of illnesses) and as we have previously stated potentially biased because of the opt-in design. Of those who had not taken any time off, 14 people (38% of the total sample) considered the job was affecting the way they did their work. Of those who had returned to work, 4 people had returned to a different job as a result of the illness (11% of the whole sample) and 5 people (14% of the whole sample) considered the illness had affected the way they did their work. This gives overall figures of 11% who had not returned to the same job and a further 52% who felt that the way they did their original job was subsequently affected. Including the one individual who had taken early retirement gives a total figure of 66% of the total sample.
whose working life may have been materially affected by the illness. These findings are again consistent with the response to the questions on residual physical effects: 88% of the whole sample reported that they were still suffering from residual physical effects of the accident at the time of the telephone interview.

In practice, a large number of these cases were subsequently interviewed at home and the extent to which chronic work-related illness compromises an individual’s working life became much clearer. For example, in conditions such as HAVS or VWF, despite not losing any time off work, most of those interviewed had changed their employer, job or specific role as a result of the illness or condition. Others had remained in their existing jobs but been left to manage their own condition, sometimes having to negotiate with colleagues to reduce exposure to relevant equipment. The case summaries illustrate that, once back at work, some people found it difficult to eliminate or maintain acceptable levels of exposure. The study results (the telephone survey results were reinforced in the home interviews) also strongly indicate that potentially chronic conditions such as HAVS and VWF are not being identified and managed until symptoms are well established and potentially irreversible. There was little evidence of effective risk assessment or systematic monitoring and intervention. Cases were typically picked up at a routine mass screening or at the stage when symptoms had become so severe as to warrant referral to an occupational health facility or other form of medical support.

Comparing the results across the two groups within the construction sector reveals some clear differences. In the accident group, conditions are acute, often traumatic in nature and can require lengthy recuperation before return to work. In the illness group, conditions are typically chronic in nature, often resulting in no time off work but nevertheless having significant impact on work outcomes.

In the healthcare sector, again taking the accident group first, within the sample of 43 people that were interviewed, most had either returned to work, or, if still off, expected to return to work. A further 9% had not taken any time off. No one in the sample had either taken early retirement or anticipated not being able to return to work. Of those who had returned to work, everyone had gone back to the same job but 14 people (33% of the whole sample) considered that the accident had affected the way they did their work. Of those people who were still off work but expected to return to work, 1 person did not expect to go back to the same job because of the accident and 2 were unsure. Of those who had not lost any time off work, 2 people considered the way they did their job to have been affected by the accident. Excluding those who were unsure, this gives this gives an overall figure of 39%. As in the construction accident group a large number of cases were still off work at the time of the interview and most expected to return to the same job. Again, using the approach adopted in respect of the construction accident group and estimating the number whose work may subsequently be affected based on cases who have already returned to work, gives a figure of 58% of the total sample whose working life may have been materially affected by the accident. This figure is consistent with the response to the questions on residual physical effects: 78% of the total sample reported that they were still suffering from residual physical effects of the accident at the time of the telephone interview.

The above findings were reflected in the home interviews. Most people in this group had already returned to work or anticipated returning to work. Patterns of return varied, depending on the nature of the accident but most had found their work subsequently affected by the accident. For example, they had needed to change jobs because of the accident, had been restricted to light duties or they had become much more cautious or apprehensive in the way that they performed their work.

The final group to consider is work related illness within the healthcare sector (the dominant conditions being upper limb disorders and occupational dermatitis). Of the 64 cases in this
sample, most people had returned to work or not had time off work. A further 12% were still off work and one person had taken early retirement on ill-health grounds. Of those who had not taken any time off, 9 people (14% of the total sample) considered the illness was affecting the way they did their work. Of those who had returned to work, 4 people had returned to a different job as a result of the illness (6% of the whole sample) and 21 people (33% of the whole sample) considered the illness had affected the way they did their work. Of those 8 people that were still off work, 2 did not expect to be able to return to work because of the illness and 3 expected to return to different job (a total of 8% of the whole sample). Excluding those who did not know if they would return to the same job, but including the one individual who had taken early retirement gives a total figure of 63% of the total sample whose working life may have been materially affected by the illness. This figure is also consistent with the response to the questions on residual physical effects: 85% of the total sample reported that they were still suffering from residual physical effects of the illness at the time of the telephone interview.

Comparing the results from the two groups shows that, as in the construction sector, accidents tend to result in more time off work than illnesses. In the healthcare sector however, those suffering from work-related illness were more likely to take time off work than the equivalent group in the construction sector. This may reflect different cultures, relative size of organisations, expectations (on the part of those affected and on employers) and levels of tolerance between the two groups, or be linked to the financial consequences of being away from work. For example, the data from the telephone interviews (which are confirmed in the home interviews) show that those working in the construction sector may be under considerable financial pressure to remain working.

7.3.2 Support from the workplace

The nature of the contact with work and any support that individuals had received was explored in the home interviews. Areas covered included support from the employing organisation, from individual managers and from colleagues.

In the construction sector there was evidence of different types and levels of support between accidents and illnesses. In respect of accidents, half the cases reported they had not received any support or contact from managers or colleagues; this was generally accepted to reflect normal industry practice. Where support was provided, this was typically in the form of a phone call from a supervisor or a visit at home from a colleague. There was no evidence of any formal support from Occupational Health or HR departments (although it acknowledged that many companies within the sector may not have these dedicated functions). These findings need to be considered in relation to the work outcomes discussed previously which demonstrate that many people have been unable to directly return to their original job and need support and help in making this transition.

Turning to the illness cases, half of whom had not lost any time off work and therefore were in daily contact with colleagues and supervisors, the pattern of support is somewhat different. Many people had received some form of support, whether from their employers, managers or colleagues and indeed there were examples provided of valuable help being given. However, over half the cases did not explicitly identify their employers or managers as a source of support and many commented negatively on their experiences. Again, colleagues provided informal support but of particular note in this group are the reports of bullying or general unpleasantness by colleagues when some individuals were allocated a different role to reduce exposure to a certain situation. Although there was greater evidence of formal involvement by Occupational Health or HR departments, this type of support was only available in a small number of cases.
In the healthcare sector, where most people who were interviewed worked for the NHS, the pattern was relatively more positive. Most cases reported that they had received some support, whether formally from HR or Occupational Health departments or from managers or colleagues. This still left a quarter of the 40 cases that felt they had received no contact or support and several of these expressed disappointment and surprise at this outcome given the nature of the organisation that they worked in. As in the construction sector, much of the support was provided by individual managers who kept in touch with employees during the relevant period of sickness absence. Whilst this contact was generally seen as valuable, there were reports in the illness group where individuals felt that this contact had not been particularly helpful, for example, where managers had been insufficiently sensitive to the emotional impact of the accident or illness. Similarly there were also reports in this group where the employee felt they had not been adequately supported when returning to work. As in the construction sector, colleagues had also provided a significant source of support either during a period of absence or in the adjustment period when back at work. Finally, only a relatively small proportion of those interviewed reported any formal contact (typically initiated by the affected person) with HR or Occupational Health departments. Of those who were in contact with occupational health departments (principally within the NHS), many felt that the support that was forthcoming was not as effective as it could have been.

Taken together, these results indicate that in the construction sector, and to a large extent within the healthcare sector, there was little evidence of any formal policy or plan to manage return to work or job change. Support and contact with individuals tended to be informal and at the behest of individual managers and colleagues. The latter is of course extremely valuable but, in instances of serious accidents or chronic illness, is insufficient of itself to provide a managed route back to work. For example, in the construction sector, it is unrealistic, and inappropriate to expect first-line supervisors or managers to have the expertise required to assess individual needs and plan accordingly. This approach also relies heavily on the quality of individual relationships between managers, colleagues and employees leaving an individual feeling vulnerable if these relationships are less than ideal.

The role of Occupational Health departments was fairly minimal (in both sectors) and generally speaking, where they were involved, their contribution was not viewed as particularly effective. For example, individuals in both the accident and illness groups within the healthcare sector expressed surprise at the paucity of information that was available to them. Lastly, although difficult to quantify, there was some indication from the follow-up interviews that individuals felt the necessary level of support was not adequately sustained following return to work or post diagnosis. This finding is also consistent with the lack of an overall policy for managing the return to work of those seriously injured or the redeployment of those suffering from a chronic condition.

7.3.3 Responsibility for the accident or illness

In the home interviews, individuals were asked who they thought was responsible for their accident or illness. The responses across both sectors and both categories of accident and illness showed a strong tendency to external attribution; most people felt that their employer, manager, co-worker or other external party were partially or fully responsible. In only 20% of the 80 cases did the individual hold themselves partially or fully responsible. A further group of 20% (primarily those in the illness groups) felt that no one individual was responsible or that the injury or illness simply reflected the state of knowledge or general working conditions within the sector. It should be remembered that these results are based on self-reported data and it was not an objective of the study to verify any details of causality. However, the findings are of some importance: they suggest that individuals who have
suffered a serious accident or work-related illness are likely to be defensive or, at worst, hostile in their attitudes to their employer. This places particular demands on the employer and employer representatives who may have responsibility for keeping in touch with the individual and dealing with return to work or redeployment issues. Poor management of these cases is likely to further reinforce these attitudes and reduce the likelihood of a successful outcome (whether this is return to work or a managed retirement process). There is also some anecdotal evidence from the home interviews that poor management by the employer can also increase the probability of the employee seeking compensation, although this issue needs further research to confirm any real linkage. The possible linkage between attribution of responsibility and the issue of compensation is also explored within economic consequences.
7.4 ECONOMIC CONSEQUENCES

7.4.1 Impact on income

The telephone survey provides the best data on the impact of the illness or accident on income because of the bigger sample size. The most revealing comparison is the degree to which individuals suffer a significant loss of income if they lose time off work. Considering the construction sector first, within the group that had lost time as a result of an accident, nearly two thirds were on less than full pay for all or part of this time and most notably, 48% were reliant on statutory sick pay or other state benefits and 15% reported that they had no form of financial support (they were either ineligible for support or awaiting payment). This group were clearly under significant financial pressure; this finding was confirmed in both the results of the telephone survey (they were the group that expressed the highest level of anxiety about money) and in the home interviews. Within the illness group, a different picture emerges: most of this group had not lost any time off work and so did not apparently suffer any financial consequences (however in reality the home interview survey reveals that one of the biggest groups in this category, namely VWF and HAVS sufferers often end up on a reduced salary because of redeployment). Of those who had lost time off work, much smaller proportions than in the accident group reported that they were not on full pay, on statutory sick pay or receiving nothing (small numbers here make giving comparable percentages inappropriate). There are a number of possible reasons for the differences between these two groups: some in the illness group were employed by local authorities who may have more generous terms and conditions than construction companies, the illness group contained more administrative personnel, overall they were off work for shorter period of time and lastly many of the illness cases were demonstrably caused by working conditions and hence could have been treated more favourably by the employers.

Within the healthcare sector, the accident group lost significantly less income than their equivalent in the construction sector. Of those who lost time off work, 33% were not receiving full pay for at least part of the time, 23% were on statutory sick pay or other benefits and 10% reported receiving no form of financial support at the time of the telephone interview. Within this group most people worked within the NHS and were typically on full pay; the remainder worked in the private sector. Within the illness group, lower proportions were on reduced income. Of those who had lost time off work, 24% were not receiving full pay for at least part of the time and 4% received statutory sick pay or other benefits. The more favourable position within the illness group can be partially explained by the higher proportion of NHS employees in this group. Generally speaking there were also a higher proportion of employees who had clinical rather than manual roles within the illness group. It should be noted here that, even though nominally on full pay whilst on sick leave, some NHS personnel in the home interview survey reported a significant loss of income because of the loss of overtime or bank work.

7.4.2 Additional outgoings

The information on individual outgoings collected in the telephone interviews was relatively crude but does serve to demonstrate that, in addition to loss of income, many individuals also incurred significant additional costs. The comparative figures are as follows: in the construction sector, 51% of those in the construction accident sample reported extra financial demands (41% had additional transport costs and 28% additional medical costs), 44% in the construction illness sample had additional costs (31% had extra transport costs and 25% additional medical costs), in the healthcare sector 63% of the accident group incurred
additional costs (49% had extra transport costs and 23% had extra medical costs) and lastly in the illness group within the healthcare sector, 67% reported additional costs (23% had extra transport costs and 51% had extra medical costs). The home interviews show that for some people this extra expenditure placed a further burden on already limited and stretched resources.

Some differences in pattern can be identified: typically the accidents involved a greater physical impairment and loss of mobility than the illnesses and also generally required more visits to hospital, hence expenditure on transport was greater, although it should be noted that the proportion incurring greater transport costs in the illness group was still relatively high because conditions such as VWF and HAVS impair the ability to drive. Whilst the additional expenditure on medical costs was mainly related to increased prescription costs, the home interview survey also identified some significant expenditure on private medicine, and, in the case of chronic and long-standing conditions such as upper limb disorders some investment in complementary medicine. Typically the latter was linked to a feeling that conventional approaches were not particularly effective and normal interventions had been exhausted with little success.

7.4.3 Compensation issues

The data from the home interviews are indicative of high levels of compensation-seeking within the construction sector in respect of both the accident and illness group (14 out of 20 and 11 out of 20 respectively). Although the samples are small and biased towards serious cases, the relative scale of response is consistent with the pattern obtained in some of the telephone interviews (the question of compensation was formally introduced late in this survey when it was identified as an area of potential interest though the numbers are seen as too small to report). These interviews suggest a lower but still a high level of compensation seeking in the accident group and an even higher level within the illness group. There are a number of possible reasons beyond the why compensation-seeking is common in the construction sector: generally speaking there are high levels of financial insecurity (as we have seen many people are receiving only basic levels of income during their period of sickness absence), job security is low and may be significantly compromised by the accident or illness, skill sets are restricted and there is less scope for redeployment either within an individual’s own company (which may be small) or in the industry as a whole. In some cases seeking compensation may be the only alternative and, overall, even low levels of compensation may be seen as providing some protection against future loss of earnings. In addition, trade unions were reported to be active in promoting these claims, particularly in relation to conditions such as VWF and HAVS.

In the healthcare sector (where most people in the home interviews were employed in the NHS), the proportion of people claiming compensation in the accident group was also high (12 cases were actively seeking compensation or considering it) but much lower in the illness group (4 out of 20). Again, the telephone data also suggested a higher proportion of cases seeking compensation in the accident group than in the illness group. In the home interviews, the proportion of cases claiming compensation in the health sector accident group was surprisingly similar to the construction sector despite the obvious differences in organisational culture, job security and level of sickness pay. The injuries themselves were also generally speaking less serious than those in the construction sector. This result may indicate that the growth of a nationally litigious culture may be swamping those traditional aspects of an organisation that typically militated against such legal action.

Despite the fact that seeking compensation is often a lengthy and, for some, a difficult or distressing process, the evidence from the study is that it is becoming a routine response to
many work-related accidents or illnesses. The growing access to lawyers who operate on a 
no-win/no-fee basis is clearly fuelling this growth. Statistically, the results of the home 
interviews suggest that those who have a serious accident at work are more likely to seek 
compensation than those who experience a work-related illness ($X^2$, 1 df, 6.08; P 0.05 – 0.01) 
and that those in the construction sector are more likely to seek compensation than those in 
the health sector ($X^2$, 1 df, 6.08; P 0.05 – 0.01). The home interview data were also used to 
examine possible linkage between attribution of responsibility for the accident or illness and 
the act of seeking compensation. For analysis purposes the data were pooled across the 
sectors, with cases divided into those who could be classified as having a purely internal 
 attribution (that is they felt the responsibility for the accident or illness lay completely with 
themselves) and those who reported a partial or full external attribution of responsibility (that 
is, they felt the accident or illness was no-one’s fault, was a feature of the industry or some 
external party or parties were responsible). The analysis showed that, based on this dataset, 
there was no significant association between attribution of responsibility and propensity to 
seek compensation. However, it should be noted that, within the sample of 80 cases, there 
were only 6 cases where individuals felt they were fully responsible for what had happened to 
them. This finding is interesting in itself and consistent with the high levels of compensation-
seeking that have been identified.

