NIHL Claims:
A Collection of Articles from BC Disease News
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BC Disease News
Volume I

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Introduction

BC Disease News has covered a wide range of issues that arise in NIHL Claims. This reference guide collates all of our articles into one collection, across two volumes, with the aim of making the information more accessible and practically beneficial.

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

As always, warmest regards to all.
Limitation and NIHL claims: Practical Tips (BCDN Edition 1)

Latency in onset of symptoms

NIHL is a non-progressive condition. Once exposure to noise ceases so does any NIHL—there is no progressive deterioration other than arising as a result of natural ageing or some other pathology. The NIHL that exists today is the same as existed at the time exposure ceased.

There is a ‘reservoir’ of hearing which can be lost before there is any subjective disability. Subjective disability typically arises at around 20-25dB of loss (the ‘low fence threshold’).

Claimants often report a recent onset of symptoms despite historic exposure to noise. It is important to check that such a history is compatible with the extent of overall hearing loss (age associated loss + NIHL). If the claimant’s overall loss is significantly greater than the low fence threshold then it is likely there has been long standing disability or there is a 3rd, recent cause of hearing loss which has caused disability to only recently onset. It is important to check that the degree of loss is ‘compatible’ with the history of onset of disability.

- Estimate the claimant’s likely hearing loss at the time exposure ceased (AAHL+NIHL). Would the overall binaural loss at this time exceed 20-25dB and so represent first disability?
- If the overall loss at this time would not exceed the low fence threshold at what point would this happen?
- Questions may need to be put to the claimant’s medical expert to establish the likely onset of disability. This exercise can also often assist on quantum as the medical expert may introduce a 3rd, later cause of hearing loss to explain
- any incompatibility between the degree of loss and recent onset of symptoms. Even though this will not assist in any limitation defence, it will reduce the overall value of the claim.

Length and reason for delay

- Explore the length and reasons for any delay by the claimant (and solicitors) in proceeding with the claim by way of questions / part 18 requests.
- Be pro-active in how you handle the claim. Do not add to any delay in the claim by not responding promptly to the claimant’s requests for information / documentation or investigating matters.

Cogency of evidence

- Examine the claimant’s evidence to identify and highlight all inconsistencies and ambiguity. This shows how delay has affected the cogency of the claimant’s evidence.
- Examine the claimant’s disclosure. Are there relevant documents which can no longer be obtained? This may include occupational health screening / testing of hearing with other employers. This shows how delay has affected the cogency of the claimant’s evidence.
- Examine and adduce evidence on how delay—not just since the expiration of limitation—but since employment ceased—has affected the cogency of the defendant’s evidence:
  - Does the defendant still exist?
  - If so have there been changes in corporate structure / ownership?
  - Do the premises / place of work still exist? If so has this changed and how?
  - Do the source(s) of noise still exist? Are the same plant / machinery available? Has the system of work materially changed?
  - Are witnesses still available? If so how has their recollection of events and evidence been affected? If there are no witnesses you should show reasonable attempts have been made to identify and locate them;
  - How has the defendant’s disclosure been adversely affected? You should show that documents existed but can no longer be located and why and what attempts have been made to locate the same—rather simply saying no documentation exists;
  - Even if there are relevant noise surveys which show a noisy workplace do not concede any issues on breach. If you cannot say where, or how long the claimant may have been exposed to noise or what (if any) hearing
conservation programme was in place, then breach remains a live issue. If necessary you can admit that if the claimant’s evidence on these issues is accepted by the court then breach would attach but you are simply unable to make any proper determination of these issues given the paucity of evidence;

- Consider the strength of the claimant’s case on breach and diagnosis / causation. If there is a genuine argument on any of these issues then there is less prejudice to the claimant in the court refusing to allow a claim to proceed out of time. Questions may need to be put to the claimant’s medical expert to at least highlight genuine issues on diagnosis / causation—even if the medical expert is unlikely to change his / her position;

- Consider the value of the claim. The lower the value the less the prejudice to the claimant if the court refuses to allow the claim to proceed out of time. Is there pre-negligent exposure or exposure with other employers who are not pursued? Introduce evidence on apportionment to reduce the value of the claim. Are there de minimis arguments?

- Are there gaps in insurance cover which mean a defendant / their insurers have to pick up the shortfall on costs? This increases the prejudice to the defendant in allowing the claim to proceed out of time.

Finally adduce evidence

Whilst the onus rests on the claimant to persuade the court to disapply the limitation period, the defendant must provide evidence by way of a witness statement on the above issues and the prejudice to the defendant in allowing the claim to proceed out of time.

The over diagnosis of NIHL (BCDN Edition 2)

The problem

The increasing volume of NIHL claims over the last few years is in some ways puzzling. Since HHJ Inglis approved the use of the ‘Coles Guidelines’ as ‘robust diagnostic criteria’ in the 2007 Nottingham Textile litigation, defendants have repudiated numerous NIHL claims on the issue of diagnosis.

The Coles Guidelines have been increasingly accepted and applied by courts at first instance and are now routinely adopted as the appropriate framework for diagnosis of NIHL by both claimants and defendants. It might reasonably be assumed that claims volumes should have fallen in recent years as claimant advisors became more discriminating and selective in the claims presented? And yet claims volumes have not only soared but an increasing percentage of claims are being presented with audiometry which purportedly supports a positive diagnosis under the Guidelines? Why is this (counter-intuitive) trend being seen? We believe that over-diagnosis of NIHL partly explains this trend and arises for the following 5 reasons:

1. Non-organic hearing loss (NOHL)

Possibly present in around 30% of NIHL claims.

2. Poor Audiometry

Audiometry is not a precise science and there are many potential sources of error/variability. Stephens (1981) found 38 sources of variance in audiometric testing. The ‘Black Book’ describes the main sources of audiometric error (Chapter 5, section 5.2.1), amongst others, as:

- Calibration error of the audiometer. The manufacturing specifications allow volume performance within a tolerance of +/-3dB;

- Unpredictable interaction between different ear types and earphones;

- Accuracy of the audiometer tone frequencies—the audiometer is in effect testing at a different frequency to that
indicated;

- Background noise in the test room;
- Fitting of the headphones / bone vibrator;
- Individual motivation / ability / attention;
- Fatigue, colds, excess wax, temporary effects of preceding noise;

The Black Book states that:

- Repeatability varies from person to person;
- Repeatability is best at 1 and 2 kHz and poorer outside these limits especially at 6 kHz;
- With 5 dB measurement steps then audiometric variability within the same test (intra-test variability) may be within +/- 10 dB.

HHJ Inglis in the 'Nottingham Textile Litigation', after hearing extensive evidence from numerous experts, found (paragraph 103) that:

'...Audiograms are taken in steps of 5 dB at each frequency. They are variable and not generally exactly repeatable...Up to 10dB is therefore an acceptable margin of error'.

Thresholds between tests may show even greater variability (inter test variability).

Atherley (1963) found inter-test variations extending to 25 dB. Robinson (1984) showed maximum inter-test variations in thresholds (between 0.5-6kHz) of just under 22 dB.

The effect of audiometric error and variability is that hearing thresholds are generally shown as worse than actual thresholds. Lawton (1991) states:

'...systematic errors [in pure tone manual audiometry] usually work to elevate the threshold, to make the hearing appear less acute than it really is'.

The ‘Black Book’ states (page 34) ‘Where only a single measurement is made on a given ear, errors of the above magnitudes [+/-10dB] will inevitably go undetected’.

Whilst in many clinical circumstances this variability may be of little consequence, the limits of precision become more important in NIHL claims where a diagnosis under the ‘Coles Guidelines’ can succeed or fail with a change in threshold of +/-5dB at a single frequency.

Audiometric error and threshold variability means that diagnosis founded on a single audiogram (particularly where the thresholds are based on a single measurement) will result in false-positive diagnoses and an overestimation of NIHL. This is particularly pronounced where:

- The depth of the notch / bulge is relatively small and just meets the diagnostic criteria R3 of the ‘Coles Guidelines’
- The notch / bulge occurs just at 6.0 kHz;
- The notch / bulge is unilateral (unless there is genuine unilateral exposure to noise such as from firearms).

McBride and Williams (2001) found that ‘the 6 kHz notch is variable and of limited importance’ in confirming a diagnosis of NIHL.

Luxon and Prasher (2007) state that:

‘...even with trained personnel, there are often appreciable differences in PTA results when different audiologists test an individual. These variations can arise from differing technique between the testers or from changes in the
individual’s subjective response to the test, despite stable audiological function. These factors can lead to threshold variations in the range of 6-11 dB.

Patients with noise exposure who have mild losses or minimal variations in their PTA results must be assessed bearing in mind the above factors.

Schlauch and Carney (2011) concluded that:

1. Notches that are observed at 6.0 kHz should be viewed with suspicion. Both the large variability in obtained thresholds using this frequency as well as problems in calibration for this frequency when supra-aural earphones are used contribute to this problem.

2. Notches at 3.0 kHz and 4.0 kHz, when they barely meet the criteria of Coles et al. (2000) or Niskar et al. (2001), should be considered as only ‘suggestive’ of a potential NIHL-shallow notches are often artifactual.

3. Consider unilateral notches suspect, unless there is a history of asymmetric noise exposure (such as in rifle or shotgun shooting).

3. The Coles Guidelines

There is much to commend in the Guidelines but they are flawed and the ‘thresholds’ to reach a positive diagnosis are set too low.

4. Inappropriate use of the Guidelines

It is often wrongly assumed that a positive diagnosis of NIHL is always made out where there is a notch or bulge of +10 dB bilaterally / in the ‘better ear’ at 3, 4 or 6 kHz. The Guidelines only allow a positive diagnosis where there is sufficient occupational noise exposure—measured as a Noise Immission Level (NIL) of 100 dB. Many cases now involve relatively modest exposures for modest durations where the overall NIL is likely to be less than 100 dB. In such cases a positive diagnosis requires a notch or bulge of at least 20 dB.

5. Diagnosis based on a single audiogram

Diagnosis of NIHL cannot reliably be established on the basis of a single audiogram—whichever diagnostic criteria are applied. Positive diagnosis rates fall with repeat audiometry.

There are a number of authorities which therefore advocate repeat audiometry (either within the same test or by repeat audiometry) to reduce the incidence of false positive diagnoses of NIHL which arise from audiometric error and threshold variability. Repeat testing of thresholds is required to reach a robust and clinically valid diagnosis of NIHL.

Burns and Robinson (1970) strongly advocated (within the context of occupational health surveillance), that audiometry be performed at least 3 times, preferably not at one sitting.

The ‘Black Book’ states:

‘… when testing the hearing of a case that seems borderline... it will usually help to carry out one of more re-tests at the defining frequencies with repositioning of the earphones between tests. The results of each re-test should be plotted on an audiogram and/or tabulated in the report.’
Sclauch and Carney in the Journal of Speech, Language and Hearing Research estimate the potential for false-positive rates and state that audiomeric error could be improved by repeating and averaging threshold measurements. They recommend that:

‘The precision of clinical decisions could be improved by basing decisions on repeated measures of thresholds...’

In a more recent paper in the American Journal of Audiology Sclauch and Carney state that:

‘...pure tone thresholds do not have perfect precision. Thresholds vary somewhat from one test to the next. For many applications, this variability is inconsequential, but these limits in the precision become more important when the goal is to identify a minimal hearing loss or a hearing loss configuration with small threshold differences between adjacent frequencies, as in notched audiograms observed in persons with incipient NIHL. The chief sources of this variability include tester and participant experience and motivation, the test procedure itself, the test equipment, standards for calibration, as well as the way that the range of normal hearing and hearing loss are defined’.

The authors go on to conclude that:

‘To improve the diagnostic effectiveness of pure tone audiometry...we advocate obtaining an accurate baseline audiogram that should include multiple measurements of threshold. These separate measurements should involve the removal and replacement of the earphones’.

This has since been ‘codified’ in the BSA 2011 Recommended Procedure for pure-tone audiometry with repeat testing in the same sitting to ensure consistent and reliable results within 5 dB at each frequency and with the more sensitive threshold being taken as the true threshold.

The solution

We would recommend that accurate repeat audiometry should be performed pre-litigation once the claimant's own medical evidence is available and where:

- There are audiometric indicators of NOHL (probably 30% of claims);
- The audiometric notch / bulge as defined by the Coles Guidelines is modest at between 10-20dB bilaterally / in the 'better ear' and could possibly arise from audiometric error / variability (probably over 50% of all NIHL claims where there is a +Coles diagnosis);
- The notch/bulge is just at 6.0kHz;
- The nature of noise exposure is relatively modest with less than 10 years of exposure. In such cases a majority of people exposed would not develop any measurable NIHL.

As a note of caution we would not advocate that the repeat audiometry be carried out by High Street audiology providers. Such providers may be inexperienced in carrying out audiology in the context of NIHL claims and may not be able to conform to the BSA guidelines on recommended procedures for audiometry. Using such services may again result in audiograms with worse than actual thresholds and simply confirm the false positive diagnosis of NIHL.

Can NIHL be de minimis? (BCDN Edition 3)

De minimis principles

Negligence is actionable only on proof of damage. Whilst such damage need not be substantial it must be more than minimal.
As a matter of policy a claim for negligence will only exist where damage has been caused that is worth suing for, and not for trivial injuries. If negligence has produced a physiological change that is neither visible, nor symptomatic and in which no way impairs the bodily function, it should not attract legal liability.

These principles were expressed in Cartledge v Jopling [1963] AC 758 by Lord Pearce (page 779):

“...it is for a judge or jury to decide whether a man has suffered any actionable harm and in borderline cases it is a question of degree... It is a question of fact in each case whether a man has suffered material damage by any physical changes in his body. Evidence that those changes are not felt by him and may never be felt tells in favour of the damage coming within the principle of de minimis non curat lex. On the other hand evidence that in unusual exertion or the onslaught of disease he may suffer from his hidden impairment tells in favour of the damage being substantial”.

It is often a difficult question to determine when an injury passes from being de minimis to one which is sufficiently significant to find a cause of action.

However in light of anecdotal reports of increasing numbers of minimal hearing loss claims, it is opportune to consider whether a de minimis defence can be advanced in such cases.

**Human hearing and speech**

The human range of hearing is between c. 20 Hz-20 kHz in children and young adults but with the high range frequencies at 8 kHz and above fading with age.

The human voice produces sound within a frequency range of about 60 Hz-7 kHz but most human speech falls within a range of 250 Hz-3 kHz. The primary importance of sound within the human speech frequency range of 250 Hz-3 kHz is internationally recognised in the transmission of speech through telecommunications networks with circuitry designed to capture sound within that range only.

However, sound at 4 kHz can also play a part in speech recognition. According to an Irish Expert Hearing Group ‘each individual frequency supplies a different quantity of information for understanding speech. All frequencies between 250Hz–4,000Hz contribute to speech comprehension, but some are more important than others. The most important frequency for understanding speech in a quiet environment is 2,000Hz. The other frequencies, e.g. 250Hz, 500Hz and 4,000Hz, are less important’. Importantly the same Expert Hearing Group concluded that ‘frequencies of 6,000Hz and 8,000Hz carry no information for speech comprehension’. This is reflected within the figure below reproduced from the Group’s report showing the frequency ranges important for understanding speech.

![Figure: Frequency range important for understanding speech](image-url)
De minimis judgments

Can a de minimis defence succeed in a NIHL claim with minimal losses?

The judgment of HHJ Inglis J in the Nottingham Textile Litigation [2007] (paragraph 125) would suggest not:

'125. This debate, started in correspondence and carried into the witness box at the end of the case by Professor Lutman, did not arise in a satisfactory way. If there is work to be published in the future, then I think any effect on awards of damages in hearing loss cases must await such publication and peer review. I do not accept, however, the argument for the Defendants based on de minimis. The smallness of a level of risk may be relevant in assessing how an employer should act in particular circumstances. It does not prevent compensation for hearing loss being appropriate where the impairment has led or will lead to some level of disability, even if only minor. For small amounts of noise damage that will lead to awards at the bottom end of the damages scale, the key decision in my judgment is whether a real degree of noise induced impairment can be confidently diagnosed on the balance of probability. I have said in that connection where there are low noise exposures in particular that the approach to that decision, in order to pass the standard of proof, must be robust. If it is sufficiently robust, then there will be a characteristic degree of impairment, typically at 4 kHz, but certainly in the range 3-6 kHz. There is likely also to be a threshold at least at one frequency raised above what would be expected by age alone. I accept that such impairment will, either at the time of examination, or later with the development of presbyacusis, result in disability that develops earlier and is more severe at the time of life it develops than would otherwise be the case. The reference to small degrees of noise induced loss being overwhelmed is misleading. In time, depending upon the degree to which presbyacusis develops, it may be. But the evidence of Professor Lutman that noise induced loss and age related loss are broadly additive at least up to about a threshold of 40dB is borne out by ISO1999, and as explained by Professor Robinson in his 1987 paper. I do not accept that impairment at 4 kHz (or even at 6 kHz in those cases where the degree of impairment at that frequency will support a diagnosis in a low noise case) is irrelevant because it will not have any practical effect on the Claimant. As to 4 kHz in particular I found the evidence of Dr Rajput convincing. As a result of extensive clinical experience she attaches great importance to 4 kHz, so much so that she used 4 kHz to arrive at an average in the one case she was concerned with. She was supported in that approach by Mr McCombe. Both he and Dr Yeoh included 6 kHz as being in the range of frequencies important to speech.'

