

QBE INSURANCE ISSUES FORUM

NOVEMBER 2005



QBE
European
Operations

MUSCULOSKELETAL DISORDERS

BACKGROUND

Musculoskeletal Disorders (MSDs) are the most common form of work-related ill health in the UK. Given this, their management and prevention remains a priority for British industry.

Is it possible to prevent MSDs? Given that susceptibility varies considerably between individuals, it would be extremely difficult to prevent all MSD related ill health. How then, can this important area of exposure be effectively managed?

In the following *Issues Forum* we examine the impact of MSDs on industry, review recent case law and present a risk-managed approach to managing MSDs in the workplace.

OVERVIEW

MSDs include a range of problems such as lower-back pain, joint injuries and various types of repetitive strain injury. Collectively they constitute the most common class of occupational illness in the UK today. Figures released by the Health and Safety Executive (HSE) suggest that over 50 per cent of individuals believe they have suffered musculoskeletal symptoms as a result of their work.

The latest published survey of self-reported work-related ill health indicates that in 2003/04 around 1,108,000 people in the UK were affected by an MSD which they believed to have been caused, or made worse, by their current or past work. Broadly, this reflects:

- 11.8 million working days lost (full-time equivalent)
- An average 19.4 days off work per year per employee affected
- An average 52,000 days lost per year per 100,000 workers
- An annual cost to industry of between £5.9 and £6.2 billion



DEFINITION: MSDs

The term Musculoskeletal Disorders refers to a group of conditions affecting the nerves, tendons, muscles, ligaments and other soft-tissue supporting structures. It covers a wide spectrum of disorders, ranging in severity from mild forms, (causing periodic symptoms), to severe chronic and debilitating conditions.

Examples of MSDs include lower-back pain, carpal tunnel syndrome, tenosynovitis and tension neck syndrome. Symptoms range from pain, numbness and tingling, through to permanent or temporary disability. MSDs routinely result in employees spending more time off work, becoming less productive and/or becoming unable to perform certain tasks.

MSDs may be either recognised diseases, such as tenosynovitis, or generic conditions such as lower back pain. MSDs are constitutional conditions, but may be aggravated by personal or work-related factors. Upper Limb Disorders (ULDs) is the term used to refer to a subset of MSDs affecting the region from the tips of the fingers to the shoulder, extending into the neck.

IMPACT ON INDUSTRY

The industry sectors reporting the highest prevalence of MSD-related ill health include: construction, agriculture, hunting and forestry, health and social work, transport, storage and communication – in particular post and telecommunications.

'Revitalising health and safety' (RHS) is a 10 year strategy jointly launched by the UK Government and the Health and Safety Commission (HSC) that sets out specific health and safety improvement targets, under a 10 point strategy and with 44 specific action points.

RHS established, for the first time, a set of measurable health and safety targets, including:

- a 20 per cent reduction in work-related ill health
- a 30 per cent reduction in working days lost

The statistical progress report released by the HSE in November 2004 reported a fall in the incidence rate of work-related MSDs between 2001/02 and 2003/04, from 750 employees per 100,000 to 640. However, once other forms of work-related ill health are factored in, there is no clear evidence of a change in the incidence of work-related ill health or the number of working days lost.

In 2004/2005 the HSC identified MSDs as a priority programme. During this period a number of initiatives have been delivered including:

- *Backs!* 2005, an HSE campaign which engaged a range of public stakeholders in raising awareness of how to manage the risks associated with work-related back pain. QBE played an active role supporting *Backs!* 2005, and was the sole representative of the insurance industry. Due to the success of the campaign, the HSE is planning a *Backs!* 2006 event, and will also be supporting a Euroweek 2007 event dedicated to MSDs.
- Publishing guidance for managers in industry on related issues (e.g. *Getting to grips with manual handling*, a booklet explaining the problems associated with manual handling and setting out best practice for dealing with them).



QBE MSD CLAIMS EXPERIENCE

QBE has analysed claims experience to understand the prevalence of MSDs within industry and the cost of MSD claims to QBE insureds. Our findings reveal a similar prevalence of MSD related ill health to that reported by the HSE and within similar industries.

