Welcome to this week’s edition of BC Disease News. In the last week the Civil Justice Council (CJC) has set out a blueprint of 45 recommendations designed to kick-start the use of damages-based agreements. Elsewhere, an appeal succeeded against a Deputy Master's case management decision refusing permission to call expert actuarial evidence.

This week we present a feature article on acoustic shock syndrome. The article will focus on this condition and how it affects call centre workers by looking at the available research.

Finally, BC Legal will be sponsoring the upcoming seminar 'Medico-Legal Report Writing For Suspected NIHL'. The seminar is due to be held on Friday 18th September 2015 at Baden-Powell House Conference Centre, London. Places for the seminar are free and still available.

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

As always, warmest regards to all.

SUBJECTS

Workplace Exposure to Nanotechnology – Mesothelioma Research – Reform of DBA Regulations – Case Management Appeal - British Airways Plc v Spencer [2015] EWHC 2477 (Ch) – Costs Halved for Hiding Second CFA – Acoustic Shock in Call Centres
HSE Assessment of Workplace Exposure to Nanotechnology

The Health and Safety Executive (HSE) has commissioned a project with the Health and Safety Laboratory (HSL) to improve understanding of the nanomaterials industry across Great Britain and its employees’ potential exposure to materials at the nanoscale. The HSE and HSL made attempts to identify and engage with companies which manufactured or used nanomaterials in order to carry out visits to assess exposure to airborne nanomaterials during their manufacture, handling and use and to assess the effectiveness of the controls used to reduce exposure to nanomaterial. Unfortunately, only four companies volunteered to take part in this project and so the outcomes only represent a very small sample of the industry and a finite selection of nanomaterials.

Across all four companies a range of tasks were monitored including production pre-processing and processing of nanomaterials, bagging, handling (e.g. weighing, moulding and machining), material recovery, emptying of powder collected in local exhaust ventilation (LEV) system bins, maintenance and cleaning activities. Most of the tasks monitored involved manufacturing processes or handling of powders with the amount of material handled ranging from hundreds of grams to greater than 100kg. It should be noted that none of the tasks or processes monitored in this project involved the manufacturing or handling of nanotubes or nanofibres. The machining of composites containing nanomaterials.

The key findings from this study are, firstly, that existing good hygiene control practices can be used to reduce exposure to airborne nanomaterials and it is therefore important that in any work with nanomaterials, a thorough assessment is made of all control methods to be used. Secondly, an exposure monitoring strategy suited to small business is in order to monitor emission of airborne nanomaterials was evaluated and found to be practical and cost effective. Thirdly, COSHH assessments were not specific to nanomaterials and all of the assessments reviewed could have been improved. Interestingly, respiratory protective equipment (RPE) offering protection against particles was provided at three of the four companies. Of the three companies using RPE only one company had carried out face-fit testing of some of their staff. The other two companies had not conducted face-fit testing. From both the occupational hygiene assessment and the measurements, it was found that in general the LEV systems in place were appropriate and effective except for a poorly designed LEV system at one company. From the measurements, it was observed that short-term release of nanomaterials could take place during maintenance work or when emptying powder collected in LEV system bins.

Finally, the HSE recommended that an effective risk management assessment strategy could include a combination of a simple exposure monitoring approach and an occupational hygiene assessment of the process and the controls. This strategy would be practical and cost-effective. It could be used to evaluate whether tasks or processes give rise to potential emissions before committing to more comprehensive monitoring. In some circumstances, the use of real-time monitors can allow the immediate detection of leaks or releases of nanomaterials. However, there remain challenges to measuring emissions of (or exposures to) specific nanomaterials where background levels of ultrafine particles are high or fluctuate. There is not enough evidence yet to propose a measurement methodology which should be used to underpin separate specific Occupational Exposure Limits (OELs) for nanomaterials if these were to be proposed.

The full report can be accessed here.