However the de minimis argument was only a very small part in what was a complex and lengthy trial. Was evidence properly developed and marshalled on the issue and were the right cases selected to advance the argument?

The judgement must also be put in context of arising before the Supreme Court’s extensive analysis of the principle of de minimis in the Pleural Plaques Test Litigation 2007 where a majority found that asymptomatic pleural plaques, which were accompanied by the usual risks for future asbestos related disease and feelings of worry, did not constitute ‘personal injury’ and so no cause of action could be pursued.

There have since been 2 further decisions on whether injuries were de minimis. In Hussain v West Mercia Constabulary, the CA held that transient physical symptoms caused by anxiety or stress did not amount to physical
or psychiatric injury and was therefore de minimis. In *Fryers v Belfast Health and Social Care Trust*, a needle stick injury was also found to be within the de minimis principle but this was subsequently reversed on appeal [2009] (NICA 57).

In *Sienkiewicz v Greif (UK) Limited*, Lord Phillips, at [108], commented that it would be impossible to define quantitatively what is de minimis.

Arguably it is not the injury but the resulting disability (in the past, now or in the future) which is paramount in determining the likely success of any de minimis defence—or adopting the words of Lord Hoffman in *Plaques* [19] is the claimant ‘appreciably worse off’?

The matter was recently considered in the context of NIHL in the 1st instance decision of *Hughes v Rhondda Cynon Taff County Borough Council* [2012]. The claimant alleged NIHL arising from exposure to excessive noise during employment with the defendant as a builder’s labourer between 1969-1986. The claimant started with difficulties in hearing speech against a noisy background from 2009 when aged 60. Breach of duty was admitted but causation was in dispute and it was further contended that any NIHL which may have existed was insignificant and fell to be de minimis. There were 5 audiograms considered by the court none of which showed any hearing disability within the 1-3 kHz frequency range and applying the ‘Black Book’ method for assessment.

In oral evidence the claimant’s medical expert for the first time advanced the argument that losses at 4 kHz gave rise to a disability. It was common ground that there were a few decibels of loss at 4 kHz caused by noise but the issue was whether it constituted a disability?

The judge found that any NIHL at 4 kHz did not give rise to any disability. The claimant’s difficulties in hearing speech arose from age related and idiopathic losses. The claimant’s hearing was still within a range of normal hearing for a man of his age and as such there was no ‘disability’. The claimant was not ‘appreciably worse off’ and the change in hearing fell within the de minimis principle so as not to be actionable.

**Success in running a de minimis defence**

*Hughes* demonstrates that de minimis defences can succeed in NIHL claims. The appropriate selection criteria for running a successful de minimis defence are:

- The main speech frequencies between 1-3 kHz unaffected by any NIHL;
- NIHL of only a few decibels at 4 kHz or 6 kHz. It is preferable that the NIHL is only at 6 kHz-firstly as there are studies to support the role of hearing at 4 kHz for speech recognition (which do not appear to have been considered in *Hughes*) and secondly, as considered in a future edition of BC Disease News, it is possible to argue that any loss at 6 kHz is transient or spurious or, if the loss is permanent, does not arise as a result of NIHL;
- Asymmetry with significantly poorer thresholds in the ‘worse ear’ which cannot be caused by noise;
- An elderly claimant with already significant non noise related losses such that it can be argued that any disability from NIHL is completely subsumed by other losses / disability. Whilst the effects of NIHL and age related losses are initially additive the effect of the noise component progressively diminishes over time. By the age of 80 it is arguable that it makes virtually no difference to an individual’s hearing ability what noise exposure has arisen (although be aware of the onset of any disability being ‘brought forward’ as a result of the NIHL).

Not all of these selection criteria need to be present for a de minimis defence -but the more present the better the prospects of success.

We would also emphasise the importance of developing proper medical evidence supported by authorities. It seems that success in *Hughes* was partly due to the claimant’s expert evidence as to disability at 4 kHz only arising at the trial itself. There are studies which suggest that hearing at 4 kHz (see earlier) and possibly 6 kHz play some role in speech recognition. Hearing aid manufacturers are also starting to introduce ‘extended bandwidth’ hearing aids which are said to amplify sounds between 6-8 kHz (traditionally insufficient amplification at these frequencies coupled with ‘feedback’ prevented this). However we are unaware of any authorities (as yet) which show significant improvements in speech recognition with the use of extended bandwidth amplification.
Quantum in NIHL claims (BCDN Edition 6)

*This article has been amended from the original to represent subsequent developments.*

The Guidelines for the Assessment of General Damages in Personal Injury Cases, published by the Judicial College (previously known as the Judicial Studies Board (JSB) Guidelines) (the ‘Guidelines’), provide guideline bracket figures for awards made for PSLA.

In NIHL claims PSLA awards are dependent upon:

- the extent of hearing loss or more particularly the disability arising from such loss;
- whether tinnitus is also present and, if so, the severity of the same and impact upon the claimant, and;
- the claimant’s age (the older the claimant the less the impact of any NIHL given that this is often subsumed by age related and possibly other causes of hearing loss).

NIHL awards fall within Chapter 4, section (B)(d) of the Guidelines. The 12th edition of the guidelines provide two sets of figures, one without the 10% uplift in general damages and one with the 10% uplift. The guidelines provide:

**Chapter 4(B)(d) Partial Hearing Loss or/and Tinnitus**

This category covers the bulk of deafness cases which usually result from exposure to noise over a prolonged period. The disability is not to be judged simply by the degree of hearing loss; there is often a degree of tinnitus present. Age is particularly relevant because impairment of hearing affects most people in the fullness of time and impacts both upon causation and upon valuation.

<table>
<thead>
<tr>
<th>Category</th>
<th>Without 10% Uplift</th>
<th>With 10% Uplift</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Severe tinnitus and hearing loss</td>
<td>£21,800 to £33,500</td>
<td>£23,980 to £36,850</td>
</tr>
<tr>
<td>(ii) Moderate tinnitus and hearing loss or moderate to severe tinnitus or hearing loss alone.</td>
<td>£11,000 to £21,800</td>
<td>£12,100 to £23,980</td>
</tr>
<tr>
<td>(iii) Mild tinnitus with some hearing loss.</td>
<td>£9,250 to £11,000</td>
<td>£10,175 to £12,100</td>
</tr>
<tr>
<td>(iv) Slight or occasional tinnitus with slight hearing loss.</td>
<td>£5,400 to £9,250</td>
<td>£5,940 to £10,175</td>
</tr>
<tr>
<td>(v) Slight hearing loss without tinnitus or slight tinnitus without hearing loss.</td>
<td>Up to £5,150</td>
<td>Up to £5,665</td>
</tr>
</tbody>
</table>

**Classifying the extent of NIHL**

There is descriptive ambiguity in the Guidelines. How do you determine what is ‘slight’, ‘some’, ‘moderate’ or ‘severe’ NIHL under the Guidelines? There is a variety of medical classifications for hearing disability according to overall hearing loss. These generally apply a ‘low fence’ threshold to show the point at which hearing loss starts to tip into a subjective disability. So for example the World Health Organisation (WHO) classification of hearing disability, shown...
below, only recognises a slight impairment in hearing once the overall loss exceeds 25 dB (at frequencies 0.5,1,2 and 4 kHz in the ‘better ear’).

**Table: WHO classification of hearing loss / disability**

<table>
<thead>
<tr>
<th>GRADE OF IMPAIRMENT</th>
<th>AVERAGE LOSS 0.5,1,2,4 kHz</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 (No impairment)</td>
<td>25 dBHL or less (better ear)</td>
</tr>
<tr>
<td>1 (Slight impairment)</td>
<td>26-40 dBHL (better ear)</td>
</tr>
<tr>
<td>2 (Moderate impairment)</td>
<td>41-60 dBHL (better ear)</td>
</tr>
<tr>
<td>3 (Severe impairment)</td>
<td>61-80 dBHL (better ear)</td>
</tr>
<tr>
<td>4 (Profound impairment)</td>
<td>81 dBHL+ (better ear)</td>
</tr>
</tbody>
</table>

These medical classifications of disability cannot be used as a direct interpretation of the JC Guidelines as:

(i) they relate to the overall hearing loss rather than NIHL;
(ii) NIHL can be compensated where there is no real subjective disability and the overall loss is below the low fence threshold;
(iii) hearing thresholds at different frequencies and different formulae are used in the assessments.

However, the WHO classification can be of interpretive assistance if a 10dB deduction is made from the average losses shown in the right hand column of the table above. Claimants in NIHL claims are typically males aged between 30-70+. The AAHL between this age range is 1.66-20dB with a median at c.10 dB. If we deduct this 10 dB AAHL from the WHO classifications then we can broadly correlate it with the JC classifications as follows:

<table>
<thead>
<tr>
<th>Description of loss / disability</th>
<th>Level of NIHL loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slight</td>
<td>Up to 15 dB</td>
</tr>
<tr>
<td>Some</td>
<td>16-30 dB</td>
</tr>
<tr>
<td>Moderate</td>
<td>31-50 dB</td>
</tr>
<tr>
<td>Severe</td>
<td>51 dB+</td>
</tr>
</tbody>
</table>

We have shown our interpretation of ‘hearing loss’ in the JC Guidelines below with added text shown in red.

**Table: The ‘JC / BC’ Guidelines**

(i) Severe tinnitus and any noise induced hearing loss

(ii) Moderate tinnitus and slight–some noise induced hearing loss of up to 30 dB or moderate to severe tinnitus or moderate–severe noise induced hearing loss alone exceeding 31 dB

| (i) Severe tinnitus and any noise induced hearing loss | £23,980-£36,850 |
| (ii) Moderate tinnitus and slight–some noise induced hearing loss of up to 30 dB or moderate to severe tinnitus or moderate–severe noise induced hearing loss alone exceeding 31 dB | £12,100 to £23,980 |
(iii) Mild tinnitus with some **noise induced** hearing loss of between 16-30 dB. | £10,175 to £12,100
---|---
(iv) Slight or occasional tinnitus with slight **noise induced** hearing loss of up to 15 dB | £5,940 to £10,175
(v) Slight **noise induced** hearing loss of up to 15 dB without tinnitus or slight tinnitus without hearing loss. | Up to £5,665

The BC Legal Ready Reckoner Table

Using this interpretation of the guidelines we have developed a Ready Reckoner Table which estimates PSLA awards based on the age of the claimant and the severity of the symptoms. The Table appears on the next pages with accompanying explanatory notes, detailing how the table was produced.

**The BC Legal NIHL Quantum Guide**

The Table is extracted from our new NIHL Quantum Guide. Our noise tool ABCNoise also includes a PSLA auto-calculator—go to [http://www.bc-legal.co.uk](http://www.bc-legal.co.uk).

**NIHL PSLA Ready Reckoner**

**Explanatory Notes:**

1. Figures in red bold are the lower and upper bracket of the 12th edition of the JC Guidelines. The lowest award (top right corner) represents HHJ Inglis’ view in the Nottingham and Derbyshire Deafness Litigation [2007] EWHC B1 (QB) [127] that the lowest award for NIHL was likely to be in the region of £3,710 (updated to October 2013).

2. It is assumed that awards at the bottom end of the JC bracket will involve cases where (i) the claimant was elderly and likely to have experienced some hearing loss anyway; and (ii) there was limited hearing loss and no tinnitus. The lower bracket figure of £3,710 is therefore placed in the top right hand corner of the table (claimants aged 70+ / limited hearing loss and no tinnitus).

3. Conversely, the upper bracket figure of £33,500 occupies the bottom left hand side of the table (claimants aged up to 40 with severe hearing loss and severe tinnitus).

4. Estimated awards at different severity of symptoms and ages are based on interpolation of the JC Guidelines between the far left and far right columns.

5. Two tables are provided, one for figures without the 10% uplift and one for figures with the 10% uplift.
# NIHL PSLA Ready Reckoner

**READY RECKONER TABLE: AWARDS BY AGE AND SEVERITY OF SYMPTOMS (WITHOUT 10% UPLIFT)**

<table>
<thead>
<tr>
<th>NIHL (dB)</th>
<th>Tinnitus</th>
<th>Up to 30</th>
<th>31-35</th>
<th>36-40</th>
<th>41-45</th>
<th>46-50</th>
<th>51-55</th>
<th>56-60</th>
<th>61-65</th>
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<td>£4,505</td>
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<td>£4,030</td>
<td>£3,870</td>
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<tr>
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<td>£8,820</td>
<td>£8,390</td>
<td>£7,965</td>
<td>£7,535</td>
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<td>£6,255</td>
<td>£5,830</td>
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</tr>
<tr>
<td>Mild</td>
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<td>£10,420</td>
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<td>£9,820</td>
<td>£9,525</td>
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<td>£17,290</td>
<td>£16,090</td>
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<td>£12,490</td>
<td>£11,290</td>
<td>£10,090</td>
<td></td>
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<tr>
<td>Severe</td>
<td>£33,500</td>
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<td>£28,300</td>
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<td>£6,640</td>
<td>£6,480</td>
<td>£6,325</td>
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<td>£5,845</td>
<td>£5,685</td>
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<td></td>
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<tr>
<td>Slight</td>
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<td>£9,835</td>
<td>£9,510</td>
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<td>£7,875</td>
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</tr>
<tr>
<td>Mild</td>
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<td>£10,620</td>
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<td>£13,400</td>
<td>£12,200</td>
<td>£11,000</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>£33,500</td>
<td>£32,310</td>
<td>£31,110</td>
<td>£29,910</td>
<td>£28,710</td>
<td>£27,510</td>
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<td>£11,680</td>
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<td>£13,400</td>
<td>£12,200</td>
<td>£11,000</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
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<td>£32,420</td>
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<td>£20,330</td>
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<tr>
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<tr>
<td>Moderate</td>
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<td>£29,690</td>
<td>£28,820</td>
<td>£27,945</td>
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<td>£24,455</td>
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<tr>
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<td>£24,530</td>
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</tr>
</tbody>
</table>
### READY RECKONER TABLE: AWARDS BY AGE AND SEVERITY OF SYMPTOMS (WITH 10% UPLIFT)

<table>
<thead>
<tr>
<th>NIHL (dB)</th>
<th>TINNITUS</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Up to 30</td>
</tr>
<tr>
<td>Slight</td>
<td>None</td>
<td>£5,665</td>
</tr>
<tr>
<td></td>
<td>Slight/occasional</td>
<td>£10,175</td>
</tr>
<tr>
<td></td>
<td>Mild</td>
<td>£12,100</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>£22,980</td>
</tr>
<tr>
<td></td>
<td>Severe</td>
<td>£36,850</td>
</tr>
<tr>
<td>Some</td>
<td>None</td>
<td>£7,665</td>
</tr>
<tr>
<td></td>
<td>Slight/occasional</td>
<td>£11,175</td>
</tr>
<tr>
<td></td>
<td>Mild</td>
<td>£12,100</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>£23,980</td>
</tr>
<tr>
<td></td>
<td>Severe</td>
<td>£36,850</td>
</tr>
<tr>
<td>Moderate</td>
<td>None</td>
<td>£18,980</td>
</tr>
<tr>
<td></td>
<td>Slight/occasional</td>
<td>£20,645</td>
</tr>
<tr>
<td></td>
<td>Mild</td>
<td>£22,310</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>£23,980</td>
</tr>
<tr>
<td></td>
<td>Severe</td>
<td>£36,850</td>
</tr>
<tr>
<td>Severe</td>
<td>None</td>
<td>£23,980</td>
</tr>
<tr>
<td></td>
<td>Slight/occasional</td>
<td>£27,200</td>
</tr>
<tr>
<td></td>
<td>Mild</td>
<td>£30,420</td>
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<tr>
<td></td>
<td>Moderate</td>
<td>£33,640</td>
</tr>
<tr>
<td></td>
<td>Severe</td>
<td><strong>£36,850</strong></td>
</tr>
</tbody>
</table>
The employer's date of knowledge in NIHL claims (BCDN Edition 15)

Introduction

Exposure to excessive noise has been recognised as a danger for over 100 years. Indeed, the resulting hearing loss was often described by association with the occupations in which it arose, such as Blacksmiths' deafness. Nevertheless, it was not until the latter part of the 20th century that thought was directed at minimising the problem in the industrial context. In June and July 1963 respectively, the Ministry of Labour's Noise and the Worker leaflet and the Wilson Committee's report were published, officially identifying the risk of excessive industrial noise.