The high level of compensation seeking in both sectors has implications for the way that HSE 
inspectors interact with those involved and also potentially for the way in which HSE seeks to 
promote improved safety practices amongst employers; these issues are addressed in the 
recommendations. It also raises a number of important research areas. For example, does the 
way that an employer manages an individual case influence the probability that the person 
will seek compensation? Similarly, does the decision to seek compensation have implications 
for the recovery process and return to work patterns? (the so-called ‘compensation neurosis’ 
pattern that has been identified in the American literature). The size and nature of the 
samples within this study do not allow for these areas to be addressed systematically, 
 principally because of the number of confounding variables and the complex and lengthy 
nature of the compensation process. However, there are some indications in the home 
interviews that individuals recognise that the process of seeking compensation may have an 
impact on the quality of employer-employee relations and some individuals have clearly 
factored this into their decision-making.

7.4.4 Economic effects on others

The telephone survey shows that, in some cases, the economic effects of the accident spreads 
beyond the affected individual to members of their family and friends. In the construction sector 24% of the accidents had resulted in someone else taking time off work (up to the 
point of interview); there was only one such case reported in the construction illness group. 
In the healthcare sector, 21% of cases reported lost time by others in the accident group and 
9% in the illness group. These findings reflect the pattern of caring and social support 
described below. It is also important to note that these data do not include time spent caring 
where there was no direct economic loss because the carer was retired or not in employment. 
In the home interviews, where the cases were generally more serious, carers (typically 
partners) were significantly more likely to have taken time off work as a result of the accident 
or illness.
7.5 SOCIAL CONSEQUENCES

7.5.1 Activities of daily living and family activities

The telephone survey provides a guide to the overall impact that these accidents and illnesses can have on activities of daily living. The evidence is that they have a serious effect on most aspects of people’s lives.

In the construction sector, results from the accident group show that between 63% and 77% of the telephone sample felt that one or more aspects of personal care, household care, or their leisure and recreational activities had been affected by the accident. Mobility (either walking or driving) had been affected in 80% of the cases. This had a knock-on effect on social life in approximately 60% of cases. The results from the home interviews and follow-up interviews confirm these findings. They show that that these accidents often have pervasive and damaging effects on personal and family life, typically restricting most normal and routine activities, particularly those that are more physically demanding. In some cases the case summaries show that this impact continues for a long period of time, leading to feelings of personal frustration and, where mobility is seriously affected, feelings of depression and social isolation. In a number of cases, it was clear at the time of the follow-up interviews that many activities were unlikely to return to normal.

Turning to the illness group within the construction sector, the telephone survey shows that the impact on activities of daily living was also marked, though the numbers affected are somewhat lower (the equivalent percentages being between 39% and 67% reporting that one or more aspects of personal care, household care, or leisure and recreational activities had been affected). Mobility (either walking or driving) had been affected in 39% of the cases, with only 17% of cases reporting an impact on their social life. In many respects the nature and extent of these effects are less predictable and less obvious than those that follow a serious accident. The results of the home interviews shed some further light on these figures. Although those that were interviewed in the illness group represented a wide range of conditions, from paint allergy to mesothelioma, and therefore the range of restrictions was considerable, some patterns did emerge in respect of conditions such as RSI, VWF and HAVS. These conditions can have an impact on normal life far beyond that perhaps expected by those unfamiliar with these conditions. For example, in HAVS dressing becomes difficult because of loss of sensitivity, normal household tasks become frustrating because of loss in dexterity and any sports or hobbies that rely on obtaining purchase or a good grip such as golf or climbing become impossible. Driving, especially driving for long periods, may become difficult because of numbness in fingers or hands. In nearly all these cases, because the impairment is at best arrrestable, these restrictions had led to feelings of frustration and anxiety about the future. Both the persistent nature of these restrictions and their emotional impact were confirmed in the follow-up interviews.

In the healthcare sector, the results of the telephone survey show that the accident group reported even higher levels of impact on activities of daily living than the equivalent sample in the construction sector, despite the accidents appearing to be less severe in terms of their physical consequences. Between 81% and 86% reported that one or more activities involving personal care, household care or leisure and recreation had been affected by the accident. Mobility was affected in 81% of cases with a knock on effect on social life in 68% of cases. This disparity may be partly explained by the gender differences between the two samples, the construction accidents involve males, whilst the health sector accidents typically involved females who arguably may be more likely to report an impact on personal care and household...
care activities and, because of their work responsibilities, may be more sensitive to these issues. As in the construction sector, the results of the home interviews with the more serious cases confirmed the nature and extent of these restrictions. In nearly all these cases, individuals reported that the majority of their routine activities had been seriously affected, and most were still experiencing significant problems at the time of the home interview, many months after the accident. The case summaries indicate that in some cases mobility remained affected for a much longer period and that engagement in physically demanding activities such as gardening or sports activities was unlikely to return to normal.

Turning to the last group of cases – illness in the health care sector - the telephone survey identified a different pattern of results to that identified in respect of construction illness. The reported impact on personal care was broadly similar (58% in construction illness and 56% in health illness) as was the impact on leisure and recreational activities (67% in construction illness and 73% in health illness). However, there are differences in the extent to which these groups reported an impact on household care activities (39% in the construction sector and 72% in the healthcare sector), on mobility (39% in the construction sector and 55% in the healthcare sector) and social activities (17% in the construction sector and 52% in the healthcare sector). Again, males dominate the construction illness sector and females the healthcare illness sector, which may offer a partial explanation for these differences. The healthcare illness sector also included a large number of cases of RSI and latex allergy. The case summaries clearly illustrate the intrusive, personal and persistent nature of these conditions. In particular, in the case of latex allergies, sufferers have to effectively engage in a constant programme of risk assessment and, in severe cases, find most normal aspects of life severely curtailed.

All the above findings have significance for the way in which groups of cases and individuals need to be managed both in a work and an out-of-work setting. Whilst the physical consequences of a serious accident are usually clearly visible and the associated restrictions that follow understandable, the extent to which these restrictions affect morale and emotional well being is generally less well understood and perhaps less well tolerated, especially when recovery is slow or incomplete. In the case of illnesses, the picture is more complex. Often the physical impact of an illness is less visible, it may also invoke less obvious public empathy than an accident and perhaps most importantly, it may have no obvious recovery path or timescale. Yet the case summaries vividly show that many illnesses place, and will continue to place, serious restrictions on people’s lives. In the case of both accidents and illness it is therefore important that those who have a professional responsibility to support these individuals do not have preconceptions about the relative impact these events may be having on people’s lives.

The telephone survey also confirms that many of the restrictions discussed above inevitably spilled over into family life. These findings were reinforced in the home interview survey. In the construction sector, the mobility problems and physical restrictions that were experienced within the accident group led to problems with many family activities. Social and recreational activities were particularly affected and, for some people, as the case summaries demonstrate, seemed unlikely to return to normal. Being unable to play normally with children or grandchildren was especially upsetting. In the illness sector, the restrictions were of a different type: HAVS and VWF caused problems with driving and so had a knock-on effect on others in the household. These conditions also had a more subtle impact on the intimacies of family life. For example, one affected person reported his distress that he could no longer get his baby daughter ready for bed because of his inability to cope with the fastenings on the baby clothes. Allergies and skin disorders also caused social embarrassment and so some affected individuals became uncomfortable about being out in public with their children.
In the healthcare sector, the accidents had a similar impact to that reported in the construction sector. Again, family leisure and recreational activities were most affected. Individuals in this group were also upset, and in some cases reported they felt guilty, about the impact the accident had on the way they were able to look after and interact with their children. Interviewers also noticed a reluctance to discuss the impact on children in the illness group, although of those who lived with children most had reported undesirable changes to their normal family life. (It should be remembered that the healthcare sample is largely female and may be more vulnerable to such feelings). The two common conditions in the illness group were RSI and latex allergy, both of which place significant restrictions on individuals, albeit of a different kind. The potential impact of latex allergy on quality of life is perhaps less well understood but clearly demonstrated in the case summaries. In particular, these individuals have to cope with living in a state of uncertainty about where they may come in contact with latex, potentially putting them and their families under great stress.

7.5.2 Provision of support and impact on relationships

The results of the telephone survey provide some basic data on the profile of individuals who provided most personal support in the aftermath of the accident or illness. In the construction sector, those recovering from accidents received support from a wide range of people, predominantly partners but also parents, older children, friends and siblings. In the construction illness group, personal support was overwhelmingly provided by partners or in a small proportion of cases by parents (typically in a younger age group). There are a number of possible reasons for this difference in profile. Serious accidents by their very nature are unexpected, traumatic and potentially life threatening and they often result in highly visible injuries. Friends and family will typically demonstrate an instinctive desire to help and, indeed, there are often obvious practical ways in which this help can be provided. In most cases, people also anticipate that their support will only be temporarily required. In the case of illness, people may genuinely not understand the condition and, generally speaking, the physical effects are much less visible. Many illnesses are also chronic and progressive in nature so the nature of the support and the level of commitment required may be more demanding. There may also be a degree of fear and stigma attached to certain types of illness, particularly those that are disfiguring. In the case of potentially terminal illness, these problems are often exacerbated. They may also be accompanied by a reluctance to raise or discuss difficult issues. Lastly, in conditions such as HAVS and RSI, the problems associated with these conditions are also often embedded in daily routines - help in this context is most easily sought from a partner or close friend.

In the healthcare sector, those involved in an accident also received support from partners, parents and particularly children (although there is less evidence of the wider network of siblings and friends being involved). However, the pattern in healthcare illness looks different from that in construction illness. In the healthcare sector, there is evidence of a wider network of support. Part of this difference may be accounted for by the nature of the conditions in this group: it included latex allergies where family members and friends may need to be closely involved. It may also reflect a greater readiness on the part of women to talk about their illness and ask for help, and again a greater preparedness of children to offer help to their mothers.

The home interviews reinforced the importance of support from partners and immediate family. In the construction sector, in both the accident and illness groups, nearly all of those who lived with a partner identified them as the primary source of emotional and practical support. Potentially this could result in pressures on a relationship and indeed, there is some evidence in the case summaries of changes in the nature and quality of relationships between
partners and within the family group. However, across both groups, the number of changes reported by those affected by the accident or illness was relatively small and indeed some individuals had clearly experienced a strengthening of relationships. In those who reported deterioration in their relationships with their partner, problems typically revolved around the financial worries and concerns that are particularly prevalent in this sector. In the healthcare sector, the results were broadly similar; partners were again viewed as the primary source of support. Where changes in relationships were reported, they tended to reflect a strengthening rather than a deterioration.

**7.5.3 Impact on those who live alone**

The study provides some insight into the relative impact of serious accident or illness on those who live alone. For example, they may be more vulnerable financially if they find themselves with a significant reduction in income and they have no partner with an independent source of income, mobility becomes a problem if they are unable to drive and can potentially lead to feelings of isolation, dependency on family members is increased and may cause friction, they do not have the close support and strong relationship with a partner that many in the study found valuable and lastly, there are very obvious practical problems for those suffering from illnesses such as RSI and HAVS which mean that help and assistance with sometimes personal and intimate tasks is not readily available. These implications need to be given serious consideration in the design and implementation of management guidance on return to work and resettlement and in the way that individuals are supported at home.
7.6 BEHAVIOURAL CONSEQUENCES

7.6.1 Impact on own behaviour

The behavioural impact of the accident or illness was explored in the home interview survey. Overall, the results clearly demonstrate that these life events can have a widespread influence on behaviour.

In the construction sector, across both accidents and illness, the most common effects reported were disturbed sleep and noticeable changes in temperament such as increased loss of temper or loss of patience. Cognitive functions, such as ability to concentrate or make decisions, were also reported to have declined in a number of cases, with this effect being relatively more pronounced in the illness group. Even though interviewers suspected that this aspect may have been under-reported, a sizable proportion of both the accident and illness groups also reported that sexual activity had decreased (in the case of the former group this was usually linked to the obvious physical restrictions that were associated with the accident). A large proportion within both groups also reported an increase in taking prescription and non-prescription drugs. The main difference that emerged between the two groups was in relation to the desire to leave the house. Whilst most in the accident group reported an increased desire, possibly because of enforced immobility, many of those in the illness group felt less inclined to want to socialise. It is worth noting that, in the case of the accident group, many of these behavioural changes were still in evidence at the time of the follow-up interview and that in the illness group, the first home interviews were in some cases a very long time after the onset of symptoms and hence the reported effects were, de facto, longstanding.

In the healthcare sector, despite the gender difference, essentially the same profile and range of effects were identified. Loss of sleep was common in both groups, but particularly marked in the accident group. Changes in temperament similar to those found in the construction sector were also reported in approximately half the cases. Cognitive functions, such as ability to concentrate or make decisions, had also declined for some, but there were no clear differences between the two groups. Again, a large proportion within both groups also reported an increase in taking prescription and non-prescription drugs.

The main difference identified between the two sectors was that the increased desire to leave the house and to socialise was not identified within the health sector accident group. This suggests that this may be a particular finding associated with a population of individuals (principally male outdoor workers) for whom the relative immobility and physical restrictions that follow a serious accident cause particular frustrations.

The prevalence of these changes suggest that many of the significant behavioural effects may be injury, illness or sector non-specific and hence a generally predictable outcome of most serious work-related injuries or illness. Again this finding is of considerable importance in terms of the support and management of such cases.

7.6.2 Perceived impact on the behaviour of others

In the home interviews, those affected by the accident or illness were asked if they had noticed any changes in behaviour in those that they lived with. In the construction sector, approximately a half of the cases reported changes; there are some findings of note. Firstly, where changes in adults were noted, these typically related to perceived increases in loss of
temper or loss of patience. Although the nature of these changes is generally consistent with the results obtained from the interviews with partners reported below, the family data suggests that the affected person may tend to either underestimate or underreport the magnitude of these changes. Secondly, there was a strong indication in both accident and illness groups that children’s behaviour can be significantly affected by these events. In the cases of accidents, 6 of the seven individuals that were living with children reported an impact on behaviour, typically an increase in disruptive behaviour at home or school. In the case of illness, 4 of the 9 cases with children at home reported a negative impact on behaviour.

In the healthcare sector, the results were similar in pattern to that identified in the construction sector. A similar proportion of cases (again approximately half) reported noticeable changes in behaviour in others. The behavioural changes in adults are also broadly similar, involving increases in loss of temper or sleep disruption. Again many of those affected who lived with children reported a detrimental impact on their behaviour. The number of family members interviewed in this sector was considerably smaller than in the construction sector. However, there was still some indication in these interviews (particularly in the accident group) that those affected underestimate the impact on others.
7.7 PSYCHOLOGICAL CONSEQUENCES

Psychological consequences were evaluated using a mixture of open-ended questions within the interview schedules and established measurement instruments (as described in Section 3 of the report). All cases (at both the telephone interview stage and the home interview stage) were asked if they felt the accident or illness was still affecting them emotionally. In the case of accidents, the degree to which individuals may have been experiencing significant symptoms of trauma was also assessed (at the telephone stage using the Trauma Screening Questionnaire (TSQ) and at the home interview stage using the Impact of Events Scale (IES)). The extent to which individuals in both the accident and illness groups were exhibiting symptoms of anxiety or depression was also assessed at the home interview stage (using Goldberg’s anxiety and depression scales).

