Poisoned by the Fluff: Compensation and Litigation for Byssinosis in the Lancashire Cotton Industry

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The literature on the history of industrial diseases is scanty, especially for byssinosis – a chronic respiratory illness caused by exposure to cotton dust that was prevalent in Lancashire cotton mills from the early nineteenth century. This article uses government, legal, medical, and trade union records to explore the development of state compensation for byssinosis. This began in 1941, but not until the early 1970s did compensation extend to all affected workers. Even then, dissatisfaction with state benefits for byssinosis ensured a steady stream of common law actions after 1975. Most of these were settled, highlighting the failure of government and industry to control dust and safeguard workers’ health. Government aversion to increasing costs in a declining industry was a major factor in the development of an inequitable compensation system, which shifted many of the costs of industrial disease onto cotton workers.

INTRODUCTION

Government figures show that in the United Kingdom at the end of the 1990s, more than 200 workers died each year from fatal accidents and about 2,000 from occupationally-related lung disorders – this is aside from the many hundreds of workers injured and disabled by their occupation.1 These

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figures are underestimates, yet the public remain ignorant of the suffering caused by industrial diseases and injuries. Historically, industrial diseases and injuries have rarely featured in the literature and even specialists in medical and industrial history have shown little interest. Aside from asbestos and lead, the history of occupational health remains largely uncharted territory. Not surprisingly, the literature on the history of compensation is sparse, there being only one case study.

Byssinosis is an occupational hazard more obscure than most. It is a chronic respiratory disease caused by exposure to cotton (or flax) dust. Over a period of years, the dust (or rather the contaminants in raw cotton released mainly during the preliminary opening and carding operations) produces asthma-like symptoms, which can lead to permanent respiratory disability or death. In the United Kingdom it is a regional disease, with most byssinosis cases occurring in Lancashire – though workers in Yorkshire, Scotland, and Northern Ireland have also been affected. Byssinosis in the United Kingdom was first identified in the nineteenth century, but it was not until the 1940s that compensation was introduced and not until the 1970s that common law actions began. Few historical accounts of byssinosis have been written: those that have concentrate on the American experience, where byssinosis was much more slowly recognized than in the United Kingdom. One study looked at byssinosis in Lancashire. It discusses the legal picture but it is somewhat dated. In this article, we take a fresh look at byssinosis, using newly-available archives. We describe the historical development of compensation arrangements for this industrial disease, looking in detail at the first legal case and other significant court actions. By placing byssinosis litigation in its historical context, we seek to explain why it took so long for tort claims to begin.

4 In the mills, cotton manufacture began in the blowing room, where compressed bales of cotton were opened and fed through machines to remove impurities. The next process was carding, in which the raw fibres were fed through an ‘engine’ and ranged.
7 P. Neild, Byssinosis – ‘The Lancashire Disease’ (1982).
The term byssinosis (derived from the Greek βυσσός, meaning flax or fine linen) gained common currency in the twentieth century. However, severe respiratory illnesses among flax workers had been described by the pioneers of industrial medicine, Bernardino Ramazzini and Charles Thackrah, in the eighteenth and early nineteenth centuries. A Manchester physician, James Kay, had also noted respiratory illnesses linked with cotton in 1831. He saw cotton workers with a lung disorder caused (he believed) by excessive cardroom dust, which appeared ‘to differ from ordinary chronic bronchitis’. In the 1850s and 1860s, doctors and novelists continued to comment on these respiratory problems. Elizabeth Gaskell described how cardroom workers were ‘poisoned by the fluff’. Government medical officers noted the excess mortality from respiratory disease following the introduction of linen manufacture in Yorkshire. They found that workers experienced marked difficulty in breathing (chest tightness) at the start of the week – a characteristic symptom later known as the ‘Monday feeling’. A similar pattern of lung disease and excess mortality was evident in Lancashire cotton mills, where cardroom workers suffered chest tightness and asthma and most were either dead or had to retire by the age of 50. Stripping and grinding the cards was known to be particularly injurious – prefiguring the popular term for byssinosis in the late nineteenth century: strippers’ and grinders’ asthma.

In the 1890s, statistical evidence linked respiratory diseases and textile manufacture. The higher death rates from phthisis among textile workers in

8 The term was first used by doctors in Germany and France in the 1870s. English physician Thomas Oliver referred to ‘byssinosis’ in Dangerous Trades (1902) 273. But in the 1930s, official reports still referred to asthma or simply ‘respiratory sickness’ in cotton workers, and ‘byssinosis’ was not commonly used in England until 1940. See A. Massoud, ‘The Origin of the Term “Byssinosis”’ (1964) 21 Brit. J. Industrial Medicine 162.
10 J.P. Kay, ‘Observations and Experiments Concerning Molecular Irritation of the Lungs as One Source of Tubercular Consumption; and on Spinners’ Phthisis’ (1830–1) 1 Art. IX N. of England Medical and Surgical J. 360.
11 E. Gaskell, North and South (1855) 102.
12 Third Report of the Medical Officer of the Privy Council. 1860 (1861), Appendix 37.
15 A carding engine consisted of a wide rotating drum, with a surface of fine saw-toothed wires. These wires had to be cleaned (stripped) of cotton debris several times a day and regularly re-sharpened by grinding.
Belfast suggested an occupational origin. In 1897, the Registrar-General’s report showed cotton, linen, and flax workers had excessive death rates. In 1908, Edgar Collis, a Medical Factory Inspector, examined a group of 126 strippers and grinders in Blackburn and found that nearly 75 per cent complained or suffered from what Collis referred to as ‘[cotton] dust bronchitis’ or an ‘asthmatic condition’, again reporting chest tightness on a Monday morning. A considerable excess of respiratory disease for strippers and grinders (compared with other cotton workers) was also noted by the Registrar-General in his report for 1910–12 (published in 1923).