In negligence, an employer is not liable for injury which arises from dangers that are not reasonably foreseeable. The earliest NIHL claims appeared in the 1960s but were unsuccessful as a result of exposure occurring many years before the risks were foreseeable. Therefore the question arises: when will an employer be held to have known about the risk of excess noise? Moreover, there is the question of 'guilty knowledge'; just because there is knowledge (actual or constructive) it does not mean that it is automatically guilty knowledge. An implementation period is normally granted before an employer will be in breach of their obligations. We will address these two issues.

Initial approach

The first judicial indication of the date at which an employer would be held to know about the danger of excessive noise was provided in Thompson v Smiths Shiprepairers (North Shields) Ltd.

In that case, concerning claims made by shipbuilders, the court held that the employer had actual knowledge by 1963, by reason of the abovementioned publications. This judgment led to a widespread approach of treating the date of knowledge as 1963.

Flexibility?

Previous authority had suggested that in a developing field of knowledge the date of knowledge is not fixed. Instead it is metamorphic, reflecting developing knowledge and the availability of that knowledge to each employer. Swanwick J held, in Stokes v Guest, Keen and Nettlefold, that 'the overall test is still the conduct of the reasonable and prudent employer, taking positive thought for the safety of his workers in the light of what he knows or ought to know; where there is a recognised and general practice which has been followed for a substantial period in similar circumstances without mishap, he is entitled to follow it, unless in the light of common sense or newer knowledge it is clearly bad; but, where there is developing knowledge, he must keep reasonably abreast of it and not be too slow to apply it.' This clearly indicates a flexible approach to an employer's date of knowledge, based on the type of industry, the particular employer and the level of exposure. Indeed, a small employer with little access to developing knowledge would be expected to take action later than a larger employer in a highly susceptible industry with access to the latest research.

So how has this flexibility been applied? In Down v Dudley, Coles, Long Ltd, it was held that 1966 was too early for a date of knowledge. The ordinary reasonable employer, safety officer or foreman in 1966 would not be aware of the dangers of cartridge-assisted nail-fixing tools.

In Kellet v British Rail Engineering Ltd however, Popplewell J held the defendant's actual date of knowledge to be 1955. The defendant had actively considered the problem of exposure to noise and had been advised by a medical officer to issue employees with hearing protection.

Conversely, in Craven v Tonks Transport, it was held that constructive knowledge was present from 1972, following the publication of the Department of Employment's Code of Practice on Noise. The defendant was a lorry company and it was only with the publication of this general national guidance that it would have been alerted to the risks.

This flexibility was more recently affirmed by the decision of the Supreme Court in Baker v Quantum Clothing Group. The Court held that not all employers should be fixed with the same date of knowledge in 1963. Moreover, knowledge in that year should be fixed from the middle of that year onwards thereby reflecting the publication of the two documents in the earlier part of the year. Smaller and medium sized employers, particularly in industries...
not associated with excessive noise, should have a later date of knowledge. This may be as late as the 1972, following publication of the Department of Education’s Code of Practice.

Although there is flexibility, it seems that the date of knowledge is unlikely to ever be after 1972: the Department of Employment’s code should have been in the minds of all employers. By then, the dangers of exposure to noise exceeding 90 dB(A) Lepd (noise over an eight hour day) were clear.

Implementation period

Once an employer knows or ought to know about the risk, it is unrealistic for them to immediately take measures to reduce the risk. Mustill J recognised as much in Thompson: ‘...one must answer this question. From what date would reasonable employer, with proper but not extraordinary solicitude for the welfare of his workers, have identified the problem of excessive noise in his yard, recognised that it was capable of solution, found a possible solution, weighed up the potential advantages and disadvantages of that solution, decided to adopt it, acquired a supply of protectors, set in train the programme of education necessary to persuade the men and their representatives that the system was useful and not potentially deleterious, experimented with the system, and finally put it into full effect’.

So what periods have the courts given? In Bowman v Harland and Wolff the court suggested the likely implementation period given would be two years.

In Armstrong v British Coal Corporation the court said the implementation period would be at least two years. Further, it suggested that the implementation period is not set in stone.

Finally, in Smith v Wright and Beyer Ltd, Brookes v South Yorkshire Passenger Transport Executive, and Maxfield v ATS North Eastern Ltd, the courts held the implementation period was two years.

In Baker, the Supreme Court rejected the Court of Appeal’s view that the implementation period was 6-9 months. Instead, it agreed with Judge Inglis’ view at first instance that the period was two years. So, with an implementation period of two years, the date of breach in relation to the 1963 documents is in the region of 1965, and in relation to the 1972 Code of Practice the date of breach is 1974.

Conclusion - implications for disease litigation

Baker confirmed the long established rule that the date of knowledge is not fixed, it can change depending on the circumstances. Moreover, the implementation period for measures is two years. It shows that investigations should always focus on when a particular industry could be reasonably expected to have been aware of the risks and, where appropriate, arguments made to the effect that the date of knowledge was later than suggested by the claimant.

In NIHL claims a 1963 date of knowledge should not automatically be assumed. Arguably this (or an earlier date) only applies to heavy industry where there was significant exposure to noise.

The publication of documents in 1963 which gave rise to this assumed date of knowledge was not widespread. Arguably for many industries and occupations a later 1974 guilty date of knowledge may be relevant.

Whilst we are not advocating change to the IDCWP Guidelines, which apply an uniform date of knowledge of 01.01.1963 for clarity and consistency of claims handling, such foreseeability arguments may be usefully employed by defendants where all their exposure occurs pre 1974.

Keefe v Isle of Man Steam Packet Co Ltd – a malevolently deployed case? (BCDN Edition 16)

Introduction

In the last edition of Disease News we discussed two cases: Goode v Abertawe Bro Morgannwg, a claim for so called ‘acoustic shock’, and Matthews v Lloyds Animal Feeds Limited, BC Legal’s first NIHL trial. These cases were linked in two ways. Firstly, and obviously, they were claims for damage to hearing as a result of exposure to allegedly
excessive noise. Secondly, and less obviously, in both cases the claimants attempted to deploy the case of *Keefe v Isle of Man Steam Packet Co Ltd* to their advantage. This is a case that is increasingly being deployed by claimants.

In this article we will examine the *Keefe* case and define the limits of its principle. We will show that it is a limited principle and was improperly advanced in both of the abovementioned cases.

**The Keefe Principle**

*Keefe* concerned a claim for NIHL. The claimant alleged that he had been wrongfully exposed to excessive noise during his employment as a seaman working in ships’ galleys. The defendant contended that the noise levels were not excessive. While there was lay evidence to the effect that the claimant had been exposed to excessive levels of noise, there was no actual evidence of the noise that he was exposed to. Longmore LJ recognised, at [18], that it might be difficult for the Court of Appeal to reverse a finding by the judge at first instance on a factual matter, even if it had reservations about it correctness. However, that was not the end of the matter. The reason there was not more accurate evidence about the level of noise was the defendant had breached its duty by failing to take accurate noise measurements.

His Lordship continued, at [19]: ‘[i]f it is a defendant’s duty to measure noise levels in the place where his employees work and he does not do so, it hardly lies in his mouth to assert that the noise levels were not, in fact, excessive. In such circumstances the court should judge a claimant’s evidence benevolently and the defendant’s evidence critically…a defendant who has, in breach of duty, made it difficult or impossible for a claimant to adduce relevant evidence must run the risk of adverse factual findings…’

His Lordship said this had been accepted law since the 1721 decision in *Armory v Delamirie*. Furthermore, in support of his argument, Longmore LJ relied at [19] on the related, albeit different, principle in *British Railways Board v Herrington*, that a defendant who fails to calls witnesses at his disposal who could provide relevant evidence to a particular issue, runs the risk of adverse factual findings on that issue.

A common element in both these principles is the element of wrongdoing on the part of the defendant. In the case of the *Keefe* principle, a defendant has obstructed a claimant from adducing relevant evidence by reason of a breach of duty. The application of the principle is dependent upon a finding of breach of duty, as demonstrated in the principle’s recent application in *Robinson v North Bristol NHS Trust*. In the case of the *Herrington* principle, a defendant has purposefully denied the court of relevant evidence on a matter in issue, although it is a legitimate tactical decision.

Accordingly, the principles can have no application where there is no wrongdoing on the part of the defendant. It is for this reason that *Keefe* was wrongfully deployed in both *Goode* and *Matthews*.

**Malevolent Deployment of the Keefe Principle**

In *Goode*, the *Keefe* principle was wrongfully deployed and could have no application because there simply was no breach of duty by the defendant. Moreover, it was noted that the claimant had not even demonstrated that they would have been disadvantaged in a way similar to *Keefe* by reason of any breach of duty. The claimant’s argument on *Keefe* was properly rejected.

In *Matthews*, *Keefe* was wrongfully deployed because there was no breach of duty. Indeed, the defendant had complied with its duty by carrying out noise surveys. Unlike *Keefe*, there was evidence of the noise the claimant was exposed to; it just did not support the claimant’s case. Moreover, in *Keefe* there was supporting independent evidence that allowed the court to make its ‘benevolent’ findings: the lay evidence. On what possible basis could benevolent findings have been made in *Matthews*? There was no other supporting evidence to base them upon. Unfortunately the Recorder in this case did not rule on the *Keefe* argument, it being unnecessary to do so.

**Restricting the Principle**

*Keefe* could not have properly been applied in *Goode* or *Matthews*. What the claimants were arguing for then was a principle to the effect that wherever a claimant lacks the evidence to definitively make their case, we should nevertheless judge their evidence favourably. Such a principle should be vigorously resisted. Acceptance of this principle would corrode the fundamental proposition that a claimant must prove their case on the balance of probabilities. The *Keefe* principle is justified because the defendant’s wrongdoing prevents the claimant from doing
exactly that. It does not come to the aid of a claimant who simply cannot establish their case. The principle is a limited one which can be stated as follows: where a defendant, by reason of a breach of duty, makes it difficult or impossible for a claimant to adduce relevant evidence, the defendant risks adverse findings of fact against them. In those circumstances alone a claimant’s evidence will be judged benevolently; the defendant’s evidence will be judged critically. The principle goes no further than this.

**Conclusion**

*Keefe* can be a powerful weapon in a claimant’s armoury. Moreover it is not an unexpected or unjustified weapon: why should a claimant be prevented from establishing their case by reason of a defendant’s wrongdoing? However, it is not a weapon to be deployed in every battle to ensure the victory of the claimant. Rather, it is a weapon to be deployed in limited circumstances, to ensure an equality of arms where a defendant has gained an unfair advantage by wrongfully making it difficult for a claimant to win the battle. In these circumstances its use is justified. Beyond these circumstances, its deployment is unjustified and should be vigorously resisted.

**Subjective evidence of noise levels in NIHL (BCDN Edition 19)**

**Introduction**

In this article we look at the use and reliability of estimated noise levels from subjective witness accounts in NIHL claims.

A common element in NIHL claims is lay, subjective, evidence on the apparent level of noise that the claimant has allegedly been exposed to. Ordinarily this comes from the claimant themselves and other lay witnesses called by the claimant.

More often than not, this evidence takes the form of the witness estimating how high the noise levels were by reference to needing to shout over a certain distance in order to be heard. This results in a need to translate those estimations into a usable noise level.

**Estimated noise levels**

Judging the level of noise by reference to difficulty in communication was adopted as a method as early as 1963, when the Ministry of Labour published ‘Noise and the Worker’. A prime consideration for an employer when trying to determine if there was a noise issue in their workplace was whether there were communication difficulties at work (although there was no guidance on how difficult it had to be). The Department for Employment’s 1972 Code of Practice was more specific, suggesting that noise limits may have been exceeded and should be surveyed where ‘it was necessary to shout in order to be audible to a person about one metre distant’. Research has led to the production of tables of estimated noise levels. One notable piece of research was conducted by Professor Lutman in 1996, which is reproduced in Sweet and Maxwell’s ‘Occupational Illness Litigation’. The table of estimated values it proposed is shown below (‘the Lutman table’):

<table>
<thead>
<tr>
<th>Voice level</th>
<th>Distance of speaker to listener</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>4 feet</td>
</tr>
<tr>
<td>Normal</td>
<td>&lt;80</td>
</tr>
<tr>
<td>Raised</td>
<td>87</td>
</tr>
<tr>
<td>Very loud</td>
<td>93</td>
</tr>
<tr>
<td>Shout</td>
<td>99</td>
</tr>
<tr>
<td>Impossible to communicate</td>
<td>-</td>
</tr>
</tbody>
</table>

It can be seen that if a ‘raised’ voice is required to communicate at a distance of 4 feet (1.21m) between people, then ambient noise levels of 87dB(A) are suggested. If the voice needs to be raised to ‘very loud’ or ‘shouting’ is required, this suggests ambient noise levels will be in excess of 90dB(A).

There are two problems with these tables. The first is that the listed voice levels are necessarily subjective; what is a ‘shout’ to one person may very well be only a ‘very loud’ voice level to another. There is no objective way of
determining an individual’s voice level without equipment to measure it, which, if it were available, would defeat the need for an estimated noise level table.

The second issue is that these tables of estimated noise levels do not all accord with one another. For example, Guidance L108, produced alongside both the Control of Noise at Work Regulations 1989 and the Control of Noise at Work Regulations 2005, provides different values to the Lutman table. The 1989 Guidance suggested, at [22], that noise was hazardous when people had to shout to be heard by someone 2m away. The 2005 Guidance (‘the Guidance’) provides the following table, at [36]:

<table>
<thead>
<tr>
<th>Test</th>
<th>Probable noise level</th>
<th>A risk assessment will be needed if the noise is like this for more than:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The noise is intrusive but normal conversation is possible</td>
<td>80 dB</td>
<td>6 hours</td>
</tr>
<tr>
<td>You have to shout to talk to someone 2 m away</td>
<td>85 dB</td>
<td>2 hours</td>
</tr>
<tr>
<td>You have to shout to talk to someone 1 m away</td>
<td>90 dB</td>
<td>45 minutes</td>
</tr>
</tbody>
</table>

A comparison between the two tables shows discrepancies. In the 2005 Guidance table, having to shout to be heard by someone 1m away is only 90dB, yet, in the Lutman table, over a distance of just 21cm more, the value increases significantly by 9 dB to 99dB. This is a very significant increase. As a logarithmic scale, a 3dB increase in noise levels represents a doubling of the intensity of sound. Conversely, when the distance is halved in the Lutman table (where the ambient noise is so loud that you must shout to be heard by someone 2 feet (60 cm) away) the value increases by 6dB to 105dB. Compared to the 2005 table, reducing the distance by 21 cm (from 1.21m in the Lutman table to 1m in the 2005 table) reduces the level by 9dB: 21cm makes a 9dB difference but 60cm only makes a 6dB difference. The point is that the difference between the tables cannot be explained by reason of the conversion from feet to metres. Rather, the Lutman table estimates the noise values more highly than the 2005 Guidance table, or the Guidance table estimates the noise values lower than the Lutman table.

So, if the tables are so discordant, does that mean that collectively they are of no value? At this juncture it is important to consider the relative authority of the tables. One (the Lutman table) was simply the product of research; the other (the Guidance to the Regulations) was directly in the contemplation of the rule makers when the 2005 Regulations were formulated. It was partially on this basis that the noise levels in the Regulations were set. They therefore carry considerably more weight than other estimations (unless they are proven to have been incorrect). However, a review of the cases shows that this authority has rarely been mentioned in the cases; where it has been mentioned the relative authority has not been observed.

Observations from cases

In cases where the difficulty in communication has been raised to establish excessive noise the majority have altogether ignored the fact that these tables exist. In some case this is the result of the judge being able to find excessive noise by reason (…)

For example, in Picton v Southfield Engineering, where the noise level was described as ‘so high that you were unable to hold a normal conversation without having to raise your voice in order to be heard at a distance of 2 to 4 feet’, the lay evidence was simply accepted in combination with accompanying engineering evidence. There was no reference to any tables or guides of estimated noise. Similarly, in Bell v Henlys Group PLC, where the noise level was described as ‘very high [making it] necessary to raise your voice to make yourself heard’, there was also no reference to any estimated values. Reliance was placed on the lay and expert evidence.