The results from the construction sector are considered first. In the case of accidents, the telephone survey showed that 60% of cases considered that they were still affected emotionally at the time of the interview (typically between 9 and 16 weeks after the event). These represent chronic, that is, long-lasting effects. In terms of the types of problems identified, the dominant responses were self-reported feelings of depression, anger and frustration. The TSQ was also administered to nearly all these cases (84 out of the 94) at the time of the telephone interview. Taking the most powerful of the screening criteria associated with this measure (out of the 10 items within the measure, an individual must report at least six re-experiencing or arousal symptoms in any combination), some 27% of cases reported a range of symptoms indicating that they were at risk of Post Traumatic Stress Disorder (PTSD). In the sample of 20 cases selected for home interview this proportion rose to 40%. Within this sample, the prevalence of some PTSD-type symptoms was confirmed by the results of IES, with nearly two thirds of the cases scoring over the threshold for the identification of moderate trauma and 6 cases scoring in the severe range. In addition, most cases were also clearly experiencing some symptoms of both anxiety and depression; as indicated by their scores on the Goldberg scales, with 70% of cases above the threshold for anxiety and 90% above the threshold for depression. Approximately half of the cases were also reporting a sufficiently wide range of symptoms to place them towards the top end of these scales (where there is an increased probability of a clinically identifiable condition). Despite the severity of their symptoms; only a small number of cases had discussed the emotional impact of the accident with their doctor or other relevant professional and several commented that they felt embarrassed or reluctant to discuss these issues with someone else. At an anecdotal level, it was noted in interviews that individuals seemed reluctant to discuss their emotional problems, although some volunteered their concerns about returning to work or the financial problems they faced. In general, individuals were more comfortable discussing their anger at those they felt were responsible for their accident and the frustrations associated with any mobility problems. These responses may reflect the occupational culture that prevails in the construction industry, which tends to macho, hard-nosed and more task than person-oriented.

In work-related illness within the construction sector, the telephone survey indicates that a similar percentage of cases to that in the accident group may be still affected emotionally by the illness (63% overall; however, it should be noted that the total sample was much smaller than in the accident group). In this group, feelings of anger and frustration dominated the responses, reflecting the restrictive and personally intrusive nature of conditions such as HAVS; self-reported depression was less prevalent than in the accident group. These results also need to be seen in the context of the timing of these interviews - in many cases they took place more than a year or more after the onset of the relevant condition. The extent of the emotional impact of these illnesses was reinforced in the home interviews. Most cases, regardless of the nature of their condition, scored above the threshold on either Goldberg’s
anxiety or depression scale indicating a 50% chance of having a clinically important disturbance (85% of the group were above the threshold for anxiety and 80% above the threshold for depression). Again, as in the accident group, in approximately half the cases, individuals reported a sufficiently wide range of symptoms to place them towards the top end of these scales where the probability of a clinical diagnosis rises sharply. The case summaries in this group include a range of different conditions, from those that are especially serious such as mesothelioma, to chronic conditions such as HAVS that are at best arrestable, and at worse, progressive. Most individuals in this group raised specific concerns about some aspect of their life. Not surprisingly, these concerns tended to focus on anxieties and uncertainties about health and the implications for work in the future. A small number of individuals voiced multiple areas of concern including financial and family concerns. Finally, although a larger number of cases within this group (as compared to the accident group) had talked about their emotional problems with their doctor the proportion was still relatively small, given the range and scale of symptoms being reported.

Turning to the healthcare sector and again first considering the accident group, the telephone survey results are broadly consistent to those obtained in construction. Some 57% of the sample reported that they felt they were still affected emotionally by the accident. Again, when details were provided, they tended to focus on feelings of depression, anger and frustration. Analysis of the TSQ scores for this group revealed that 31% (of the 43 cases interviewed) reported symptoms that indicate they were at risk of PTSD. In the sample of 20 cases selected for home interview, as in construction, this proportion again rose to 40%. Within this sample, the prevalence of PTSD-type symptoms was also confirmed by the results of the IES, with 9 (or 45%) of the cases scoring over the threshold for the identification of moderate symptoms and 3 cases falling within the severe range. Many of the home interview sample were also experiencing symptoms of anxiety and depression, as measured on the Goldberg scales with 12 cases (60%) and 15 cases (75%) over the basic thresholds for anxiety and depression respectively and a number of cases scoring at the top end of these scales indicating potentially serious symptoms. Approximately half of this group commented on feeling anxious about a particular aspect of their life as a result of the accident. These concerns mainly focused on their own health and the implications for their career and future. Financial concerns were only raised by a small number of individuals in this group – most people in the sample had already returned to work at the time of the interview, had lost no time off work or had received adequate sick pay. Although these interviews involved individuals working in the healthcare sector, again only a small number of cases reported they had discussed the emotional impact of the event with a doctor or other appropriate professional.

Lastly, the final group to consider is the healthcare illness group. In the telephone survey, a similar proportion of cases to that in the other groups reported residual emotional effects (61% of the 64 cases interviewed). The profile of reports was very similar to that in the construction illness group, with anger and frustration being the most common set of feelings. This is not surprising given the similarity between many of the conditions that are involved in terms of their intrusion into daily life and their chronic nature (for example, HAVS and RSI). This group also includes the latex allergy sufferers. These individuals have to make significant adjustments to their lives, taking great care over aspects that they had previously taken for granted. The scores on the Goldberg scales for anxiety and depression reflect the telephone findings. Of the 20 cases in the home interview sample, 9 cases (45%) and 12 cases (60%) were respectively above the basic threshold for anxiety and depression. A number of these cases (but less than in the construction illness group) had scores towards the top end of these scales. Most individuals specifically commented on feeling worried about some particular aspect of their life as a result of their illness. Not surprisingly, given the nature of the chronic conditions included in this group (for example latex allergy and RSI) these concerns focused on health problems and implications for future work prospects and careers. There was also concern in a small number of cases of the potential burden on
caregivers. Again, despite the severity of some of the symptoms, only a quarter of the 20 cases had discussed their emotional problems with a doctor or other professional.

Taken in their totality, these results indicate potentially high levels of psychiatric morbidity in all of the four populations that were sampled. In the accident groups, the risk of PTSD as measured by the TSQ in the telephone survey was 27% in the construction sector and 31% in the healthcare sector (it should be noted here that the TSQ is a screening tool not a diagnostic measure which typically includes a structured clinical interview with specific diagnostic criteria). Current estimates of the prevalence of PTSD in trauma populations are highly diverse but confirm that it is a relatively common response (see Brewin, 2005 for a recent summary of prevalence figures associated with a wide range of trauma studies). These results compare, for example, to a prevalence of 39% in 158 motor vehicle accident victims (Blanchard et al, 1995) where PTSD was assessed using CAPS and a prevalence rate of 26.8% in a group of violent crime victims as measured by PSS-SR (Rose et al, 1999). The reported rates should also be seen in the context of an estimated lifetime prevalence of PTSD. Estimates for this vary from 1.3% (Davidson et al, 1991) to 7.8% (Kessler et al, 1995). Examining the TSQ scores solely for the accident cases subsequently included in the home interview sample, reveals evidence of PTSD type symptoms in 40% of the sample. This difference can be explained by the selection criteria applied. As discussed in the methodology, the cases for home interview were, in association with other criteria, selected on the basis of severity of injury and reported impact on quality of life. The IES scores from the home interviews generally confirmed the severity of the symptoms experienced by those in the home interview sample.

Levels of anxiety and depression, as measured by the Goldberg scales administered in the home interview sample, were also high within both sectors (with mean scores for both scales somewhat less in the health sector). In practice, the prevalence of anxiety and depression that was identified in this study is commensurate with that reported by respondents who were suffering from work-related conditions variously described as stress, depression, anxiety, or a physical condition ascribed to stress, in the HSE household survey of work-related illness (HMSO, 1998). These results indicated that 80% of individuals reached the threshold level for anxiety and 83% for depression. The equivalent results for a control group matched by age and sex was 21% and 31% respectively. These results are broadly in line with those obtained in the construction sector for both the accident and the illness group. In the healthcare sector, the proportions achieving scores above the threshold on both scales (and also the mean scores) are less than in the construction sector for both accidents and illness. Although this may be indicative of a real difference, the sample sizes in the home interviews are small and the results potentially confounded by other variables (most notably gender). However, the proportion of cases above the threshold for anxiety and depression in both the accident and illness groups are still between double and three times the level reported in the HSE control group.

Given the high level of compensation seeking in the study sample, there is clearly a risk that individuals may report symptoms that seek to validate this behaviour; they may also have a raised awareness of symptoms as a direct result of the compensation process. The study design does not allow this hypothesis to be fully tested. However, the potential link between psychological well being and compensation seeking was examined. The results show that, taking the complete home interview dataset of 80 cases, there is a significant association between incidence of depression, as measured by the Goldberg scale, and seeking compensation (P 0.05-0.01). However, no such association was present for the Goldberg anxiety scores or the TSQ scores in the accident sample.
7.8 IMPACT ON FAMILY MEMBERS

The home interview survey also tried to explore the personal impact that the accident and illnesses had on others. Where possible, interviews were carried out with those family members (or relevant others) who had been involved in the primary care and support role. For reasons of confidentiality, details of these interviews have not been included in the case summaries since affected individuals and their partners were often interviewed separately and spoke in confidence. For the same reason any sensitive comments made by the affected person about their partner or carer has similarly not been included. To some degree, the impact of these interviews has therefore been diluted in the report. However, taken overall these interviews demonstrate quite clearly that serious workplace accidents and illness are responsible for significant collateral damage.

In the construction sector 26 family members were interviewed; the vast majority of these were partners. There was clear evidence in this sector of a major impact on those who care for or live with those who have suffered serious injury or illness. Family members were frequently required to take time off work to provide practical support or care and they often incurred lost pay as a result (this was more common in accidents than illness because of the length of time off work and the resulting physical restrictions and mobility problems). Many normal family and social activities were reported as disrupted or affected; most notably, serious and long-term chronic illness such as mesothelioma and silicosis had had a fundamental impact on family life. Nearly all those that were interviewed felt there had been a deleterious impact on their own behaviour: for example, an increase in impatience, problems with sleeping or changes in eating habits. Relationships had often been affected, sometimes positively where the accident or illness had strengthened family ties, but more frequently, negatively. In the case of accidents where individuals (typically males) were at home for long periods the dynamics of a relationship had often changed. In the illness group, despite the considerable time since the onset of the condition, some couples had recently or were still experiencing significant problems in their relationship at the time of the interviews. Lastly, some family members had clearly been seriously affected emotionally by the accident or illness and reported experiencing feelings and symptoms characteristic of anxiety and depression. This issue is further explored at the end of this section.

In the healthcare sector, 14 family members were interviewed and again the majority were partners. Although there was also evidence in this sector of an impact on those who care for or live with those who have suffered serious injury or illness, because of the smaller number of interviews the results are more fragmented. Family members had sometimes taken time off work to provide practical support or care (the small numbers make it difficult to judge whether this was more common in accidents than illness in this sector). Many normal family and social activities were reported as disrupted or affected in both the accident and illness groups, particularly family leisure and sport activities. Nearly all those that were interviewed in the accident group felt there had been some deleterious impact on their own behaviour: for example, an increase in impatience or problems with sleeping.

However there was a clear difference in the findings in respect of relationships and emotional impact between the construction sector and the healthcare sector. Generally speaking, in the healthcare sector, relationships were not seen as being significantly affected, and where changes were reported they tended to be positive suggesting that family links had been strengthened. Lastly, only one family member out of both groups in this sector reported being seriously affected emotionally. Some of the other results of the study offer some possible reasons for these differences. Those involved in construction accidents typically have long periods off work, often experience significant loss of income and have longer term concerns about return to work and job security. In construction illness, although many do not lose time
off work, there are also indications of high levels of frustration, disruption of normal activities and significant challenges in the work situation to reduce relevant exposures. This population is almost exclusively male, so lengthy periods at home with reduced mobility may be placing extra pressures on relationships. In contrast, in the healthcare sector, where the sample is primarily female, the accidents tend to result in less time off work and income tends not to be significantly reduced; the overall pressures on the family may therefore be less. Furthermore, in the illness group, some of those affected reported that the level of support and understanding that they had received from their partners had actually served to strengthen their relationships.

Finally, family members in the home interview survey were also asked to complete the Goldberg questionnaire to assess levels of anxiety and depression. The degree to which there was an association between the score of the affected person and their partner was also examined (partners represented the biggest group of family members in this sample). For the purpose of this analysis data were pooled across both sectors and both groups (accidents and illness) giving a sample of 35 valid cases. No correlation was found in respect of reported anxiety but a significant correlation was found in respect of depression ($r = 0.41$, 34 df, $P < 0.01$). This area clearly warrants further research to clarify the nature of this relationship but again is strongly indicative of the potential collateral impact that may follow serious accident or illness.
7.9 COMPARISON WITH OTHER STUDIES

The literature review that was carried out prior to this study is available as a separate publication (HSE, 2003). This review confirmed that, prior to this study, there have been only few small-scale studies that have explicitly examined the consequences of work-related accidents or ill health on individuals and their families. However, the review identified a number of strands of related research, carried out in non work-related domains, which contribute to the general body of knowledge about the consequences of accidents and ill-health on individuals and their families. In particular, the work carried out in relation to motor vehicle accidents (MVAs) was highlighted. When comparing the results of this study with the main conclusions drawn from the literature review the following emerged.

- The study results reflect the nature of the social consequences that have been well established in the literature in relation to serious trauma (experienced in a wide range of contexts) and major illness. These include financial pressures, emotional distress, feelings of isolation, problems with relationships and, depending on the injuries, limited abilities to perform daily activities. Although much of this evidence comes from general trauma studies there are also a small number of work-related studies, albeit on small samples, that have also reflected these findings (see for example, Burton et al, 2002). The present study now clearly confirms that these effects can be demonstrated in relation to serious workplace accidents and ill health.

- The literature review identified substantial evidence that a significant proportion of individuals who are exposed to major trauma will experience a wide range of psychiatric, psychological and behavioural symptoms. Much of this evidence comes from studies of motor vehicle accident victims (MVAs), many of which have been carried out in the U.K. For example, in a study involving a sample of 770 individuals involved in an MVA it was found that PTSD, phobic travel anxiety, general anxiety and depression were reported by a third of the participants at both the 3-month and 1-year follow-up, though with different frequencies and manifestations. Some participants found their psychiatric symptoms improved between the 3-month and 1-year follow-up, whereas others displayed a late onset of symptoms over this period (Mayou, et al 2001). Long-term follow-up studies have found consequences were still present up to 3 years after the accident (Mayou & Bryant, 2002). In the context of workplace accidents, the present study has also demonstrated that psychological and behavioural effects are still being reported many months after a serious workplace accident and often when physical recovery is well under way.

- The evidence from specific work-related studies is more limited, but generally consistent with these findings. In particular, the few studies (based on small samples) that have examined the relationship between PTSD and work-related injuries have suggested that around 20% to 30% of individuals may be at risk of developing the disorder (see for example, Asmundson & Norton, 1998). As noted earlier in the discussion of the psychological impact of the accidents, the findings of the present study are therefore comparable in terms of the nature of the psychological and behavioural effects reported and the scale of these effects.

- Earlier research studies into the effects of trauma and chronic illness on families and caregivers all demonstrate that these effects can be significant and long lasting. Again, the present study has demonstrated that family members (partners and children) of those involved in a serious workplace accident or a period of chronic ill-health can also experience collateral effects as a result of changes in family dynamics and altered domestic and economic circumstances.
Previous research has also appeared to show that litigation can exacerbate certain psychological symptoms and impact more widely on the individual’s social and work life - although this work is primarily U.S. based. However, of note is the work in the healthcare sector in the U.K. that has examined the psychological consequences of medical accidents in personal litigants (see for example, Church & Vincent, 1996). This has demonstrated long-term effects on work, social life and family relationships as a result of litigation. The present study has also demonstrated a significant association between incidence of depression (as measured by the Goldberg scale) and seeking compensation. Given that this study has also identified high levels of compensation seeking within the research sample, this is an area that may require more work to clarify the nature of these links and to elucidate any causal relationships.

The literature search also highlighted the economic impact of work-related injury and illness on individuals and families. However, the relevant studies were primarily based on American research. Extrapolation to the U.K. is difficult because of differences in the benefit and compensation systems. However, previous research has suggested that major work-related injury or illness can lead to a significant reduction in family income, to financial pressure on partners and to resulting stresses on the family unit. The present study has confirmed that, for many individuals, a serious accident or period of chronic ill health can lead to significant financial pressure on the family and may compromise return to work decisions. These findings were more evident in the construction sector than the health sector.