However, compensation for byssinosis never featured on the government’s agenda before the inter-war period. The Workmen’s Compensation Act 1897 entitled any workman (excluding domestic servants and agricultural labourers) injured by an occupational accident (not illness) to claim compensation from his employer. In 1906, the Act was first extended to include six industrial diseases. Anthrax, lead poisoning, mercury, phosphorus and arsenic were covered, as was ankylostomiasis – but dust diseases were ignored. In 1918, silicosis was included. Asbestosis followed in 1930, but byssinosis remained uncompensated. The government adopted the position that diseases that were undoubtedly associated with certain industries would not be listed (‘scheduled’) for compensation if they were also common in the general population. Given the damp climate and the prevalence of bronchitis and other lung disorders in Lancashire, scheduling an asthmatic condition would always be difficult.

In 1922, the cardroom union, the Amalgamated Association of Card, Blowing & Ring Room Operatives (ACO), demanded compensation for grinders’ and strippers’ asthma. (The union had been campaigning for better dust control since 1908.) In 1927, the government responded by commissioning a Medical Research Council study by Dr Bradford Hill on dust in cotton cardrooms. Using medical data provided by the ACO, Hill confirmed the excess rates of respiratory disease among cardroom workers; a fuller government report (published in 1932) concluded that ‘chronic bronchitis and emphysema are commoner in card room operatives than in the general population of the district’. The report provided a three-stage

16 E.H. Osborn, Reports upon the Conditions of Work in Flax and Linen Factories in the United Kingdom (1894) C. 7287.
18 Annual Report of Chief Inspector of Factories and Workshops for the Year 1908 (1909) 203.
20 A.B. Hill, Sickness amongst Operatives in Lancashire Cotton Spinning Mills (With Special Reference to Workers in the Cardroom) (1930).
21 Home Office, Report of the Departmental Committee on Dust in Card Rooms in the Cotton Industry (1932) 38. Transcripts of the evidence (and other material) are in the
diagnostic model: temporary (and reversible) irritation; temporary disable-
ment or incapacity; and total disablement or incapacity. The report noted
Monday-morning symptoms; and also correctly stated that the clue to
diagnosing the disease lay in its causation (that is, in the workers’ histories)
rather than in the specific character of the illnesses.

The trade unions felt vindicated and expected byssinosis to be scheduled.
However, in the midst of the Depression, Home Office ministers had little
taste for statutory compensation, as they believed that ‘the disease could not
be scheduled as there was no indication of a specific disease’ – a surprising
conclusion to draw from the Bradford Hill report. The government’s
strategy for dealing with this ‘non-existent’ disease was to promise more
research into the biological character of cotton dust, which would later result
in another (mostly inconclusive) MRC report. Meanwhile, the trade unions
and the employers were encouraged to create a voluntary compensation fund
– thus by-passing common law claims and avoiding disputes under
Workmen’s Compensation law. The employers objected to the costs and, in
1937, they withdrew from the negotiations.

In 1937, another government committee – chaired by (Sir) David Ross – was
established to reconsider compensation. Another investigation using trade
union insurance records showed that, although cardroom conditions had
improved, there was still an excess of respiratory sickness among cardroom
workers. Little had changed as regards medical knowledge – byssinosis could
still only be diagnosed from the worker’s history – but in 1939 compensation
was recommended under the Byssinosis (Workmen’s Compensation) Scheme
and the Byssinosis (Benefit) Scheme. Compensation applied to those employed
on or after 1 May 1941; benefits covered those who had been disabled before,
but not after that date. When the Industrial Injuries Act 1946 replaced the
Workmen’s Compensation Acts, new benefits were introduced from 1948.

For the first time, a disease that could not be recognized clinically or by
X-ray had been legally recognized as compensatable. Also for the first time,
payment would be made to sufferers still alive who had left the industry
before the disease was officially recognized. In that sense, cardroom workers
were ‘privileged’. But the compensation scheme for byssinosis – as for all
industrial diseases – was strictly circumscribed.

Papers of the Oldham Textile Employers’ Association in the John Rylands Library
[JRL], Manchester (OLD /3/2).
22 Amalgamated Association of Card, Blowing & Ring Room Operatives (ACO),
Report . . . for Quarter Ending 23 April 1932 5.
23 C. Prausnitz, Investigations on Respiratory Dust Disease in Operatives in the Cotton
24 Home Office, Report of the Departmental Committee on Compensation for Card
Room Workers (1939).
25 In 1952, the Pneumoconiosis & Byssinosis Benefit Scheme was introduced for ‘old’
cases, which were not covered by either workmen’s compensation or Industrial
Injuries provisions.

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Compensation payments were meagre and invariably meant a drastic fall in income for the sick worker. Under the benefit scheme, 10s [50p] a week was payable; under Workmen’s Compensation, payments ranged from 10s to 30s [50p–£1.50] a week – at a time when a stripper and grinder could earn nearly £5 a week and blowroom worker well over £4.26 No financial help was offered for medical or caring costs, which could be ruinous. Death payments for a dependent widow and family rarely exceeded £200–£300 and this was only paid if the government accepted byssinosis as the cause of death. Payments under the National Insurance scheme were equally miserable. In 1948, benefit for 100 per cent disablement was £2 5s [£2.25p]; yet the average wage in the cotton industry was close to £5. To be sure, various state payments, such as unemployability supplement, could increase compensation, but the yawning gap in these figures shows little intention by the government to compensate workers fully for their industrial disability.