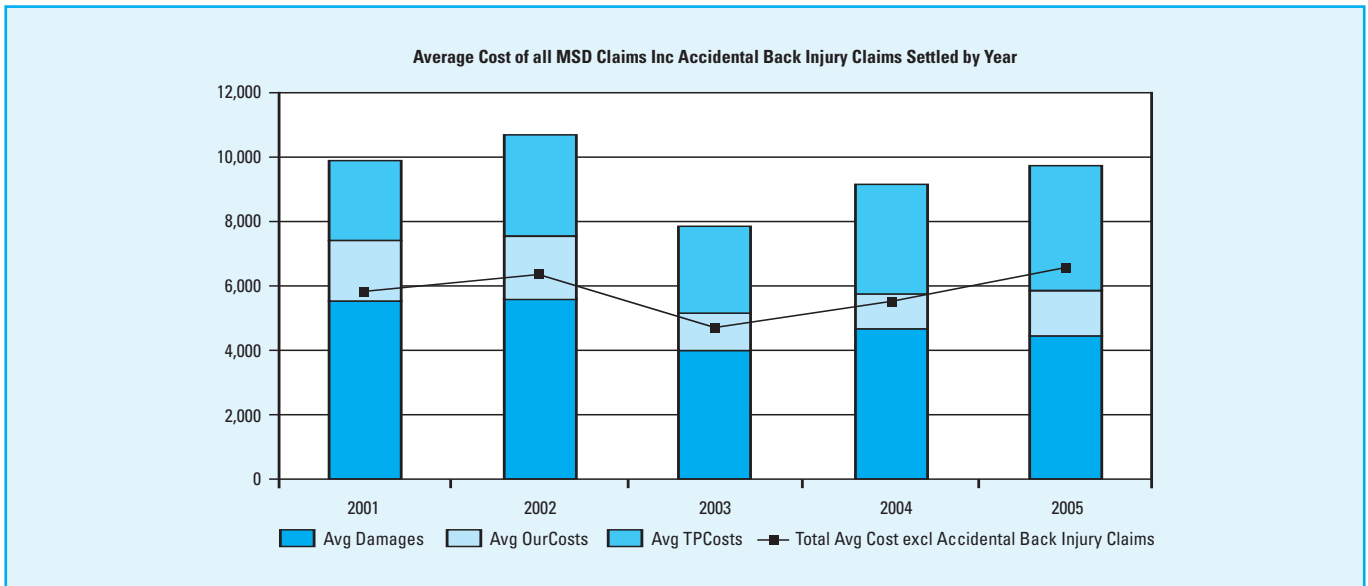
When considering whether a specific MSD claim is capable of defence, foreseeability and medical causation are key factors. It is not always a simple matter, to determine whether there is 'a real risk of injury'. It may also be necessary to identify what preventative steps could or should have been taken that might have influenced the outcome. Claims may fail because many MSD conditions are considered to be constitutional in origin or to be either caused or aggravated by factors outside the workplace.

When MSD claims are successful, the overall cost tends to be relatively high. Graph 1 reveals that between 2001 and 2005 the average spend on MSD cases where damages were payable ranged from £8,000 to £10,500. The actual level of damages payable remained reasonably static over the period. The increase in legal costs and fee spend over time, as a proportion of the total paid, is attributable to the introduction in 2000 of the additional liability regime for claims funding in England and Wales – specifically conditional fee agreements and after the event insurance.

One of the difficulties with MSD conditions is that there is often no objectively verifiable medical evidence that would allow an employer either to substantiate or disprove the claimant's complaints. Pain is a highly subjective phenomenon.