The literature review also explored a number of other factors that may moderate the impact of injury and illness. For example, attribution and coping styles have been found to influence recovery. Studies report that people who attribute blame for their accidents to themselves and use ‘self-blame’ coping styles tend to recover from the psychological consequences of their accident more quickly (see for example, Hickling et al, 1999). In contrast, ‘avoidant’ coping styles are associated with blaming others and result in a slower recovery. However, this area of research has not been explored specifically in relation to work-related injuries and ill health. It is however an important area for further research given the finding of this study that there was a high degree of external attribution within the study sample.
8 IMPLICATIONS FOR PRACTICE AND AREAS FOR IMPROVEMENT

The following summarises the main implications for practice to emerge from the study in respect of HSE, employing organisations and health professionals. Where identified, the areas for improvement are aimed at upgrading the quality of the interactions between these groups and those affected by a serious work-related injury or illness and at facilitating the overall return to work process.

Whilst the focus of the study was on the impact of the injury or illness on the individual it also gathered information on interactions with employers and healthcare professionals. In some cases the latter information emerged informally rather than being covered in detail in the interviews. It should therefore be noted that the comments made below and the associated areas for improvement flow from a consideration of the full findings of the study, including information that was not formally captured in the interview schedules. Where appropriate, the distinction is therefore made between comments that are based on the quantitative results of the study and those based on more anecdotal findings.

It is also evident that the study suffered from some methodological limitations that restrict the extent to which one can generalise from the results - in particular, the small numbers of cases within specific accident or illness categories, the diversity of conditions included in the study and the delays in carrying out the interviews. However, some strong themes do emerge from the study and many of these confirm the potential impact of these events on individuals and their families. Lastly, whilst the study results may not surprise those that are familiar with the consequences of serious workplace related injury or illness, they do, for the first time, provide some firm evidence of the scale of these consequences.
8.1 INTERFACING WITH THOSE SUFFERING FROM SERIOUS ACCIDENTS OR CHRONIC ILLNESS

8.1.1 Implications for HSE

One of the main drivers for this research was the need to provide better support and guidance for HSE inspectors who are required to interview those affected by workplace trauma or serious work-related illness. In particular, to raise the general level of awareness and sensitivity to the range and scale of consequences that may follow the occurrence of serious injury or ill health. In this context, we would draw attention to the following findings.

Individuals frequently report that they are still affected emotionally by the accident or illness, even a relatively long period after accident or onset of the illness. The formal psychological measures that were administered reflect these (self-reported) symptoms. Feelings ranged from anger and frustration to serious symptoms of anxiety and depression; the latter often reflecting the changed circumstances that followed the accident or illness. There was also evidence of a sizeable proportion of individuals being at risk of developing PTSD within both accident groups. These findings all indicate the need for inspectors to be sensitive to the psychological impact of both accidents and illness and to be equipped to deal with situations where individuals (which will include family members) may be experiencing signs of serious distress. In the case of fatalities, these situations are of course likely to be even more demanding. In these cases, inspectors themselves may also feel especially vulnerable and distressed.

The responses across both sectors and both categories of accident and illness showed a strong tendency to external attribution; most people blamed someone other than themselves for their accident or illness. These findings suggest many individuals are likely to be potentially defensive or, at worst, hostile in their attitudes to their employer or their work situation. There may be a natural tendency for individuals to look to inspectors to support or reinforce their own views. Although inspectors are trained to be neutral observers, this still places considerable demands on their technical and inter-personal skills. They need to instil the appropriate level of confidence in the relevant individual and create the right atmosphere to gather objective information. They may also need the skills to manage situations of potentially escalating tension and conflict.

The HSE clearly recognise the need to have clarity about the role of the organisation and its responsibilities with respect to those involved in a workplace related accident or illness and indeed have developed leaflets and other forms of information designed to meet this need. However, there was some anecdotal evidence that, despite these initiatives, individuals may still be unclear about the role of HSE and, in particular, the extent to which the organisation and its representatives are there to personally support an individual or solely to discharge an enforcement and legal role. There was also anecdotal evidence that individuals who had been interviewed, or were otherwise aware that HSE had been involved in their case, did not receive any feedback from HSE or their employer on the results of any investigation.

The high level of compensation seeking that was identified suggests that this is rapidly becoming an established pattern across all sectors. Again, this reinforces the need for inspectors to develop the personal skills to maintain an atmosphere of neutrality in any dialogue, whether with employers, employees or family members. They also need to be conversant with the basic principles of the legal processes involved to fully explain the boundaries of their role when required. Lastly, there may be further scope for HSE to
increase awareness amongst employers of their growing vulnerability to such action and to increasingly factor this into its strategy for influencing health and safety performance.

The physical evidence of a serious accident is usually all too evident. However, the results of the study suggest that there is less understanding of the impact of serious work-related illness, both from a physical and emotional perspective. Conditions such as RSI and latex allergy have been shown to have a significant impact on the quality of life for the relevant individual and their family and also to lead to subsequent performance problems at work. Raising awareness of these potential outcomes may influence some employers to invest in better risk assessment and improved working conditions.

Finally, in its totality, the study has shown that serious work-related accidents and illnesses can have an impact across a whole family group: personal relationships can be affected, partners may suffer emotional distress, children may become more attention seeking or disruptive and future job and financial security threatened. All of these issues may need to be considered when a full evaluation is made of the consequences of an individual event.

**Areas for improvement**

- The training of inspectors (and any associated procedures) should be reviewed in the light of the findings of the study. In particular, the extent to which this training equips inspectors with the competencies and supporting information to deal with the situations discussed above should be assessed and updated as appropriate. In the light of the findings on the risk of PTSD, the HSE should explore the need to formalise its policy and procedures on the identification, support and referral of individuals who are experiencing serious psychological consequences as a result of a workplace related event. The review should also consider the stage at which this training needs to be provided and how its impact can be evaluated.

- The HSE should reinforce its established procedures for ensuring that individuals are clear about the role of HSE and its inspectors. If there is a formal investigation an inspector has an opportunity to explain the role personally and can provide appropriate explanatory leaflets. Equivalent information should be readily available to those involved in cases where there is no such investigation or formal contact with inspectors (the majority of even relatively serious cases) and HSE should utilise a wide variety of routes to ensure this happens including the use of the Internet.

- Where HSE has had a formal involvement in a case the individual concerned should be kept fully informed in line with stated HSE policy. The HSE should assess the extent to which this policy is being reflected in practice and the reasons for any non-compliance.

- Guidance on preventing chronic conditions such as HAVS or latex allergy should also highlight the psychological and social repercussions of these conditions as well as the physical consequences; opportunities should be taken to reinforce this message when HSE inspectors or advisors are in personal contact with employers. HSE guidance documents should be reviewed to assess if they give sufficient emphasis to these issues.
### 8.1.2 Implications for employers and managers

Most of the points made above are equally applicable to employers and managers who have a responsibility of care for those involved in a serious work-related accident or illness. The study results suggest that employing organisations need to be aware of the full impact and consequences of accidents and chronic illness including the wider impact on members of the family.

There is anecdotal evidence from the study that contact with employers can be overly focused on procedural aspects, and on the likelihood or timing of return to work. Whilst these are legitimate areas of concern for employers as discussed below, the study shows that most of these individuals are emotionally vulnerable and some are exhibiting serious psychological symptoms - contact with these individuals needs to be handled with sensitivity. The study has also shown that many individuals are likely to be considering seeking compensation. Managing contact with individuals with care and sensitivity may also reduce the likelihood of protracted and potentially costly confrontations.

**Areas for improvement**

- Where possible, primary contact with the individual should be via someone who is well known to the individual and likely to be trusted. This may be a manager who has worked with the individual for an extended period, a first-line supervisor or colleague.

- Unless otherwise directed by the person themselves, contact and discussion about recovery and general well-being should be clearly separated from discussion of return to work issues.

- Where it is likely that a number of departments or individuals may wish to be in contact with an individual, these contacts should be effectively co-ordinated so as not to overwhelm or confuse the individual.

- Concern for the psychological well-being of employees should extend beyond return to work. For example, there was some anecdotal evidence in this study that those redeployed as a result of a chronic condition such as HAVS suffered bullying when back at work. Employers should be alert to these types of problems.

### 8.1.3 Implications for healthcare professionals

The study has shown that many individuals report that they are still affected psychologically by an injury or illness even a relatively long period after the accident or onset of a condition. In some cases these effects are severe and cumulative. Individuals who were interviewed at home were explicitly asked if they had discussed the emotional or psychological impact of the accident/illness with their doctor. The majority reported that they had not done so. From informal comments made at the time of the interviews, reasons included embarrassment or reluctance to discuss such issues with someone else. Given these findings, it seems appropriate that medical professionals take the lead in initiating discussions in these areas.

The study has also shown that, not surprisingly, family activities are affected by a serious accident or illness in a family member. Although the sample numbers are small there are also consistent findings indicating knock-on behavioural effects in family members particularly in
relation to changes in temperament (for example increased loss of patience and effects of sleep disruption). Of those individuals living with children, many also reported a negative impact on their behaviour. Confirmation of these effects was also provided in the family member interviews. Moreover, these interviews suggested that affected individuals can often underestimate the impact on those they live with. General practitioners, in particular, may need to be aware of these effects and to factor them in when developing a management strategy for the individual and family members who may also be registered patients.

Lastly, the study is the first in the UK to formally explore the social and psychological impact of work-related accidents and illness. Whilst occupational health professionals may already be aware of these effects from their own personal experience, the study results provide a strong argument for the more proactive management of specific conditions such as latex allergy and HAVS. They also highlight the need for occupational health professionals to take the initiative in advising and supporting managers and employees in the return to work process.

Areas for improvement

- General practitioners and others who have clinical responsibility for those suffering from work-related accidents or illness need to develop an increased awareness of occupational health and safety issues. In particular, clinicians need to be more proactive in identifying and exploring the psychological repercussions of both work-related accidents and illnesses (particularly chronic illness such as HAVS and latex allergy); the evidence from this research is that those affected are not likely to initiate this discussion.

- General practitioners in particular may wish to consider the wider implications of work-related accidents and illness for the family group, particularly in the light of the study findings relating to the impact of long-term sickness absence and chronic illness on partners and children.

- Occupational health professionals need to consider the wider repercussions of work-related illness in developing effective policy for the proactive identification and management of those affected; in particular, they need to be aware of the psychological dimension associated with many conditions and be able to advise and support managers in dealing with such issues.

8.2 MANAGING LONG-TERM SICKNESS ABSENCE AND RETURN TO WORK

8.2.1 Implications for HSE

The evidence from this study is that, whilst some individual managers and supervisors may be in contact with individuals whilst they are on sickness absence, patterns of contact are not indicative of any clear policy or plan to manage return to work. HSE have acknowledged the need for advice and support for employers in addressing these issues and have produced a comprehensive guidance document (HSG249) covering good practice in a number of areas: keeping in contact with individuals, planning workplace control measures, making use of professional or other advice or treatment, agreeing and reviewing a recovery/return to work plan and co-ordinating the return to work process (HSE, 2004).
The interviews carried out in this study also highlighted the lack of information that may be available to employees in the aftermath of an accident or following diagnosis of a work-related condition. At an anecdotal level, the interviews suggested that individuals were often unaware of the role of HSE or their employers in advising on or helping to manage their condition; they were also unclear as to where they should seek more specific advice or help for a range of problems.

Areas for improvement

• The research findings reinforce the need to more widely promulgate HSG249. However, it is also clear that different sectors, such as the construction and healthcare sectors, will face different problems in implementing this guidance. Each will be at different levels of maturity in their thinking and practice and will inevitably face a different range of issues. For example, in the construction sector, many companies will still need to think about developing a policy in this area, whereas in the NHS, there may need to be a greater focus on the effective implementation of existing policy. Likewise, small and medium companies will have less formal resources to call upon than large organisations or those that are part of a bigger network of companies. Consideration should therefore be given to producing a range of shorter guidance documents that are specifically tailored to target areas such as the construction sector and the particular problems they face.

• To complement HSG249, HSE has also developed a leaflet for employees entitled ‘Off work sick and worried about your job’ which is available on the Internet and HSE outlets. Extending this approach, HSE should consider developing a similar leaflet for employees and their families specifically aimed at those who have suffered a work-related accident or illness. The guidance should be available at the point of need, which is as soon as possible after the accident or diagnosis of work-related illness. HSE should explore a wider range of alternatives for distributing such guidance: options include making the guidance available through employers, through medical channels (GPs and hospitals) or more directly from HSE itself using a RIDDOR report to trigger the despatch of relevant guidance to the employee at their home address.

• The study has identified relatively high levels of psychological distress within the study samples, including high levels of anxiety and depression in both the accident and illness groups. The HSE guidance does not currently address this area, although it provides good general advice about how to communicate and deal with potentially sensitive issues. The study also raises particular areas of concern as to how those involved in serious trauma (including personal attacks and potentially traumatic events such as anaphylactic shock) are supported in the immediate aftermath of the event. HSE should extend its advice on good practice to cover these areas and, in addition, take action to raise awareness amongst employers of the psychological and social impact that may accompany these events.

• HSE should capitalise on all the contacts it has with employers to reinforce good practice in this area. For example, as part of the formal investigation process that may follow a serious accident, HSE inspectors could draw attention to the guidance and review the policy and processes that are in place to support those involved in the accident.
8.2.2 Implications for employers and managers

The HSE guidance referred to above also confirms that, unless employers take positive action to help individuals return to work, short-term absence can drift into long-term absence and may eventually lead to the loss of the employee. Furthermore, long-term absence and inactivity are, of themselves, likely to be associated with further physical and psychological problems. The concept of a window of opportunity for effective clinical and occupational management is also supported by research (Waddell et al, 2003). Supporting employees and managing return to work therefore makes good business sense for the employer and has obvious benefits for the employee. However, although the study has demonstrated that contact with managers, supervisors and particularly colleagues are seen as extremely valuable, as discussed above, the general finding is that employers are not implementing the type of planned approach envisaged in the guidance.

The study results demonstrate that many individuals (particularly those in the construction sector) experience a significant drop in income when they are on sickness absence. This can cause pressure on the individuals to return to work and, in some cases, may be one of the drivers for seeking redress in compensation for the accident or illness. Financial worries were also one of the most frequently reported sources of anxiety in the study, again especially in the construction sector where there are also financial pressures associated with self-employment status. Individuals who were reliant on state benefits also reported frustrations and difficulties in dealing with social services and benefits offices, compounding their anxieties.

Employers may also find themselves dealing with individuals who are suffering symptoms of psychological distress either in the immediate aftermath of an accident or during the period of absence from work that may follow. They may also have to deal with employees who, whilst not losing any time from work, are experiencing psychological symptoms such as anxiety or depression as a result of a workplace-related condition such as HAVS or RSI. In such cases, there were also indications in the study that these conditions are being identified at a stage when symptoms are well developed and that redeployment may not be well managed, particularly in the construction sector.

Lastly, the study has shown that many of those involved in serious accidents or those who suffer from a work-related illness will endeavour to seek redress through a compensation claim. This trend is likely to continue with greater access to no-win/no-fee legal advice. Whilst good policy and practice in helping and supporting employees to get back to work will not completely insulate employers from this trend, it may go some way towards reducing the potential conflict that can arise. Conversely, it is probable (although not possible to verify in this study because of the selective nature of the home interview samples) that employees who feel that they have been dealt with unfairly are more likely to seek such redress.

Areas for improvement

- Employers should develop and implement a policy and associated procedures for managing the consequences of accidental injury at work and work-related illness. Both policy and procedures should reflect the HSE guidelines for good practice outlined above. Small companies will need to reflect the spirit of the guidance, although the need for formal processes and documentation may not arise. The study identified a number of specific issues that need to be covered within this approach. These included: information on pay and benefits, long-term job and career implications, alternative strategies for gradual return to work and the need for managers and supervisors to continue to keep a watching brief on those returning to work after a long period of sickness absence to assess the need for any further
Employers should consider the wider implications of not maintaining appropriate levels of pay when employees are on protracted periods of sickness absence as a result of a workplace-related accident or illness. These include the impact on the well-being of employees, their relationship with their employee, motivation to return to the same job, attitudes on return to work and propensity to seek compensation.