Even worse, very few workers or their dependants were eligible. Nothing was payable to relatives of those who had died from byssinosis before 1941. Women, who were also known to be at risk, were originally excluded. No rationale was offered by the government for this gender discrimination, but girls and women were in the majority in the cardrooms and it is difficult to avoid the conclusion that the government excluded them to reduce costs, while targeting compensation at strippers and grinders, who were invariably male, unionized, and ‘vital’ to the industry.27 The scheme was also confined to the blowing and card rooms, thus excluding workers in other cotton processes. Fees for the medical examinations were payable by the claimant – effectively confining claims to workers who had financial backing from their trade union. If workers had left their job, compensation claims had to be lodged within a year. The government sidestepped most of the diagnostic problems by demanding that twenty years’ employment in the industry were necessary for a claim and the worker also needed to be totally incapacitated. Clinical signs of partial disability and disease caused by shorter exposures were to be discounted (even though there was evidence that such cases occurred). Compensation was to be intrinsically linked to the symptoms and occupational history of the claimant, especially the ‘Monday feeling’. This meant diagnostic and hence definitional problems, not least since many workers suffering from byssinosis did not consult a doctor until the disease was well developed – and hence presented with what appeared to be ordinary bronchitis. Demonstrating the requisite Monday symptoms and occupational

26 Wages are from the files of the Federation of Master Cotton Spinners’ Association (JRL OLD 2/23/6/1). Ironically, the compensation scheme had coincided with a wartime shortage of strippers and grinders that had increased wages.
27 In 1923, ACO estimated that 80 per cent of cardroom operatives were women. See ACO, Report . . . for Quarter Ending 23 June 1923 6. In the mid-1950s, of 58,000 workers covered by the byssinosis compensation scheme, 36,000 were women.
history remained a problem (for the worker) since it depended on physical examination alone to differentiate byssinosis from chronic bronchitis and emphysema of other origin. As with the Silicosis and Asbestosis Schemes, part-time government-appointed doctors on the Pneumoconiosis Medical Panel (PMP) conducted the medical examinations that decided whether workers were eligible for compensation.\textsuperscript{28}

Under the Byssinosis Scheme, the disease suddenly became remarkably rare. Between 1942 and 1947 only thirty-nine cotton workers from well over 20,000 cardroom workers were diagnosed with byssinosis.\textsuperscript{29} As with asbestosis in the 1930s – when keeping asbestotic workers on the job was thought a lesser evil than throwing them on the dole or antagonizing the industry – the government had made byssinosis disappear. The cost to the industry of compensating these workers is unknown, but the total expenditure, set against the size of the industry, would have been low.\textsuperscript{30} Unfortunately, no business records appear to have survived to show how the scheme operated in practice.\textsuperscript{31} Official byssinosis deaths were also initially rare – an average of less than five a year between 1940 and 1950. This was certainly an undercount, because mortality figures only related to cases in which a dependant made a claim and the death from byssinosis was certified by the government Medical Board.\textsuperscript{32} By 1950, physicians and the government (though not the trade unions) believed that byssinosis was a minor problem.

As the sudden ‘decline’ of byssinosis was mostly a government construct, the disease ‘reappeared’ in the 1950s. Two factors were influential. One was the pioneering work of Dr Richard Schilling (1911–1997), a physician who had joined the Nuffield Department of Occupational Health at Manchester

\begin{itemize}
  \item \textsuperscript{28} In practice, the Manchester PMP dealt with virtually all byssinosis cases.
  \item \textsuperscript{29} R.S.F. Schilling, ‘Byssinosis in Cotton and Other Textile Workers’ \textit{Lancet} ii (11 August 1956) 265. Over 150 workers, representing ‘old’ cases (those who had left the industry by 1941) were also paid under the Benefit Scheme.
  \item \textsuperscript{30} The Ross Committee had calculated the costs of the Benefit Scheme alone at £7,000 a year for a projected 250 workers. This figure would progressively diminish as the men died. As it transpired, the number of ‘old’ cases seems to have been well under 200 in the early 1940s.
  \item \textsuperscript{31} G. Tweedale, \textit{Magic Mineral to Killer Dust: Turner & Newall and the Asbestos Hazard} (2000) has described the operation of the Asbestosis Scheme in the 1930s and 1940s, showing that workers experienced many problems in securing payments under a system in which benefits were paid by employers.
  \item \textsuperscript{32} In cases of industrial disease (especially), death certificates do not always accurately record the cause of death; not all cases are reported to the coroner; and not all cases that are reported result in an inquest. Death benefit for byssinosis also required proof of ‘dependency’. Thus it was not normally payable for the death of a female sufferer or the death of a male sufferer who did not leave a widow. Moreover, byssinosis deaths would not be accepted unless a worker had been recognized as having the disease in life, as there was no accepted criteria for diagnosing byssinosis at necropsy. See G.B. Rooke, ‘Compensation for Byssinosis in Great Britain’ (1981) 79 \textit{Chest} 124S.
\end{itemize}
University in 1947. Schilling carried out work the government had neglected: visiting the mills, interviewing workers, and conducting detailed investigations. He showed (as the workers already knew) that byssinosis was still rife in the industry and that many sick workers were not being compensated. He demonstrated that byssinosis was not only widespread among carders and blowroom workers, but also among mule and ring spinners. To Schilling, it was clear that these workers were ‘disabled by blatantly bad working conditions over which they had no control.’ Schilling returned byssinosis to the occupational health agenda and prompted a steady stream of medical studies through the 1960s and 1970s.

The second factor was the slow, but steady, widening of the government parameters for compensation (Table 1). Women were brought into the scheme, disablement and employment criteria necessary to win compensation were abolished, and workers in other cotton processes (besides blowing and carding) were included. This reflected the work of the cardroom and spinning trade unions, who fought a long campaign against a sceptical government and medical community for compensation for all affected workers, especially spinners. The trade unions regarded the extension in 1974 of compensation to all jobs up to beaming and winding as long overdue.

