Welcome

Welcome to this week’s edition of BC Disease News.

This week, we hosted the first of our mesothelioma breach of duty conferences, titled: ‘Bussey: Where Next?’ in Leeds. Our London conference will be taking place on 31st May. If you wish to book a place at the conference later this month, you can find the appropriate contact details here.

In this edition, we examine the High Court authority of *R.G. Carter Building Limited v Kier Business Services Limited* [2018] EWHC 729 (TCC), in which the judge gave an answer to the question: from what point does limitation begin, under s.10(4) of the Limitation Act 1980, if a party wishes to proceed with a contribution claim, in respect of the costs of settlement.

In addition, we report on a recent study, which did not find evidence of a definitive link between mobile phone use and brain cancer development, despite newspaper headlines implying the opposite. In the same article, we report that legal proceedings have been brought against Nokia. The claimant developed an acoustic neuroma tumour and attributed this to years of mobile phone use.

In this week’s feature article, we look into sheep scab and the effect of a common treatment method, sheep dipping, on associated workers. We do so after recently published data conveyed a 40-fold increase in sheep dipping over the past half-decade.

Any comments or feedback can be sent to Boris Cetnik or Charlotte Owen.

As always, warmest regards to all.

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On 5 April, the High Court handed down judgment in the case of *R.G. Carter Building Limited v Kier Business Services Limited* [2018] EWHC 729 (TCC). This case questioned the proper construction of s.10(4) of the Limitation Act 1980 in respect of a contribution claim. Was the claim statute barred?

Arbitration proceedings were brought against the claimant. A settlement agreement, in principle, was reached during April of 2015, but the official agreement was signed on 29 June 2015. Subsequently, on 20 September 2017, the claimant issued proceedings agains the defendant for a contribution of £205,908.60, in respect of the costs of settlement. The defendant submitted that the contribution claim was statute-barred, under the Limitation Act, when the parties entered into a standstill agreement, on 28 April 2017.

Section 1 of the Civil Liability (Contribution) Act 1978 states that ‘any person liable in respect of any damage can recover contribution from another person liable in respect of the same damage’ and, specific to the case of Carter, s.1(4) provides that:

‘A person who has made or agreed to make any payment in bona fide settlement or compromise of any claim made against him in respect of any damage… shall be entitled to recover contribution in accordance with this section…’

However, contribution claims are subject to restrictions afforded by the Limitation Act. Section 10(1) provides that no action to recover a contribution may be brought from the date on which the right to recover is accrued. Pursuant to s.10(3), the right is deemed to have been accrued after the expiry of a two year period from the date of judgment or settlement award against the party seeking contribution. Alternatively, pursuant to s.10(4), the right is accrued from the earliest date on which an agreed settlement is made.
For the purpose of Carter, the issue was ‘whether time runs under section 10(4) only once the parties have entered into a binding agreement for the payment of compensation, as Mr Walker QC [claimant Counsel] submits, or whether something short of a binding agreement is sufficient to start time running, as Miss McCafferty [defendant Counsel] submits’.

Mr Pepperall QC, at the High Court, considered the case authorities on the s.10(4) requirements. In Aer Lingus plc v Gildacoff Ltd [2006] EWCA Civ 4, Rix LJ found that an agreement, under the sub-section, must be in relation to ‘the amount of the payment and not merely as to liability’. Further, Morris J, in Spire Healthcare Limited v Brooke [2016] EWHC 2828 (QB), ruled that the date of agreement runs ‘from the date of agreement of the final sum to be paid’.

Counsel for the defendant argued that the sub-section did not necessitate a binding agreement, instead that an agreement in principle would suffice. It was submitted that, even though the defendant’s interpretation of s.10(4) was to be contrasted with s.1(4) of the 1978 Act, which requires binding settlement, Parliament could have explicitly stated, within the Limitation Act, that a binding agreement is obligatory, if that had been its intention.

Moreover, defendant counsel cited McGee on Limitation (7th edition), at paragraph 15-024:

‘Section 10(4) states quite clearly that time runs from the date on which the amount of compensation is agreed. In out-of-court settlements there may well be a number of other matters requiring to be agreed, such as date of payment, possibility of instalments and method of payment. However, none of these has any relevance. Agreement on them will not set time running but absence of agreement on them will not prevent it from running – it is only the amount of compensation that must be agreed’.

Indeed, Knight v Rochdale Healthcare NHS Trust [2003] EWHC 1831 was a case where the agreement as to the settlement sum, without agreement as to the method of payment, was enough to start the limitation clock.