New Mesothelioma Research

Mesothelioma currently has no cure and only 1 out of every 10 people who are diagnosed will survive longer than three years.1 Chemotherapy is the most common treatment for this disease, but more than half of people gain only 2-3 more months of life, or fail to respond to it completely. Sarah Martin at the British Lung Foundation has set about finding more effective ways of helping people with mesothelioma and to learn what drives its growth. Sarah leads a team of 7 researchers in a laboratory focused on finding new ways of treating cancer based on their genetic makeup. This research was inspired by work carried out by Dr Peter Szlosarek who discovered that half of mesothelioma tumours have lost the function of a certain gene called ASS1. This gene produces an amino acid called ‘arginine’, which is one of the building blocks that cells, and therefore mesothelioma, need to grow. Those mesothelioma tumours which have lost the ability to produce arginine themselves are forced to get it from the blood instead. So by blocking them from getting the arginine, it is hoped that the cancer cells can be killed. A recent clinical trial was carried out with encouraging results. The research that is carried out by Sarah and her team involves an approach termed ‘synthetic lethality’ – this uses a library of drugs which have been used to treat other conditions to see if they have any positive effect in treating mesothelioma-potentially killing the tumour cells without harming the healthy cells, and so reducing the difficult side-effects that often happen with chemotherapy.

Urgent Reform of DBA Regulations

The Civil Justice Council (CJC) this week set out a blueprint of 45 recommendations designed to kick-start the use of damages-based agreements.2 The funding method, which calculates the lawyer’s fee as a percentage of the financial benefit received from a successful case, was a cornerstone of the Jackson reforms introduced in April 2013. But few lawyers have opted to use DBAs, prompting the CJC to convene a set of experts from across the sector to suggest changes.

Recommendations include:• Technical amendments to existing regulations to make them clearer and therefore more attractive;
• Increasing some of the caps on payments for cases;
• Allowing lawyers and clients to agree a ‘trigger point’ at which a DBA becomes payable and the circumstances under which it can be terminated.

Master of the rolls Lord Dyson said he hopes the changes recommended will encourage greater use of DBAs: ‘I now urge [the government] to consider further modifications to the regulations to help promote confidence in them as one of the funding arrangements available to those involved in a personal injury or commercial dispute,’ he added in a statement.

The Ministry of Justice requested the formation of a working group to look into the issue last December. The group, chaired by Professor Rachael Mulheron and with representatives from across the profession, met six times in the subsequent months.

The CJC took the view that some aspects of the DBA policy which have been adopted or endorsed by the last government have created ‘sufficient disquiet or opposition’ in the legal profession to warrant further consideration. The report said the two sums liable for payment under a DBA, the representative’s payment and expenses incurred by the representative, were seen as ‘eating away’ at the contingency fee earned by the solicitor.

The working group found that a list of ‘expenses’ falling outside the DBA cap was not necessary, but the term ‘expenses’ should be deleted from regulation and replaced with ‘disbursements’. It was also agreed that where VAT is recoverable, it should be excluded from the cap.

Case Management Appeal: British Airways Plc v Spencer

In a pensions dispute, an employer appealed against a Deputy Master’s case management decision refusing permission to call expert actuarial evidence on the grounds that it was not necessary. The employer contended that the Deputy Master had applied the wrong test by considering that, in order for the expert evidence to be admitted, it had to be reasonably required in order to determine a specific issue in dispute.³

On appeal, Warren J found that firstly, appellate courts would not lightly interfere with case management decisions, (Chartwell Estate Agents Ltd v Fergies Properties SA [2014] EWCA Civ 506, [2014] C.P. Rep. 36 followed). However, any exercise of a case management power had to accord with the overriding objective, which informed what was reasonably required in terms of expert evidence. The court should not be overzealous in excluding evidence in order to save time and cost (see para.25 of judgment).

In addition, evidence could be helpful even if it was not determinative of any issue, Mitchell v News Group Newspapers Ltd [2014] EWHC 3590 (QB) applied. However, it was also necessary to be mindful of CPR r.35.1, which required that the evidence had to be reasonably required to resolve the proceedings. Therefore, it had to be considered in each case whether the evidence was necessary - in the sense that a decision could not be made without it - or whether it was of marginal relevance, in which case a balance had to be struck and the proportionality of its admission assessed. In striking that balance, the court had to take into account such factors as the value of the claim, the effect of a judgment either way on the parties how the commissioning of the evidence was to be paid for, and any delay likely to be entailed by the production of the evidence (paras 61-63, 68).