Byssinosis now stood revealed as a disease that affected thousands of Lancashire cotton workers and killed hundreds. In the 1950s and 1960s, over 4,000 workers were diagnosed with the disease (Table 2). Annual certified byssinosis deaths (albeit an undercount) grew steadily to a peak of over fifty in 1959 and remained at a relatively high level through the 1960s. Byssinosis continued to kill workers, even during the 1980s, when an average of twenty-five deaths were recorded each year. From the late 1960s, there was a sharp decrease in the number of byssinosis cases diagnosed, although the number still surpassed a hundred a year in the early 1980s, and only fell markedly in

33 Schilling had started his career as a Medical Inspector of Factories, then served as secretary of the Industrial Health Research Board of the MRC between 1942 and 1946. In 1956, he moved from Manchester to the London School of Hygiene and Tropical Medicine, where he later became professor of occupational health. See Times, obituary, 28 October 1997.

34 R.S.F. Schilling et al., ‘An Epidemiological Study of Byssinosis among Lancashire Cotton Workers’ (1955) 12 Brit. J. of Industrial Medicine 217–27; Schilling, op. cit., n. 29. Schilling cited the case of one severely disabled man, who had spent sixteen years in the blowroom, but had spent twenty years as a spinner (thus placing him outside the compensation scheme).


37 Beaming and winding involved putting cotton onto beams and bobbins for weaving.
Table 1. Compensation for Byssinosis

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tr>
<td>1923</td>
<td>Amalgamated Association of Card, Blowing &amp; Ring Room Operatives demands compensation for occupational ‘asthma’.</td>
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<td>1932</td>
<td>Government investigations confirm excess respiratory sickness amongst Lancashire cardroom workers.</td>
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<td>1937</td>
<td>Employers withdraw from negotiations with trade unions over a voluntary system of compensation.</td>
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<td>1939</td>
<td>Ross Committee recommends workmen’s compensation for byssinosis.</td>
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<tr>
<td>1941</td>
<td>Compensation and Benefit Scheme for permanently disabled men with 20 years in the cardrooms (or for dependants of men certified to have died of the disease).</td>
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<tr>
<td>1948</td>
<td>Female workers included. Qualification for disablement reduced from 100% to 50%.</td>
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<tr>
<td>1951</td>
<td>Waste cotton workers covered (including some mule spinners).</td>
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<tr>
<td>1955</td>
<td>20-year qualification period reduced to 10 years.</td>
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<tr>
<td>1960</td>
<td>Trade unions launch a campaign to bring mule and ring room workers within scope.</td>
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<tr>
<td>1974</td>
<td>Compensation extended to all processes up to and including winding and beaming. Qualifying period reduced to five years and the permanent disablement clause abolished.</td>
</tr>
<tr>
<td>1979</td>
<td>Five-year minimum period of employment condition abolished.</td>
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Table 2. Byssinosis Disablements/Deaths Certified by the Pneumoconiosis Medical Panels in the United Kingdom, 1942–2000

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<tbody>
<tr>
<td>Disable-ments</td>
<td>163</td>
<td>1,884</td>
<td>2,220</td>
<td>913</td>
<td>519</td>
<td>33</td>
</tr>
<tr>
<td>Deaths</td>
<td>57</td>
<td>279</td>
<td>420</td>
<td>–</td>
<td>250</td>
<td>80 (to 1999)</td>
</tr>
</tbody>
</table>

the 1990s. Between 1942 and 2000, nearly 6,000 workers were diagnosed and compensated for byssinosis.

**SIMMONS v. WALLER BROTHERS**

Legal experts and historians have shown that common law claims for industrial diseases and injuries were a relatively late phenomenon. Nick Wikeley, Bill Felstiner, and Robert Dingwall have highlighted that asbestos litigation began in modest fashion in the early 1960s.\(^{38}\) They also identified the reasons: the existence of state compensation; the lack of resources and claims consciousness on the part of workers; and, particularly, the rules on limitation, which until 1963 meant that legal actions had to start within three years of the last relevant exposure – effectively blocking claims for latent industrial diseases that took decades to manifest themselves. By the 1960s, however, after the limitation rules had been amended, this picture changed as trade unions became more involved, personal-injury lawyers acquired more experience, and legal aid became available.

Byssinosis broadly corresponds to this general picture, except that the initial common law case was much later than the first for asbestosis. Not until 1974 was the first successful action tried. However, it was always likely that litigation for byssinosis would be delayed longer than for other hazards. It was not a fibrotic condition (unlike other lung diseases, such as asbestosis and coal miners’ black lung) and so diagnosis was often problematical. Byssinosis was undefined in law and was specifically excluded from the definition of pneumoconiosis in the government’s Prescribed Diseases Regulations.\(^{39}\) Moreover, the sharp decline of the Lancashire textile industry after the 1950s weakened the trade unions precisely when the legal situation became more favourable.

It was a trade union, however, which underpinned the first common law claim for byssinosis – an action precipitated by long-standing grievances against the PMPs. Byssinosis cases rejected by the PMPs always exceeded, by a substantial margin, those where byssinosis was confirmed. This trend has been mirrored in virtually all prescribed industrial diseases and has regularly drawn complaints from claimants and their supporters.\(^{40}\)

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\(^{39}\) Rooke, op. cit., n. 32, p. 125S.

example, between 1942 and 1947, 107 claims were rejected and only thirty-nine accepted. By 1950, the cardroom union was also reporting problems at byssinosis inquests, where compensated workers were deemed not to have died of the disease, but of ‘bronchitis and emphysema’. The union was ‘completely dissatisfied with the attitude of the Medical Panel’. So, too, was the spinners’ union, the Amalgamated Association of Operative Cotton Spinners & Twiners (ACS), which first considered suing manufacturers in 1967, triggered by their frustration with the decisions of the PMPs. Between 1972 and 1982, the PMPs diagnosed 1,101 cases of byssinosis, but they rejected 2,657 claims.