By contrast, counsel for the claimant submitted that the natural meaning of ‘agreed’, under s.10(4), infers the existence of a binding agreement. On the interpretation pursued by the defendant, limitation would begin running before the claim for contribution, under the 1978 Act, arose. The claimant cited the case of Baker & Davies plc v Leslie Wilks Associates [2005] EWHC 1179 (TCC), which, unlike Knight, found that limitation ran from upon the execution of the subsequent settlement agreement, rather than from the agreement of a proposed settlement on a subject to contract basis.

Mr Pepperall QC agreed with Rix LJ, in Aer Lingus, in stating that s.10(3) and (4) are mutually exclusive and, as a result, limitation cannot start to run if an unenforceable agreement is reached.
The judge favoured the construction of the defendant, i.e. that a binding agreement is relevant to the date on which the right to recover is accrued. He perceived this to be necessary for the ‘interplay’ between the 1980 and 1978 Acts, as claimant counsel had highlighted. Following the approach taken in Baker, Mr Pepperall QC determined:

‘It will be evident from my earlier review of the evidence that the negotiations during April 2015 were expressly conducted on a subject to contract basis ... Binding terms as to the payment in kind were only agreed upon the execution of the settlement agreement on 29 June 2015.

In view of this finding and my conclusions as to the proper construction of section 10(4), it follows in my judgment that this contribution claim is in time’.

The judge went on to set out his conclusion, in the event that he was wrong as to the proper construction of s.10(4). Earlier in his judgment, he stated that ‘if something less than a binding agreement suffices, it is entirely unclear what lower standard is to be applied’. Mr Pepperall QC established that there had not been, in any event, agreement as to the payment.

Consequently, the defendant’s limitation defence failed.

Full text judgment can be accessed here.


Last week, judgment was handed down in the case of Harrap v Brighton & Sussex University Hospitals NHS Trust [2018] EWHC 1063 (QB). The ruling demonstrates the importance of reviewing witness evidence and the adverse costs consequences of failing to do so.

The case involved a clinical negligence claim. It was alleged that the defendant Hospital Trust had failed to perform a cardiology review, which could have prevented the claimant’s stroke, in 2012. The claim was discontinued on the 3rd day of the trial.

In her judgment, Mrs Justice Lambert DBE considered the costs consequences of the action. The claimant argued that it should only bear the burden of costs up to the date of witness statement exchange, as evidence, fatal to the claimant’s case on factual causation, was adduced for the first time during trial cross-examination.

Did the ‘wholly new evidence’ create a change of circumstances?

The claimant submitted that the defendant had ‘failed to set out the full story’, thereby constituting good reason for the Court to depart from the general default position that discontinuing claimants should pay the defendant’s costs in their entirety.

The defendant argued that the discontinuance was ‘merely a smokescreen to avoid the inevitable costs consequences of a trial which was doomed to failure from the outset’ and the evidence relied upon having accelerated the discontinuance was irrelevant.

Rules on costs liability following discontinuance is provided for in CPR 38.6:

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<th>Liability for costs</th>
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<td>38.6</td>
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<td>(1) Unless the court orders otherwise, a claimant who discontinues is liable for the costs which a defendant against whom the claimant discontinues incurred on or before the date on which notice of discontinuance was served on the defendant.</td>
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<td>(2) If proceedings are only partly discontinued –</td>
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<td>(a) the claimant is liable under paragraph (1) for costs relating only to the part of the proceedings which he is discontinuing; and</td>
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<td>(b) unless the court orders otherwise, the costs which the claimant is liable to pay must not be assessed until the conclusion of the rest of the proceedings.</td>
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<td>(3) This rule does not apply to claims allocated to the small claims track.</td>
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(Rule 44.9 provides for the basis of assessment where the right to costs arises on discontinuance and contains provisions about when a costs order is deemed to have been made and applying for an order under section 194(3) of the Legal Services Act 2007)

Claimants may escape the presumption that the liability for costs may shift, however. In Teasdale v HSBC Bank Plc [2010] EWHC 612, Judge Waksman QC stated:

i) When a claimant discontinues the proceedings, there is a presumption by reason of CPR 38.6 that the defendant should recover his costs; the burden is on the claimant to show a good reason for departing from that position;

ii) the fact that the claimant would or might well have succeeded at trial is not itself a sufficient reason for doing so;
iii) however if it is plain that the claim would have failed, that is an additional factor in favour of applying the presumption;
iv) the mere fact that the claimant’s decision to discontinue may have been motivated by practical, pragmatic or financial reasons as opposed to a lack of confidence in the merits of the case will not suffice to displace the presumption
v) if the claimant is to succeed in displacing the presumption he will usually need to show a change of circumstances to which he himself has not contributed;
v) however, no change in circumstances is likely to suffice unless it has been brought about by some form of unreasonable conduct on the part of the defendant which in all the circumstances provides a good reason for departing from the rule’.