The study results suggest that employers need to be more vigilant in addressing the full range of risks present in their workplace including those that potentially affect the health of their employees. In particular, employers should apply effective risk assessment and risk reduction strategies to minimise the occurrence of chronic conditions such as HAVS or latex allergy. Individual employees should also be actively involved in this process. The study also shows that there may be hidden costs associated with these conditions where individuals remain at work but perform below par or seek alternative employment with associated costs to the organisation. These costs need to be factored in when making any cost benefit analysis with respect to risk reduction initiatives. There should be a policy of early detection and treatment of mild to moderate symptoms (whether the worker is absent or not) to promote early recovery and prevent the development of persistent symptoms, progressive disability and long-term incapacity. Where necessary, a realistic redeployment strategy should be agreed and adhered to with the involvement of the affected individual. The effectiveness of this strategy needs to be reviewed at appropriate intervals.

As part of the return to work strategy, employers need to ensure they manage the longer-term aspects of reintegrating individuals back into normal work. The study results show that many people feel that, following return to work, the way in which they are able to do their job remains affected by the relevant accident or illness. Return to work should therefore not be seen as the end point but only one of the stages in the reintegration process.

Employers should pay particular care in the case of individuals who are known to live on their own and for whom the impact of serious injury or illness may be especially difficult to deal with. There may be a need to ensure a higher level of social support from managers and work colleagues and a greater recognition of practical issues such as transport to work problems which are difficult to overcome without help and support from others.

Employers are often in the position of making decisions on how best to manage return to work (including the need for redeployment or the identification of acceptable levels of exposure) on the basis of limited knowledge of a particular condition. They need to be aware of the boundaries of their skills and experience in this area and be prepared to call on the advice and help of professionals as appropriate. The serious cases described in this research require careful management and support to ensure a successful outcome. Those companies that employ occupational health practitioners or have contracts with independent advisors should actively use these resources to ensure that an individual case is being handled effectively. In particular, employers need to be fully aware of the psychological dimension that may arise in cases of serious accidents or ill health.

Where employers seek medical reports for employment or insurance purposes, the individual concerned has right of access to this report under the Access to Medical Records Act 1988. This right of access should be automatically guaranteed. There

support. Larger employers should be encouraged to provide this information in a similar format to the HSE leaflet referred to earlier.
were examples provided in the study where individuals complained they had not been given automatic access to such reports.

8.2.3 Implications for health care professionals

There can be a tendency for individuals to see recovery from accident or illness as a largely passive process, where they rely on health professionals to deliver a solution. However, the recovery/return to work process should be an active process that harnesses the participation, motivation and effort of the individual, supported by health professionals and employers. It is therefore important that health professions are engaged in an active dialogue with individuals about both their physical and psychological state and that they also have a clear understanding of the return to work issues that may be involved for a particular individual, including the pressures that may be delaying return to work or driving too early a return to work. The study results strongly suggest that individuals tend not to discuss this full picture with their own doctors and that contact with dedicated occupational health professionals is rare. Informal comments also confirm that individuals may be reluctant to put such issues on the table and the GP (or other relevant medical professional) cannot assume that because the individual has not raised any problems, these problems do not exist.

There was also anecdotal evidence from the study that individuals (primarily in the ill-health category) were not being provided with information and contacts that may be useful in the management of their condition or the management of their return to work. As an illustration of this, the main interviewer in the study was instrumental in providing contact details of relevant support groups in a number of cases of latex allergy.

The difficulties facing employers in making decisions with respect to return to work, redeployment or reducing relevant levels of exposure have already been highlighted. Similarly, the employee may have to make a difficult judgement as to when and in what capacity to return to work. The quality of this decision-making may be improved if there was greater opportunity for a dialogue between the employer and GP (or other relevant health professional).

The results of the study indicate that such a dialogue could be valuable. For example, construction sector employees are clearly under some financial pressure when off work (a significant loss of income was documented in the study). There are dangers that they may return to work too quickly (the study has shown that many return to so called light work) or move from light work to original job too early (light work frequently results in less pay or loss of overtime). Access to occupational health advice may be limited and decisions about redeployment or exposure periods may be being made by supervisors or managers based on incomplete or inadequate knowledge. Lastly, at an anecdotal level, a small number of individuals with HAVS made comments that suggested that there was either significant peer pressure to return to previous job responsibilities (and old exposure levels) or that reducing exposure by changing roles was being ‘soft’. Although the numbers are small they are indicative of the real problems individuals face in the workplace. A closer link between GPs and the workplace may serve to improve decision making about return to work, the management of conditions where there may be no absence from work (such as many cases of HAVS) and help legitimise and support the employee’s needs in respect of redeployment or the need for temporary work. Providing issues of consent and confidentiality are addressed such a dialogue is in keeping with the guidance provided in HSG249.

Lastly, some individuals in the healthcare sector informally reported general dissatisfaction with the quality of the support they received from occupational health departments. Although
others were complementary, there was sufficient divergence of opinion to raise some concern. The flavour of the comments related to the lack of proactivity and the lack of practical support and advice. In the construction sector the findings on HAVS also indicates a lack of expertise and support in terms of occupational health to identify and manage these cases effectively. For example, many cases were identified a long period after the onset of symptoms and redeployment was badly managed.

Areas for improvement

• Health professionals, including GPs, should try to ensure that they obtain the fullest picture possible about the individual circumstances of those who have experienced a serious work-place accident or illness, including the psychological, behavioural as well as physical impact. Some individuals in the study identified the need for emotional support outside their circle of family and friends. GPs may wish to consider referring cases for specialist help as appropriate.

• GPs and Occupational Health departments should aim to become aware of the main support groups that offer advice in respect of specific conditions such as latex allergy or HAVS and ensure that individuals are made aware of such groups as appropriate. There is also a need to provide individuals with practical advice on managing the impact of their condition on aspects of their daily life. They should also be prepared to discuss the applicability and availability of complementary approaches as appropriate.

• Whilst operating within the bounds of patient confidentiality, GPs may wish to consider establishing a dialogue with the employer so that he or she obtains all the necessary information to effectively support the employee. With the individual’s consent this may include providing the employer with information that may be helpful to planning the return to work process.

• Some individuals in the study (primarily those involved in a serious accident) felt they needed reassurance about their complete fitness to return to work. Where appropriate GPs or Occupational Health departments, where available, may wish to offer a formal return to work medical check as part of the return to work process.

• Anecdotal evidence suggests that, even when organisations such as the NHS have specialist occupational health provision, this function is not always seen as delivering as effectively as it could. It is difficult to give a blanket recommendation here since few organisations have a dedicated occupational health function and the quality of provision may vary widely across these organisations. However, there does seem scope to recommend that the profile of occupational health needs to be raised in organisations with a specialist function and that Occupational Health departments ensure they are identifying the needs of the workforce they are supporting and are prepared to be proactive rather than passive in their approach. Where such a function does not exist (as in many companies in the construction sector), there is also a need to promote wider access to such professional advice.
9 APPENDIX

Appendix: Interview forms used in telephone and home interviews.

Telephone interview

Good afternoon, could I speak to (name)? My name is .......... and I'm calling from Human Reliability Associates on behalf of the Health and Safety Executive. Can I ask: have you received a letter from the HSE recently, outlining the study? You have? Well, as you might remember, the Health and Safety Executive is engaged in a research project into the effects of accidents and you have been asked to take part. [If no letter received, inform HRA co-ordinator, inform interviewee and tell them that you'll call again in 10 days, after they will have received the letter.]

We hope that you will take part, since the study will help the HSE to understand how these accidents affect individuals and their families. Hopefully, that means that, in the future, we will be able decide how to provide better help and support. It's important to tell you, however, that you are under no obligation to take part in the study and that even if you decide to help us, you can withdraw at any time – and you won't have to give us a reason.

All the information we gather is entirely confidential – we are operating under the Data Protection legislation – and the information will never be shared with anyone else. You do have a legal right to see the information yourself, however. Do you feel that you would like to participate in the study?

[If not, thank them for their time and end the call, note response and inform HRA:]

Is this a good time to talk? I would guess that we'll need about 15 to 20 minutes at this point.

[If not, make arrangement to call at a more convenient time, thank the interviewee and end the call, note response and inform HRA.]

What I'll be doing is asking you a few basic details about the accident and also taking you through a short questionnaire. All the people taking part in this study are being asked exactly the same questions, by the way. There are no right or wrong answers, either – we want to learn how you as an individual were affected by the accident. If there is any question you'd rather not answer, then you don't have to, and you don't have to give a reason why – it's up to you. And you can stop the interview at any time, too, without giving a reason. Is that okay?

[If not, and the interviewee wishes to withdraw or reschedule, thank them and enter into database.]

1 Can I just have your full name? 

2 Is the interviewee male or female? 

3 And your date of birth? 

4 At the time of the accident/illness, what was your job or profession? 

5 And what was your employer's business? 

6 The records from the HSE indicate that you had (details of accident/illness). Can you let me have some brief details? [Enter detail in box A6]
Human Reliability Associates  
Telephone Questionnaire HSE 1 Section B  

1. Are you still off work?  
   - Yes  [ ]  Go to question 2  
   - No  [ ]  Go to question 6  
   - Haven't lost any time  [ ]  Go to question 8  

2. How long have you been off work to date?  
   [ ]  Go to question 3  

3. Do you expect to be able to return to work?  
   - Yes  [ ]  Go to question 4  
   - No  [ ]  Go to question 6  
   - Don't know  [ ]  Go to question 5  

4. How much longer do you think you may be off work?  
   [ ]  Go to question 5  

5. Do you expect to return to the same job?  
   - Yes  [ ]  Go to question 9  
   - No  [ ]  Go to question 8  
   - Don't know  [ ]  Go to question 6  

6. How long were you off work?  
   [ ]  Go to question 7  

7. Have you gone back to the same job?  
   - Yes  [ ]  Go to question 6  
   - No  [ ]  Go to question 9  

8. Now that you're back at your normal job, is the accident/illness having any effect on the way you are able to work?  
   [ ]  Go to question 10  

9. Is this as a result of your accident/illness?  
   [ ]  Go to question 10  

10. Apart from work colleagues, has anyone else lost time off work because of your accident/illness?  
    - Yes  [ ]  Go to question 11  
    - No  [ ]  Go to section C  

11. Can you tell me who has had time off work, their relationship to you, and how long they had to take off?  

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Time off (weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/partner</td>
<td>1</td>
</tr>
<tr>
<td>Boyfriend/Girlfriend</td>
<td>3</td>
</tr>
<tr>
<td>Mother</td>
<td>5</td>
</tr>
<tr>
<td>Father</td>
<td>5</td>
</tr>
<tr>
<td>Mother-in-law</td>
<td>6</td>
</tr>
<tr>
<td>Father-in-law</td>
<td>6</td>
</tr>
<tr>
<td>Brother (1)</td>
<td>9</td>
</tr>
<tr>
<td>Brother (2)</td>
<td>9</td>
</tr>
<tr>
<td>Brother (3)</td>
<td>9</td>
</tr>
<tr>
<td>Sister (1)</td>
<td>10</td>
</tr>
<tr>
<td>Sister (2)</td>
<td>11</td>
</tr>
<tr>
<td>Sister (3)</td>
<td>12</td>
</tr>
<tr>
<td>Daughter (1)</td>
<td>13</td>
</tr>
<tr>
<td>Daughter (2)</td>
<td>13</td>
</tr>
<tr>
<td>Daughter (3)</td>
<td>13</td>
</tr>
<tr>
<td>Son (1)</td>
<td>15</td>
</tr>
<tr>
<td>Son (2)</td>
<td>17</td>
</tr>
<tr>
<td>Son (3)</td>
<td>19</td>
</tr>
<tr>
<td>Friend (1)</td>
<td>20</td>
</tr>
<tr>
<td>Friend (2)</td>
<td>20</td>
</tr>
<tr>
<td>Friend (3)</td>
<td>21</td>
</tr>
<tr>
<td>Other</td>
<td>23</td>
</tr>
</tbody>
</table>
1. Which of the following have been affected by your accident/illness?

<table>
<thead>
<tr>
<th>Activity</th>
<th>If yes, details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal care, e.g. bathing, getting dressed</td>
<td>1</td>
</tr>
<tr>
<td>Household care, e.g. cooking, housework</td>
<td>2</td>
</tr>
<tr>
<td>Leisure and Recreation, e.g. sports, eating  out</td>
<td>3</td>
</tr>
<tr>
<td>Mobility, e.g. walking, driving</td>
<td>4</td>
</tr>
<tr>
<td>Social interactions, e.g. visiting friends/family</td>
<td>5</td>
</tr>
<tr>
<td>Money management, e.g. paying bills</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
</tr>
</tbody>
</table>

2. Do you live alone?
   - Yes [ ] Go to question 5
   - No [ ] Go to question 3

3. Do you live with your family?
   - Yes [ ] Go to question 4
   - No [ ] Go to question 5

4. Since the accident/illness, are there any activities that you used to carry out with your family that you are now unable to do?

5. Can you let me have some details of these activities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>If yes, give details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family-related activities, e.g. days out, sports and leisure activities</td>
<td>1</td>
</tr>
<tr>
<td>Child-related activities, e.g. helping with homework, playing</td>
<td>2</td>
</tr>
<tr>
<td>House work or DIY</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
</tbody>
</table>

Go to question 6
1. Which of the following have been affected by your accident/illness?

<table>
<thead>
<tr>
<th>Activity</th>
<th>✓ If yes, details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal care, e.g. bathing, getting dressed</td>
<td>1</td>
</tr>
<tr>
<td>Household care, e.g. cooking, housework</td>
<td>2</td>
</tr>
<tr>
<td>Leisure and Recreation, e.g. sports, eating out</td>
<td>3</td>
</tr>
<tr>
<td>Mobility, e.g. walking, driving</td>
<td>4</td>
</tr>
<tr>
<td>Social interactions, e.g. visiting friends/family</td>
<td>5</td>
</tr>
<tr>
<td>Money management, e.g. paying bills</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
</tr>
</tbody>
</table>

2. Do you live alone?

   - Yes
   - No

3. Do you live with your family?

   - Yes
   - No

4. Since the accident/illness, are there any activities that you used to carry out with your family that you are now unable to do?

5. Can you let me have some details of these activities?

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<th>Activity</th>
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</tr>
<tr>
<td>Child-related activities, e.g. helping with homework, playing</td>
<td>2</td>
</tr>
<tr>
<td>House work or DIY</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
</tbody>
</table>
6. Who has provided you with support or assistance since your accident/illness?

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/partner</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Boyfriend/Girlfriend</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Mother in law</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Father in law</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Brother (1)</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Brother (2)</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Brother (3)</td>
<td>9</td>
<td></td>
</tr>
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<td>10</td>
<td></td>
</tr>
<tr>
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<td>11</td>
<td></td>
</tr>
<tr>
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<td>12</td>
<td></td>
</tr>
<tr>
<td>Daughter (1)</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Daughter (2)</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Daughter (3)</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Son (1)</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Son (2)</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Sorn (3)</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Friend (1)</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Friend (2)</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Friend (3)</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>22</td>
<td></td>
</tr>
</tbody>
</table>

7. Is the accident/illness still having an impact on your family?

Yes  Go to question 8

No   Go to question 9

8. Which of the following are still affected?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leisure and recreation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social interaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. Are you seeking compensation from your employers as a result of the accident/illness?

Yes  Go to question 10

No  Go to question 10

Possibly  Go to question 10

10. Are you pursuing other legal action in connection with your accident/illness?

Yes  Go to question 11

No  Go to question 11

Possibly  Go to question 11

11. Can you let me have any details?
I am now going to ask you some questions to help us assess how the accident/illness has affected you personally. These questions are often used with people who have been exposed to a traumatic event, and in fact we will be asking around 500 people to answer the same questions. If you'd like to take a break at any time, just let me know.

1. Is the accident/illness still affecting you physically?
   - Yes
   - No

2. Can you give me some brief details?

3. Is the accident/illness affecting you emotionally?
   - Yes
   - No

4. Can you give me some brief details?

5. Please consider the following reactions that sometimes occur after a traumatic event. This part of the questionnaire is concerned with your personal reactions to the experience that you have had. After each statement, please answer with a "yes" only if you have had any of the following reactions at least twice in the past week.