In those cases at least, it is readily justifiable that no reference was made to estimated values of noise levels; after all there was expert evidence available on the point. However, in Keefe v Isle of Man Steam Packet Company, there was no scientific evidence because the defendant had failed to take noise measurements, and expert evidence could no longer be acquired. The lay evidence was to the effect that hand signals were used between employees owing to the noise and that a raised voice would be necessary for conversation. But, instead of making reference to estimated noise values to establish excessive noise, the court made ‘benevolent’ findings of fact to conclude that the noise levels had been excessive. This approach was justified, the Court of Appeal said, because the defendant had wrongfully failed to take noise measurements. This principle was dealt with in the feature article
in Edition 16 of Disease News. Had the tables of estimated values been used, it may not have been necessary to use this principle at all.

In Parkes v Meridian Ltd, at [135]-[136], HHJ Inglis made reference to tables of estimated noise values. However, reference was not made to the more authoritative table in the 2005 Guidance, reference was instead made to the Lutman table. It is conceivable that HHJ Inglis had not been made aware of the Guidance (….)

In any event, the lay evidence and Lutman table was not relied on by the learned Judge because there was scientific evidence available. The Judge held, at [135], that anecdotal lay evidence cedes to scientific evidence when it is available.

In summation then, it appears that no cases have relied on tables of estimated noise levels, even where there is an absence of expert evidence. The one case that has mentioned the tables made reference to the less authoritative table and did not rely on it in any event.

Conclusion: deployment in cases

On the basis that the table in the Guidance is more authoritative, the Lutman table overestimates the noise levels. For that reason, if and when it is deployed in NIHL claims its use should be challenged. The discrepancies between it and the Guidance table should be highlighted, and the Guidance table used in preference to it.

The Guidance table can fill an evidential gap where there is a lack of scientific evidence. Moreover, use of the Guidance table could have implications for the Keefe principle. Rather than benevolent findings of fact being made in favour of claimants where there is no scientific evidence, the Guidance table could be pointed to and relied on as evidence of the noise level where it is beneficial to do so.

Tables of estimated noise values are no substitute for scientific evidence. However, they can plug evidential gaps in appropriate cases. So far they have not been effectively used. Where they are used, the table in the 2005 Guidance is more authoritative and should be preferred.

The 2005 table is also of practical use in the application of the ‘Coles Guidelines’ and the diagnosis of NIHL. The table can be used to give a broad brush indication of likely daily noise dose (Lep,d) and from that an assessment made of the employee’s likely noise immission level (NIL). Diagnostic Requirement R2 of the (…)

There must be a cumulative exposure which gives rise to a NIL of 100dB(A). At such exposures, diagnosis is broadly established by a notch/bulge bilaterally, or in the ‘better’ ear at thresholds 3, 4 or 6 kHz. For a lower NIL between 90-99dB(A) the diagnostic hurdle is raised with a required notch/bulge of at least 20dB.

Case note: limitation (BCDN Edition 22)

The decision is McCabe v John Laing PLC has provided another example of the application of limitation principles in an NIHL claim.

The claimant worked for the defendant between 1987 and 1995 operating various noisy tools. He alleged that he was never warned of the dangers of noise and that hearing protection was provided only sporadically.

He was diagnosed with binaural hearing loss of 18.3dB in 2003 and alleged this was caused by a breach of duty on the part of the defendant. The claim was time barred on the face of it and the claimant conceded he had actual knowledge by 2003. The claim should therefore have been commenced in 2006. The concession was not accepted by the defendant. It was determined on the evidence that the claimant should have been sufficiently curious about his hearing loss in 1996 such that he should have sought advice. The claimant was therefore fixed with knowledge in 1996 and the claim should have been issued in 1999. Proceedings were issued in 2012 and were therefore 13 years out of time. The question was therefore whether the court should exercise its section 33 discretion to disapply the time limit.

Judge Simon Brown held that although the suggestion that the exercise of the discretion was ‘exceptional’ had been disapproved in Sayers v Chelwood[2013] 1 WLR 1695 (which we considered in edition 1 of Disease News) the
principle was still essentially sound. Ultimately it is an issue of respective prejudice to the parties and the effect of delay on the defendant’s ability to defend. In the event, it was not equitable to allow the claim to proceed because the delay had caused evidential disadvantage, the reasons for the delay and length were not good ones and the issue of proportionality fell in the defendant’s favour since the hearing loss had had only a modest effect on the claimant’s life.

Re-litigating claims – a second bite at the cherry? (BCDN Edition 22)

Introduction

The last few years have seen a surge in NIHL claims. The Deafness Working party of the Institute of Faculties of Actuaries estimated some 60,000 claims in 2012. Most insurers appear to be reporting a two-three fold increase in notifications in 2013, although perhaps with the first signs of a slowdown. Amongst this deluge are undoubtedly cases which have been previously notified or litigated but were unsuccessful at first instance.

So when can a claimant re-litigate an issue? And can a claim be re-litigated when it has been struck out because of the claimant’s non-compliance with the CPR and court orders? This second issue is likely to be of importance in the near future since the strict Jackson approach is likely to result in an increased number of claims struck out for non-compliance.

In this article we consider, firstly, whether a claim is capable of being re-litigated and, secondly, whether a claim can be litigated when it has been struck out following a claimant’s non-compliance.

Why should a claim be prevented from being re-litigated? In essence, the purpose of barring subsequent claims is to limit abusive and duplicative litigation. With that objective in mind, we now consider the law.

Re-litigating a decided case

In determining whether a decided case can be re-litigated it important to note from the outset that both a substantive and a procedural regime applies to the issue, each of which requires consideration.

Substantive regime: res judicata

The substantive principles concerning whether a decided claim can be re-litigated are collected under the term res judicata, as recently noted by Lord Sumption in his review of the law in Virgin Atlantic Airways v Zodiac Seats UK Ltd at [17]. More recently still, the legal principles have been usefully summarised by Sir Terence Etherton C in Price v Nunn at [66] – [69] as follows:

Cause of action estoppel – precludes a party from pursuing a cause of action which is identical to the cause of action in earlier proceedings where the same parties and the same subject matter were involved. In such a case, unless fraud or collusion is alleged, such as to justify setting aside the earlier judgment, the bar is absolute in relation to all points which had to be and were decided in order to establish the existence or non-existence of the cause of action. Furthermore, cause of action estoppel prevents the raising of new issues in the subsequent proceedings if they could with reasonable diligence and should in all the circumstances have been raised.

Issue estoppel – precludes a party from disputing the decision on an issue reached in earlier proceedings even though the cause of action in the subsequent proceedings is different. It may arise where a particular issue forming a necessary ingredient in a cause of action has been litigated and decided and in subsequent proceedings between the same parties to which the same issue is relevant one of the parties seeks to re-open that issue. In such a situation, and except in special circumstances where this would cause injustice, issue estoppel bars the re-opening of the same issue in the subsequent proceedings. The estoppel also applies to points which were not raised if they could with reasonable diligence and should in all the circumstances have been raised, but again subject to special circumstances where injustice would otherwise be caused.

Procedural regime: abuse of process
Alongside the substantive principles of res judicata are the procedural powers of strike out for abuse of the court’s process in CPR 3.4(2)(b). They are ‘juridically very different’ powers even though they share the common purpose of limiting abusive and duplicative litigation.

When does re-litigating a decided case or issue abuse the court’s process? No specific test has been laid down. Instead, a broad, merits-based judgment should be adopted, taking account of all of the public and private interests involved and all the facts of the case. Nevertheless the courts have provided some assistance. In Dexter v Vlieoland-Boddy the Court of Appeal suggested that a subsequent action against the same original defendant is much more likely to be an abuse of process than a later action against another individual. It also suggested that the court will rarely find that the later action is an abuse of process unless the later action involves unjust harassment or oppression of the defendant. This was approved by the Court of Appeal in Aldi Stores Ltd v WSP Group Plc. Later, in Stuart v Goldberg Linde, the Court of Appeal held that a claimant who keeps a second claim against the defendant up their sleeve while prosecuting the first is at high risk of being held to have abused the court’s process.

Determining whether a second claim is an abuse of process, then, is a fact specific decision and there is no generally applicable principle. Nevertheless it appears that the threshold is a reasonably high one; the courts will not readily find an abuse. An abuse is only likely to be found where there is some fault on the part of the claimant. It is also worth bearing in mind that the courts must ultimately deal with cases justly and at proportionate cost (CPR 1.1(1)). Strike out is a draconian course of last resort that the courts do not willingly take. Where the court can justly impose some other sanction, such as a costs sanction, it is likely to do so in preference to striking out the claim.

So the above substantive and procedural rules can prevent repeat claims from being made where the court has already adjudicated on the claim. Arguably, the procedural rules could be relevant to claims which were withdrawn pre-litigation or discontinued during litigation where the subsequent claim is abusive and duplicative. Perhaps of more relevance in such claims is that many of them will have become statute barred.

Re-litigating a case struck out for non-compliance

When a case is struck out for the claimant’s non-compliance with the CPR or court orders, the principles of res judicata cannot apply because no issues or causes of action have been decided. Nevertheless, is it an abuse of process to re-litigate a claim which has been struck out because of the claimant’s non-compliance?

In Securum Finance Ltd v Ashton the Court of Appeal held that it could be an abuse of process. Whenever a claim is struck out for misconduct by the claimant and that claimant commences a second claim in respect of the same subject matter, the court should start with the assumption that some special reason has to be identified to justify the second claim being allowed to proceed. Specifically in relation to where an initial claim has been struck out on the grounds of the claimant’s delay, the Court of Appeal held that a subsequent claim can be struck out (even when it is brought within the limitation period). The claimant’s attempt to have a ‘second bite at the cherry’ has to be weighed with the overriding objective of the CPR in mind, and particularly the court’s need to allot its limited resources to other cases. However, that factor would carry ‘little weight’ if the second action also raised claims which, for good reasons, were not raised in the initial action.

The approach in Securum was followed by the Commercial Court in Laemthong International Lines Co Ltd v Artis (The Laemthong Glory)(No. 1), and the Court of Appeal in London Borough of Enfield v Sivanandan. It is clear, then, that a second claim can be struck out as an abuse of process where the initial claim has been struck out on the grounds of the claimant’s non-compliance. A second claim in these circumstances is not, however, automatically regarded as an abuse of process. Rather, it is a matter of discretion for the court, as Securum and Laemthong make clear in particular. A second claim is unlikely to be struck out in these circumstances where it brings forward issues that were validly withheld in the first claim.

Will the Jackson reforms alter how the discretion is applied? After all, the Jacksonian approach is a strict one. The courts are no longer going to tolerate non-compliance by parties and strike out can be expected to follow more often in future. Would it not frustrate the Jackson reforms to allow a second action to proceed when the initial one has been struck out for non-compliance? It appears this approach was adopted recently in Robins v NIG Insurance Company. The claimant was involved in a road traffic accident with another individual, whom he consequently claimed against. The claim was struck out after the claimant failed to comply with an unless order to file certain documents. The claimant subsequently claimed directly against the individual’s motor insurer under the European Communities (Rights Against Insurers) Regulations 2002. It was struck out as an abuse of process. On appeal, Judge
Lochrane held at [22] that the *Securum* principle was a point of general principle in civil litigation. The CPR had developed to ‘reinforce the need for the courts to show decreasing tolerance of sloppy or lax conduct in proceedings and to consider much more closely the impact of litigation so conducted on resources, both of the parties to the claim under consideration and the wider public purse’. It would have been an unjustified windfall to the claimant to allow him to escape the consequences of his misconduct by reason of him being able to sue another defendant (the insurer) through the unusual procedural opportunity open to him under the 2002 Regulations. The judge below was perfectly entitled to strike out the second claim.

It appears, then, that the Jackson approach may well impact on the approach of the courts when deciding whether to strike out a second claim as an abuse of process where the first claim has been struck out for non-compliance. Any argument resisting a second claim in these circumstances should certainly be couched in Jacksonian terms: to allow a second claim to proceed would be to frustrate the very purpose of the Jackson reforms – to secure strict compliance with the CPR and court orders. Allowing a second claim to proceed tolerates the non-compliance which the reforms have determined is intolerable. The argument will be less strong where a second claim raises an additional issue that was justifiably withheld in the first claim.

**Conclusion**

Subsequent claims concerning issues that have been previously litigated can be struck out on a number of substantive and procedural grounds. Strike out as an abuse of process is not an automatic procedural step. The court must instead exercise its discretion. Like so many procedural areas, that discretion will probably be heavily influenced in the future by the strict Jackson reforms. Either way, ‘second bite at the cherry claims’ which give rise to abusive and duplicative litigation are ripe for applications to strike out. This has implications for how defendants react to claimant misconduct. For example, where the claimant defectively serves proceedings (which we will consider in a future feature article), not only should the defendant apply to strike out the proceedings for defective service but they should also resist any future proceedings on the grounds of abuse to process. Accordingly, in addition to claimants having to ensure they remain compliant in the future, defendants should also be alert to appropriately react to claimant misconduct.

**An effective claim? Defective service of the claim form (BCDN Edition 23)**

**Introduction**

One issue that is arising with increasing frequency is apparent service of the claim form when, in fact, it has been defectively served. This is surprising; the relevant rules in the CPR cannot fairly be described as ambiguous or difficult to comply with. Nevertheless, a stream of defectively served claims continues to flow.

So how should a claim form be served and when is service defective? What is the appropriate response to a defectively served claim? And what consequences visit a defectively served claim?

**How is service of proceedings properly effected?**

This is best approached by considering three issues: how service can be effected, when must service be effected, and to what location must service be effected.

With respect to how proceedings can be served, CPR 6.3(1) provides the following methods: personal service; first class post, document exchange or other services which provide delivery on the next business day; leaving the proceedings at a place specified in the rules; fax or other electronic communication, or; any other method authorised by the court. A company may, under CPR 6.3(2) be served by any of the above methods or by any method permitted under the Companies Act 2006. This includes ‘leaving [the proceedings] at, or sending it by post to, the company’s registered office’ under section 1139(4) of the 2006 Act.

A dissolved company cannot have proceedings effectively served on it since it does not exist. The company must be restored to the register of companies by way of Part 8 proceedings for a claim to proceed. However, so long as the company is restored to the register it matters not if the proceedings are purportedly served before or after the
restoration. Restoration to the register will retrospectively validate any purported service of proceedings prior to restoration: Joddrell v Peaktone Ltd.

On the issue of when service has to be effected, CPR 7.5(1) provides that the claimant must complete the relevant step (which depends on the chosen method of service) before 12.00 midnight on the calendar day four months after the date of issue of the claim form. Under CPR 7.6 the claimant can apply for an extension of the four month period. Ordinarily such an application must be made within the period. After the four months has expired the court can only extend the time for compliance if the court has failed to serve the proceedings or the claimant has taken all reasonable steps to comply with CPR 7.5 but has been unable to do so, and, in either case, the claimant has promptly made the application for an extension.

Where should the proceedings be served? CPR 6.9 establishes a hierarchy for the place of service. When personal service on the defendant is required, personal service must be used. Where it is not required and the defendant has given in writing the business address of a solicitor as an address at which the defendant may be served with proceedings, or a solicitor acting for the defendant has notified the claimant in writing that the solicitor is instructed by the defendant to accept service of proceedings, the proceedings must be served at the business address of that solicitor. Where service in either of those ways is not necessary the claimant can either serve proceedings at an address which the defendant has given as a place at which they may be served, or must serve it at the place shown in the following table:

<table>
<thead>
<tr>
<th>Nature of defendant to be served</th>
<th>Place of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Individual</td>
<td>Usual or last known residence.</td>
</tr>
<tr>
<td>2. Individual being sued in the name of a business</td>
<td>Usual or last known residence of the individual; or principal or last known place of business.</td>
</tr>
<tr>
<td>3. Individual being sued in the business name of a partnership</td>
<td>Usual or last known residence of the individual; or principal or last known place of business of the partnership.</td>
</tr>
<tr>
<td>4. Limited liability partnership</td>
<td>Principal office of the partnership; or any place of business of the partnership within the jurisdiction which has a real connection with the claim.</td>
</tr>
<tr>
<td>5. Corporation (other than a company) incorporated in England and Wales</td>
<td>Principal office of the corporation; or any place within the jurisdiction where the corporation carries on its activities and which has a real connection with the claim.</td>
</tr>
<tr>
<td>6. Company registered in England and Wales</td>
<td>Principal office of the company; or any place of business of the company within the jurisdiction which has a real connection with the claim.</td>
</tr>
<tr>
<td>7. Any other company or corporation</td>
<td>Any place within the jurisdiction where the corporation carries on its activities; or any place of business of the company within the jurisdiction.</td>
</tr>
</tbody>
</table>

When is service defective?
Put simply, service of the claim form is defective when the above rules are not complied with. The most common examples of defective service are serving the proceedings out of time or serving the proceedings at the wrong location. Proceedings are not infrequently served on a defendant’s employers’ liability insurer. However, there is absolutely no right to do this. Unlike road traffic accident claims, the insurer cannot be directly sued by the claimant (under the European Communities (Rights Against Insurers) Regulations 2002). Service must be on the defendant: service on the insurer is defective.