Amongst the rejects was Thomas Simmons, a fifty-four-year-old textile worker, disabled with a chest complaint. He was not a Lancastrian, but had worked most of his life in West Yorkshire, where he had been a stripper and grinder in a cardroom. His employers were Waller Brothers, owners of the Wharncliffe Mills in West Vale, Halifax, and spinners of very coarse yarns. Simmons had worked in carding between 1934 and 1936, but his main stint was between 1956 and 1971. Always affected by the dust, he noticed in 1969 that he was coughing in the morning and getting breathless. His symptoms progressively worsened, until late in 1971 he had to stop work. Simmons had the support of the ACS in Manchester, who sent him for examination at Manchester Royal Infirmary. A doctor diagnosed emphysema, but added that ‘his employment as a stripper and grinder was involved in the development of his present disability’. However, Simmons’s claim for byssinosis benefit was rejected by the PMP in 1972. More expert opinions were sought. A Halifax chest physician, Dr Bertram Mann, saw him in that year and argued that he was ‘probably suffering from byssinosis’, had a three to four year reduction in lifespan, and 50 per cent disability. The ACS paid for Simmons to travel to London for a consultation with Schilling, who confirmed Simmons’s byssinosis and believed that his claim had been rejected because he did not have classic Monday chest-tightness.

In 1972, the ACS decided to underwrite a common law action for Simmons. They referred the case to the Manchester branch of the solicitors firm, Thompsons, where the claim was handled by John Pickering, a solicitor who had launched his career by taking on asbestos claims against

41 ACO, Report ... for Quarter Ending 24 February 1951 6.
42 DHSS, Social Security Statistics (annual).
44 Dr Mann was no stranger to occupational hazards. He had diagnosed many cases of asbestosis and asbestos cancers from the notorious Cape Asbestos factory in Hebden Bridge.
45 Thompsons was the leading personal-injury solicitors in the country. It had been founded in 1921 by W.H. Thompson, a radical civil rights lawyer, with strong links to the labour movement. After Thompson’s death in 1947, the firm had been continued as a partnership by his two sons, Brian and Robin.
Cape Asbestos in Hebden Bridge. While Simmons was encouraged to persist with his claim to the PMP, Thompsons told the ACS: ‘the medical evidence in this case is strong . . . [and] . . . there are reasonable prospects that a judge would come to the conclusion that your member is suffering from byssinosis’. On the other hand, it might cost the trade union £2,000 if Simmons lost (and £400 even if he won). By September 1973, Simmons had been rejected by the PMP for the fourth time and the union was instructing Thompsons to press ahead. A barrister’s report confirmed that the prospects for winning the case looked promising, pending engineers’ reports of Simmons’s workplace. These reports are not extant, but presumably they confirmed the barrister’s suspicions that Waller Brothers had failed to install sufficient dust extraction machinery and had been negligent in the provision of adequate respirators. In 1974, the action began in earnest against Waller Brothers. It was settled the following year, with an out-of-court settlement for £13,000. Losing the action would have hit the union hard (as it was, Thompsons’ bill was £432), but the ACS had won the first legal settlement for a worker with byssinosis.

In some ways it was a hollow victory. Simmons was profusely grateful, but as he told Joe Richardson, the secretary of the ACS: ‘if I had my health back . . . I would gladly be at my work tomorrow, as all the money in the world cannot buy health.’ The ACS ceased to exist in 1976 – the year when Simmons’s claim for benefit was rejected yet again by the PMP. He told Richardson:

...this Pneumoconiosis Panel Board will not believe that this industrial disease cannot be had by working in the cotton industry. Yet it has been proved to them by the best chest specialist. And as you know, I myself have taken that proof to them, time and again. Mr Richardson surely there must be some higher up medical counsel somewhere. And they must be made to believe that this disease can be caused by working in the cotton industry, as not only myself who is having to suffer from it. But there might be many, many more cotton workers like myself suffering from the same complaint. As Dr B. Mann said on the telly vision that byssinosis is a terrible disease as there is no cure, only a slow death. Surely you cannot let that happen to our fellow cotton workers.

I have to go again to see Dr Mann . . . by ambulance, as I can only walk very short distances at a time. Then I have to stop for a breather. Mr Richardson, the insurance officer has informed me that it cannot be altered the decision of the Medical Board. But I can appeal against it . . . and I will appeal, as I know I am suffering from this disease and I am sure the Medical Counsel and the Medical Board know it as well. But they just will not go against one another’s decisions . . . Can you advise me on what grounds I can appeal on, as they say I have 21 days to send in another appeal . . . Mr Richardson, I am not a good letter writer. Hope you can understand my letter to you and thanks again for making that award which you won for me for damages. ...
SUBSEQUENT LITIGATION

Nothing suggested that the Simmons’ case was anything more than a one-off. State compensation remained the mainstay of support. At the end of the 1970s, 3,000 people were receiving compensation for byssinosis, totalling £2.25 million a year. In 1979, the Pneumoconiosis Act introduced lump sum compensation by the state for byssinosis sufferers who were unable to sue their employer because the firm was no longer in business.

Ironically, improved state compensation increased the profile of byssinosis and encouraged common law claims. Byssinosis even began attracting media interest. Despite their declining strength, the unions began encouraging workers to sue for damages. From early 1980, the Amalgamated Textile Workers’ Union organized a series of meetings at which solicitors addressed members on their case for claiming compensation from the employers. The meetings were landmarks for many byssinosis sufferers (who in the past often had no idea that they could even claim state benefits). One byssinotic worker recalled: ‘It was there that I realised that I could claim compensation . . . Until I attended that meeting I had not been advised that the right thing to do was to start court proceedings against my employer.’

Many decided to pursue such a course and, with the help of the trade unions and legal aid, a groundswell of common law claims for byssinosis occurred during the late 1970s and early 1980s. Some of the case files from these actions have survived and these documents provide an important piece in the historical jigsaw of byssinosis compensation.