These requirements were approved by Moore Bick LJ in the case of Erica Brookes v HSBC Bank [2011] EWCA Civ 354. Further, the displacement of CPR 38.6(1) is a high threshold to satisfy, per Beatson LJ in Nelson’s Yard Management Co v Eziefu [2013] EWCA Civ 235.

As such, the judge highlighted that she ‘must find that there has been a change of circumstances (and if so, separately, that ... it is due to the unreasonable conduct of the Defendant ...) to which the Claimant has not contributed’, to displace the burden.

CHANGE OF CIRCUMSTANCES?

Firstly, Lambert J stated, at paragraphs 20 and 21:

‘I find that there has been a change of circumstances as a consequence of the new evidence which was elicited at trial. The new evidence had a direct bearing upon the Claimant’s case and its effect was to shut down the claim on factual causation. Mr Mylonas found himself confronting a new factual scenario in respect of which he had no effective means of challenge.

Nor do I find that the Claimant or his team contributed to the change in circumstances.

UNREASONABLE CONDUCT?

On this question, Lambert J went on to reason, at paragraph 23, that:

‘I accept Mr Mylonas’ submission that, by oversight, salient details were omitted from the witness evidence. This failure to set out the full story was unreasonable. I note that no explanation for the absence of this evidence has been provided by the Defendant at any stage.

For these reasons, I therefore conclude that, on the unusual facts of this claim, the default position that, following discontinuance, the claimant should bear the entirety of the defendant’s costs should be displaced. I accept that the threshold for rebutting the presumption in CPR 38.6 is high, but I find that the threshold has been reached in this case’.

The judge ordered that the claimant should bear the defendant’s costs in the usual way, up to the date of the cardiologist’s December 2017 report, as opposed to the date of exchange of witness evidence, in July of 2016. Thereafter, each party was responsible for its own costs.

Full text judgment can be accessed here.

Conspiracy to Commit Misconduct in Sale of Information to GT Law

An ex-police officer has been ordered to repay £368,000 at a Chester Crown Court hearing, following an RTA claims conspiracy¹.

An investigation, conducted by Lancashire Constabulary’s Professional Standards, Integrity and Anti-Corruption Team, found that the former immediate response officer had sold over 20,000 accident logs to a business development manager at GT Law, over the course of 7 years.

Subsequently, the claimant personal injury firm contacted members of the public to whom the logs concerned, inviting them to pursue compensation claims. This was met with complaints, as affected individuals had not disclosed their personal details to anyone outside of the police. GT Law entered into administration in October of 2015.

In October of 2017, the discharged officer was given a 5 year jail sentence (reduced on appeal to 4) after pleading guilty to misconduct in a public office, conspiracy to commit misconduct in public office, money laundering and unauthorised access to a computer. Last week, at a proceeds of crime hearing, he was ordered to pay £368,000.

As for the conspiring business development manager, he had previously been given a two-year suspended sentence and a £115,000 confiscation order for conspiring with to convert criminal property (money laundering) and commit unauthorised access to a computer.

Ben Fletcher, Director of the Insurance Fraud Bureau, in reaction to last week’s Crown Court ruling, said:

‘This result is another victory in this shocking case. Mungur used his position as a trusted member of the police to capitalise on other’s misfortune, by selling their information illegally to companies that encouraged fraudulent insurance claims. It is only right that money he used to fund his extravagant lifestyle is recuperated, hitting him exactly where it hurts. Our message is clear, punishment doesn’t stop at a prison sentence, you will pay for your crimes in every possible way’.

S&G UK Closes Two Regional Offices, as £30 Million Investment is Prepared

Last week, Slater and Gordon’s UK operations, now separate from the Australian Stock Exchange listed entity, announced that it would be closing two of its regional offices (Fareham and Sheffield).
while also revealing plans to invest £30 million in new technology and services over the next three years. We last spoke about closures of S&G offices in Chester, Wrexham, Milton Keynes and Preston, in edition 210 [here].

The proposed cash injection of £30 million will be invested in ‘legal technology and growing areas of the law’. Chief Executive of S&G, David Whitmore, has said that the investment will attempt to grow the firm’s market share and capitalise on opportunities created by a reforming personal injury sector.