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes (at least twice)</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Upsetting thoughts or memories have come into my mind against my will</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Upsetting dreams about the event</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Acting out or feeling that the event was happening again</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Talking endlessly about the event</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Strong feelings of shame about the event</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Body sensations such as fast heartbeat, stomach churning, sweating, dizziness when reminded about the event</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Difficulty in falling or staying asleep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Strong feelings of self-blame associated with the event</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Irritability or outbursts of anger</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Feeling able to put the event &quot;away&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Feeling upset by reminders of the event</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Difficulty concentrating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Frightened awareness of potential danger to yourself or others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Returning to normal activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Being jumpier or being startled at sometimes unexpected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Strong feelings of anger with others who were connected with the event</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Score for the above: [ ]

A positive response to 6 or more of the above (excluding the grey-shaded filler questions) indicates cause for concern. Refer to IES-E
1. As part of the study, our trained interviewers will be carrying out more in-depth interviews. If your case is similar to one they are looking for, would you consider taking part? The interviews will be held at your convenience - probably in your own home - and might be significant in a face-to-face interview.

2. Interviewer: record any notes or comments that may be significant in a face-to-face interview.

3. What would have helped you personally to cope better with this accident/illness?

<table>
<thead>
<tr>
<th>Employer/work-related issues</th>
<th>2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial issues</td>
<td>2.2</td>
</tr>
<tr>
<td>General support</td>
<td>3.1</td>
</tr>
<tr>
<td>Contact with professionals (police, medics, HSE etc.)</td>
<td>5.1</td>
</tr>
</tbody>
</table>

4. Finally, as part of the study, we need to be sure that our sample is as representative as possible. Would you mind telling me which of the following ethnic groups you belong to?

<table>
<thead>
<tr>
<th>White</th>
<th>British</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Irish</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other (please specify)</td>
<td>1</td>
</tr>
<tr>
<td>Mixed</td>
<td>White/Black Caribbean</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>White/Black African</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>White/Asian</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other (please specify)</td>
<td>1</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>Pakistani</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Indian</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Bangladeshi</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other Asian (please specify)</td>
<td>1</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>Caribbean</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>African</td>
<td>1</td>
</tr>
<tr>
<td>Chinese or other ethnicities</td>
<td>Chinese</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other (please specify)</td>
<td>1</td>
</tr>
</tbody>
</table>

Thank you for your help.
Home interview

Human Reliability Associates
Health and Safety Executive - Effect of Accidents Study
AP 1 - section A

| Interviewer name: |
| Interviewee study ID number |
| Interview date and start time |

1. Can I just confirm your full name?  
2. Is the interviewee male or female?  
3. And your date of birth?  
4. At the time of the accident/illness, what was your employment situation?  
5. What is your present employment situation?  
6. Can you tell me who else lives with you at this address?

<table>
<thead>
<tr>
<th></th>
<th>Age if below 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/spouse</td>
<td>11 3.2</td>
</tr>
<tr>
<td>Boyfriend/girlfriend</td>
<td>22 2.2</td>
</tr>
<tr>
<td>Mother</td>
<td>3.2 3.2</td>
</tr>
<tr>
<td>Father</td>
<td>4.2 4.2</td>
</tr>
<tr>
<td>Mother-in-law</td>
<td>5.2 5.2</td>
</tr>
<tr>
<td>Father-in-law</td>
<td>6.2 6.2</td>
</tr>
<tr>
<td>Brother 1</td>
<td>7.2 7.2</td>
</tr>
<tr>
<td>Brother 2</td>
<td>8.2 8.2</td>
</tr>
<tr>
<td>Brother 3</td>
<td>9.2 9.2</td>
</tr>
<tr>
<td>Sister 1</td>
<td>10 18.2</td>
</tr>
<tr>
<td>Sister 2</td>
<td>11.2 11.2</td>
</tr>
<tr>
<td>Sister 3</td>
<td>12 12</td>
</tr>
<tr>
<td>Son 1</td>
<td>13 13.2</td>
</tr>
<tr>
<td>Son 2</td>
<td>14 14.2</td>
</tr>
<tr>
<td>Son 3</td>
<td>15 15.2</td>
</tr>
<tr>
<td>Daughter 1</td>
<td>16 16.2</td>
</tr>
<tr>
<td>Daughter 2</td>
<td>17 17.2</td>
</tr>
<tr>
<td>Daughter 3</td>
<td>18 18.2</td>
</tr>
<tr>
<td>Friend 1</td>
<td>19 19.2</td>
</tr>
<tr>
<td>Friend 2</td>
<td>20 20.2</td>
</tr>
<tr>
<td>Friend 3</td>
<td>21 21.2</td>
</tr>
<tr>
<td>Other</td>
<td>22 22.2</td>
</tr>
<tr>
<td>Other</td>
<td>23 23.2</td>
</tr>
</tbody>
</table>

Go to section B
1. Can you tell me about the injuries/physical symptoms incurred as a result of the accident/illness?

2. Have you suffered from any other symptoms directly attributable to the accident/illness? Yes/No

3. Can you give me some brief details?

4. Are you still off work? Yes/No

5. How long have you been off work to date?

6. Do you expect to be able to return to work? Yes/No

7. How much longer do you think you may be off work?

8. Do you expect to return to the same job? Yes/No

9. How long were you off work?

10. Have you gone back to the same job? Yes/No

11. What job do you do now?

12. Is your new job with the same employer? Yes/No

13. Is your new job the same kind of work? Yes/No

14. Is this related to your accident/illness? Yes/No

15. Has the way you do your job been affected by the accident/illness? Yes/No

15a. Please give some details
16. If rating 1 is represented by ....... and rating 5 by ....... which rating between 1 and 5 represents your feeling about your job before the accident/illness? Use Flashcard 1

17. If rating 1 is represented by ....... and rating 5 by ....... which rating between 1 and 3 represents your feeling about your job before the accident/illness? Use Flashcard 1

18. Have you received any support (apart from financial) from your employers, managers or work colleagues since your accident/illness?

Yes

No

19. Please give some brief details of the type of support you have received:

<table>
<thead>
<tr>
<th>Employing organisation</th>
<th>1.1</th>
<th>Type of support</th>
<th>1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managers/supervisors</td>
<td>2.1</td>
<td></td>
<td>2.2</td>
</tr>
<tr>
<td>Colleagues/Co-workers</td>
<td>3.1</td>
<td></td>
<td>3.2</td>
</tr>
<tr>
<td>Trade Unions</td>
<td>4.1</td>
<td></td>
<td>4.2</td>
</tr>
</tbody>
</table>

20. Before your accident/illness, how would you rate your employer overall? Use Flashcard 2

| Very poor employer | 1 |
| Poor employer      | 2 |
| Adequate employer  | 3 |
| Good employer      | 4 |
| Very good employer | 5 |

21. After your accident/illness, how would you rate your employer overall? Use Flashcard 2

| Very poor employer | 1 |
| Poor employer      | 2 |
| Adequate employer  | 3 |
| Good employer      | 4 |
| Very good employer | 5 |
22. Before your accident/illness, how would you rate your relationship with your immediate manager/supervisor? Use Flashcard 3

<table>
<thead>
<tr>
<th>Rating</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very poor</td>
<td>1</td>
</tr>
<tr>
<td>Poor</td>
<td>2</td>
</tr>
<tr>
<td>Adequate</td>
<td>3</td>
</tr>
<tr>
<td>Good</td>
<td>4</td>
</tr>
<tr>
<td>Very good</td>
<td>5</td>
</tr>
</tbody>
</table>

Go to question 23

23. After your accident/illness, how would you rate your relationship with your immediate manager/supervisor? Use Flashcard 3

<table>
<thead>
<tr>
<th>Rating</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very poor</td>
<td>1</td>
</tr>
<tr>
<td>Poor</td>
<td>2</td>
</tr>
<tr>
<td>Adequate</td>
<td>3</td>
</tr>
<tr>
<td>Good</td>
<td>4</td>
</tr>
<tr>
<td>Very good</td>
<td>5</td>
</tr>
</tbody>
</table>

Go to question 24

24. Before your accident/illness, how would you rate your relationship with your immediate colleagues? Use Flashcard 3

<table>
<thead>
<tr>
<th>Rating</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very poor</td>
<td>1</td>
</tr>
<tr>
<td>Poor</td>
<td>2</td>
</tr>
<tr>
<td>Adequate</td>
<td>3</td>
</tr>
<tr>
<td>Good</td>
<td>4</td>
</tr>
<tr>
<td>Very good</td>
<td>5</td>
</tr>
</tbody>
</table>

Go to question 25

25. After your accident/illness, how would you rate your relationship with your immediate colleagues? Use Flashcard 3

<table>
<thead>
<tr>
<th>Rating</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very poor</td>
<td>1</td>
</tr>
<tr>
<td>Poor</td>
<td>2</td>
</tr>
<tr>
<td>Adequate</td>
<td>3</td>
</tr>
<tr>
<td>Good</td>
<td>4</td>
</tr>
<tr>
<td>Very good</td>
<td>5</td>
</tr>
</tbody>
</table>

Go to question 26

26. Who, if anyone, do you think is responsible for your accident/illness? Tick more than one box if appropriate.

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myself</td>
<td>1</td>
</tr>
<tr>
<td>Employing organisation</td>
<td>2</td>
</tr>
<tr>
<td>Manager/Supervisor</td>
<td>3</td>
</tr>
<tr>
<td>Colleague/Conformer</td>
<td>4</td>
</tr>
<tr>
<td>Member of public</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
</tbody>
</table>

Go to question 27
27 Apart from work colleagues, has anyone else lost time off work because of your accident/illness - for example, a partner or parent?

Yes  No

28 Can you tell me who has had time off work, their relationship to you, and how long they had to take off?

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Time off so far (weeks)</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/partner</td>
<td>1.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Boyfriend/Girlfriend</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Mother</td>
<td>31</td>
<td>3.1</td>
</tr>
<tr>
<td>Father</td>
<td>41</td>
<td>4.2</td>
</tr>
<tr>
<td>Mother in law</td>
<td>51</td>
<td>5.2</td>
</tr>
<tr>
<td>Father in law</td>
<td>61</td>
<td>6.2</td>
</tr>
<tr>
<td>Brother (1)</td>
<td>71</td>
<td>7.2</td>
</tr>
<tr>
<td>Brother (2)</td>
<td>81</td>
<td>8.2</td>
</tr>
<tr>
<td>Brother (3)</td>
<td>91</td>
<td>9.2</td>
</tr>
<tr>
<td>Sister (1)</td>
<td>10.1</td>
<td>10.2</td>
</tr>
<tr>
<td>Sister (2)</td>
<td>11.1</td>
<td>11.2</td>
</tr>
<tr>
<td>Sister (3)</td>
<td>12.1</td>
<td>12.2</td>
</tr>
<tr>
<td>Daughter (1)</td>
<td>13.1</td>
<td>13.2</td>
</tr>
<tr>
<td>Daughter (2)</td>
<td>14.1</td>
<td>14.2</td>
</tr>
<tr>
<td>Daughter (3)</td>
<td>15.1</td>
<td>15.2</td>
</tr>
<tr>
<td>Son (1)</td>
<td>16.1</td>
<td>16.2</td>
</tr>
<tr>
<td>Son (2)</td>
<td>17.1</td>
<td>17.2</td>
</tr>
<tr>
<td>Sons (3)</td>
<td>18.1</td>
<td>18.2</td>
</tr>
<tr>
<td>Friend (1)</td>
<td>19.1</td>
<td>19.2</td>
</tr>
<tr>
<td>Friend (2)</td>
<td>20.1</td>
<td>20.2</td>
</tr>
<tr>
<td>Friend (3)</td>
<td>21.1</td>
<td>21.2</td>
</tr>
<tr>
<td>Other</td>
<td>22.1</td>
<td>22.2</td>
</tr>
</tbody>
</table>
29. Do you anticipate that they will need further time off work, and if so, how much?

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Further time off needed (weeks)</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/partner</td>
<td>1.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Boyfriend/Girlfriend</td>
<td>2.1</td>
<td>2.2</td>
</tr>
<tr>
<td>Mother</td>
<td>3.1</td>
<td>3.1</td>
</tr>
<tr>
<td>Father</td>
<td>4.1</td>
<td>4.2</td>
</tr>
<tr>
<td>Mother in law</td>
<td>5.1</td>
<td>5.2</td>
</tr>
<tr>
<td>Father in law</td>
<td>6.1</td>
<td>6.2</td>
</tr>
<tr>
<td>Brother (1)</td>
<td>7.1</td>
<td>7.2</td>
</tr>
<tr>
<td>Brother (2)</td>
<td>8.1</td>
<td>8.2</td>
</tr>
<tr>
<td>Brother (3)</td>
<td>9.1</td>
<td>9.2</td>
</tr>
<tr>
<td>Sister (1)</td>
<td>10.1</td>
<td>10.2</td>
</tr>
<tr>
<td>Sister (2)</td>
<td>11.1</td>
<td>11.2</td>
</tr>
<tr>
<td>Sister (3)</td>
<td>12.1</td>
<td>12.2</td>
</tr>
<tr>
<td>Daughter (1)</td>
<td>13.1</td>
<td>13.2</td>
</tr>
<tr>
<td>Daughter (2)</td>
<td>14.1</td>
<td>14.2</td>
</tr>
<tr>
<td>Daughter (3)</td>
<td>15.1</td>
<td>15.2</td>
</tr>
<tr>
<td>Son (1)</td>
<td>16.1</td>
<td>16.2</td>
</tr>
<tr>
<td>Son (2)</td>
<td>17.1</td>
<td>17.2</td>
</tr>
<tr>
<td>Sons (3)</td>
<td>18.1</td>
<td>18.2</td>
</tr>
<tr>
<td>Friend (1)</td>
<td>19.1</td>
<td>19.2</td>
</tr>
<tr>
<td>Friend (2)</td>
<td>20.1</td>
<td>20.2</td>
</tr>
<tr>
<td>Friend (3)</td>
<td>21.1</td>
<td>21.2</td>
</tr>
<tr>
<td>Other</td>
<td>22.1</td>
<td>22.2</td>
</tr>
</tbody>
</table>
The HSE is concerned with getting accurate figures for the financial cost of accidents and illnesses at work, both for individuals and their families. To help us to do this, I'm going to ask you some questions about any loss of income that might have been incurred as a result of your accident/illness, as well as any additional costs you may have had to bear.

Interviewers should obtain bracketed figures. Use discretion in continuing with this section if the interviewee is particularly uncomfortable.

1. What was your average net monthly income before your accident/illness? Use flashcard 4

<table>
<thead>
<tr>
<th>Under £500</th>
<th>£500 - £1000</th>
<th>£1000 - £1500</th>
<th>£1500 - £2000</th>
<th>£2000 - £2500</th>
<th>£2500 - £3000</th>
<th>Over £3000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   Go to question 2

2. During your time off work, did you receive full pay? Yes No

3. During your time off work, what was your net monthly income from your employer?

<table>
<thead>
<tr>
<th>Monthly income percentage - e.g. 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 1</td>
</tr>
<tr>
<td>Month 2</td>
</tr>
<tr>
<td>Month 3</td>
</tr>
<tr>
<td>Month 4</td>
</tr>
<tr>
<td>Month 5</td>
</tr>
<tr>
<td>Month 6</td>
</tr>
<tr>
<td>Month 7</td>
</tr>
<tr>
<td>Month 8</td>
</tr>
<tr>
<td>Month 9</td>
</tr>
</tbody>
</table>

   Go to question 4

4. Have there been any other sources of financial support that you have received because of the accident/illness? Yes No

5. Please give me details of additional financial support:

<table>
<thead>
<tr>
<th>Month</th>
<th>State</th>
<th>Trade Union</th>
<th>Employer</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>13</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>2</td>
<td>11</td>
<td>13</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>3</td>
<td>12</td>
<td>13</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>4</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>5</td>
<td>13</td>
<td>13</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>6</td>
<td>13</td>
<td>13</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>

   Go to question 6
6. If you have now returned to work, can you tell me your current monthly net income? Use Flashcard 4

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000 - £500</td>
<td>1</td>
</tr>
<tr>
<td>£500 - £1,000</td>
<td>2</td>
</tr>
<tr>
<td>£1,000 - £1,500</td>
<td>3</td>
</tr>
<tr>
<td>£1,500 - £2,000</td>
<td>4</td>
</tr>
<tr>
<td>£2,000 - £2,500</td>
<td>5</td>
</tr>
<tr>
<td>£2,500 - £3,000</td>
<td>6</td>
</tr>
<tr>
<td>Over £3,000</td>
<td>7</td>
</tr>
</tbody>
</table>

7. Have any other direct financial losses been incurred as a result of the accident/illness? For example, loss of company car; pension, perks etc.