Despite the relaxation of the Limitation Act and the availability of legal aid, the problems for workers who wished to sue their employers remained formidable. Many of the old cotton firms were disappearing (or had ceased business), making employers and insurers difficult to trace. The trade unions were declining, as their membership contracted. Above all, plaintiffs still had to prove their case, surmount the medical hurdles, and demonstrate that they had a history of the ‘Monday feeling’. Byssinosis was now well established as a medical condition, but the medical picture was changing as knowledge about the disease deepened. In the 1960s, Schilling and others used international comparisons to suggest that Lancashire air pollution was significant not only in aggravating but in initiating respiratory disease. Several epidemiological studies also suggested that byssinosis was linked to smoking.

51 ‘Dust to Dust’, BBC2, 17 August 1982. Copy in North West Film Archive, Manchester Metropolitan University.
52 John Pickering Archive (JPA); Thomas Draper v. Richard Harwood, Statement of Thomas Draper. AC/DRAPER/F10165.
53 We are grateful to John Pickering & Partners for access to their old byssinosis files.
habits, so that by the 1980s most doctors accepted that smoking and dust exposure interacted to cause loss of lung function in cotton textile workers. More disconcertingly for plaintiffs, professional conflicts began amongst doctors. It had been assumed for almost a century that cotton textile workers had an excess mortality, but some studies in the 1980s suggested otherwise—some even arguing that exposure to cotton dust did not cause permanent respiratory disability. Towards the end of his career, Schilling found his views on byssinosis contested (albeit by a minority), while his forthright opinions on the byssinosis issue led to accusations that he was exaggerating the problem in the cotton industry.

Manufacturers, it seemed, would have plenty of opportunity to defend themselves against what one insurer described as the ‘onerous’ duty to protect workers. In the courts they could exploit medical disagreements, whilst reinvoking the environment/lifestyle debate concerning the way in which Lancastrian air pollution and the smoking habits of cotton workers contributed to their byssinosis. But byssinosis plaintiffs had certain rights. Under workmen’s compensation law, byssinosis had traditionally been narrowly defined, with claims decided entirely by a medical examination that took almost no account of working conditions. The medical criteria had been defined by epidemiologists: in other words, government policy demanded medical certainty (even though this was frequently not available through epidemiology). Personal-injury lawyers work to a different remit and are able to utilize a wider range of evidence, using different standards of proof. A worker’s disability has to be proved medically (though even here multiple medical experts can be canvassed): but the crux of a common law action against an employer involves the issue of negligence. This means closely scrutinizing working conditions and employers’ actions, then matching that against contemporary knowledge and especially the duty of care set out by the Factories Acts (1901, 1937, 1961).

In byssinosis litigation, workers usually alleged that the conditions in many mills were hazardous:

Starting at J.& J. Hayes in 1949, I worked in No 4 mill which was all cotton on jackframes, slubbers and intermediates. It was dusty and I think coarse, but I do not know the counts. People used to bat down. Floors were swept dry two

57 Schilling, op. cit., n. 35, p. 115.
or three times a day and there were no vacuum cleaners and masks. The only medical I had was when I started there. 59

Individual testimony also emphasized the problems of life with byssinosis:

I need my wife to wash (and bath) and dress me. She then has to make my breakfast. My wife does all my washing, cooking and cleaning up. Baths take 1 hour. I have two per week . . . My wife does all the shopping . . . I have to use an oxygen cylinder . . . about 6 times a day on average . . . I do not sleep well. I need a walking stick. I only get out once a day if the weather is okay. I just manage to get round the block. I have a lot of pain in my chest. It is constantly there . . . I often find it difficult to eat. It is exhausting. When I am having a coughing fit it feels like I am having a heart attack, it is that painful . . . 60

In particular, byssinotic workers claimed that they suffered financially (besides physically) under a system which shifted economic costs from industry to the sick. Workers claimed loss of income in two ways. The first occurred if and when a worker was sufficiently debilitated by byssinosis so that he or she could no longer work in a cotton mill but were not sufficiently ill that they were unable to work. Employment in other jobs, it was said, could lead to a reduction in weekly income of up to 50 per cent. 61 If and when the worker could no longer undertake any paid work, this loss in earnings was total. Often workers claimed further costs could be incurred in buying special equipment – such as a chair lift – required in the home. Some byssinosis sufferers argued that the financial costs of such special equipment took up all their savings. 62

Workers’ testimony and pleadings can obviously be questioned because of their potential for bias. However, solicitors representing byssinosis plaintiffs also searched for (and found) corroborating evidence from independent consulting engineers, expert medical witnesses, government documentation, and Factory Inspectorate reports (sometimes produced in ‘discovery’). One expert who testified frequently was Frank Brownsett, an engineer from the cotton industry’s research foundation, the Shirley Institute. Emphasizing the crucial role played by Brownsett in byssinosis cases, one solicitor recalled ‘a very modest man [who] came over in court as an expert in the true sense of the word in that he knew his subject, which was machinery for suppressing cotton dust and removing it, better than probably anyone else in the country, possibly in the world’. 63