GRAPH 1 – AVERAGE COST OF QBE SETTLED MSD CLAIMS

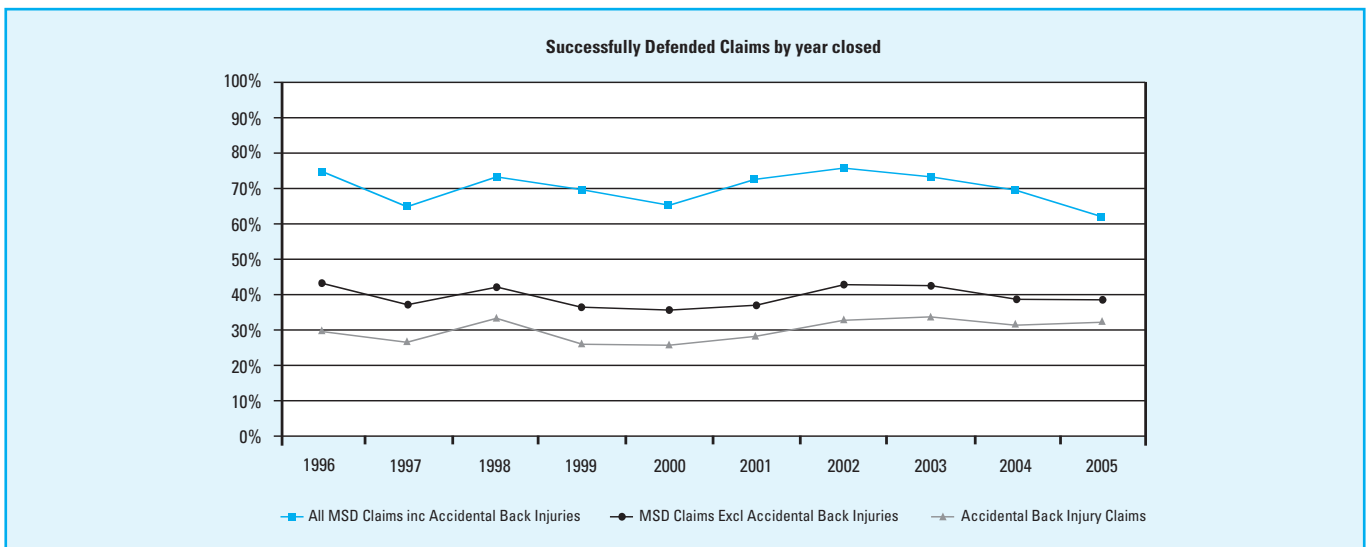


Where MSD claims are contested, the key defences are:

- i. Common law duties of care – no breach
- ii. Regulatory duties – no breach
- iii. Causation - even if a breach has occurred, on the basis that the breach did not:
 - cause or materially contribute to the development of the condition
 - aggravate a constitutional condition
 - accelerate the onset of a constitutional condition
 - prolong symptoms in an otherwise constitutional condition

Analysis of claims data reveals that the failure rate for MSD claims, from a plaintiff perspective, ranges from 35 to 45 per cent. For back injury cases the rate fluctuates between 25 and 35 per cent. This compares with overall failure rates of around 25 per cent for employers’ liability accident claims.

GRAPH 2 – PROPORTION OF QBE MSD CLAIMS RESOLVED WITH NO DAMAGES PAYMENTS BY YEAR OF CLOSURE



CIVIL LIABILITY

In interpreting the regulations and assessing the foreseeability of risk, an element of realism must be applied. For MSD claims to succeed, claimants must establish a causative link between exposure and injury. In simple terms, this means determining whether the alleged breaches actually led to the injuries sustained, either in whole or part. Causation is judged broadly. If workplace exposure, taken together with factors outside the workplace, has materially contributed to injury, damages may be payable, at least in proportion to the extent of the contribution.

A further complication occurs where medical evidence reveals an underlying constitutional cause or weakness. Disputes arise as to the extent to which workplace exposure has contributed. Where workplace exposure is seen as having merely extended the natural time to recover by days or weeks, damages payable may be limited to relatively small sums – although costs may still be very substantial. In many cases, however, a workplace incident or exposure is identified as being the principle causative factor.

For a claim to succeed, injury must be shown to have arisen directly from a breach of duty on the employer's part. Whilst common law concepts of foreseeability remain important, our experience is that most cases are pursued on the basis of an alleged breach of regulation. Return to work management is also important once the employer has become aware that an employee may have incurred a sensitivity or weakness increasing the risk of recurrence.