8. Can you let me have details of direct financial losses?

<table>
<thead>
<tr>
<th>Month</th>
<th>Type of Loss</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 1</td>
<td></td>
<td>1.1</td>
</tr>
<tr>
<td>Month 2</td>
<td></td>
<td>2.2</td>
</tr>
<tr>
<td>Month 3</td>
<td></td>
<td>3.3</td>
</tr>
<tr>
<td>Month 4</td>
<td></td>
<td>4.4</td>
</tr>
<tr>
<td>Month 5</td>
<td></td>
<td>5.5</td>
</tr>
<tr>
<td>Month 6</td>
<td></td>
<td>6.6</td>
</tr>
</tbody>
</table>

9. If it is known that others have lost time off work, but will NOT be interviewed, ask respondent to estimate their loss of earnings to date:

<table>
<thead>
<tr>
<th>Relationship to Interviewer</th>
<th>Number of Weeks Caring</th>
<th>Losses to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carer 1</td>
<td>1.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Carer 2</td>
<td>2.2</td>
<td>2.3</td>
</tr>
<tr>
<td>Carer 3</td>
<td>3.3</td>
<td>3.3</td>
</tr>
</tbody>
</table>

10. Have any of the following additional costs been incurred by yourself or your family as a result of the accident/illness, and can you estimate the amounts?

<table>
<thead>
<tr>
<th>Type of Cost</th>
<th>Details</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>1.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Transport</td>
<td>2.2</td>
<td>2.3</td>
</tr>
<tr>
<td>Alterations to house</td>
<td>3.3</td>
<td>3.3</td>
</tr>
<tr>
<td>Utilities</td>
<td>4.4</td>
<td>4.4</td>
</tr>
<tr>
<td>Caregivers</td>
<td>5.5</td>
<td>5.5</td>
</tr>
<tr>
<td>Domestic help</td>
<td>6.6</td>
<td>6.6</td>
</tr>
<tr>
<td>Special equipment</td>
<td>7.7</td>
<td>7.7</td>
</tr>
<tr>
<td>Other</td>
<td>8.8</td>
<td>8.8</td>
</tr>
</tbody>
</table>

Go to question 11
The HSE is also interested in whether individuals who’ve been involved in work-related accidents or illnesses are actively seeking compensation or are involved in legal action.

11. Have you received any financial compensation as a result of the accident/illness?  
   - Yes  
   - No  
   Go to question 12

12. Can you tell me how much you have received and from whom?  
   [Table]
<table>
<thead>
<tr>
<th>Source of compensation</th>
<th>Amount</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
   Go to question 13

13. Are you seeking any financial compensation as a result of your accident/illness?  
   - Yes  
   - No  
   Go to question 14

14. Has being involved in seeking compensation been a positive or a negative experience for you?  
   - Positive  
   - Negative  
   - Don’t know  
   Go to question 15

15. Why is this?  
   [Blank space]
   Go to question 16

16. Are you taking any legal action as a result of your accident/illness?  
   - Yes  
   - No  
   Go to question 17

17. Has being involved in legal action been a positive or a negative experience for you?  
   - Positive  
   - Negative  
   - Don’t know  
   Go to question 18

18. Why is this?  
   [Blank space]
   Go to section D
The HSE is interested in the social impact of work-related accidents and illnesses on individuals. I'm going to take you through a series of questions about the effect of your accident/illness on your social life.

1. To what extent do you feel that the following activities have been affected by your accident/illness? Use flashcard 5.

<table>
<thead>
<tr>
<th>Activity</th>
<th>No change</th>
<th>Was restricted, now back to normal</th>
<th>Still restricted</th>
<th>Unlikely to return to normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathing/washing</td>
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<td>2.5</td>
<td>2.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Dressing</td>
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<td>2.3</td>
<td>2.2</td>
<td>2.4</td>
</tr>
<tr>
<td>Interest in personal appearance</td>
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<td>2.5</td>
<td>2.2</td>
<td>2.4</td>
</tr>
<tr>
<td>Other</td>
<td>4.1</td>
<td>4.2</td>
<td>4.3</td>
<td>4.4</td>
</tr>
<tr>
<td>Household activities</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Cooking</td>
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<td>2.4</td>
<td>2.1</td>
<td>2.4</td>
</tr>
<tr>
<td>Shopping</td>
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<td>2.5</td>
<td>2.3</td>
<td>2.5</td>
</tr>
<tr>
<td>Housekeeping</td>
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<td>2.6</td>
<td>2.3</td>
<td>2.7</td>
</tr>
<tr>
<td>House maintenance</td>
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<td>2.2</td>
<td>2.5</td>
</tr>
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<td>Gardening</td>
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<td>2.6</td>
<td>2.1</td>
<td>2.3</td>
</tr>
<tr>
<td>DIY</td>
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<td>13.5</td>
<td>12.8</td>
<td>12.4</td>
</tr>
<tr>
<td>Other</td>
<td>12.3</td>
<td>12.7</td>
<td>11.7</td>
<td>12.4</td>
</tr>
<tr>
<td>Leisure and recreation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>List main activities carried out prior to accident below</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking</td>
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<td>13.5</td>
<td>13.1</td>
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<tr>
<td>Driving</td>
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<td>13.5</td>
<td>13.3</td>
<td>13.8</td>
</tr>
<tr>
<td>Use of public transport</td>
<td>13.3</td>
<td>13.5</td>
<td>13.3</td>
<td>13.8</td>
</tr>
<tr>
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<td>18.1</td>
<td>19.1</td>
<td>19.3</td>
<td>19.1</td>
</tr>
<tr>
<td>Social interaction</td>
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</tr>
<tr>
<td>Visiting friends/family</td>
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<td>13.5</td>
<td>13.1</td>
<td>13.8</td>
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<tr>
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<td>13.3</td>
<td>13.8</td>
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<tr>
<td>Other</td>
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<td>13.5</td>
<td>13.3</td>
<td>13.8</td>
</tr>
<tr>
<td>Money management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paying bills</td>
<td>25.1</td>
<td>25.2</td>
<td>25.1</td>
<td>25.2</td>
</tr>
<tr>
<td>Monitoring expenditure</td>
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<td>25.2</td>
<td>25.1</td>
<td>25.2</td>
</tr>
<tr>
<td>Other</td>
<td>25.1</td>
<td>25.2</td>
<td>25.1</td>
<td>25.2</td>
</tr>
</tbody>
</table>
If respondent lives alone, go to question 5

3 To what extent do you feel that your involvement in the following family activities has been affected by your accident/illness? Use flashcard 5

<table>
<thead>
<tr>
<th>Activity</th>
<th>No change</th>
<th>Was restricted, now back to normal</th>
<th>Still restricted</th>
<th>Unlikely to return to normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family leisure activities</td>
<td>3.1</td>
<td>2.2</td>
<td>1.9</td>
<td>1.4</td>
</tr>
<tr>
<td>Family sport activities</td>
<td>3.1</td>
<td>2.2</td>
<td>1.9</td>
<td>1.4</td>
</tr>
<tr>
<td>Social drinking/fasting out</td>
<td>2.4</td>
<td>2.0</td>
<td>1.9</td>
<td>1.4</td>
</tr>
<tr>
<td>Days out/holidays</td>
<td>4.1</td>
<td>4.2</td>
<td>4.3</td>
<td>4.4</td>
</tr>
<tr>
<td>Going to church</td>
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<td>6.2</td>
<td>6.3</td>
<td>6.4</td>
</tr>
<tr>
<td>Other</td>
<td>6.3</td>
<td>6.2</td>
<td>6.3</td>
<td>6.4</td>
</tr>
<tr>
<td>If living with children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking/picking up from school</td>
<td>3.1</td>
<td>3.2</td>
<td>3.3</td>
<td>3.4</td>
</tr>
<tr>
<td>Helping with homework</td>
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<td>3.2</td>
<td>3.3</td>
<td>3.4</td>
</tr>
<tr>
<td>Paying with children</td>
<td>3.1</td>
<td>3.2</td>
<td>3.3</td>
<td>3.4</td>
</tr>
<tr>
<td>Bathing/getting children ready for bed</td>
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<td>10.2</td>
<td>10.3</td>
<td>10.4</td>
</tr>
<tr>
<td>Taking children to/from other activities</td>
<td>11.1</td>
<td>11.2</td>
<td>11.3</td>
<td>11.4</td>
</tr>
<tr>
<td>Other</td>
<td>10.1</td>
<td>10.2</td>
<td>10.3</td>
<td>10.4</td>
</tr>
</tbody>
</table>
4. Who has provided you with support and help since you had your accident/illness? Try and assess how valuable their help has been on a scale of 1 to 5, five being "very valuable", and please provide details of the nature of the support. Use flashcard 7.

<table>
<thead>
<tr>
<th>Individuals</th>
<th>How helpful?</th>
<th>Nature of support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/partner</td>
<td>3.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Boyfriend/girlfriend</td>
<td>3.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Mother</td>
<td>3.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Father</td>
<td>4.1</td>
<td>2.2</td>
</tr>
<tr>
<td>Parents in law</td>
<td>3.1</td>
<td>2.2</td>
</tr>
<tr>
<td>Brother(s)</td>
<td>6.1</td>
<td>6.2</td>
</tr>
<tr>
<td>Sister(s)</td>
<td>7.1</td>
<td>7.2</td>
</tr>
<tr>
<td>Daughters(s)</td>
<td>8.1</td>
<td>8.2</td>
</tr>
<tr>
<td>Sons(s)</td>
<td>9.1</td>
<td>9.2</td>
</tr>
<tr>
<td>Friends(s)</td>
<td>10.1</td>
<td>10.2</td>
</tr>
<tr>
<td>Other</td>
<td>11.1</td>
<td>11.2</td>
</tr>
<tr>
<td>Groups</td>
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<tr>
<td>Religious Institution</td>
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<td>12.2</td>
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<tr>
<td>Trade Union</td>
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<td>13.2</td>
</tr>
<tr>
<td>Other</td>
<td>14.1</td>
<td>14.2</td>
</tr>
<tr>
<td>Services</td>
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<tr>
<td>Medical</td>
<td>15.1</td>
<td>15.2</td>
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<td>Social</td>
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<tr>
<td>Voluntary</td>
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<tr>
<td>Other</td>
<td>18.1</td>
<td>18.2</td>
</tr>
</tbody>
</table>

Go to question 5
5. What changes in your relationships with members of your family have you noticed since your accident/illness?

Use flashcard B

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Rating</th>
<th>If rating is 1 or 2, give example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/partner</td>
<td>1.1</td>
<td></td>
</tr>
<tr>
<td>Boyfriend/Girlfriend</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>3.1</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>4.1</td>
<td></td>
</tr>
<tr>
<td>Mother-in-law</td>
<td>5.1</td>
<td></td>
</tr>
<tr>
<td>Father-in-law</td>
<td>6.1</td>
<td></td>
</tr>
<tr>
<td>Brother (1)</td>
<td>7.1</td>
<td></td>
</tr>
<tr>
<td>Brother (2)</td>
<td>8.1</td>
<td></td>
</tr>
<tr>
<td>Brother (3)</td>
<td>9.1</td>
<td></td>
</tr>
<tr>
<td>Sister (1)</td>
<td>10.1</td>
<td></td>
</tr>
<tr>
<td>Sister (2)</td>
<td>11.1</td>
<td></td>
</tr>
<tr>
<td>Sister (3)</td>
<td>12.1</td>
<td></td>
</tr>
<tr>
<td>Daughter (1)</td>
<td>13.1</td>
<td></td>
</tr>
<tr>
<td>Daughter (2)</td>
<td>14.1</td>
<td></td>
</tr>
<tr>
<td>Daughter (3)</td>
<td>15.1</td>
<td></td>
</tr>
<tr>
<td>Son (1)</td>
<td>16.1</td>
<td></td>
</tr>
<tr>
<td>Son (2)</td>
<td>17.1</td>
<td></td>
</tr>
<tr>
<td>Sons (3)</td>
<td>18.1</td>
<td></td>
</tr>
<tr>
<td>Friend (1)</td>
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</tr>
<tr>
<td>Friend (2)</td>
<td>20.1</td>
<td></td>
</tr>
<tr>
<td>Friend (3)</td>
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<td></td>
</tr>
<tr>
<td>Other</td>
<td>22.1</td>
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</tr>
</tbody>
</table>
6 What changes in your own behaviour have you noticed since the accident/illness? Use flashcard 9

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Increase</th>
<th>Decrease</th>
<th>No Change</th>
</tr>
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<tbody>
<tr>
<td>Sleeping</td>
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<td>1.5</td>
</tr>
<tr>
<td>Eating</td>
<td>1.1</td>
<td>1.2</td>
<td>1.5</td>
</tr>
<tr>
<td>Ability to concentrate</td>
<td>3.1</td>
<td>3.2</td>
<td>3.3</td>
</tr>
<tr>
<td>Ability to take decisions</td>
<td>4.1</td>
<td>4.2</td>
<td>4.3</td>
</tr>
<tr>
<td>Ability to remember things</td>
<td>5.1</td>
<td>5.2</td>
<td>5.3</td>
</tr>
<tr>
<td>Avoidance of certain situations</td>
<td>6.1</td>
<td>6.2</td>
<td>6.3</td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td>7.1</td>
<td>7.2</td>
<td>7.3</td>
</tr>
<tr>
<td>Use of prescription drugs</td>
<td>8.1</td>
<td>8.2</td>
<td>8.3</td>
</tr>
<tr>
<td>Use of non-prescription drugs</td>
<td>9.1</td>
<td>9.2</td>
<td>9.3</td>
</tr>
<tr>
<td>Use of illegal drugs</td>
<td>10.1</td>
<td>10.2</td>
<td>10.3</td>
</tr>
<tr>
<td>Using anger/aggression</td>
<td>11.1</td>
<td>11.2</td>
<td>11.3</td>
</tr>
<tr>
<td>Desire to leave house</td>
<td>12.1</td>
<td>12.2</td>
<td>12.3</td>
</tr>
<tr>
<td>Desire to socialise</td>
<td>13.1</td>
<td>13.2</td>
<td>13.3</td>
</tr>
<tr>
<td>Using patience</td>
<td>14.1</td>
<td>14.2</td>
<td>14.3</td>
</tr>
<tr>
<td>Sexual activity</td>
<td>15.1</td>
<td>15.2</td>
<td>15.3</td>
</tr>
<tr>
<td>Other</td>
<td>16.1</td>
<td>16.2</td>
<td>16.3</td>
</tr>
</tbody>
</table>

7 Thinking about the people who live with you, have you noticed any changes in their behaviour since the accident/illness?

8 For the family members concerned, please indicate the changes you have noticed. [Use the table below for adults, and the tables overleaf for further adults and children.]