There were many areas where expert actuarial evidence might be relevant and would assist the court, and some areas where it would not only assist but be necessary. Factors in favour of admitting evidence which would be of assistance, but not necessary, to the resolution of an issue included: the very large sum of money turning on the outcome of the case for the employer; the undesirability of tying the hands of the trial judge if that could sensibly be avoided; and the fact that the trustees would be at no financial risk because the costs of obtaining the evidence would be borne by the employer in any event, even if none of it was adduced or relied on in court. Those factors in favour of admission were not displaced by the time and energy required by the court in considering the evidence or the pressure on trial preparation (paras 103-104, 115). The appeal was therefore allowed.

This decision is generally supportive of the introduction of expert evidence provided that it is necessary to resolve an issue or that it would be helpful in doing so. It also indicates that whilst there is a general reluctance on the part of appeal Courts to interfere with case management powers, this decision makes it clear that if a decision is contrary to the overriding objective that appeals will be heard.

Costs Halved For Not Disclosing Existence of Second CFA and BTE

A district judge has decided to halve the costs awarded to claimant solicitors for unreasonable and improper conduct in concealing from the paying party the existence of a previous conditional fee agreement and before-the-event (BTE) insurance.⁴

District Judge Griffith, sitting at Birmingham County Court, said: ‘The word “improper” is not limited to situations where there would be a significant breach of professional conduct, but encompasses conduct which can be regarded as improper according to a consensus of professional or judicial opinion. Although I have not been referred to a professional
code of conduct, I would be surprised if the
court greatly valued the claimant’s solicitors which I
have described, has not fallen foul of some provision
of the rules which govern solicitors. Misrepresenting the position in a
bill of costs intended for consideration by an
opponent in litigation and use at a court
hearing in order to gain practical advantage, can be regarded as improper
conduct. It is, in any event, likely to be so regarded by a consensus of solicitors or
judges, in my view’.

Delivering judgment in Kerins v Heart of
England NHS Trust (County Court
(Birmingham), 31 July 2015), DJ Griffith said
the case involved a medical negligence claim which settled in
September 2013. The defendant argued that
costs should be disallowed entirely
because of abuse of process and
misconduct under CPR 44.11. DJ Griffith said
the claimant, Ryan Kerins, entered into
two conditional fee agreements with Rapid,
one signed in April 2012 even though the
BTE policy was known about at the time,
and one in March 2013 when proceedings
began and he was able to choose Rapid as
his solicitors under the policy. The notice
of funding, served in July 2013, only referred
to the first CFA, however.

The claimants’ costs bill, as originally
drafted, was for £127,885, but, following an
“unofficial response” from the defendant,
was reduced to £49,369. Neither bill
referred to the second CFA nor to the BTE
cover and they were only disclosed four
days before the hearing. Given the lack of a
notice of change of CFA under CPR 44.15,
the district judge said the success fee in the
case was not recoverable, as the claimant
had conceded.

DJ Griffith said he was ‘of the firm view’ that
the claimant could be criticised ‘with regard
to the way that the existence of the second
CFA and the available BTE funding was
intentionally kept secret from the defendant.
They had ample opportunity to put right the
position they had misrepresented, but failed
to do so’.

The judge said an inaccurate portrayal of the
funding position could ‘serve to strengthen the claimant’s arguments’ in
justifying the success fee and weaken the
defendant’s position. DJ Griffith concluded
that not only was the claimant solicitor’s
court of the case improper under CPR
44.11, but it was also unreasonable, by
stating that: ‘The court very much
disapproves of conduct of this type in these
days of openness between the parties.
There is an obligation on legal
representatives to assist the court and
present the client’s case fairly and without
misrepresentation’.

However, he said it would be
disproportionate to disallow all of the costs,
and so disallowed 50%.

Feature
Acoustic Shock:
Indecent Exposure in
Call Centres

Introduction

Noise is probably the most widespread of
industrial hazards. Although we associate
noise at work with noise induced hearing
loss (NIHL), concerns have also been
raised regarding what is known as ‘acoustic
shock’ and ‘Acoustic Shock Syndrome’
among people using telephone headsets
and other similar communication devices.