MEDICAL CAUSATION

By way of example, in the case for *Warner v Huntingdon District Council (2002) LTL 16/5/2002*, a refuse collector claimed that repeated lifting of refuse sacks had led to chronic back pain and forced him to give up work. It was shown that, irrespective of whether a breach in regulation or statutory duty could be proved, medical evidence did not demonstrate that any such breach had caused the injury, the case was dismissed. (See also *Spencer v Boots LTL 31/10/2002*.)

In *Mughal v Reuters News Agency (1993) IRLR 571*, a desk editor at news agency Reuters claimed for repetitive strain injury allegedly caused by work completed between 1987 and 1989. Judge Prosser QC found at first instance that the medical evidence presented left the diagnosis 'repetitive strain injury' open to question. This was not a condition recognised by mainstream medicine. By contrast, damages have been payable in many other cases where the medical experts made a specific diagnosis of a condition related to workplace exposure.

DUTY OF CARE – STANDARD AND BREACH?

If medical causation is established, the focus shifts to the issue of breach of duty. For instance, the *Manual Handling Operations Regulations 1992 (amended 2002)* establish a standard requiring an employer to:

- avoid requiring employees to carry out manual handling involving a risk of injury
- complete a risk assessment where manual handling is unavoidable
- introduce controls to minimise the risk as far as is reasonably practicable

(Regulation 4.1)

Whether or not the defendant is in breach of regulatory duty is determined based on the facts and evidence of each case. This requires carrying out an investigation comparing the reality of the workplace regime with the employer's duties as set out in relevant regulations, codes of practice, guidelines or indeed legislation.

LEGAL CAUSATION

When interpreting regulations, for instance, the standard of care and requirement for positive action on the part of the employer will be judged in the light of:

- the likelihood of injury arising
- the potential severity of injury involved, and
- practical steps which could be taken to minimise the risk and consequences

Even where an arguable or technical breach exists, the question must be asked: did this make a difference? The answer could be no, because compliance with the relevant duty would not have made the workplace safer. In such circumstances any breach is factually immaterial.

By way of example, in *Koonjul v Thameslink Healthcare Services NHS Trust (2000)* Lady Justice Hale found that 'making beds' (and, in the process, moving beds away from walls) was an innocuous task presenting a low risk. She found it 'beyond the realms of practicability' for an employer to reduce this risk further. Thus no causative breach of regulation was found.

In *Spencer v Boots the Chemist (2002)* it was held that the development of a specific shoulder condition could not have been foreseen – irrespective of whether a risk assessment had been carried out. The lack of assessment was found to be immaterial.

Thus liability is not automatic where a risk assessment has not been undertaken. Equally, completion of a risk assessment is no guarantee of a successful defence.

CONTESTING UNMERITORIOUS CLAIMS

The key to creating the safest possible workplace, with the secondary benefit of improving prospects of defence, is to implement all practicable measures to reduce the risk to its lowest possible level. Carrying out a risk assessment should lead to selecting appropriate controls, establishing safe systems, training employees in those systems, and highlighting residual risks. Once employers have established systems, they must actively implement them.

In the claims arena, two recurrent themes are: 1) neglect in documenting steps taken to create and implement safe systems of work and 2) failure to archive such documents – preventing them from being produced in evidence. When dealing with a claim, it is important to build up a body of evidence that presents a clear picture of the work tasks said to be relevant. Defendants should be prepared to challenge any inconsistencies in the account given by the claimant.

A full review of medical records will always be required. Evidence from engineering experts may also be necessary to provide an account of the system of work and how this compares with that prevalent within the industry. Although these tasks can impose considerable demands on management time for the employer, the rewards can also be significant in terms of cost savings, claims containment, and prevention of future recurrence.

THE FUTURE

UK plc has invested significant resources in improving safety standards and reducing the number of accidents at work, but equivalent investments and improvements have not been achieved in Occupational Health (OH) terms. The government has recognised this gap and developed *Securing Health Together, an Occupational Health Strategy for England, Scotland and Wales*, which sets out how current levels of work-related ill health can be managed.

With over two million people suffering from work-related ill health, there is a clear need for industry to embrace a strategy that addresses this issue. The risk managed approach set out below focuses on helping you develop a robust strategy for tackling MSD related ill health. It can and should, also be used as a framework for managing other forms of work-related ill health.