Responding to a defectively served claim

When proceedings are defectively served there are no proceedings upon which a court could properly adjudicate. Accordingly, the appropriate response to a defectively served claim is to dispute the court’s jurisdiction to try the claim. To do so, the defendant must file an acknowledgment of service and indicate on the form (by ticking the relevant box) that they wish to dispute the court’s jurisdiction: CPR 10.1(3)(b); CPR 11.1(2). The acknowledgement of service must be filed 14 days after the receipt of the claim form and the particulars of claim: CPR 10.3(1). A defendant who files an acknowledgement of service does not accede to the court’s jurisdiction: CPR 11.1(3). Indeed, failure to acknowledge service would leave the defendant open to an application for default judgment. The defendant must apply for an order declaring that the court has no jurisdiction within 14 days after filing the acknowledgement of service: CPR 11.1(4). If the defendant does not make an application within 14 days then they are treated as having accepted the court’s jurisdiction to try the claim: CPR 11.1(5) In those circumstances, the right to challenge service of the proceedings as defective is waived: HDDidding v Persimmon Homes (Wessex) Ltd. A defendant cannot seek to deploy the court’s powers in CPR 3.4 to strike out the claim to avoid CPR 11.1(5): Burns-Anderson Independent Network Plc v Wheeler. There is one chance alone to set aside proceedings for defective service and that is disputing the court’s jurisdiction in accordance with CPR 11.1(4).

Where the court agrees that the proceedings have been defectively served it will make an order declaring that it has no jurisdiction to try the claim and set aside the claim form: CPR 11.1(6)

Abuse of Process?

Where a defectively served claim form has been set aside by the court, is it an abuse of process to reissue the proceedings and comply with the service rules second time around?

The Court of Appeal in Atkas v Adepta held that, generally, it was not an abuse of process to reissue proceedings. A mere negligent failure to serve a claim form in time had not, the Court said, ever been held to amount to an abuse. Even where the second action is out of time where the first action was commenced in time but had been lost by a failure to serve proceedings in time was not an abuse – the court could still be asked to apply its discretion to extend the limitation period (following the decision in Horton v Sadler). Something more was required for an abuse, such as inexcusable delay, intentional and contumelious default, or at least wholesale disregard of the rules. Where one of those additional features is present then of course an application should be made to strike out the proceedings as an abuse of process.

However, Atkas is not the end of the story. Is the general position adopted in that case still valid in light of the Jackson reforms? In Atkas, the Court of Appeal stated at [92]:

‘There is of course the (possibly) new argument in the era of the CPR which emphasises the importance of any misuse of court resources. It is well to be aware of the important public interest bound up in the efficient use of those limited resources. However, to seek to turn that proper concern, in such a case as these, into a surrogate for the doctrine of abuse of process is to my mind a disciplinarian view of the law of civil procedure which risks overlooking the overriding need to do justice’.

The Jackson reforms, however, represent a new era of the CPR which elevates dealing with cases at proportionate cost to the same importance as dealing with cases justly. ‘Proportionate cost’ means not only in an individual case but also as between all cases in the justice system. Each case should only take up a proportionate share of resources. Moreover, the overriding objective has been amended so that dealing with cases justly includes ‘enforcing compliance with rules, practice directions and orders’: CPR 1.1(2)(f). The approach to compliance is now
undoubtedly strict: the rules have become more disciplinarian. In *Fons HF v Corporal Ltd* for example, the High Court held that:

‘failure to comply with a rule, direction or order is of itself a clear breach of the overriding objective and is likely to result in severe sanctions...all parties and the wider litigation world should be aware that all courts at all levels are now required to take a very much stricter view of the failure by parties to comply with directions, particularly where the failure to comply is likely to lead into a waste of the limited resources made available to those with cases to litigate’ (emphasis added).

This strict Jacksonian approach is perhaps already making inroads into the arena of applications for extensions of time to serve proceedings. In *Venulum Property Investments Ltd v Space Architecture* an application to extend time for service of the particulars of claim was refused. Edwards-Stuart J held, at [58], ‘when the circumstances are considered as a whole, particularly in the light of the stricter approach that must now be taken by the courts toward those whole fail to comply with rules following the new changes to the CPR, this is a case where the court should refuse permission to extend time’. Nevertheless, it is by no means clear that reissued claims will be struck out as an abuse of process. In *Venulum* itself, Edwards-Stuart J opined at [56] that were the case simply a balance between there being no good reason to have served the particulars out of time against not extending time having the effect of barring the claim, then he would have had ‘difficulty in seeing how it would be either just or proportionate’ to prevent the claim going forward. In the event, the claim was not that simple balance: there was delay of over five years before instructing solicitors, the case was not a strong one and part of the case had been poorly pleaded. For Edwards-Stuart J it was these additional factors that justified not extending time. Moreover, the authors of the White Book 2013 suggest that the rules were amended to restore the principles initially adopted under the CPR, not to be doubly strict. Those principles recognised that compliance with time limits was important but not an end in itself. If the result of not granting an extension (or, presumably, of striking out a reissued claim when time elapsed in the first) would be draconian, the court has to decide whether such a result is proportionate to the crime. Undoubtedly, the courts will, even in the Jackson era, be alert to the injustice of shutting out what might be potentially valid claims. Any application to strike out a reissued claim as an abuse of process will inexorably be rebuffed by the opposing side with arguments on the injustice of such a course.

So where does this leave applications to strike out reissued claims? The reality is the courts will need to decide. But there is certainly every reason to think the courts can be persuaded to adopt a stricter approach. There is very rarely a good reason not to serve proceedings in time – the CPR generously give claimants four months to serve proceedings. There is almost never a good reason not to apply for an extension of time within the time limit (which the demanding approach for extensions out of time in CPR 7.6(3) reflects). The new rules aim to secure compliance. Why should claimants be permitted to reissue proceedings when they have lost their first claim for failing to serve it within the one third of a year they are given to do so by the rules? To allow claims to be reissued this way in anything but the most exceptional circumstances would undermine the strictness of the amended CPR, the strictness which is the very essence of the reforms. For the reforms to be effective they must be strictly enforced.

Conclusion

The rules on service of proceedings are unambiguous and well established. Compliance with them should not be challenging. Where service of proceedings is defective, prompt action should be taken to dispute the court’s jurisdiction and have the claim form set aside. In the event that the proceedings are reissued, attempts should be made to resist this. The potential success of these attempts is unclear: we stand at the vanguard of the reforms, reforms which are yet to be significantly adjudicated upon. Judgments made in the near future on issues such as this will temper the course of litigation for years to come. Now is the time to present arguments at their highest on sanctions for non-compliance. No one is any doubt about the approach the Jackson reforms intend. So when a party does not comply there can be no injustice when a severe sanction meets them in reply.

**Asymmetry in NIHL claims (BCDN Edition 24)**

This 2 part feature article explores asymmetry in NIHL claims. Today we look at definitions of asymmetry and how common it is and whether it can be compatible with a diagnosis of NIHL. In Part 2 we look at how the courts have dealt with asymmetry in *Cran v Perkins Engines Ltd, Aldred v Corllaids* and *Sutton v BT* and what lessons can be
learnt from these decisions. Patrick Limb QC, who acted for the successful defendant in Sutton v BT will provide his own insight into that case.

Introduction

Occupational exposure to excessive noise is usually associated with bilateral and symmetrical hearing losses. The American College of Occupational Medicine defined the audiometric characteristics of NIHL and said that ‘it is almost always bilateral’ and ‘audiometric patterns are usually similar bilaterally’.

That is not to say that asymmetrical hearing loss cannot arise in claims for NIHL and it may be explained by:

- Exposure to firearms noise—with the ear closest to the muzzle of the gun having worse hearing (so called firearms shadowing effect)
- Acoustic trauma or blast, such as the use of explosives in mining or construction or tyres exploding
- Unilateral or greater conductive hearing loss in one ear having a ‘protective effect’ against exposure to excessive noise
- Unilaterally poorly fitted hearing protection
- Genuine asymmetrical noise exposure
- Asymmetrical AAHL / disease.

Definition and incidence of asymmetry

In many cases however the asymmetry is unexplained and Alberti found such asymmetry in about 10% of people exposed to excessive noise.

Small differences in thresholds between the ears are bound to occur simply as a result of the imprecise nature and errors of audiometry which were previously discussed in an article in BCDN Edition 2. This imprecision means that differences of 5-10 dB can typically arise between audiometric tests. So what differences between the ears qualify as genuine asymmetry? Alberti defined it as a greater than 10dB difference between the thresholds. Lutman & Coles in a 2009 study on asymmetric thresholds in the non-noise exposed population said that ‘a threshold shift at 4 kHz measured with an audiometer using 5 dB steps must be at least 15 dB to be treated as significant with a probability error below 5%’.

[This statement may seem puzzling from 2 of the authors of the ‘Coles Guidelines’ which are prepared to accept a diagnosis of NIHL based partly on an audiometric notch or bulge of 10dB and so within audiometric error?]

Within a population of 1231 people aged between 18-80 years and screened to exclude noise exposure and conductive hearing loss, asymmetry was seen in just under 10% of some 9,848 threshold readings. The prevalence increased with age and the study concluded that ‘inter-aural threshold differences greater than attributable to measurement error are not uncommon in the adult population, even after screening for conductive hearing loss and substantial noise exposure. They are typically of unknown origin’.

The Coles Guidelines

Unexplained cases of asymmetry are considered in the ‘Coles Guidelines’ at Note 11 which states:

‘In yet other cases, there is no apparent explanation for the presence of a significant NIHL-like notch or bulge on one side only. These cases are compatible with the presence of NIHL but with varying degrees of probability’.

The Guidelines go on to consider 4 types of asymmetry and the probability of a diagnosis of NIHL in each as follows.

Asymmetry Type 1

‘….if one ear meets R3(a) or R3(b), and the other ear also shows a notch or bulge but it is smaller than the 10 dB or 20 dB required, then the probability of NIHL is still high’.

We show such a case in the figures below. The first figure shows the thresholds in both ears and compares these with a range of ‘normal hearing’ for the non-noise exposed population (for the claimant’s age / gender) as shown by the grey shaded area. The left ear is clearly the ‘better ear’. The red shading in figures 2 and 3 show worse than expected hearing applying the calculation within the Guidelines. The left ear in figure 2 demonstrates a clear
audiometric bulge greater than 10 dB [for the purpose of this example assume R2(a) is satisfied under the Guidelines with a NIL of at least 100 dB(A)]. The worse right ear in figure 3 shows a bulge of 7dB-so not qualifying as a bulge within the Guidelines (see paragraphs 7.5, 7.6 and 8.2).

The Guidelines are ambiguous in that:

- They do not state that the ear meeting R3(a) or R3(b) must be the ‘better ear’
- They do not define the extent of the notch / bulge in the non-qualifying ear which would allow a claim to fall within this category.

**One ear ‘qualifying’ notch/bulge and other ear smaller ‘non qualifying’ notch/bulge - HIGH**

![Graph showing hearing levels](image)

**Asymmetry Type 2**

‘If one ear is markedly better at high frequencies and shows a significant notch or bulge, but the worse ear shows little or no trace of such, then there is still a more-likely than-not probability of NIHL’.

The Guidelines explain that ‘the greater impairment in the worse ear may be due to some unidentified cause additional to NIHL and ordinary AAHL, that additional disorder having hidden or obliterated the noise-induced notch or bulge’.

We show such a case in the figures below—the green shading in figure 3 denotes better than expected hearing after applying the calculation within the Guidelines.
Notch / bulge better ear / none or little trace in worse ear – MORE LIKELY THAT NOT

Asymmetry Type 3

In other cases there is not much difference between the two ears at high frequencies but, without apparent explanation, only one ear shows a significant notch or bulge and the other shows little or no trace of one: such cases should be regarded as very borderline and be decided on the strength of other evidence (e.g. severity of noise exposure or of temporary postexposure symptoms).

Such a case is shown in the figures below—although again there is ambiguity within the Guidelines as to what is meant by a ‘little’ notch or bulge.
Not much difference between ears / unilateral notch / bulge – VERY BORDERLINE

Asymmetry Type 4

‘Finally, if only the worse ear at high frequencies shows a significant notch or bulge, and there is little or no trace of NIHL in the better ear, then there is only a possibility of NIHL, not a probability.

Again there is ambiguity as to what is meant by ‘little’.

An example of such a case is shown in the figures below where there is a notch/bulge in the worse left ear but no evidence of the same in the better right ear.
Conclusion

Asymmetry may have a number of causes or simply be unexplained. Unexplained asymmetry seems to be fairly common within the non-noise exposed population and so there is no reason to assume that it should be uncommon within cases of NIHL—particularly where the population is older and the incidence of asymmetry is likely to increase.

The Coles Guidelines allow for unexplained asymmetry within a diagnosis of NIHL but with varying degrees of strength-dependent on the audiometric configuration of that asymmetry—ranging from ‘high’, ‘more-likely than not’ ‘very borderline’ and ‘only a possibility / not a probability’.

As a general rule of thumb in cases where there is only a unilateral notch / bulge, then diagnosis of NIHL can be accepted in those cases where this arises in a clearly ‘better ear’. Unilateral notches / bulges only in the worse ear should be discounted. As stated by Alberti ‘Conventional wisdom suggests that a claimant for compensation who has occupational hearing loss and also asymmetric hearing thresholds is unlikely to have a noise induced-deafness in the worse ear’ [where no evidence exists in the better ear].

There is ambiguity within the Coles Guidelines on diagnosis in cases where there is a qualifying notch / bulge in one ear and a smaller non-qualifying notch / bulge in the other. What qualifies as a ‘smaller’ notch / bulge? Can this smaller notch / bulge be in either ear or would diagnosis only be met where it arose in the ‘worse’ ear?

Is NIHL a ‘disease’? (BCDN Edition 29)
Is NIHL a ‘disease’? It might seem a rhetorical question. After all, NIHL has always been dealt with as a disease. However, the legal position is far from clear. In this article we seek to determine if NIHL really is a ‘disease’.

Why does it matter?

Why does it matter if NIHL is a disease or not? Firstly, it matters because it affects the level of success fee paid to claimants in pre-1 April 2013 cases (of which there is a significant number). In ‘disease’ claims that settle the success fee is set at 62.5% by the pre-1 April CPR 45.24(2)(c)(ii) (CPR 45 Section V). In other employers’ liability ‘bodily’ injury claims the success fee is 25% (CPR 45 Section IV). Accordingly, it is preferable for claimants if NIHL is treated as a ‘disease’ and preferable for defendants if NIHL is not treated as a ‘disease’. Secondly, it matters for the purposes of the new EL/PL Protocol. When claims enter but subsequently drop out of the Protocol a regime of fixed recoverable costs still apply, unless the claim is a disease claim. It therefore matters what is a ‘disease’ so practitioners know if fixed costs apply.

The position under the CPR

What does the CPR tell us about the meaning of ‘disease’? There is no specific definition. However, the pre-1 April CPR 45.23(3) provides that ‘disease’ includes Type A, B and C claims. Type A claims relate to disease or physical injury alleged to have been caused by exposure to asbestos. Type B claims relate to psychiatric injury alleged to have been caused by work-related psychological stress and work-related upper limb disorder which is alleged to have been caused by physical stress or strain (but excluding hand/arm vibration injuries). Type C claims related to diseases not within Types A or B. The Pre-Action Protocol for Disease and Illness Claims provides, in paragraph 2.2, that a ‘disease’ is essentially an injury not caused by a single accident or event.

The definition appears to be very wide. The ‘diseases’ mentioned in Types A and B include conditions that would not be referred to in ordinary parlance as ‘diseases’. But they all arise after more than a single event. On that basis, NIHL is plainly a ‘disease’: it arises after prolonged exposure to excessive noise. Moreover, NIHL has consistently been treated as such.

Smith v Secretary of State for Energy and Climate Change

The cases do not agree that NIHL is a ‘disease’. In the recent (non-binding) county court decision in Smith v Secretary of State for Energy and Climate Change, District Judge Davies held that NIHL was not a ‘disease’. Accordingly, the lower rate success fee applied.

At [22] the District Judge concluded that NIHL represents ‘excessive wear and tear on the delicate inner ear structures’. In answering the question of whether this ‘wear and tear’ amounted to a disease or an injury, the District Judge determined at [26]:

‘In my judgment, a disease, unless specifically included and incorporated into the rules is a biological process caused by a virus, bacteria, noxious substance of parasite’. Therefore NIHL was not a ‘disease’ because it was not caused in any of those ways.