What Is Acoustic Shock?

As this is still a relatively new and
developing field, there are still several
slightly different definitions of acoustic
shock and global consensus has yet to be
reached. One of the first definitions of
acoustic shock was produced by the
International Telecommunications Union
European Transmission Standards Institute
in 1998. It defined acoustic shock as ‘any
temporary or permanent disturbance of the
functioning of the ear, or of the nervous
system, which may be caused to the user of
a telephone earphone by a sudden sharp
rise in the acoustic pressure produced by it’. In a 2008 Position Paper the HSE defined it
as ‘a term used in connection with incidents
involving exposure to short duration, high
frequency, high intensity sounds through a
telephone headset’. The Health Services
Australia Group has produced the most
expansive definition which states that
‘acoustic shock refers to the combination of
exposure to a brief, sudden, unexpected,
high frequency, high intensity sound
emitted (the stimulus) and the subsequent
symptoms (the response) which can
develop’. This group also produced a
definition for the causative sound or
‘acoustic incident’: ‘acoustic incident refers
to a sudden, unexpected, high-pitched
sound of high intensity…. It is generally
accepted that these ‘acoustic incidents’ are
unexpected and randomly occurring with a
high frequency at between 2.3-3.4 kHz and
with intensities varying between 82-120 dB
and of varying durations.

Acoustic Shock Syndrome

It should be noted that acoustic shock
appears to be unrelated to NIHL, the latter
potentially arising from repeated exposure
to sounds of an intensity greater than 85dB
causing cochlear damage. Whilst a call
handler may be shocked or startled by an
acoustic incident the HSE state in their
2008 Position Paper that exposure to these
acoustic events is not sufficient to cause
hearing damage as assessed by
conventional methods.

However some sources suggest that
acoustic shock incidents are associated
with a range of physiological and
psychological symptoms that have been
reported amongst headset wearers.
Symptoms include a sense of
fullness/blockage of the ear, recurrent pain
in the ear, sensations of numbness or
burning felt in the head, neck, shoulder and
down the arm on the affected side, unusual
sensitivity to everyday sounds
(hyperacusis) followed by fear of loud
sounds and associated anxiety and panic in
some acoustic environments. Serious
depression has also been linked to acoustic
shock incidents.

In a recent study carried out in 2014, the
medical notes and occupational health
records of 30 ‘sufferers’ were scrutinised
followed by interview and examination.
There was a range of oto pathological
identified with an average of 3.2 per
patient), the most common being tinnitus
which was present in 90% of the subjects.
It was also found that 70% of study
participants had previous oto pathology,
63% had psychopathology and 17% had head injuries. It was again concluded that hearing loss was not necessarily a feature of acoustic shock syndrome.

Anecdotally, one of the common complaints of people who have experienced an acoustic shock is that their symptoms are ignored or minimised by medical staff. Following normal audiological tests many patients are merely reassured that no damage has been sustained and are dismissed. It has been suggested that recognition of the condition and a sympathetic approach are simple and helpful measures. Techniques used for mainstream hyperacusis and phonophobia patients, such as tinnitus retraining therapy and psychological therapies, have been used to treat patients with acoustic shock. However, no firm evidence of the efficacy of this approach has yet emerged. Westcott,^{6} reported four cases of acoustic shock which were treated with sophisticated in-the-ear digital hearing aids, set up to act as electronic filters and compress all sounds down to the range of conversational speech. The rationale for this approach was that it would protect against dangerous sound levels while avoiding the risk of overprotection. Three of the four patients treated in this study showed improvement, but it is difficult to draw firm conclusions from such a small study.

**Who is at Risk?**

Employees within the call centre industry are typically seen as being most at risk. A press announcement made by the Call Centre Management Association on 5 November 2004, suggested that 300.000 such workers may be victims of acoustic shock syndrome. Acoustic shock in this scenario may be caused by interference on the telephone line, by mis-directed faxes, or by a smoke or fire alarm sounding at the caller’s end. There have also been incidences of malicious callers blowing whistles into the sending headset.\(^5\)

In response to such unexpected loud sounds, the natural reaction is to remove the headset quickly, thus limiting the exposure duration to a few seconds, it is highly unlikely that an exposure lasting a few seconds would produce any lasting shift of the hearing threshold.