RISK MANAGED APPROACH

When reviewing or establishing an MSD risk management system, it is important to focus on preventing MSD ill health and managing any MSDs that may result from unavoidable workplace activities.

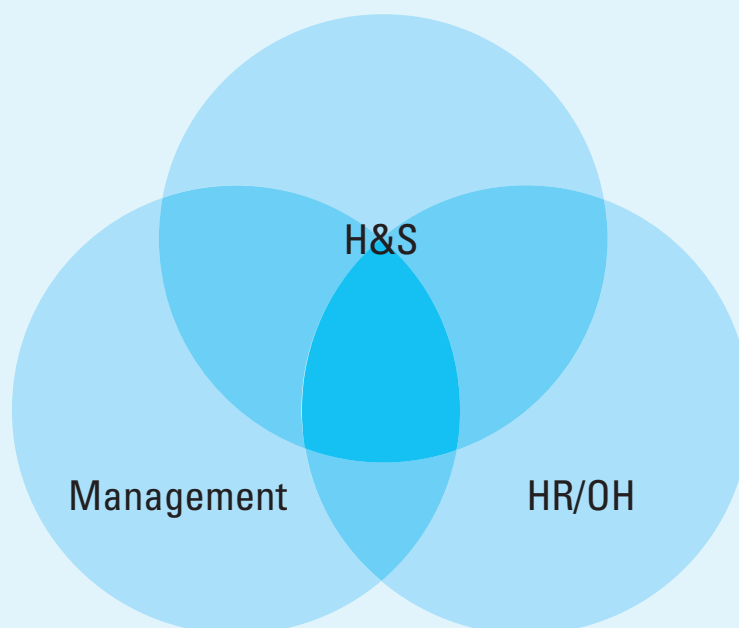
The approach outlined here embraces the HSE's seven-stage risk managed MSD approach . It identifies opportunities to build robust liability controls that will lead to reduced accident and claims frequency rates and improve defensibility. Achieving this will provide your QBE underwriters with the information they need to support you in positively managing your Employer's Liability (EL) insurance programme.

Central to managing any form of work-related ill health is a tripartite relationship engaging the key stakeholder constituencies within your company: health and safety, OH/HR and management.

Different functions become engaged at different times in managing exposures resulting from a reported instance of work-related ill health. The health and safety function will often undertake an investigation, re-assess risk factors and recommend any appropriate changes to be implemented. The OH/HR function will often supervise treatment of the reported ill health, monitor absence and arrange the employee's return to work. Management often reacts to absence and oversees the employee's reintroduction following their initial return to work.

Successfully managing any form of work-related ill health requires joined-up thinking on the part of all these stakeholders. In order to understand the magnitude of the issue fully and to develop a coordinated approach to its management, all three functions must communicate effectively with one another.

The approach outlined below highlights where the functions overlap and recommends appropriate responses on the part of each stakeholder constituency.



WHAT MIGHT CAUSE MSDs IN YOUR WORKPLACE?

Effectively managing any exposure requires understanding its potential magnitude. HSE guidance includes a great deal of material covering methodologies, that can help you understand your MSD exposure.

The following indicators offer an insight into your MSD potential:

- Having a robust near-miss reporting system will help identify potential MSD risks which do not necessarily show up in ill-health or claims reports. This information will highlight areas of exposure to be addressed in your risk management plans.
- Analysing accident data for MSD trends will allow you to pinpoint specific areas of causation, enabling you to tailor your plans to address these specific risks.

This of course requires that reports are accurately recorded by causation.

- Assessing risk using the HSE's risk assessment filter provides a structured approach to identifying key MSD risk factors. This focuses on factors such as repetition, posture, force, the work environment, psychosocial factors (e.g. do employees work to deadlines, are they paid for piecework, is there lack of support from supervisors?) and individual differences. The filter allows you to identify risks and develop an action plan with controls that minimise risk as far as possible.
- Analysing absence from work data can help you identify whether or not absences are work-related, determine the root cause of absence, and measure its severity. Analysing this information allows you to focus on the key areas in which your business is incurring costs due to absence.