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Increase</th>
<th>Decrease</th>
<th>No Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping</td>
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<td>1.5</td>
</tr>
<tr>
<td>Eating</td>
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<td>1.5</td>
</tr>
<tr>
<td>Ability to concentrate</td>
<td>3.1</td>
<td>3.2</td>
<td>3.3</td>
</tr>
<tr>
<td>Ability to take decisions</td>
<td>4.1</td>
<td>4.2</td>
<td>4.3</td>
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<tr>
<td>Ability to remember things</td>
<td>5.1</td>
<td>5.2</td>
<td>5.3</td>
</tr>
<tr>
<td>Avoidance of certain situations</td>
<td>6.1</td>
<td>6.2</td>
<td>6.3</td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td>7.1</td>
<td>7.2</td>
<td>7.3</td>
</tr>
<tr>
<td>Use of prescription drugs</td>
<td>8.1</td>
<td>8.2</td>
<td>8.3</td>
</tr>
<tr>
<td>Use of non-prescription drugs</td>
<td>9.1</td>
<td>9.2</td>
<td>9.3</td>
</tr>
<tr>
<td>Use of illegal drugs</td>
<td>10.1</td>
<td>10.2</td>
<td>10.3</td>
</tr>
<tr>
<td>Using anger/aggression</td>
<td>11.1</td>
<td>11.2</td>
<td>11.3</td>
</tr>
<tr>
<td>Desire to leave house</td>
<td>12.1</td>
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<td>12.3</td>
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<tr>
<td>Desire to socialise</td>
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<td>13.3</td>
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<tr>
<td>Using patience</td>
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<td>14.3</td>
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<tr>
<td>Sexual activity</td>
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<tr>
<td>Other</td>
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<td>16.2</td>
<td>16.3</td>
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</table>
9 continued: further adults in the family

<table>
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<th>On</th>
<th>Increase</th>
<th>Decrease</th>
<th>No Change</th>
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</thead>
<tbody>
<tr>
<td>Behaviour</td>
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<td></td>
</tr>
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<td>1.2</td>
<td>1.2</td>
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</tr>
<tr>
<td>Eating</td>
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<tr>
<td>Ability to concentrate</td>
<td>2.2</td>
<td>2.2</td>
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<td>Ability to take decisions</td>
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<td>Ability to remember things</td>
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<tr>
<td>Avoidance of certain situations</td>
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<td>6.3</td>
<td></td>
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<tr>
<td>Alcohol consumption</td>
<td>7.3</td>
<td>7.3</td>
<td>7.3</td>
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</tr>
<tr>
<td>Use of prescription drugs</td>
<td>8.3</td>
<td>8.3</td>
<td>8.3</td>
<td></td>
</tr>
<tr>
<td>Use of non-prescription drugs</td>
<td>9.3</td>
<td>9.3</td>
<td>9.3</td>
<td></td>
</tr>
<tr>
<td>Use of illegal drugs</td>
<td>10.3</td>
<td>10.3</td>
<td>10.3</td>
<td></td>
</tr>
<tr>
<td>Losing temper/agression</td>
<td>11.3</td>
<td>11.3</td>
<td>11.3</td>
<td></td>
</tr>
<tr>
<td>Desire to leave home</td>
<td>12.3</td>
<td>12.3</td>
<td>12.3</td>
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</tr>
<tr>
<td>Desire to socialise</td>
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</tr>
<tr>
<td>Losing patience</td>
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<tr>
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<td>Other</td>
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</table>

<table>
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<th>Relationship to Interviewee:</th>
<th>On</th>
<th>Increase</th>
<th>Decrease</th>
<th>No Change</th>
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</thead>
<tbody>
<tr>
<td>Behaviour</td>
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</tr>
<tr>
<td>Sleeping</td>
<td>1.2</td>
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<tr>
<td>Eating</td>
<td>2.2</td>
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<tr>
<td>Ability to concentrate</td>
<td>3.2</td>
<td>3.2</td>
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<tr>
<td>Ability to take decisions</td>
<td>4.2</td>
<td>4.2</td>
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<tr>
<td>Ability to remember things</td>
<td>5.2</td>
<td>5.2</td>
<td>5.2</td>
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<tr>
<td>Avoidance of certain situations</td>
<td>6.3</td>
<td>6.3</td>
<td>6.3</td>
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</tr>
<tr>
<td>Alcohol consumption</td>
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<td>7.3</td>
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</tr>
<tr>
<td>Use of prescription drugs</td>
<td>8.3</td>
<td>8.3</td>
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</tr>
<tr>
<td>Use of non-prescription drugs</td>
<td>9.3</td>
<td>9.3</td>
<td>9.3</td>
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<tr>
<td>Use of illegal drugs</td>
<td>10.3</td>
<td>10.3</td>
<td>10.3</td>
<td></td>
</tr>
<tr>
<td>Losing temper/agression</td>
<td>11.3</td>
<td>11.3</td>
<td>11.3</td>
<td></td>
</tr>
<tr>
<td>Desire to leave home</td>
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<td>Desire to socialise</td>
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<td>13.3</td>
<td>13.3</td>
<td></td>
</tr>
<tr>
<td>Losing patience</td>
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<td>14.3</td>
<td>14.3</td>
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</tr>
<tr>
<td>Sexual activity</td>
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<td>Other</td>
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### Relationship to interviewees: children in the family

<table>
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</tr>
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<td>3.2</td>
<td>3.1</td>
<td>3.0</td>
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<tr>
<td>Ability to make decisions</td>
<td>3.2</td>
<td>3.1</td>
<td>3.0</td>
</tr>
<tr>
<td>Ability to remember things</td>
<td>3.1</td>
<td>3.2</td>
<td>3.0</td>
</tr>
<tr>
<td>Avoidance of certain situations</td>
<td>0.2</td>
<td>0.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td>3.4</td>
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</tr>
<tr>
<td>Use of illegal drugs</td>
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<td>1.3</td>
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<td>1.2</td>
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<tr>
<td>Desire to socialize</td>
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<tr>
<td>Disruptive behaviour at school</td>
<td>1.4</td>
<td>1.2</td>
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<tr>
<td>Disruptive behaviour at home</td>
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<tr>
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### Relationship to interviewees:

<table>
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<th>Decrease</th>
<th>No change</th>
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<td>3.2</td>
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<tr>
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<td>0.1</td>
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<td>0.2</td>
</tr>
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<td>Alcohol consumption</td>
<td>2.2</td>
<td>2.2</td>
<td>2.2</td>
</tr>
<tr>
<td>Use of illegal drugs</td>
<td>2.1</td>
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<td>2.2</td>
</tr>
<tr>
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<td>2.1</td>
<td>2.2</td>
<td>2.2</td>
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<tr>
<td>Losing temper/anger</td>
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<td>1.2</td>
<td>1.2</td>
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<td>1.1</td>
<td>1.1</td>
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<tr>
<td>Desire to socialize</td>
<td>1.1</td>
<td>1.2</td>
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<tr>
<td>Disruptive behaviour at school</td>
<td>1.1</td>
<td>1.2</td>
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</tr>
<tr>
<td>Disruptive behaviour at home</td>
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<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Other</td>
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### Relationship to interviewees:

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Increase</th>
<th>Decrease</th>
<th>No change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping</td>
<td>1.1</td>
<td>1.2</td>
<td>1.1</td>
</tr>
<tr>
<td>Eating</td>
<td>2.1</td>
<td>2.2</td>
<td>2.1</td>
</tr>
<tr>
<td>Ability to concentrate</td>
<td>3.1</td>
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<td>3.1</td>
</tr>
<tr>
<td>Ability to make decisions</td>
<td>3.1</td>
<td>3.2</td>
<td>3.1</td>
</tr>
<tr>
<td>Ability to remember things</td>
<td>3.2</td>
<td>3.1</td>
<td>3.0</td>
</tr>
<tr>
<td>Avoidance of certain situations</td>
<td>0.1</td>
<td>0.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td>2.2</td>
<td>2.2</td>
<td>2.2</td>
</tr>
<tr>
<td>Use of illegal drugs</td>
<td>2.1</td>
<td>2.2</td>
<td>2.2</td>
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<tr>
<td>Use of non-prescription drugs</td>
<td>2.1</td>
<td>2.2</td>
<td>2.2</td>
</tr>
<tr>
<td>Losing temper/anger</td>
<td>1.1</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Desire to leave house</td>
<td>1.1</td>
<td>1.1</td>
<td>1.1</td>
</tr>
<tr>
<td>Desire to socialize</td>
<td>1.1</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Disruptive behaviour at school</td>
<td>1.1</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Disruptive behaviour at home</td>
<td>1.1</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Other</td>
<td>1.1</td>
<td>1.2</td>
<td>1.2</td>
</tr>
</tbody>
</table>
The final part of this interview relates to the emotional impact of the accident/illness. I’m going to take you through a short questionnaire to help us to assess this.

1. Have you discussed the emotional impact of your accident/illness with a doctor?
   - Yes
   - No

2. What symptoms did you discuss with your doctor?

3. What diagnosis, if any, did the doctor give for your symptoms?

4. Has the doctor prescribed any medication to deal with the emotional effect of the accident/illness?
   - Yes
   - No

5. Can you tell me what medication the doctor prescribed?

6. After the accident/illness, were you psychologically debriefed? [Interviewers may need to explain the meaning of “debriefing.”]
   - Yes
   - No

7. Who debriefed you?

<table>
<thead>
<tr>
<th>Person who carried out debriefing</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bector</td>
<td>1</td>
</tr>
<tr>
<td>Social worker</td>
<td>2</td>
</tr>
<tr>
<td>Trained counsellor</td>
<td>3</td>
</tr>
<tr>
<td>Psychologist</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>
8. Did you find the debriefing useful?

   Yes  No

   Go to question 9
   Go to question 10

9. What was useful about the debriefing?

   Go to question 11

10. What did you not find useful about the debriefing?

    Go to question 11


**Human Reliability Associates**  
**Health and Safety Executive - Effect of Accidents Study**  
**AP 1 - section E continued**

11. Spend a minute or two thinking about the past two weeks. For each of the statements below, indicate how often the following things have occurred according to the response on flashcards 10.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I felt as if it hadn't happened or wasn't real</td>
<td>1.1</td>
<td>1.2</td>
<td>1.3</td>
<td>1.4</td>
<td>1.5</td>
</tr>
<tr>
<td>2. I tried not to think about it</td>
<td>2.1</td>
<td>2.2</td>
<td>2.3</td>
<td>2.4</td>
<td>2.5</td>
</tr>
<tr>
<td>3. I tried not to talk about it</td>
<td>3.1</td>
<td>3.2</td>
<td>3.3</td>
<td>3.4</td>
<td>3.5</td>
</tr>
<tr>
<td>4. My feelings about it were kind of numb</td>
<td>4.1</td>
<td>4.2</td>
<td>4.3</td>
<td>4.4</td>
<td>4.5</td>
</tr>
<tr>
<td>5. I stayed away from any reminders</td>
<td>5.1</td>
<td>5.2</td>
<td>5.3</td>
<td>5.4</td>
<td>5.5</td>
</tr>
<tr>
<td>6. I tried to remove it from my memory</td>
<td>6.1</td>
<td>6.2</td>
<td>6.3</td>
<td>6.4</td>
<td>6.5</td>
</tr>
<tr>
<td>7. I was aware that I still had a lot of feelings about it but did not deal with them</td>
<td>7.1</td>
<td>7.2</td>
<td>7.3</td>
<td>7.4</td>
<td>7.5</td>
</tr>
<tr>
<td>8. I felt down or depressed for no reason</td>
<td>8.1</td>
<td>8.2</td>
<td>8.3</td>
<td>8.4</td>
<td>8.5</td>
</tr>
<tr>
<td>10. I experienced tiredness in my body</td>
<td>10.1</td>
<td>10.2</td>
<td>10.3</td>
<td>10.4</td>
<td>10.5</td>
</tr>
<tr>
<td>11. I was irritable with others</td>
<td>11.1</td>
<td>11.2</td>
<td>11.3</td>
<td>11.4</td>
<td>11.5</td>
</tr>
<tr>
<td>12. I had a tendency to avoid other people</td>
<td>12.1</td>
<td>12.2</td>
<td>12.3</td>
<td>12.4</td>
<td>12.5</td>
</tr>
<tr>
<td>13. I jumped or feel startled by sudden noises</td>
<td>13.1</td>
<td>13.2</td>
<td>13.3</td>
<td>13.4</td>
<td>13.5</td>
</tr>
<tr>
<td>15. I thought about it when I did not mean to</td>
<td>15.1</td>
<td>15.2</td>
<td>15.3</td>
<td>15.4</td>
<td>15.5</td>
</tr>
<tr>
<td>17. Pictures about it peeped into my mind</td>
<td>17.1</td>
<td>17.2</td>
<td>17.3</td>
<td>17.4</td>
<td>17.5</td>
</tr>
<tr>
<td>18. I had waves of strong feelings about it</td>
<td>18.1</td>
<td>18.2</td>
<td>18.3</td>
<td>18.4</td>
<td>18.5</td>
</tr>
<tr>
<td>19. I had dreams about it</td>
<td>19.1</td>
<td>19.2</td>
<td>19.3</td>
<td>19.4</td>
<td>19.5</td>
</tr>
<tr>
<td>20. I had trouble getting asleep or staying asleep</td>
<td>20.1</td>
<td>20.2</td>
<td>20.3</td>
<td>20.4</td>
<td>20.5</td>
</tr>
<tr>
<td>22. Any reminder brought back feelings about it</td>
<td>22.1</td>
<td>22.2</td>
<td>22.3</td>
<td>22.4</td>
<td>22.5</td>
</tr>
<tr>
<td>23. I avoided letting myself get upset when I thought about it or was reminded of it</td>
<td>23.1</td>
<td>23.2</td>
<td>23.3</td>
<td>23.4</td>
<td>23.5</td>
</tr>
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</table>

Go to question 12
12. Everyone can feel the effects of stress from time to time. Please indicate which of the following statements have been true for you during the past month:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have felt keyed up or on edge</td>
<td>1.1</td>
</tr>
<tr>
<td>I have been worrying a lot</td>
<td>2.1</td>
</tr>
<tr>
<td>I have been irritable</td>
<td>3.1</td>
</tr>
<tr>
<td>I have had difficulty relaxing</td>
<td>4.1</td>
</tr>
<tr>
<td>I have been sleeping poorly</td>
<td>5.1</td>
</tr>
<tr>
<td>I have had headaches or neck aches</td>
<td>6.1</td>
</tr>
<tr>
<td>I have suffered from trembling, dizzy spells, staggering, sweating, or diarrheea</td>
<td>7.1</td>
</tr>
<tr>
<td>I have been worried about my health</td>
<td>8.1</td>
</tr>
<tr>
<td>I have had difficulty in falling asleep</td>
<td>9.1</td>
</tr>
</tbody>
</table>

I have had low energy
I have lost interest in things
I have lost confidence in myself
I have felt hopeless
I have had difficulty in concentrating
I have lost weight due to poor appetite
I have been waking early
I used to feel worse in the mornings
1. What would have helped you personally to cope better with this accident/illness, both at the time of the event and in the following weeks? [Interviewer: it is likely that many of these issues will already have been covered during the interview. Complete the table below where appropriate, but it is not necessary to prompt specifically about each section.]

<table>
<thead>
<tr>
<th>Issue</th>
<th>At the time of the event</th>
<th>During the following weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer/work-related issues</td>
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<td></td>
</tr>
<tr>
<td>Financial issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social support issues (inc. family, friends)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional support issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact with professionals (police, medics, HSE etc.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Is the accident/illness still affecting you physically?  
   - Yes  
   - No

3. Can you give me some brief details?

4. Is the accident/illness still affecting you emotionally?  
   - Yes  
   - No

5. Can you give me some brief details?
Explanation of follow-up

1. As part of this research the HSE is interested in the longer-term effects of serious accidents and illnesses on individuals and their families. As you are (still at work/working in a different job/still suffering physically or emotionally) ideally we would like to contact you again over the coming months to see how you are getting on. This may involve arranging a further interview with you. Would it be acceptable for us to talk to you again in about three months?

   Yes
   No

If yes, one of the study team will contact you nearer the time to arrange a date.

2. Is there anything else you feel we haven’t covered about the impact of the accident/illness on you or your family?

   

Thank you for your time and help.

Interview close time: 

   

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10 REFERENCES


Cormack, H & Whittington, C., Identifying and evaluating the social and psychological impact of workplace accidents and incidents of ill health on employees - A literature review. HSE, 2003


Mayou, R. & Bryant, B. (2002). Outcome 3 years after a road traffic accident. Psychological Medicine, 32, 4, 671 – 675.


Managing sickness absence and return to work: An employer’s and managers guide, HSG249, HSE Books, 2004