More Personal Injury Reform Scrutiny

We last spoke about personal injury reforms in edition 228 [here], when the House of Lords undertook the second reading of the Civil Liability Bill.

We also reported that the House of Lords Delegated Powers Committee were not convinced by proposals for vesting powers with the Lord Chancellor to set the tariff for damages, over judges or independent medical experts.

However, last week, Lord Keen argued that the Government should set out compensation for soft tissue injuries within a statutory instrument, after the Bill has been passed.³

‘Our view is that it is right to set the tariff through regulations, which will help to control those costs and ensure greater certainty to both claimants and defendants when they come to deal with these claims [and] This is essentially a matter of policy to deal with a very particular problem. It is a political decision; it is not one that we consider is for the judges; it is one that is ultimately for the lord chancellor to deal with in his capacity as a minister.’⁴

Since the committee stage of the Bill, MPs on the Justice Select Committee have voiced issues with the Government’s plans. The Committee recommends that the PI small claims limit should be £1,500 (uprated by the consumer price index since 1999), rising with inflation. It finds little credibility in the Government’s decision to raise RTA and PI claims to the figures suggested:

‘Given the potential complexity of these claims and the role of litigation in maintaining safe and healthy workplaces, MPs recommend that they be subject to a small claims threshold of £1,500’.⁶

The Committee also advised that the implementation date of the Bill should be delayed until April of 2020, in order to make sure that the Government can assure a ‘fully functional electronic platform’. This would require significant work and testing on a wide range of users. The Committee stressed that a ‘new online platform’ would not be appropriate for EL and PL claims, given the associated complexities.

The electronic platform system was also criticised by the Justice Select Committee for not yet overcoming the issue of ‘inequality of arms between professionally represented insurers and self-represented claimants’, especially regarding disputes on liability and quantum:

‘… we conclude that the government has not done enough to explain how claimants of limited means with legitimate claims are expected to finance court fees and expert reports’.⁷

Bob Neill MP, Justice Committee Chair, concluded that:

‘The small claims limit for personal injury should not be increased unless ministers can explain how it will make sure that access to justice is not affected.’

We will provide additional Civil Liability Bill updates in due course.

Erroneous Link Between Brain Cancer and Mobile Phones

Several news articles have reported that mobile phones use leads to an increase in brain cancer cases in England.⁸ ⁹ ¹⁰

However, in a recent study, although researchers reported that there had been an increase in the incidence of one type of brain tumour in England, no association with mobile phone use was identified.¹¹

The researchers investigated the number of brain cancer cases in England, between 1995 and 2015, and observed the variation of tumour incidence over time. Analysis showed that diagnoses of an aggressive tumour, known as glioblastoma multiforme (developing in the front temporal lobe), rose sharply during the study period. The numbers of cases of other brain tumours have either remained constant or decreased.

The study used data from the Office of National Statistics to determine the number of cancer diagnoses. There were no investigations into the lifestyles of the brain cancer patients, nor comparisons made between brain cancer patients and the remainder, who did not develop cancer. Since all that was investigated was the number of cases, the design of this study does not allow any conclusions to be made in respect of the cause of any changes.

There are, however, a number of factors that could explain the increase in this type of brain cancer, including improvements in diagnosis and changes in the way brain tumours are classified.¹² Other potentially causative factors, discussed in the paper, include mobile phones. It would seem that news articles have reported mobile phone use as a ‘likely cause’ of brain cancer cases, although the paper did not explicitly say this.

In spite of dramatic newspaper headlines, this British study does not provide evidence
of a link between mobile phone use and brain tumours.

However, this week, the Daily Mail has reported that an ex-salesman in the UK, has brought a claim against Nokia worth ‘up to £1 million’.

Neil Whitfield, 60, developed an acoustic neuroma tumour between his ear and brain. After a tumour removal operation, in 2001, he was left deaf in one ear and was subsequently unable to work. In this landmark case, Mr Whitfield has attributed long periods of mobile phone use to the cancer suffered. The implications for the mobile phone industry, should this claim succeed, could cost the mobile phone industry millions.

Nokia’s spokesman echoed the position of the Journal of Public Health and Environment article, on medical causation:

“All products comply with international exposure guidelines and limits that are set by public health authorities. The World Health Organisation factsheet states that “A large number of studies have been performed over the last two decades to assess whether mobile phones pose a potential health risk. To date, no adverse health effects have been established for mobile phone use”.