The decision in Smith was based almost exclusively on the reasoning of Males J in Patterson v Ministry of Defence, which is the only direct binding authority on the point. We will shortly consider this decision in detail.

Is NIHL really not a disease?

At first blush the decision in Smith is nonsensical. NIHL has always been treated as a disease. Surely it cannot be right that ‘disease’ is so narrowly defined? In fact, do the CPR and the disease protocol not show that ‘disease’ is wider than the natural meaning adopted in Smith: the conditions mentioned in Type A and B claims are wider than this natural meaning (including, for example, work related repetitive strain injury) and the disease protocol captures essentially all injuries that are not the result of a single incident or event? Is this not the real test – whether the condition is caused by a single event?

These were in fact the arguments deployed in Patterson, a case concerning non-freezing cold injury (NFCI).
Against these arguments, the defendant in Patterson argued that the express inclusion of certain injuries in Type A and B claims in the definition of diseases does not justify treating ‘disease’ as a term wider than its ordinary meaning. Further it was argued the Protocol definition of ‘disease’ is not suitable either. The provisions in CPR 45 section V were an exception to the general rule in section IV and should be construed narrowly.¹

Males J noted at [14(4)] that the definition of disease in the CPR appeared to have a wider meaning than its ordinary meaning of the word having regard to the express inclusion of some injuries not traditionally regarded as diseases.

At [18] Males J set out ‘clear’ principles of interpretation: ‘(1) The task of the court is to ascertain the intention of the legislator expressed in the language under consideration. This is an objective exercise. (2) The relevant provisions must be read as a whole, and in context. (3) Words should be given their ordinary meaning unless a contrary intention appears. (4) It is legitimate, where practicable, to assess the likely practical consequences of adopting each of the opposing constructions, not only for the parties in the individual case but for the law generally. If one construction is likely to produce absurdity or inconvenience, that may be a factor telling against that construction. (5) The same word, or phrase, in the same enactment, should be given the same meaning unless the contrary intention appears’.

Having identified these principles of interpretation the Judge expressed the following general principles at [24]: ‘First, “disease” must if possible be construed in a way which does not result in the exception taking up most of the room occupied by the basic or default rule in Section IV. Second, and as already noted, the starting point must be the natural and ordinary meaning of the words used, in their context. It may be of course that the context shows that a more extended or unusual meaning was intended…but I start from the position that unless that is demonstrated to be the case, the likelihood is that the words used were intended to have their natural meaning. Third, if there is to be a departure from or extension of the natural meaning, it must be at least reasonably clear what extended meaning the term “disease” was intended to have. It is unlikely to be enough to say that an extended meaning was intended unless it is reasonably clear what that meaning was.’

Applying these principles, Males J dealt, firstly, with the suggestion that the inclusion of certain injuries in the definition of Type A and Type B ‘diseases’ meant ‘disease’ should be construed widely. His Lordship concluded at [39] that the inclusion of these bodily injuries represented specific extensions of the ordinary meaning of the term ‘disease’ and did not demonstrate with sufficient clarity that the intention of the legislator was to apply an extended meaning more generally. More compellingly still, Males J held that the term ‘disease’ could not be defined at all by reference to the conditions included in Type A and B claims because the term ‘disease’ appeared as an exclusion from Section IV when Section IV was first introduced in October 2004. At that time however, Section V had not yet exist (it being introduced on 1 October 2005). ‘Disease’ must nevertheless still have had a meaning before then by reason of its inclusion in Section IV and it was not suggested that the introduction of Section V changed the definition of ‘disease’ in section IV. The definition of ‘disease’ could not be determined by provisions that were not in existence. Accordingly if ‘disease’ did have an extended meaning, the justification had to be found elsewhere.

Turning then to consider if justification could be found in the definition of ‘disease’ in the disease pre-action protocol, Males J found that the meaning of ‘disease’ in the protocol was ‘extremely wide’, including almost anything not solely caused by an accident or other single event’. He rejected that it could be used to determine the definition of ‘disease’. Firstly, the definition in the protocol only purported to describe ‘primarily’ what was covered by the term and ‘only for the purpose of this protocol’: it explicitly applied no further and is not strictly part of the CPR. Secondly, the terms of paragraph 2.2 of the protocol were available to the draftsman of CPR 45 who could have used or adapted the definition if he wished, but he did not do so. For that reason there were no grounds for concluding that ‘disease’ in CPR 45 was to be interpreted by reference to the protocol.

Consequently it had not been demonstrated that ‘disease’ in CPR 45 was used in other than its natural and ordinary meaning, save to the extent that certain conditions had been included in Type A and B claims. Moreover, it would not be practicable or sensible for the court to attempt to supply its own definition. In view of that, Males J concluded that NFCI was not a ‘disease’ because it was ‘not caused or contributed to by any virus, bacteria, noxious agent or parasite’.

**Implications and conclusion**

Patterson was not an NIHL claim and does not strictly bind other courts in such cases. However, its reasoning is seemingly impeccable and doubtlessly drove the court in Smith to the conclusion it reached.
NIHL is not, we are told, a ‘disease’. This means practitioners have unquestioningly incorrectly treated it as such for years, as noted in Smith. Can we be genuinely sure that NIHL is not a disease? After all the Civil Procedure Rules Committee and the wider justice system is well aware of how the ‘disease’ has been treated and yet no steps have been taken to clarify that NIHL is not a disease. Does this suggest that it was intended that NIHL should be treated as a disease? Further litigation on this point should be expected. In the meantime, defendant practitioners should strongly resist the proposition that NIHL is a ‘disease’ in cases concerning success fees.

What about the position under the new EL/PL Protocol? The decision is only strictly applicable to questions concerning the old success fee regime. It will not be binding in cases arising from the EL/PL Protocol where the issue of what a ‘disease’ is arises. However, it will be strong persuasive authority. How is likely to affect the arguments made in Protocol cases? In relation to claims that complete passage through the Protocol it will have no effect: the same fixed recoverable costs apply irrespective of the nature of the injury/condition. It is of no consequence if the case relates to a disease or not. However, it will have an impact on cases that enter the Protocol but subsequently leave it. In these cases fixed recoverable costs still apply to injuries but they do not apply to disease claims: CPR 45.29A(2). Accordingly for the losing defendant in such a case it would be desirable for the claim not to be treated as a disease so that the lower fixed recoverable costs apply. In those circumstances arguments based on the reasoning in Patterson and Smith should be deployed. Arguably the converse is also true: when defendants are successful they would want the case treated as a disease so that fixed recoverable costs do not apply and full recovery can be made in the normal way. While this reasoning is correct in principle, the suggestion that this argument could be deployed is flawed for two reasons. Firstly, you cannot have your cake and eat it. Defendants cannot argue that NIHL is both a disease and not a disease to their advantage depending on the outcome of the case. Logically it must be one or the other and, in any event, the courts would not tolerate such an inconsistent approach. Secondly, in future claims defendants will not be making recovery at all where they are successful because of the introduction of the qualified one way costs shifting regime (QOCS) (in Section II of Part 44). Recovery will only be possible in the event that one of the exceptions in CPR 44.15 or 44.16 is established (such as fundamental dishonesty). Where this happens the defendant can make full recovery irrespective of whether the injury/condition is a disease or not because the Protocol costs rules do not then apply: CPR 45.29F(10). There is no reason therefore to argue that NIHL is a ‘disease’.

Accordingly practitioners should argue in the future that NIHL is not a ‘disease’. Similar arguments should be made in respect of other so called ‘diseases’.

Obtaining expert medical evidence in disease cases (BCDN Edition 32)

In this article we consider the law on obtaining expert medical evidence in disease cases.

Introduction

In disease cases it is very frequently desirable, indeed often necessary, for defendants to obtain expert medical evidence as part of their case. This should not be surprising. Much of a disease claim concerns medically centred issues that can only be answered by experts in the field. Take a claim for noise induced hearing loss, for example. One issue that arises in all cases is whether the claimant has even suffered noise induced hearing loss. The
audiometric evidence presented on behalf of the claimant, or the way in which it is interpreted, is often questionable. The only way to challenge this legitimately doubtful evidence is with further expert evidence. Similarly, the issue of whether the alleged tortious noise exposure has even caused the alleged hearing loss is a matter that can also only be addressed by medical professionals. Accordingly the necessity often arises for the defendant to seek permission to obtain expert evidence, either to fairly challenge the claimant’s case or to properly to make its own case. Nevertheless, claimant solicitors are increasingly resistant to the defendant obtaining evidence pre-litigation and/or once a claim enters litigation, and it is not uncommon for the courts to refuse permission in the first instance resulting in the need to make an application for permission to obtain expert evidence.

When can permission to obtain this evidence be granted? And what arguments can be deployed to persuade the courts to grant permission?

**Obtaining permission for expert evidence: the Civil Procedure Rules**

The relevant rules are set out in Part 35 of the Civil Procedure Rules. CPR 35.4(1) provides that no party may call an expert or put in evidence an expert’s report without the court’s permission. Accordingly permission is a matter for the court alone. CPR 35.1 provides that expert evidence shall be restricted to that which is reasonably required to resolve the proceedings. According to Bandegani v Norwich Union Fire Insurance Society Ltd, the particular policy objective underlying this rule is that of reducing the incidence of inappropriate use of experts to bolster cases.

Part 35 should also be read alongside Part 1. CPR 1.1(1) provides the court must deal with cases justly and at proportionate cost. This includes, so far as practicable, and amongst other things, ensuring the parties are on an equal footing (CPR 1.1(2)(a)) and dealing with the case in ways which are proportionate to the complexity of the issues (CPR 1.1(2)(c)(iii). The combination of these rules with those in Part 35 results essentially in a test that expert evidence should be permitted where it is reasonably required to resolve proceedings or where the refusal of permission would result in the case being dealt with unjustly.

What arguments might be made on the basis of these rules to convince the court to give permission to obtain expert medical evidence? Firstly, if the claimant has been permitted to adduce expert evidence themselves and there are concerns about the cogency of the evidence, then expert evidence is reasonably required to fairly challenge the case and to ensure that the parties are on an equal footing. Indeed far from being reasonably required, the expert evidence would be strictly required to fairly meet the case and to ensure the case is dealt with justly. Secondly, it may also be the case that the defence is unable to properly make its case without expert evidence. In those circumstances it is axiomatic that the expert evidence is reasonably required. Moreover, it would be unjust to expect the party to present its case without the expert medical evidence that is an essential component of the party’s case.

Whatever the exact nature of the argument to obtain permission, they all rely on similar elements: that the evidence is reasonably necessary, that fairness requires the admission of the evidence, that the parties would not be on an equal footing, that the complexity of the case demands it, or that it is required to deal with the case justly. Depending on the exact nature of the case, combinations of these elements can be deployed to make persuasive arguments.

Aside from the Civil Procedure Rules, what other authorities can be put forward to convince the courts to grant permission?

**Obtaining permission for expert evidence: other authorities**

Article 6(1) of the European Convention on Human Rights provides: ‘In the determination of his civil rights and obligations…everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Ordinarily, provisions of the Convention can only be claimed against the state or public bodies, they cannot be deployed in proceedings between two private parties. However, section 6(1) of the Human Rights Act 1998 provides that public authorities (which include the courts (section 6(3)(a)) must not act incompatibly with the Convention rights. Therefore a court must not apply the law in a way that is incompatible with the Convention rights, including Article 6. Consequently, even in proceedings between two private parties the court must apply the fair trial rights guaranteed by Article 6. That is to say Article 6 is indirectly effective in private proceedings. This can also be a powerful instrument to persuade the courts to grant permission for defendants to
obtain expert evidence. Under Article 6(1) there is no explicit right to call expert evidence where the court considers that it would serve no useful purpose. However, there is such a right if it is necessary to ensure the fairness of the proceedings. Accordingly, if it can be argued that expert evidence is necessary to ensure the fairness of the proceedings because, for example, it is required to fairly meet the claimant’s evidence, or the defence is unable to make it case properly without it, the implication is that Article 6(1) demands the right to obtain expert evidence.

Furthermore, the common law has considered the question of when expert evidence is admissible. In Barings Plc (in Liquidation) v Coopers and Lybrand (No 2), Evans-Lombe J held that expert evidence was, prima facie, admissible where there was an acknowledged body of expertise governed by established principles and rules of conduct which was pertinent to an issue to be decided by the court. However, the court has a discretion to exclude such evidence if it would not help the determination of the issues. Applying this analysis to, for example, a NIHL claim, it is undeniable that there is an acknowledged body of expertise on NIHL or that the relevant medical professionals are governed by established principles and rules of conduct. That expertise is pertinent to, at the very least, diagnosis and causation issues. Therefore the evidence is prima facie admissible. The court retains a discretion to exclude the evidence if it will not assist the issues. One could therefore argue that so long as the evidence is necessary to meet the claimant’s evidence, or to make fully the defence case, it is difficult to argue that expert evidence would not assist determination of the issues.

Obtaining expert evidence: pre-litigation

Claimants are also increasingly resistant to defendants obtaining expert medical evidence in cases that are pre-litigation. What are the relevant applicable principles in these cases? Paragraph 9.4 of the Pre-Action Protocol on Disease and Illness Claims provides that where the claimant obtains a medical report prior to writing the letter of claim, the defendant will as matter of course be entitled to obtain their own medical report. In other cases, paragraph 9.4 notes that a ‘flexible’ approach must be adopted to obtaining expert evidence. Paragraph 9.13 provides that further guidance can be found in CPR 35, suggesting the principles applicable there are also relevant. Moreover, paragraph 1.2 provides the aim of the protocol is to, amongst other things, settle claims ‘fairly’. The combination of these rules results in almost identical principles to those that we have considered under Part 35. Consequently, broadly similar arguments can be utilised where claimants resist expert evidence at the pre-litigation stage.

Comment and conclusion

The arguments that can be deployed to persuade a court to grant permission to obtain expert evidence are multitudinous, being located in the Civil Procedure Rules, the common law, and even the European Convention. It is vital that such a wide variety of arguments are available, for it is often the expert evidence that is crucial to success in a claim; being unsuccessful in securing permission to obtain expert evidence can be fatal to a claim. Moreover, it must be remembered that applications for permission are on occasion made when the defendant has already instructed an expert having recognised the necessity to do so, for example to help decide if there is a defence to pursue. Obtaining permission is crucial in these cases lest the defendant will be unable to recover the costs of instructing the expert.

However, merely raising a half-baked argument based on some of the above principles will not be enough. The Jacksonian age is one of proportionality. Permission will not be granted if it is not proportionate to do so. Moreover, as the decision in Mitchell v News Group Newspapers Ltd makes clear, the courts are acutely aware of allotting an appropriate share of the court’s time and resources to all court users, and not merely to the parties in individual cases. Arguments on permission must be cogent so that the court is convinced it is proportionate to allot court time for expert evidence to be adduced. However, properly argued, there is every possibility of convincing the court that the case demands the admission of expert evidence.

Sensoineural hearing loss – causes and evidence (BCDN Edition 37)

In the coming weeks we will examine the various conditions that have been linked with sensoineural hearing loss and consider the nature and strength of evidence for causation.
This week we begin by considering the link between sensorineural hearing loss and diabetes.

**Introduction**

Hearing loss is very common in the UK. About 10 million people are thought to have hearing loss (1 in 6 people).

There are 2 main types of hearing loss: conductive hearing loss arising from problems in the outer and middle parts of the ear, and sensorineural hearing loss that results from damage to the sensitive hair cells of the cochlea in the inner ear or to the auditory nerve that transmits sound to the brain.

Hearing loss increases sharply with age - 6.5 million people aged 60 and over have hearing loss. Age-related hearing loss is referred to as presbycusis and is a gradual process. Most people begin to lose a small portion of their hearing between the ages of 30 and 40. The hearing loss becomes progressively worse with age so that by age 65 and over a 1/3rd of people are affected and by the age of 80 most people will have significant hearing difficulties. Age is the primary cause of hearing loss.

Age related hearing loss is a form of sensorineural hearing loss resulting from the progressive and natural deterioration of hair cells of the cochlea.

Another common cause of sensorineural hearing loss that is familiar to disease practitioners is noise. Noise-induced hearing loss is caused by the effect of noise on the delicate hair cells in the ear. The process of the development of NIHL was described in Smith v Secretary of State for Energy and Climate Change thus:

NIHL is caused by increased oxygen free radical production within the ears, a process already taking place naturally, as a result of the stress caused by excessive noise where, due to the clear relationship between exposure and the condition, it is clearly akin to an injury. Damage is caused by a discreet albeit repeated external stimulus and represents an acceleration brought about by external factors similar to other acceleration cases. A normal metabolic process is sped up by the trauma caused by excessive noise. NIHL is the result of an external insult speeding up a natural process which occurs with ageing.