QBE also advocates that you work with your insurer to analyse claim trends, costs, and their impact on your EL insurance programme. Using a selection of indicators to measure this potential will enable managers in the areas of risk, insurance and health and safety to quantify the impact of MSDs on your business accurately – and to build a business case to support specific strategic plans for dealing with MSDs.

The data generated by these types of exercise then needs to be collated and a focussed plan established to address any gaps and/or exposures identified.

PREVENTION AND MANAGEMENT – ONE STRATEGY, TWO APPROACHES DESIGN

Wherever possible, the optimum response is to re-engineer work systems to eliminate risk factors associated with MSDs (for example redesigning the work task, or substituting a tool through automation). It is well worth undertaking a risk assessment when preparing capex projects, relocating to new premises, planning process modifications, or re-deploying individuals to new areas. Properly documenting such assessments will help you demonstrate, as and when a claim arises, that you have applied a risk management methodology to eliminate MSD risk, or reduce it as far as is reasonably practicable.

At this stage you should carefully consider whether you have the full range of skills and expertise required to undertake this exercise in house. It may be prudent to employ the services of a specialist ergonomist who can assess the work environment and help identify practical, cost-effective strategies for controlling the risk factors present. An ergonomist will be able to suggest interventions appropriate to specific individuals – both in relation to the specific tasks they are required to perform and their work environment.

Where risks cannot be eliminated, you should apply a structured approach to identify the potential, assess the impact, determine and implement controls to reduce them as far as reasonably practicable.

PRE-EMPLOYMENT

All employees should undergo a pre-employment medical as a matter of course. The screening tool provides you with a medical history highlighting any contra-indications or susceptibilities to developing a MSD. This allows you to select individuals who are fit for their intended role. It is now commonplace within industry to use a written medical questionnaire. This can provide the trigger for initiating a physical medical with an occupational health physician. However QBE would recommend requiring a physical medical for all positions involving a significant amount of manual handling and lifting. This provides documented evidence that you have sought to understand the employee's capabilities and to ensure that these are well matched to the tasks they will be required to perform. It is important for your HR team – or any other function that may be responsible for recruitment – to liaise with line managers and your Occupational Health Practitioner (OHP) to establish pre-employment criteria and determine appropriate responses once this information is received.

JOB DESCRIPTION – DEFINING THE JOB

Before recruiting a new employee or agency worker you should formulate and document a job description identifying the tasks and risks involved in the job. This provides the mechanism for informing the potential candidate of job demands and risks, and can be used by the OHP when assessing an individual's fitness to perform the job. It also provides a vehicle for educating employees about potential risks, as well as an opportunity to raise any concerns regarding their capacity in line with the requirements of the *Management of Health and Safety at Work Regulations (amended 2002)*. Putting this process in place will require your HR function to work with line managers and shop floor personnel.

INDUCTION

Building on the job description, it is vitally important that both employees and the front line management who supervise them are aware of the potential MSD risks of the particular tasks they undertake. Induction provides an opportunity for employers to i) adequately train employees and supervisors in the risks of the task, ii) inform them of the reporting systems through which symptoms or potential risks can be reported, and iii) provide documented evidence of this training. It is also important for HR to work with line managers and shop floor personnel in developing this induction.

TRAINING

Any job-related training, whether manual handling or otherwise, should reflect the specific tasks involved in the role, the environment in which it is carried out, and any specific consideration relevant to particular individuals. Manual handling training is often now delivered in the form of an 'off the shelf' package showing the employee how to lift a box in a controlled environment. QBE recommends ensuring that the training you provide properly reflects the specific nature of the job, the working environment and the weights handled.

You might wish to consider developing your own customised training video demonstrating correct handling and lifting techniques, highlighting risks where appropriate, and showing the safe systems of work you have established in the actual environment in which they will be put into practice. Evidence of this training should be documented to validate the risk managed approach you have taken in highlighting systems of work, residual risks and technical aspects of correct handling technique.