**Private Treatment in Non-Melanoma Skin Cancer Claims?**

A new study has estimated the total costs and the costs per case of newly diagnosed non-melanoma skin cancer (NMSC) attributable to workplace sun exposure, in Canada, in 2011. An estimated 2,846 (5.3%) cases of basal cell carcinoma (BCC) and 1,710 (9.2%) cases of squamous cell carcinoma (SCC) were attributable to occupational solar radiation.

The researchers investigated direct costs and indirect costs of NMSC. Direct costs included healthcare costs, out-of-pocket costs (travel to healthcare appointments, medicines, vitamins and supplements, and hotel costs) and informal caregiver costs.

Indirect costs included loss of income and home production costs (the cost of domestic tasks that the patient would not be able to do). They also considered intangible costs, i.e. the monetary value of the loss of health-related quality of life.

The combined total for direct and indirect costs of 4,556 occupational NMSC cases was $28.9 million, of which $15.9 million was for BCC and $13.0 million was for SCC. The total intangible costs for NMSC cases was $5.7 million, of which $0.6 million was for BCC and $5.1 million for SCC.

In terms of broken down costs per case, the average cost of a BCC case was $5,670 and the average cost of a SCC case was $10,555. The costs are higher for SCC because SCC has a lower survival rate, which results in higher indirect and intangible costs.

Canada sits at a similar latitude to the UK, which means that outdoor workers in both countries will be exposed to similar levels of solar radiation: Fort McMurray (Canada) and Dundee (UK) are both at 56°F degrees, Calgary and Winchester are both at 51°F, and Plymouth and Winnipeg are both close to 50°F. Some major Canadian cities are slightly further South, with Ottawa at 45°F and Toronto at 43°F.

Roughly 1 in 10 workers in Canada are exposed to solar radiation at work, and the majority of these spend 6 hours or more outdoors per day. In the UK, workers in agriculture, leisure, landscaping and construction are the most likely to be exposed to solar radiation.

The study’s main investigator, Dr. Emile Tompa, said:

‘The findings suggest that policy-makers might give greater priority to reducing sun exposure at work by allocating occupational cancer prevention resources accordingly’.

Recently, in issue 229 of BC Disease News (here), we reported that the Industrial Injuries Advisory Council has undertaken a review of occupational NMSC, and found that there is insufficient evidence to add NMSC to the list of diseases for which industrial injury disablement benefit may be claimed. As a result, it is possible that patients will attempt to bring private claims against their employer for direct, indirect and intangible costs in NMSC claims.

**Global Melanoma Data and UV Radiation**

The International Agency for Research on Cancer (IARC) has published a study into the global burden of melanoma of the skin attributable to UV radiation in 2012. The information is also presented on a website, where data can be filtered to produce tailored representations of data.

In the study, the researchers quantified the number of melanomas of the skin that are attributable to UV radiation. Figures for 153 countries were collected and then separated by age and gender. Comparisons were then made between melanoma cases and those with minimal exposure to UV. Researchers also compared melanoma cases with dark-skinned African populations who have low susceptibility to the effects of UV.

Results of the study found that Worldwide, there were at least 168,000 cases of melanoma, attributable to UV radiation, in 2012. This corresponded to 75.7% of all new melanoma cases and 1.2% of all new cancer cases. Positive cases were concentrated in highly developed countries and was most pronounced in Oceana, where 96% of all melanomas were attributed to UV radiation. If incidence rates in every population were equivalent to those in low-risk (dark skinned, skin with lots of pigment) populations, there would be approximately 151,000 fewer melanoma cases each year.

The IARC concludes that these findings underline the need for public health action. Its findings show an increasing risk of melanoma. It is important to improve public awareness as to the risk posed by UV radiation, especially, and to promote
changes in behavior as a means to reduce sun exposure worldwide.

The IARC has also launched a new website that allows users to explore the results of the study. The database gives information about the proportion of cancers, such as melanoma, that are attributable to UV radiation in different countries.\(^\text{16}\)

**Figure 1:**

![Relative proportions (by age group) of cancer cases in 2012 attributable to ultraviolet (UV) radiation exposure, among men and women of all ages (30+ years), by continent](image)

The first figure shows how the cases of melanoma attributable to UV radiation are distributed by age, for different continents.

**Figure 2:**

![Population attributable fraction (PAF) of melanoma cases worldwide in 2012, among men and women of all ages (30+ years), attributable to ultraviolet (UV) radiation exposure, by country](image)

The second figure shows what proportion of melanomas in each country are attributable to UV exposure.
Figure 3: 

The third figure shows the numbers of cases of melanoma attributable to UV exposure among men aged 35-49 in different continents.

Relevance to the UK?