While age and excessive noise account for a large proportion of sensorineural hearing losses they are not the only causes. There are plentiful conditions that can cause or contribute to sensorineural hearing loss. These include:

- Genetic hearing loss – either from birth or developing over time, and even where there is not always a familial history.
- Viral infections of the inner ear, such as mumps or measles.
- Viral infections of the auditory nerve, such as mumps or rubella.
- Ménière’s disease – where an individual suffers with vertigo (dizziness), hearing loss which can fluctuate, tinnitus and a feeling of ear blockage.
- Acoustic neuroma – a rare benign (non-cancerous) tumour on or near the auditory nerve.
- Meningitis – an infection of the protective membranes surrounding the brain and spinal cord.
- Encephalitis – inflammation of the brain.
- Multiple sclerosis – a neurological condition affecting the central nervous system.
- Stroke – interrupted supply of blood to the brain.
- Otoxic drugs – that is, drugs which are damaging to hearing. These include chemotherapy and certain types of antibiotics.
- Complications at birth.
- Head trauma.
- Diabetes.
- High cholesterol.
- Heart disease.

Adding further to this mix is idiopathic sensorineural hearing loss-hearing loss that arises from unknown causes when all of the other potential causes have been excluded.
It is vital that disease practitioners are aware of the various conditions that can cause sensoineural hearing loss. The reason is axiomatic – the presence of any condition linked to hearing loss may in fact be the cause of hearing loss in an NIHL claim where it is alleged excessive noise is the cause of the hearing loss. A defence on causation will arise if it can be demonstrated that an alternative condition was the cause for the hearing loss. A defence will also arise if it can be shown that noise only contributed to hearing loss caused by another condition in a trivial way: de minimis causation.

Whilst the 2 main types of hearing loss-conductive and sensorineural–can be distinguished from each other by both tuning fork tests and audiometry-the different causes of sensorineural hearing loss are not always readily identifiable or distinguishable from each other.

This week we begin our review series by considering the link between sensoineural hearing loss and diabetes

**Diabetes**

Diabetes is a lifelong condition characterised by a person’s blood sugar level becoming too high. In the UK diabetes affects approximately 2.9 million people. In addition, it is thought that a further 850,000 people have undiagnosed diabetes. Ten per cent of sufferers have type 1 diabetes, while ninety per cent of sufferers have type 2 diabetes. Five per cent of pregnancies result in gestational diabetes.

**Diabetes and sensoineural hearing loss**

Diabetes is strongly associated with sensoineural hearing loss. A number of studies show sensoineural hearing loss is significantly more common in those with diabetes compared to those without.

In 2003, Karkarlapudi et al set out to identify whether patients with diabetes have a higher incidence of sensoineural hearing loss than the general population and to examine whether control of diabetes was related to the severity of hearing loss. They examined the medical records of 53,461 non-diabetic age-matched patients and 12,575 diabetic patients. They found that sensoineural hearing loss was more common in the diabetic patients than in age-matched non-diabetic patients. Specifically, the prevalence of sensoineural hearing loss in the diabetic group was 13.1% compared 10.3% in the non-diabetic group. In addition, they found that poor control of diabetes correlated with worsening hearing in patients with diabetes who had sensoineural hearing loss.

In 2007, Sakuta et al considered type 2 diabetes and hearing loss in the personnel of Japanese military forces. Of the 669 subjects, 103 had type 2 diabetes. Hearing loss was found to be more prevalent in diabetic individuals: 60.2% of diabetic patients had hearing loss while 45.2% of control subjects had hearing loss. Diabetic patients were 1.87 times more likely to have hearing loss. Levels of hearing loss were more than 3dB larger at high frequency range (between 2-8 kHz). The levels of loss were smaller at low frequency range (0.25-1 kHz).

In 2008, audiometric evidence from the United States’ National Health and Nutrition Examination Survey from 1999 to 2004 showed that the prevalence of low or mid-frequency hearing loss of mild or greater severity in the worse ear was 21.3% among 399 adults with diabetes compared with 9.4% of the 4,741 adults without diabetes. Similarly, the prevalence of high-frequency hearing impairment of mild or greater severity in the worse ear was 54.1% among those with diabetes compared with 32.0% of those without diabetes. This suggests that diabetes in particularly prone to induce high frequency hearing loss.

In 2011, Rejendran et al sought to evaluate the incidence of sensoineural hearing loss in patients with type 2 diabetes. Sixty diabetic patients of age 40-50 years underwent audiometry as did sixty patients without diabetes. Sensoineural hearing loss was present in 73.3% of the diabetic patients compared with hearing loss in just 6.7% of non-diabetic patients. Hearing loss was found more towards the higher frequencies, particularly between 4 and 8 kHz. Hearing loss also affected the different sexes equally.

Lerman-Garber’s 2012 study also examined the prevalence of hearing impairment in type 2 diabetics. Patients were 30 to 50 years old with type 2 diabetes diagnosed before the age of 40. 46 diabetic patients were age-matched with 47 control subjects with rheumatoid arthritis. The prevalence of unilateral and bilateral hearing loss was significantly higher in patients with diabetes compared to those with arthritis: 21.7% versus 6.4% respectively. Most cases of hearing loss were mild but involved high or acute tones.
In 2013, Horikawa et al conducted a meta-analysis of other studies to compare the prevalence of hearing impairment between diabetic and non-diabetic adults. Data were obtained from 13 studies. Overall, hearing impairment was 2.15 times more likely in diabetic patients. In younger patients, those 60 and under, diabetic patients were 2.61 times more likely to suffer hearing loss. Diabetic patients over 60 were 1.58 times more likely to have hearing loss. The strength of the association between diabetes and prevalence of hearing impairment was not significantly influenced by whether participants were matched for age and gender or whether participants chronically exposed to noise environments were excluded. This is crucial since it suggests noise does not exacerbate the effect of diabetes. Diabetes can independently cause hearing loss. This study was very widely reported within the popular press and the lead author Chika Horikawa of Niigata University said that ‘The association of hearing impairment with diabetes is controversial, but it is believed that over time, high blood glucose levels can damage vessels causing hearing loss’.

However, not all of the studies, particularly earlier ones, support the link between diabetes and sensorineural hearing loss. In 1993, Gates et al examined the relationship between hearing in the elderly to the presence of cardiovascular risk factors, one of which was diabetes. 1662 elderly men and women were considered, 676 men and 996 women. No association was found between diabetes and hearing loss. This may have been because hearing loss was treated as loss only in excess of 40dB.

Similarly, in 1998, Ma et al examined diabetes and hearing loss in Mexican American adults using data from the Hispanic Health and Nutrition Examination Survey. Hearing threshold levels were obtained at 500 Hz, 1 kHz, 2 kHz and 4 kHz. The crude hearing thresholds for diabetic patients were significantly higher than for non-diabetics at all four frequencies. However, after adjustment for age, gender, and socioeconomic status, diabetics had a higher threshold only at 500 Hz. Diabetics not using insulin had significantly higher hearing thresholds than those using insulin. It was therefore concluded that associations between hearing loss and diabetes in the higher frequencies are present only in those not using insulin. The conclusion in this earlier study is anomalous given the number of studies that have found an association, particularly at the higher frequencies.

Conclusion

The association between diabetes and sensorineural hearing loss is still controversial. Older studies did not find a link but these appear to have been superseded consistently by more recent studies which show diabetics with a greater risk for hearing loss particularly affecting higher frequencies. Either type of diabetes is seemingly capable of causing hearing loss. Disease practitioners should closely scrutinise claims for NIHL to determine if there are other possible causes of hearing loss: diabetes is a common condition which will no doubt be present in many NIHL claimants. Where it is present questions should be put to the medical expert to consider whether it could be a sole or contributing cause of sensorineural hearing loss. The expert should be directed to the above, more recent, studies showing a positive causal association for comment.

Sensoineural hearing loss – high cholesterol (BCDN Edition 38)

Introduction

This week we continue our series on the link between various conditions and sensorineural hearing loss. The focus this week will be on the link between high cholesterol and hearing loss.

Cholesterol

Cholesterol is a fatty substance – known as a lipid – and is vital for the normal functioning of the body. It is predominately manufactured by the liver but is also found in some foods. It is carried in the bloodstream by proteins.

High Cholesterol can be caused by a variety of factors. As to lifestyle related causes, an unhealthy diet, particularly one that is high in saturated fat, often results in high cholesterol. In addition, certain foods, such as eggs, contain cholesterol, although they have little effect on overall blood cholesterol level. In addition, a lack of physical activity
and exercise can be responsible for high cholesterol. Linked with that is obesity, another leading cause of high cholesterol. Similarly, regularly consuming high quantities of alcohol and smoking can also result in higher levels of cholesterol. Certain underlying conditions are also associated with high cholesterol. This includes kidney disease, liver disease and an underactive thyroid gland.

High cholesterol is strongly linked with an increased risk of heart attacks, atherosclerosis – that is, narrowing of the arteries –, strokes and mini-strokes. It does not, however, cause any symptoms.

In addition, high cholesterol is a prevalent condition. In 2008, the percentage of people with high cholesterol levels ranged between 54-64% for men across different regions of England, and between 56 and 68% for women.

To what extent is high cholesterol linked to sensoineural hearing loss? Given the high prevalence of the condition, if there is a strong link between the two then high cholesterol may in fact be the cause of, or a contributor to, hearing loss in many NIHL claims where it is alleged that prolonged exposure to excessive noise is the cause of the hearing loss. High cholesterol may provide a full or partial defence in many claims.

High cholesterol and sensoineural hearing loss

According to Consultant Audiological Physician John Irwin, in 1983, ‘considerable evidence’ had accumulated over the last quarter of a century that sensoineural hearing loss was associated with hyperlipidaemia – high cholesterol.

Early studies certainly support the apparent link between high cholesterol and sensoineural hearing loss. In the 1960s Rosen studied the Mabaan people of Sudan. They had no noise exposure, were vegetarian and had a diet containing no saturated fats. High cholesterol was entirely unknown amongst the people. Rosen found that at the age of 70-79 years, subjects had normal hearing thresholds from 125 Hz to 2 kHz and at 6 kHz the maximum hearing loss was just 25 dB, the suggestion being that their low cholesterol levels insulated them from hearing degradation.

In 1970, Rosen et al considered the effects of diet on hearing loss in two institutions for long-stay patients in Finland. One group had their diet altered to reduce polyunsaturated fat intake while the other carried on with the ‘normal’ high fat Finnish diet. After 5 years the study group had significantly lower serum cholesterol levels and significantly better hearing. At 5 years, the diets were reversed and the populations restudied for a further 3.5 years. The cholesterol levels were again lower in the group on the low fat diet and there was now no difference in mean hearing levels between the groups. The pattern of loss was then typical of age associated hearing loss. The conclusion was that high cholesterol was clearly associated with the induction of hearing loss – high cholesterol appeared to induce hearing loss while low cholesterol did not affect the ordinary course of age associated hearing loss.

Evidence of an association between high cholesterol has also come from studies of the hearing impaired. In 1977, Booth investigated 44 subjects aged between 25 and 55 with symmetrical hearing loss of unknown origin. 38% of the subjects were found to have abnormally high cholesterol levels. Spencer found an even stronger association. In 1983 he studied 300 patients, including himself, who had symptoms of unspecified inner ear disease. He found 51% of patients had elevated cholesterol levels. In a comparative group of patients attending an otolaryngology clinic for unrelated reasons, only 19.3% had elevated levels, despite that group containing only those who were overweight or had a family history of diabetes or heart disease.

In 1985, Axelsson and Lindgren posited a relationship between high cholesterol and noise induced hearing loss. They recognised that previous studies had found a link between high cholesterol and hearing loss, and that noise also affects hearing, especially at higher frequencies, noting that noise appears to increase cholesterol levels during short-term experiments. They sought to address whether a combination of high cholesterol levels and noise exposure had an increased adverse impact on hearing. They considered 78 50-year-old men with high cholesterol levels from a WHO study and compared them with 75 50-year-old men who were randomly selected from the same WHO material. Audiograms showed that hearing was similar in both groups, with a moderate high frequency hearing loss having a configuration suggestive of noise induced hearing loss. Analysis of histories and audiograms showed that noise was the predominant factor affecting hearing loss. However, there was a statistically significant tendency for the high-cholesterol group that had suffered the most noise exposure to have high frequency hearing loss. But
there was also a tendency for the low-cholesterol group to have high frequency hearing loss if they had been excessively exposed to occupational noise. Nevertheless, they concluded that there was a slightly increased risk of acquiring high frequency hearing loss in those who work in noisy environments and have high cholesterol. This finding plainly supports an argument of contributory negligence in those cases where the claimant has high cholesterol even if the hearing loss can also be attributed to exposure to excessive occupational noise.

In 2007, Sutbas et al suggested that lowering cholesterol levels can in fact improve hearing. Their aim was to outline the prevalence of high cholesterol in patients who had high frequency hearing loss and tinnitus due to noise exposure. They investigated the role of a low cholesterol diet and statins (cholesterol lowering medicines) to alleviate the severity of tinnitus and possibly promote hearing improvement. 42 patients with high cholesterol and tinnitus and noise induced hearing loss were placed on a low cholesterol diet and statins for 24 months. They were then designated either as responsive or unresponsive according to whether their cholesterol levels had lowered in response to the diet and medication. In those patients that responded their changes in tinnitus scores were significant: 35% of them reported decreased tinnitus and 20% reported no tinnitus at all. Similarly, significant improvement was found at high frequency hearing thresholds (4 kHz to 8 kHz) in the responsive group. Before treatment the average hearing threshold in the responsive group was 43.1 dB for the right ear and 45.2 dB in the left ear. However, after treatment the thresholds had improved to 37.4 dB in the right ear and 40.9 dB in the left ear. The researchers concluded that the incidence of high cholesterol is high amongst those with noise induced hearing loss and that significant improvement in hearing and tinnitus can be achieved by lowering cholesterol level. This is an important finding. It raises the prospect of defendants raising arguments about claimants mitigating their loss when they are responsive to cholesterol lowering treatments (diet and medication). Since all claimants are under a duty to mitigate their loss, if they have high cholesterol and respond to treatment it would be incumbent on them to take steps to lower their cholesterol and therefore mitigate the severity of their hearing loss. Failure to do so would lead to a reduction in damages equivalent to the difference between their current hearing loss and what it might have been had the claimant lowered their cholesterol.

Similar findings were reported by Gopinath et al in 2011. They examined the link between cholesterol with the prevalence, incidence and progression of age-related hearing loss, and the link between statins and hearing loss. Hearing loss was measured in 2956 patients. The likelihood of hearing loss increased in those with the highest cholesterol intake. Among those reporting statin use, a 48% reduced odds of prevalent hearing loss was observed. Participants with higher monounsaturated fat intakes had a significantly reduced risk of hearing loss progression 5 years later. They concluded that a diet high in cholesterol could have adverse influences on hearing, whereas treatment with statins and the consumption of monounsaturated fats may have a beneficial influence.

More recent studies confirm the link between high cholesterol and hearing loss. In 2014, Chang et al considered the association between high cholesterol and senoaineural hearing loss, testing the hypothesis that high cholesterol is a risk factor for developing hearing loss. 73,957 individuals with high cholesterol diagnosed from 2001 to 2006 were compared with the same number of control patients. Each patient was followed until the end of 2009. It was found that senoaineural hearing loss was 1.6 times more likely to occur in those with high cholesterol.

Conclusion

There is strong evidence of a link between high cholesterol and hearing loss. Given the wide prevalence of high cholesterol in the nation it could be a relevant factor in many noise induced hearing loss claims. The nature of the research suggests arguments on contribution, or even full causation, and the duty to mitigate loss may be tenable. Where high cholesterol is present questions should be put to the medical expert to consider its impact; could it have been a sole or contributing cause of the senoaineural hearing loss? Could the claimant have improved their condition with an altered diet and/or medication? Experts should be pointed to the above research for comment.

Does hearing protection prevent NIHL claims? (BCDN Edition 49)

Introduction

A retired textiles worker has been diagnosed with NIHL but they wore hearing protection for the entire duration of their working life with the defendant employer. How can they have NIHL despite wearing hearing protection? And is the employer potentially liable?
It may seem curious to suggest that a claim could be made for NIHL where apparently adequate hearing protection has been provided to sufficiently attenuate hazardous levels of noise; however, such claims are entirely feasible and indeed foreseeable, particularly to larger employers.

This article will explore how NIHL can develop despite the use of hearing protection devices (HPD) and the potential liability of employers for that NIHL.