Since 1991, major manufacturers have incorporated an acoustic limiter in the electronics of their headsets to meet the requirements of the Department of Trade and Industry (DTI) specification 85/013. In the UK, this limiter ensures that any type of noise (eg conversation, short duration impulses) above 118 dB is not transmitted through the headset. However, it is said that reducing the overall output level through a headset can reduce the intelligibility of speech, particularly within the sometimes noisy environments of call centres and this can result in operatives straining to hear and therefore increasing their central auditory gain. This may render the operative more susceptible to acoustic shock. As a result there have been several attempts to design more sophisticated filtering equipment, such as an in-line acoustic shock limiter that can recognise and reject acoustic incidents while allowing normal speech to pass through in a largely unaltered state. Some manufacturers are now bringing ‘acoustic shock protection’ and ‘headset noise limiter’ devices to market.

**Prevalence**

The HSE considers that, in general, call handlers’ daily personal noise exposure is unlikely to exceed the 80 dB lower exposure action value defined in the Control of Noise at Work Regulations 2005, provided good practice in the management of noise risks is followed. However, the Communication Workers Union (CWU) estimated in 2005 that there had been more than 500 claims in the UK for damages associated with the symptoms of acoustic shock, resulting from breaches in common law by the employer, for example, the Provision and Use of Work Equipment Regulations 1998, Reporting of Injuries Diseases and Dangerous Occurrences Regulations 1995 and the Health and Safety at Work Act 1974 all enforce a duty of care upon the employer over their employee. These claims resulted in out of court settlements in excess of £3 million and there were reported to be an average of 10-15 new cases every month at this time.

In their local authority circular (LAC Number 94/2, Advice Regarding Call Centre Working Practices), the HSE recommend that employers keep up to date with developments in this field through professional associations and other representative bodies. Employers should also train call handlers to recognise incidents that result in any adverse reactions and how to report them. This should be encouraged alongside them implementing a traceable reporting system for headset users who may have been exposed to incidents. More recently, in 2011, the National Institute for Occupational Safety and Health (NIOSH) made recommendations for both employees and employers. They claim that employees should notify their supervisors and take protective action if they experience tinnitus, a dulled sense of hearing or a fullness in the ears after a work shift or exposure to noise (that was not present before the exposure or work shift) as this can indicate an overexposure that, if repeated will likely cause permanent effects. They also recommend that employees do not set the volume control above the middle point, the lower the better and that they ask to try different headsets with improved protection or noise-cancelling features. Employers are advised to consider supplying communication systems with noise-limiting features and to install noise controls to reduce background noise levels in the work environment, such as barriers between workstations or sound-absorbing materials on hard surfaces in the room.

**Conclusion**

Whilst the research in this area is somewhat limited, it is clear that acoustic shock syndrome is significantly different to NIHL in both its causes and its symptoms. It should be noted that Acoustic Shock Syndrome is not a recognised medical diagnosis. Acoustic Shock Syndrome is no more than a descriptive term for a constellation of symptoms - many of which appear to be ill-defined and unrelated and with no (as yet) physiological link between exposure to acoustic shock and the suggested symptoms. The HSE has not found evidence to establish whether the reported symptoms of acoustic shock
syndrome are caused directly by the exposure to the unexpected sound. Currently scientific/medical evidence in support of the existence of Acoustic Shock Syndrome remains extremely limited. Interestingly, a recent study carried out by Hooper RE,\textsuperscript{10} identified cases of pseudohypacusis (exaggerated or false hearing loss) and suggested that acoustic shock syndrome is predominantly psychogenic with indications that malingering is a factor in some cases. Due to this absence of real epidemiological or other medical evidence, it is difficult to see how claims for acoustic shock syndrome can succeed although, employers should endeavour to limit their liability by taking all preventative measures available. We will continue to watch the developing research for Acoustic Shock Syndrome to predict how the future landscape for any such claims may develop.

References


3 [2015] EWHC 2477 (Ch)


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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