This large set of data reveals which countries have similar patterns of melanoma, caused by UV exposure, to the UK. Employers may be able to extrapolate this data and estimate the extent of melanoma caused by occupational exposure to UV radiation.

Mesothelioma Onset by Asbestos: Environmental Versus Occupational Exposure

A new Turkish study, investigating malignant mesothelioma (MM) patients, has found that ‘Environmental asbestos exposure is as important as occupational exposure to develop MM and it has its own unique exposure features on the risk of MM’.\(^1\)

Mesothelioma is known to be strongly associated with asbestos exposure. Although the predominant source of asbestos exposure is found in workers who have been exposed to asbestos-containing materials, non-occupational exposure is also common. Sources of non-occupational exposure include:

- Handling clothing belonging to an asbestos-exposed worker which contains asbestos fibres (this may be referred to as para-occupational exposure);
- Living close to an asbestos mine, thereby susceptible to airborne fibre exposure;
- Living in a building with damaged asbestos materials, such as insulation boards; and
- Undertaking recreational activities, such as hiking in areas where asbestos is commonly occurring.

Cases of mesothelioma have been reported in three villages in Turkey, in which the mineral, erionite, is present. Erionite has a similar fibrous structure to asbestos, and it suspected to be the cause of these mesothelioma cases. We discussed the risks posed by erionite, along with other non-asbestos related sources of mesothelioma, in edition 229 of BC Disease News [here](#).

The new study compared data from multiple studies. Participants were exposed to both environmental (8 groups) and occupational (13 groups) asbestos.

In groups exposed to asbestos in the course of their employment, the incidence rate of MM increased as median cumulative exposure dose increased.
Interestingly, among the groups with environmental exposure, incidence of mesothelioma increased with median duration of exposure. However, incidence decreased as the median cumulative dose increased.

Moreover, prevalence of mesothelioma in those with environmental exposure was higher in women than in men. By contrast, occupationally exposed patients tended to be primarily male, as more men have historically been employed in workplaces where asbestos is present than women.

The findings of this study suggest that environmental factors play a significant role in the onset of mesothelioma. As different consequences were observed in occupational cases and environmental cases, increased knowledge of the geography and duration of exposure is vital.

**Increased Risk of Chronic Obstructive Pulmonary Disorder with Occupational Exposure to Biological Agents**

A new study of more than 3,000 participants has linked occupational exposures to biological dusts, gases, fumes and pesticides to a higher incidence of chronic obstructive pulmonary disorder (COPD). This finding is not surprising, as many earlier studies have suggested links between COPD and these agents. However, this latest study is well-designed, and provides stronger evidence of associations than past studies with less robust designs.

The strength of the design of this study lies in how the occupational exposure was assessed, the type of sampling method used, and the way COPD was defined.

The study group was a random sample of the population. They were followed for 20 years to see whether or not they developed COPD. The participants provided information on what their past jobs were, and a job exposure matrix was used to estimate the exposure to the agents of interest from each type of job. This meant that participants were asked to recall only their previous job types or titles, and were not asked to recall their exposure to various agents. In doing so, this avoided the collection of biased results through loss of memory or exaggeration of exposure.

At the start of the study, none of the group had COPD or asthma. Whether or not a participant developed COPD was determined by the difference in spirometry, or lung function, between the test results when subjects were first recruited and the final tests 20 years later.

Out of 3,343 participants, 89 of them had COPD at follow up. Participants exposed to biological dust had a higher incidence of COPD compared with those that were not. Those exposed to gases and fumes were also at higher risk, as were those exposed to pesticides. Overall, 21% of COPD cases were associated with occupational exposures.

‘Previous studies had estimated that about 15% of COPD cases are attributable to workplace exposures. Our results strengthen this evidence base substantially,’ says Jan-Paul Zock, lead author of the study.19
Feature:
40-Fold Increase in Sheep Dipping Treatment for Sheep Scab Since 2013

In our feature, we discuss the occupational risks associated with sheep dipping, in light of new evidence, suggesting that sheep scab is becoming more prevalent. Could this emerging trend result in future EL disease claims?

INTRODUCTION

Farmer's Weekly has reported a large increase in the numbers of sheep being infected with, and treated for, sheep scab since 2013. One of the most effective ways to treat sheep scab is to dip sheep into a liquid containing organophosphate insecticides. Use of organophosphate insecticides is now heavily regulated, as long-term exposure to the pesticides is suspected of causing diseases, such as Parkinson's.

WHAT IS SHEEP SCAB AND HOW IS IT TREATED?