60 JPA. High Court of Justice, Queen’s Bench Division, Oldham District Registry, Partington v. Atherton Estates, 1984. Statement by Fred Partington AC/Partington/ T13119, 2–4. Partington was first diagnosed with byssinosis by the PMP in 1980 and two years later was assessed at 60 per cent disability.
62 Partington, op. cit., n. 60, pp. 2–4.
Engineers’ reports usually provided the proof of employers’ negligence and of the unnecessarily dusty working conditions, which existed, even in the largest mills, into the 1980s. Practices such as ‘wafting’ or ‘batting’ (fanning dust from machines with pieces of stiff card) had survived in many mills from the 1920s, despite the fact that government reports at that time had identified these as hazardous procedures that should be banned. Confidential reports by the Factory Inspectorate confirmed the poor working conditions. To give an example: in 1981 an Inspectorate visit to Mutual Mills in Heywood revealed that the company was still wafting dust, instead of using vacuum cleaners, while general cleanliness and other matters (such as the use of masks) needed improvement. The critical indictment in all the engineers’ reports was ‘failure to adopt recommendations made in various reports’ dating back to the 1900s. This and this alone ‘can be the main basis for alleging negligence’ and/or breach of statutory duty. The lack of specific dust regulations for the cotton industry (unlike asbestos) did not hinder litigation. Specialists in occupational hygiene from the University of Manchester provided supporting scientific evidence on dangerous concentrations of airborne dust in the mills where plaintiffs worked, or had worked. By the mid-1980s, solicitors were routinely issuing lists of negligence and breaches of statutory duty against employers, using specialists’ reports to demonstrate company negligence on a wide range of health and safety issues. Also useful in these actions was the plentiful literature that had accumulated on byssinosis: namely, Factory Inspectors’ reports from the 1920s, the government report on dust in cardrooms (1932), Prausnitz’s study (1936), and Joint Advisory Committee reports stretching over the decades from 1946.

Typically, manufacturers had little defence to failures in dust control. For example, on one occasion Fine Spinners & Doublers Ltd and Courtaulds

64 JPA. Health and Safety Executive correspondence in Doreen Stott v. Mutual Mills Ltd, 1985. HSE reports published in the 1970s also described how the continued use of brushes and compressed air caused the unnecessary creation of dust in many mills. See HSE, op. cit., n. 5, p. 16.

65 JPA. Comments by F. Brownsett, on Thomas Draper v. Richard Harwood, AC/DRAPER/F10165. 7 May 1981.


67 See, for example, the report by F.F. Cinkotai (6 December 1985, JPA AC/SMITH/T141112), on airborne dust in the cardroom of Caleb Wright Mill which was used to support Elsie Smith’s claim against Courtaulds in 1984. Cinkotai’s work confirmed that control limits were exceeded in nearly all the sampling points in the cardroom and concluded that ‘a person working in these workrooms is over-exposed to cotton dust’.

68 The Joint Advisory Committees on the cotton industry (which published four reports between 1946 and 1961) had been set up by the government, with the intention of improving working conditions in the mills.
accepted ‘breach of duty ... in respect of the control of exposure to cotton dust and its inhalation by those employed.’

Significantly, only one byssinosis case ever came to trial, when in a landmark case in 1983 the manufacturers tested the medical evidence that byssinosis was mostly due to ‘lifestyle’. The worker was Thomas Brooks, who sought compensation from J. & P. Coats for his byssinosis, which he alleged had been caused by long exposure to cotton dust at Eagley Mill in Bolton. Brooks was a ‘moderate smoker’, smoking ten to twenty cigarettes a day. He had worked in the carding rooms mainly as a stripper and grinder from 1935 until 1965, with a five-year gap during the Second World War. Three consultant physicians diagnosed byssinosis. This was the first claim from a worker in a fine cotton mill, and at issue was whether the employers were in breach of their duty to take ‘appropriate measures to reduce the dust in the atmosphere’. J. & P. Coats argued that Brooks had brought his claim too late and that byssinosis was practically unknown in the mill in which he worked. They also alleged that ‘the symptoms and the condition of which the plaintiff has complained are attributable to cigarette smoking.’ Medical evidence indeed suggested that about half of Brooks’ disability was due to smoking. Despite skilful advocacy by the defence barrister, however, the judge awarded compensation to Brooks notwithstanding his smoking. It was ruled that Coats had failed to take all practicable measures to protect the plaintiff from inhaling dust, had failed to prevent the accumulation of dust (by not brush stripping under a vacuum hood and by not vacuum cleaning the machines), and had failed to fit appropriate exhaust appliances – all breaches of the Factories Act 1937. Brooks won £22,688 in damages, plus interest and costs. No longer was byssinosis a problem of the coarse cotton trade: fine-count cotton workers could also be affected – and claim damages: nor would smoking prevent workers suing their employers.

One further hurdle needed to be surmounted: many cotton mills had shut and the companies had disappeared. In the early 1980s, one plaintiff had worked for the defunct Dart Mill in Bolton. Logically, the insurers of the mill (Eagle Star) were the next target, but in Bradley v. Eagle Star Insurance Co. Ltd. (1989), the House of Lords ruled that it was necessary to sue the company direct. However, the government immediately amended the law through the Companies Act in 1989, so that companies could be nominally restored to the Register of Companies (even though they were no longer in business), allowing any action against the insurers to proceed. The dissolution had to have occurred after November 1969 – that is, within

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71 id., p. 23.
72 id., p. 10.
73 id., p. 29.
twenty years of the Act instead of the two-year period allowed before the 1969 Act. Solicitors restored Dart Mill to the register and sued again, with the result that Mrs Bradley won compensation from Eagle Star. Had the original decision stood, it could have threatened compensation for many victims of occupational disease (not only byssinosis plaintiffs).

Solicitors for the legal practice that handled most of the Lancashire claims for byssinosis estimate that they alone handled over 3,000 cases between the late 1970s and 1980s. Claims were almost invariably settled without trial, with an agreement often reached at the door of the court. Thus, as byssinosis faded from the national memory, some of the victims of byssinosis were able to claim partial recompense for their industrial injury from a disease that was over 150 years old.

**PERSPECTIVES ON BYSSINOSIS**

Cotton manufacture is rarely considered a dangerous occupation: indeed, the toxic nature of cotton dust would come as a surprise to most. Perhaps this explains why there have been few studies of specific industrial diseases in the cotton industry. This survey of byssinosis therefore has intrinsic relevance to that industry: it is also useful in highlighting wider facets of British occupational health.