FUNCTIONAL CAPACITY EVALUATION

An additional tool you can use in conjunction with the pre-employment medical is the Functional Capacity Evaluation assessment (FCE). The purpose of this tool is to assess a person's physical ability to perform specific work, predict their potential ability to perform work after a rehabilitation program, and assess their level of functionality. FCEs can be used to simulate the task demands (i.e. force, posture, repetition, flexibility, coordination and body mechanics) of a job, to assist in measuring employees' capacity to perform in a controlled environment. It should be stressed that FCEs should not be used in isolation, but alongside medical questionnaires, physicals and employment interviews.

Combined with the input of an OH physician, the quantitative output from FCEs provides employers with objective data on their fitness to perform specific tasks and enables them to deploy individuals in work environments suited to their capacities.

The FCE tool is most commonly used to measure a person's capacity prior to returning to the workplace, to perform the same tasks as previously or alternative duties following time off work. Whilst an FCE assessment provides the employer with objective evidence to support a return to work, the support of the employee and their GP should also be secured prior to their return.

FCE assessments may not be suitable for all employees – particularly those with medical conditions that might put them at undue risk or result in them performing tasks that exceed their capacity. For this reason is very important to consult an occupational physician before employing FCE assessments as part of your OH programme.

REPORTING SYSTEMS

For rehabilitation to be effective, early reporting of the signs and symptoms of MSDs is essential. Employees should be educated in recognising these, and made aware of the process for reporting them. Reporting need not necessarily lead to time off work, but it should help to ensure that potential risks are managed proactively. If absence is reported to HR, this should trigger communication with the health and safety function to enable proactive steps to be taken in assessing and controlling the risk.

As previously mentioned, it is important that the categories under which you classify causation allow you to record incidents accurately. It may be advisable to consider reviewing the RIDDOR causation codes used by the HSE and include additional codes that will allow you to record all possible MSDs accurately. Not only will this aid you in analysing MSD trends, but, should any reports lead to a claim being made, having accurate data on file will enable your insurer to code claims by their true causation and deliver accurate claims analysis.



MSD INCIDENT

Early medical intervention and investigation is of paramount importance when an employee makes a report. It may be that an employee has reported discomfort, but can and does return to normal duties. Where this is the case, it is important to advise your OHP, noting the type and onset of symptoms, and refer the employee as and when they experience renewed discomfort subsequently.

Where an employee has reported MSD ill health, they should be redeployed from work tasks thought to be causing problems to other duties that do not make the same physical demands. Early medical intervention is crucial in controlling severity of injury. Where injury is acute, medical attention should be sought from and provided by your OHP at the first possible opportunity. Where applicable, you should also seek a specific diagnosis from the treating GP.

It is critical that you commence an investigation into any reported ill health, to determine its root and contributory causes. Gathering contemporaneous, factual data will be critical to building a sound defence, should the employee subsequently lodge a claim.

When carrying out your investigation into the root cause of the ill health, you should assemble and review the following types of documents:

- The accident report form
- Witness statements
- Pertinent training records (e.g. inductions, manual handling, display screen assessment)
- Job description
- A chronology of work history
- Other reports made where the same process is involved
- OH records
- Policy statements and safe system of work relevant to the task concerned
- Risk assessments
- Photographs or film of the work process/work environment

These documents will form the basis on which the case for defending or settling a claim is built. Claimants have three years in which to bring a claim, so gathering this information at the time of the incident is crucial. Should a claim be lodged in future, you will want be sure that all factual data has been captured and is available for review by your claim inspector.

REHABILITATION

The first step for any company offering rehabilitation will be to set out its approach to injury management, rehabilitation and Return to Work (RTW). Identifying an OHP who can support your OH programme is imperative, this should include: pre-employment, health surveillance, well being and rehabilitation.