Sheep scab is a parasitic disease caused by a mite that lives on the skin of sheep, and is highly contagious; an infection can start from a single mite. The main symptoms are itching and scratching. As the disease progresses, wool is lost and the skin underneath becomes covered with scabs. This causes rapid weight loss in affected sheep and lowers the birthweight in lambs born to infected mothers, with an increased of premature death. Increased feed costs and possible loss of stock can be costly for farmers. In Scotland, sheep scab is regulated by the Sheep Scab (Scotland) Order 2010, as amended by the Sheep Scab (Scotland) Amendment Order 2011.

Figure: The Psoroptes Ovis Mite, which causes sheep scab

Sheep scab was eradicated from the UK in 1952, but reappeared in 1973. Between 1973 and 1984, there were numerous UK scab outbreaks. In the 1980s and early 1990s, dipping sheep to prevent the spread of scab was compulsory in the UK. During the compulsory dipping era, organophosphate plunge dips were the treatment of choice (they were a safer alternative to organochlorine products that had been used earlier). Sheep are dipped into a large container of liquid that contains pesticides effective against the mites that cause scab, as well as lice, blowflies and ticks. Typically, dipping was performed by the farmers themselves. During the 1980’s, there was little awareness of the potential health hazards associated with pesticide exposure.

In 1992, the sheep dipping process ceased to be compulsory. This change was implemented by the Government because its eradication policy had failed and because the farming industry was undergoing deregulation. However, many farmers and activists attributed the change in approach to increasing awareness of the adverse health effects of long-term exposure to OPs.

The use of OPs is a controversial topic. We have previously discussed the risk of organophosphate exposure in the context of so-called ‘Aerotoxic Syndrome’, last mentioned in edition 201. Elsewhere, we reported on an academic study, in issue 126, which found that children in agricultural communities, frequently exposed to organophosphates, were associated with decreased lung function.
As an alternative to plunge dipping with OP insecticides, injections have also been effective against scab in the past. Pour-on and shower-based treatments are also available, but according to Farmers Academy and Vet Times, these are not effective and should not be used.

However, in early 2018, it was reported that scab-causing mites had developed a resistance to macrocyclic lactones, found in certain injectable solutions. If resistance spreads, the range of treatment options available will be constricted to a smaller range of injectables and OP dipping.

Current OP regulations require any person dipping sheep to have a license to use and dispose of the product. Suggested preventative measures include the use of visors against eye protection; respirator masks for respiratory protection; and 300 mm rubber gloves, hazard chemical suit/lined waterproofs and wellington boots for skin protection.

Post-treatment, there is a withdrawal period of 49 days before sheep may be processed for meat or offal production. The Health and Safety Executive (HSE) advises that OP sheep dips are only to be used with ‘closed transfer systems’. These devices are designed to reduce the risk of operator exposure to the dip concentrate while dipping baths are filled. HSE guidance also includes advice on engineering controls, PPE and risk reduction throughout the dipping procedure.

Figure: A typical sheep dip setup

HEALTH EFFECTS OF ORGANOPHOSPHATE INSECTICIDE EXPOSURE

It is well known that, like many other pesticides, single, intense doses of OP insecticides can result in death by poisoning. OPs are known to affect the nervous system by preventing an enzyme called acetylcholinesterase from functioning normally, resulting in muscles being continuously instructed to contract. Sheep dipping farmers are concerned with the effects of long-term exposure to small doses. Many have reported chronic symptoms, such as fatigue, memory loss, weakness, joint and muscle pain and depression. These symptoms have been attributed to chronic exposure to OPs. However, as these chronic and acute symptoms are vague and have non-discernable causes, clinicians are unable to attribute them to OP exposure, or define a particular condition caused by OPs.

Clinical Studies

In 2013, a meta-analysis of 14 studies, investigating the neurotoxic effects of long-term exposure to low levels of OPs in occupational settings, was published. Data from more than 1,600 participants was considered.

The authors of the study reported that:
“The majority of well-designed studies found a significant association between low-level exposure to OPs and impaired neurobehavioural function which is consistent, small to moderate in magnitude and concerned primarily with cognitive functions such as psychomotor speed, executive function, visuospatial ability, working and visual memory.”

By contrast, in 2014, the Committee on Toxicology issued a statement which indicated that:

“The current balance of evidence suggests that there is no long-term risk of clearly demonstrable peripheral neuropathy from exposure to organophosphates that does not cause overt short-term poisoning; a conclusion that has strengthened with the passage of time.”