In particular, this article demonstrates the slow development of state compensation for byssinosis and shows the difficulty encountered by workers in obtaining adequate recompense. Companies, their shareholders, and their customers never paid the real costs of industrial disease: instead these were shifted mostly to the workers. The workers were inadequately compensated; while the failure to impose significant costs on the industry meant that financial (or legal) incentives to improve working conditions dramatically were weak. A similar picture has been drawn in studies on the British asbestos industry and there are also parallels with studies of silicosis and black lung in America. The development of compensation languished, particularly during the 1930s (when the government declined to

74 Wikeley, op. cit., n. 2, pp. 47–8.
75 Personal information from John Pickering, who recalls undertaking an average of about 200 to 300 cases a year for a decade.
76 For example, one plaintiff, Fred Partington, was awarded £42,500 in an out-of-court settlement in 1986 (Letter from Anthony Coombs to the Gen. Sec. ATWU, 26 March 1986, JPA AC/PARTINGTON/T13119).
act upon the Bradford Hill report) and the 1960s (when it stonewalled for a
decade on extending compensation to spinners).\textsuperscript{80}

Such prevarication only partly reflected medical uncertainty over the
nature of byssinosis. The delay in the inter-war years was due to the govern-
mament’s aversion to increasing costs in an industry already burdened by the
adverse effects of declining export demand. Politicians were more interested
in encouraging employers to rationalize and restructure the industry than in
re-equipping existing factories to reduce dust.\textsuperscript{81} The timing of the Depression
was particularly unfortunate for byssinosis sufferers – it delayed
compensation until the 1940s, when the demands of a war economy forced
the government to devote more attention to working conditions (and com-
pensation).\textsuperscript{82} State action owed less to medical ‘proof’ than the need to recruit
a labour force which might be deterred from entering the cotton industry if (as
it did) it perceived that in so doing it risked contracting a serious and
potentially fatal industrial disease. Later, it was the post-war productivity
drive and the need to persuade workers to join and return to the cotton
industry which were the key motivating factors behind the extension of
compensation legislation.\textsuperscript{83} As the Factory Inspectorate noted:

\begin{quote}
It had become increasingly apparent in 1944 that unless the conditions of
employment in these textile mills were made more attractive, workers would
be very loath to return to them, particularly after experiencing some years of
employment on munitions in modern premises with all the latest amenities.\textsuperscript{84}
\end{quote}

By the 1960s, with Britain’s productivity and export drive firmly
associated with the ‘white heat’ of ‘high-technology’ rather than the ‘old’
cotton industries, the government could afford a more lenient approach to
compensation. Civil servants observed that ‘there has been a fall in the
number of new claims … [and that] with the continuing contraction of the
cotton industry it is likely that the number of claims will continue to
decline\textsuperscript{85} since ‘workers who might have suffered from the disease will
have left the dusty atmosphere altogether’.\textsuperscript{86} But even with the extension of
state compensation in the 1970s, there was still enough dissatisfaction with
the system to provide a steady stream of common law claimants. This
litigation highlighted the continuing problems of an out-dated industry in
providing safe working conditions.

\textsuperscript{80} The tardy introduction of compensation for flax workers (in 1965) should also be
highlighted.
\textsuperscript{82} Coal miners’ pneumoconiosis, it should be mentioned, was also scheduled during the
Second World War.
\textsuperscript{83} Board of Trade, \textit{Working Party Reports: Cotton} (1946) ch. 5.
\textsuperscript{84} \textit{Annual Report of the Chief Inspector of Factories … for 1944} (1945; Cmnd. 6698)
80.
\textsuperscript{85} Public Record Office: PRO PIN 20/507. Letter to Senior Medical Officer of PMP, 23
April 1968.
\textsuperscript{86} PRO PIN 20/507: File Note, 20 March 1968, 2.

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There can be little doubt that, even allowing for the problems of a declining industry, Britain’s performance in combating and compensating byssinosis was poor (though perhaps not as bad as the United States of America, where byssinosis was not taken seriously until after the 1960s). Much more could have been done through better dust extraction and careful ‘housekeeping’ to reduce the incidence of the disease. In this sense, we regard the continuance of byssinosis as symptomatic of a wider failure of occupational health in the United Kingdom, which extended to many other industries. Certainly, Richard Schilling believed so. At the end of a lifetime in occupational health, he still found it incomprehensible that the government remained deaf to requests to provide environmental monitoring and medical surveillance of cotton workers – something he had been recommending since the mid-1950s (and the Departmental Committee on Dust in Cardrooms had suggested in 1932).

One feature that stands out as perhaps less typical is the role of trade unions. In the textile industry, the trade unions have often been seen as ineffective, with their interests centred more on pay than working conditions. This image is belied by the engagement of the cotton trade unions with byssinosis. As with mule-spinners’ cancer, the unions’ performance in occupational health issues was highly creditable. Crucially, the unions opened the door for common law actions. Litigation was slow to materialize, but it seems to have been generally successful (given the constraints) – though it is apparent from the number of suspensions for byssinosis that many workers did not launch a claim.

In Britain, byssinosis is almost at an end: only the occasional case is reported (and no new cases were diagnosed in 2000). The forecasts by doctors in the 1940s that byssinosis would be ‘wiped out’ have been realized – if belatedly and not entirely in the fashion predicted. The disappearance of byssinosis in Britain has owed much to the shutdown of the cotton industry and the ‘export’ of the disease overseas, where byssinosis is still a serious problem. In the developing countries of the Far East and in South Africa, the legal mechanisms of compensating workers remain an issue.

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87 Byssinosis has at least one counterpart in the slow recognition of the link between chronic bronchitis/emphysema and coal mining. See N. Wikeley, ‘The Prescription of Chronic Bronchitis and Emphysema’ (1994) 23 Industrial Law J. 85.
90 ‘Workers in Cardrooms’ (7 June 1941) i Lancet 728.

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