It would be prudent to consult not only your nominated OHP but also your employees as to what should be covered by the rehabilitation policy. This will encourage ownership and support. The policy should identify:

- What constitutes an MSD
- How injuries are managed
- The details of the OHP
- The importance of early reporting
- Details of the reporting procedure
- Referral triggers
- Expectations of treatment/rehabilitation
- What alternative (light) duties can be offered
- Nomination of an internal Injury Management Coordinator (IMC) who can liaise with key stakeholders e.g. the injured employee, the treating practitioner, the case manager, and the line manager – to ensure effective communication and a coordinated response to the employee's rehabilitation. This role could be incorporated within an existing function such as HR

When an employee seeks the services of their own GP, it is important that you, as the employer, effectively communicate the company rehabilitation policy to the medical practitioner. Highlight what support the company offers, what alternative duties can be provided, an understanding of the employee's job (detailing the kind of tasks undertaken) and the graduated RTW systems in place to assist the employee in re-entering the workplace. This makes it easier for GPs, who are unlikely to be familiar with your business operations, to support the employee through the rehabilitation process and thereby minimise the likelihood of prolonged absence and higher claim costs.

RETURN TO WORK

When an employee has been certified to return to work, it is critical that the employer has the systems in place to support a successful return. The IMC can coordinate an RTW meeting at which the employee's line manager can ensure that the RTW plan (highlighting work restrictions and changes to duties) is clearly communicated and understood. It may be necessary to ensure that regular reviews are undertaken every few weeks until the employee returns to full or pre-injury duties.

ABSENCE MANAGEMENT

As previously noted, absence monitoring provides data that can be analysed to help understand the root causes of injury related absence. Just as it is vital to record the cause of accidents accurately, it is important to be able to identify the root cause of absence (e.g. MSD, ill health, stress etc). Once the root causes are identified, the management team should develop a plan to address absence, establishing targets and key performance indicators (e.g. severity rates, total number of absence reports, percentage of employees taking more than allocated leave) which can be used to monitor progress and evaluate effectiveness of responses.

CLAIM PROCESS

Should an MSD claim be lodged, it will be crucial that you can supply your insurer with all relevant information pertaining to the individual's employment (see MSD incident above), alleged ill health or injury, and details of rehabilitation offered. Collating this type of information will enable your claim inspector to work efficiently with you in building a strong defence against the claim allegations. The three-year limitation applies to individuals bringing a claim against an employer for injuries sustained during their employment. If you can assemble this information at the time of the report; it is much easier to proceed with handling the claim efficiently, which will ultimately lead to reduced claim costs.

CLIENT FEEDBACK

As an insured, you should expect to understand how the claim inspector assesses the various aspects of a claim and consults with you in reaching a decision as to whether a particular claim is one to settle or defend. It is from these discussions that you can learn what gaps may have been present in your defence and where robust strategies are required to improve health and safety systems and build a more secure platform for defence.

FURTHER CONSIDERATION

Much has been written on the subject of MSDs and you will no doubt have systems in place to manage this area. Our intention in this *Issues Forum* has been to provide some additional support around guidance available elsewhere, and to propose a liability-centred approach to managing what is currently the most common form of work-related ill health.

We expect you will already have integrated some or all of the approaches covered above into your MSD Risk Management Plan. In the former case, we hope you may be able to cherry-pick additional interventions that align with your systems and can enhance the robustness of your liability controls. In the latter case, we hope we have at least provided you with a useful 'health check' on your current system.

For further information or support, please consider talking to a member of the Liability Risk Management team.

AUTHORS

Emma Zotti, Liability Risk Manager

Emma Zotti began joined QBE in 2004 from Ernst & Young, having previously been a health and safety consultant in both Australia and the UK. Prior to this, she worked for eight years in the manufacturing and mining industry in Western Australia for CSR Limited and has wider practical health, safety and environmental management experience in the building and finance industries. Emma holds 'Bachelor of Physical and Health Education' and has also completed a Graduate Diploma in Occupational Health and Safety (MIOSH).

Julie Dixon, Claims Controller, Strategic Claims Team

As a Claims Controller in the Strategic Claims Team, Julie Dixon handles sensitive and high value claims. In addition, she provides support for the audit function and the organisation of technical training. Julie acts as a point of referral on technical matters for both Claims and Underwriters within QBE.

REFERENCES

1. HSE website - MSD home page: www.hse.gov.uk/msd/
2. HSE website – MSD Statistics: www.hse.gov.uk/statistics/causdis/musc.htm
3. HSG 60 – Upper limb disorders in the workplace

ADDITIONAL INFORMATION

Please download supporting documents, tools and information at: www.qbeeurope.com/LRM



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