It went on to state, in terms of low-level OP exposure, that:

‘Overall there is no consistent evidence that low-level exposure to organophosphates has adverse effects on any specific aspect of cognitive function. If organophosphates do cause long-term neuropsychological impairment in the absence of overt poisoning, then the effects at least in the large majority of cases, must be minor and subtle’.

Since the 2014 report, studies have hinted at possible links between OPs and cancers, reproductive effects, lung function and Parkinson’s disease. However, assessment of the extent to which study participants have been exposed to OPs is difficult to quantify. As such, many studies have presented weak evidence at best, in support of associations with diseases.

In March of 2015, the International Agency for Research on Cancer (IARC) classified OP insecticides, malathion and diazinon, as ‘probably carcinogenic to humans’, along with insecticides, tetrachlorvinphos (banned in the EU) and parathion (also banned in the EU).

Further, the Veterinary Medicines Directorate publishes figures on the number of adverse health conditions onset by veterinary medicines. In its latest publication, it reported on incidents in 2016. Two incidents were related to skin dip products, both in large/food animal owner/handlers, but no more detail was provided, in respect of these incidents.

RECENT INCREASE IN CASES OF SHEEP SCAB

Ever since compulsory dipping ceased, the number of sheep scab cases in the UK has risen. However, accurate figures recording the number of sheep affected do not exist, as many cases go unreported.

However, in a Farmer’s Weekly article, contract sheep dipper, Neil Fell, alleged an increase in sheep scab, from 2,500 sheep in 2013, to more than 107,000 in 2017. Mr Neil’s automatic dipping tank can dip up to 300 ewes an hour.

He believes that ‘sheep scab is definitely a worsening problem’, and ‘the fact that scab is a taboo subject makes the condition harder to address’. Indeed, among livestock farmers, sheep scab is a source of embarrassment.

SHEEP DIPPING CASE LAW

The only successful UK court settlement was brought by a farm worker, John Amos Hill, in 1997. It was found that he ‘had not been given adequate warnings of the health risks of using the chemical or protective clothing’.

Elsewhere, a former farm college shepherd was forced to retire from his job after his health deteriorated over a 12 year period. He claimed that he was suffering from fatigue, mood swings, tingling, numbness, and memory problems. His job was the twice-yearly dipping of the college sheep flock. As a result, he sought compensation from his employers (Lancashire County Council) and an out of court settlement was reached for £80,000.

Snell & Ors v Robert Young & Co Ltd. & Ors

This was a landmark UK group litigation case, involving 25 farmers who alleged that they had been poisoned by OP sheep dip. In this case, the farmers pursued the chemical companies responsible for making the dip.

A pilot study was undertaken and the farmers were subjected to ‘conduction analysis, bone examinations, immune testing and psychometric tests’ to identify if there was a link between the use of OPs and the range of symptoms presented amongst the group.
On review of the test results, Dr Sarah Myhill opined:

"Taken as a whole, if you look at all the tests done among all those farmers there’s a very clear pattern that emerges which I think, on the balance of probabilities, one can say is almost certainly is almost due to pesticide or chemical poisoning." 42

The judge at first instance suggested that a consultant should review the report. However, the defendant chemical companies applied to strike out the claim, on the basis that there was no evidence in support of OP poisoning.

The High Court struck the claims out on causation arguments. 43 It could not be proven that the claimants' symptoms were directly caused by OP exposure. On appeal, Morland J upheld the High Court decision. 44 45

CONCLUSION

If the numbers of sheep scab are indeed increasing in Britain, it is likely that the amount of OP sheep dip being used will increase. Many users of OP sheep dips are likely to be contractors, as was the individual featured in Farmer’s Weekly. Users of OP dips are required to limit the exposure of anyone directly involved in dipping, and dispose of the product carefully, thus limiting exposure to others. Since 2006/2007, there has been far tighter control and regulation on the use of OP sheep dip, and working practices have improved significantly. Therefore, the potential for success in sheep dip exposure claims will be reduced if exposure is alleged to have occurred post-2006/2007. However, an increase in the use of OP-based products to treat the 40-fold increase in sheep scab will no doubt increase the probability of exposure incidents.
References

4. Ibid
6. Ibid
7. Ibid
21. Figure from https://www.fwi.co.uk/academy/lesson/scab-in-sheep
27 Image from HSE
44 High Court (QB), 31 July 2001 (unreported).
Disclaimer

This newsletter does not present a complete or comprehensive statement of the law, nor does it constitute legal advice. It is intended only to provide an update on issues that may be of interest to those handling occupational disease claims. Specialist legal advice should always be sought in any particular case.

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