The Need to Provide Hearing Protection

Under the Noise at Work Regulations 1989 and the Control of Noise at Work Regulations 2005, employers have a duty to protect their employees from injury as a result of exposure to noise. The first defence against noise exposure entails reducing noise levels as far as possible by engineering means; however, these measures do not always reduce ambient noise levels sufficiently so as to ensure that employees are exposed to a daily noise dose that does not exceed 85 dB(A) Lep,d (8 hours) under the 1989 Regulations or 80 dB(A) Lep,d (8 hours) under the 2005 Regulations. Accordingly, provision of HPD is sometimes a necessary second method of attenuating the level of noise affecting each worker. Each employee may experience a different daily noise dose depending on their proximity to the source of noise, the level of noise, and the duration for which they are exposed.

Hearing Protection and Attenuation

HPD that are typically considered suitable for the work environment are usually either earmuffs (also called ear defenders) or earplugs. Earmuffs can be worn by means of a headband or be integral to a safety helmet. Ear plugs can either be disposable or reusable, ‘one-size-fits-all’ or custom.

Manufacturers are required to test the attenuation level of their HPD in accordance with particular standards and label their HPD as providing a certain level of attenuation. Accordingly, if, for example, our textiles worker was exposed to 90 dB(A) Lep,d (8 hours) but wore a HPD that was stated to provide attenuation of 15dB (reducing exposure to 75 dB(A) Lep,d (8 hours)), how is it possible that he developed NIHL? And is the employer responsible?

In short, NIHL will have developed because the HPD did not provide the stated level of protection. Why might this be? There are two principle reasons. Firstly, manufacturers’ data is obtained in laboratory conditions which can rarely truly replicate the changing workplace of an individual over an eight hour shift. Quite simply, attenuation measured in laboratory conditions is not representative of the attenuation provided in ‘real world’ conditions. Secondly, the variability of fit can affect attenuation. HPDs fit different individuals in different ways. Real world noise exposure and poor fitting caused by improper instruction can significantly affect the effectiveness of any HPD.

Can employers be responsible for this? They can because it is well known that both of these factors affect the effectiveness of HPD. As long ago as 1972, the Code of Practice on Noise alerted employers to that knowledge. Accordingly, employers that fail to ensure that a genuinely sufficient level of attenuation is provided can be liable for what remains a hazardous level of noise.

Selecting Adequate Hearing Protection

In order to select genuinely sufficient hearing protection employers must be aware of the defects in the standards used to measure attenuation levels for HPD. There are a number of standards for this measurement.

European manufacturers of HPD are required to use the Single Number Rating (SNR) system. In order to ascribe such a rating, the manufacturers test HPD in a laboratory environment which involves the subject fitting himself with the HPD with assistance from the experimenter. The resultant rating shows the difference, expressed in dB, between the noise levels experienced by the subject with and without the HPD. Unless otherwise stated, the SNR is taken to be representative of the 84th percentile, or 84% of all subjects.

The HSE provides general guidance for the appropriate SNR at certain noise levels, though it stipulates that such guidance is not appropriate where there are significant low-frequency components, for example in press shops, generators and generator test bays, plant rooms, boiler houses, concrete shaker tables, moulding presses and punch presses:
Noise levels | Appropriate SNR
--- | ---
85 – 90dB | 20 or less
90 – 95dB | 20 – 30
95 – 100dB | 25 – 35
100 – 105dB | 30 or greater

The SNR rating also involves a designation of H, M, or L depending on the noise environments in which the HPD is used. H ratings pertain to high-frequency environments (2000 – 8000 Hz), M to mid-frequency environments (1000-2000 Hz), and L to low-frequency environments (63 – 1000 Hz). The H, M, L designation does not refer to noise level, but the spectrum of the noise. The numbers associated with H, M, L are meant to generally show the attenuation levels at high-, mid-, and low-frequency environments.

In order to account for ‘real world’ factors outside the laboratory environment, the HSE recommends ‘de-rating’ the SNR by 4dB to estimate the actual attenuation level of HPD in the work environment. This means assuming that the sound level at the ear when HPD is worn will be 4dB higher than the attenuated sound level predicted by the SNR. This de-rating equation can be expressed as follows:-

\[ A\text{-weighted noise level under HPD} = \text{Workplace noise level in dB(C)} - (\text{SNR + 4dB}) \]

The HSE provides a hearing protection calculator that estimates the attenuation of HPD with the SNR method, using C-weighted noise levels. Most measured noise levels currently are A-weighted, and there is no standard method of converting between A-weighted and C-weighted levels. An example of A-weighted and C-weighted curves are below:-

In order to use the formula for the A-weighted noise level under HPD, noise levels measured with a C-weighting must be used. It should be noted that C-weighted Leq measurements are to be used in the formula, and not C-weighted peak measurements.

US manufacturers of HPD, on the other hand, are required to use the Noise Reduction Rating (NRR) system. The manufacturers test HPD in a laboratory environment which involves the experimenter fitting the subject with the HPD. As with the SNR, the NRR shows the difference, expressed in dB, between the noise levels experienced by the subject with and without the HPD. However, the NRR is taken to be representative of the 98th percentile, or 98% of all subjects.

As with the SNR above, it is generally accepted that the NRR ascribed to HPD in a laboratory environment is not representative of the actual attenuation achieved by the HPD when used in a workplace. For this reason, a ‘de-rating’ system is used as follows:-

<table>
<thead>
<tr>
<th>HPD</th>
<th>Estimated actual attenuation in workplace</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earmuffs</td>
<td>75% of NRR</td>
</tr>
<tr>
<td>Earplugs (formable)</td>
<td>50% of NRR</td>
</tr>
<tr>
<td>Earplugs (other)</td>
<td>30% of NRR</td>
</tr>
</tbody>
</table>
A study conducted by Berger, Franks and Lindgren in 1996 reviewed 22 studies of HPD in the workplace and found that NRR derived from US laboratory experiments overestimated protection by 140 – 2000%. The overestimation was greatest for earplugs and least for earmuffs. This study underscores the importance of de-rating the NRR in order to roughly estimate the actual attenuation provided by HPD in the workplace.

In order to calculate the A-weighted noise level between the HPD and the ear, that is, the level of noise that a worker wearing the HPD is exposed to, the following formula is used:

\[
\text{A-weighted noise level under HPD} = \text{Workplace noise level in dB(A)} - (\text{derated NRR} - 7)
\]

Though noise levels are mainly A-weighted, they are occasionally C-weighted in order to measure lower frequencies. If the workplace noise level is measured in dB(C) rather than dB(A), the A-weighted noise level between the HPD and the ear is as follows:

\[
\text{A-weighted noise level under HPD} = \text{Workplace noise level in dB(C)} - \text{derated NRR}
\]

Alternative methods of measuring attenuation include the HML method (high, medium and low frequency) which was developed for use in the UK and the rest of the EU to overcome the shortcomings of SNR and NRR, and the Octave Band method, which is the most accurate; it is designed to make some allowance for the variable amount of attenuation received by a population of those using HPD, assuming they are correctly fitted. The 2005 Regulations permit the use of the Octave Band method, the HML method and SNR in decreasing order of accuracy.

**The Impact of Intermittent Use**

Assuming an employer selects genuinely adequate hearing protection for its employees, is it enough to merely to provide this along with proper training? Regulation 8 of the 2005 Regulations makes it clear that employers must ensure hearing protection is worn. The reason for this is that hearing protection is only fully effective if it is used at all times when there is exposure to hazardous levels of noise. Intermittent use will dramatically reduce the protection afforded. By way of example, the chart below, prepared by the Canadian Centre for Occupational Health and Safety (CCOHS), shows that even the ‘best’ hearing protection with 100% attenuation affords only minimal protection when not worn continuously.

<table>
<thead>
<tr>
<th>Percent time used</th>
<th>Maximum Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>3 dB</td>
</tr>
<tr>
<td>60%</td>
<td>4 dB</td>
</tr>
<tr>
<td>70%</td>
<td>5 dB</td>
</tr>
<tr>
<td>80%</td>
<td>7 dB</td>
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<tr>
<td>90%</td>
<td>10 dB</td>
</tr>
<tr>
<td>95%</td>
<td>13 dB</td>
</tr>
<tr>
<td>99%</td>
<td>20 dB</td>
</tr>
<tr>
<td>99.9%</td>
<td>30 dB</td>
</tr>
</tbody>
</table>

What might encourage intermittent use by employees? One particular issue is overprotecting employees with excessive hearing protection that attenuates hearing disproportionately. This can result in the so-called ‘occlusion effect’, whereby the ear canal is sealed by an earplug or covered by an earmuff, resulting in an increase in bone conductivity of sound. The occlusion effect often causes wearers to hear their own voices as distorted, louder, booming, or muffled. Owing to the distortion in the perception of their own speaking voices, workers wearing...
occluding HPD may speak more quietly to compensate, which in consequence makes it more difficult for their colleagues wearing HPD to hear them. This inconvenience can cause workers to remove their HPD for short or long periods of time in noisy environments in order to communicate comfortably and effectively with their colleagues, resulting in a loss of protection.

Accordingly, employers should not merely seek attenuate all noise, rather they should seek to reduce noise to an appropriate level. British Standard EN 458:2004 recommends optimal protection reduces noise to between 75-80 dB. Therefore, wherever claims are made for NIHL with the presence of hearing protection, it is of no consequence that the employee could hear noise despite wearing hearing protection. The very essence of good protection is that the employee can still hear.

Liability

The above discussion demonstrates that NIHL can develop notwithstanding the provision of hearing protection and employers can be liable for this where the hearing protection was not genuinely sufficient, inadequate training was provided or the wearing of protection was not enforced. The provision of hearing protection alone does not satisfy the duties imposed on employers.

Is it a defence for employers to say that they thought the attenuation provided by the hearing protection was sufficient, having regard to the attenuation stated by the manufacturer? This depends on what the employer knew or could have been expected to know about hearing protection attenuation. From at least 1972, larger employers have been aware of the difference between stated and 'real world' attenuation and the impact of variability of fit. Smaller employers, who would not necessarily have been aware, or could be expected to have been aware, of the Code of Practice may be able to argue their date of knowledge on these issues was later. That is a factual question to be determined in each case. It may therefore be a defence to show that an employer did not know about real-world attenuation and the impact of variable fit.

Conclusion

Claims for NIHL where hearing protection was provided and worn are entirely feasible and foreseeable. Defendant practitioners should focus on whether a defendant employer knew or ought to have reasonably known about the possible inadequacy of seemingly suitable hearing protection. That will depend on the information being circulated in the employer’s industry at the relevant time, as well as what they actually knew from their own internal or external advisors.

Service of proceedings against dissolved companies (BCDN Editions 50, 51 and 52)

This is a consolidated and amended version of a series of articles that appeared in editions 50, 51 and 52 to BCDN.

I. Introduction

Disease claims are commonly made for conditions which have taken a considerable number of years to develop. Those conditions are allegedly caused by the employer’s historic breach of duty. Often, because of the historic nature of the exposure, the employer no longer exists and is a dissolved company. What happens in those circumstances? How can a claim be brought? And if it is brought incorrectly what are the consequences? How should defendant practitioners respond?

This article discusses, firstly, the need to restore a dissolved intended defendant company to the Register of Companies, what the position is when a claimant fails to do so, and how the courts could be expected to respond. It then considers, secondly, the approach that has actually been adopted by the courts, whether that is correct and how it can be responded to. Finally, it considers the costs issues that arise and the practical benefits of challenging defective service.
Dissolved Companies and Null Proceedings

The Need to Restore the Company

Where an intended defendant is a dissolved company the would-be claimant is required to restore the dissolved company to the Register of Companies. If the intended defendant dissolved company is not restored then it will not subsist for the purpose of a claim.

The power to restore a company to the register is now located in section 1029 of the Companies Act 2006. An application for restoration can be made by, amongst others, any person with a potential legal claim against the company. When an application for restoration is granted, section 1032(1) of the 2006 Act provides that the effect of an order for restoration to the register is that the company is deemed to have continued in existence as if it had not been dissolved or struck off the register.

Once a company is restored any claim can be issued and served in the ordinary way. For a comprehensive guide to service see edition 23 of Disease News.

However, what is the position where a claimant neglects to restore the company before issuing and serving proceedings and purports to issue and serve against a dissolved company?

Null Proceedings

Proceedings served on a dissolved company are a nullity: In re Workvale Ltd (in dissolution) (No 2). The proceedings are null because one of the parties does not exist, in this case the intended defendant: Joddrell v Peaktone Ltd. Accordingly, despite the claimant’s purported issue and service of proceedings, the claim does not in fact exist. Proceedings would only have existed, and service would only have been effective, if the claimant had secured restoration of the intended defendant under sections 1029-1032 of the Companies Act 2006.

Although the purported proceedings are a nullity, they, and service of them, may be retroactively validated by an order of the court under section 1032 of the Companies Act 2006 restoring the intended defendant to the register: Joddrell v Peaktone Ltd.

What options do defendant practitioners have when null proceedings have been issued and served against a dissolved defendant? This is a scenario that is arising with increasing frequency. They may, of course, simply await the order for restoration, which following Joddrell will bring the proceedings to life and effect compliant service. Further, they may also be content to proceed in the absence of restoration. Alternatively, and especially where the claimant has not intimated they will commence restoration proceedings, they may rightly consider that a claim has purportedly been brought against a non-existent being and question whether the court has the power or authority to deal with a case that does not strictly exist. That is to say they can question the court’s jurisdiction to try the claim and seek to have the claim form set aside on the basis that the court does not have jurisdiction to try the claim because there is no claim. It is important to be clear at this stage that the defendant is not seeking to have the claim struck out, or for the claim to be dismissed with judgment in the defendant’s favour; rather, it is seeking to set aside the claim form as the claim does not exist. Once the would-be defendant is restored to the register the claim may then be issued.

In arguing that the court does not have authority to try the claim (because the claim does not exist), the defendant is challenging the court’s jurisdiction. Such an argument engages CPR 11: Hoddinott v Persimmon Homes (Wessex) Ltd. CPR 11 provides, so far as relevant:

11 Procedure for disputing the court’s jurisdiction
   (1) A defendant who wishes to –
       (a) dispute the court’s jurisdiction to try the claim; or
       (b) argue that the court should not exercise its jurisdiction

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may apply to the court for an order declaring that it has no such jurisdiction or should not exercise any jurisdiction which it may have.

(2) A defendant who wishes to make such an application must first file an acknowledgment of service in accordance with Part 10.

(3) A defendant who files an acknowledgment of service does not, by doing so, lose any right that he may have to dispute the court's jurisdiction.

(4) An application under this rule must –
   (a) be made within 14 days after filling an acknowledgment of service; and
   (b) be supported by evidence.

(5) If the defendant –
   (a) files an acknowledgment of service; and
   (b) does not make such an application within the period specified in paragraph (4),
   he is to be treated as having accepted that the court has jurisdiction to try the claim.

(6) An order containing a declaration that the court has no jurisdiction or will not exercise its jurisdiction may also make further provision including –
   (a) setting aside the claim form;
   (b) setting aside service of the claim form;
   (c) discharging any order made before the claim was commenced or before the claim form was served; and
   (d) staying the proceedings.'

From CPR 11 it is clear that a defendant must acknowledge service of the proceedings – indicating on the acknowledgement that it will challenge the court's jurisdiction – and make an application supported by evidence challenging the court's jurisdiction within 14 days of filing the acknowledgment of service. The argument would run as follows: the claimant purported to serve proceedings on a dissolved company; thus the proceedings are null and do not exist. Accordingly, there is nothing upon which the court could conceivably adjudicate. Consequently the court does not have power to deal with the claim – for there is nothing it can have authority over – and therefore it does not have jurisdiction to deal with the matter, save for declaring there are no proceedings (because they are null) and setting aside the claim form. Were the court to agree it could then set aside the claim form under CPR 11(6) and it would be for the claimant to secure restoration before issuing new proceedings.

**Dissolved Company Proceedings in Practice**

Although the above argument appears to be eminently logical, claimants argue an alternative: that the (null) claim can be stayed pending restoration. Such an argument is especially likely after *Joddrell*, which confirms that restoration repairs the defects retrospectively.

It is understandable why claimants contend for a stay: aside from the practical consequences of having its claim set aside and needing to reissue the proceedings (often after having to secure permission from any legal expenses insurer to reissue), or indeed a potential professional negligence action for having failed to issue effective proceedings in the first instance, CPR 11(6)(d) itself says that the court may stay the claim even where it concedes it does not have jurisdiction. The argument would be to the effect that the rules contemplate a stay and therefore a stay may be granted. Further, that course would be preferable because it would be less expensive and more expeditious, thus pursuing the overriding objective.

It is suggested that such an argument can be readily rebuffed. It must be recalled that the jurisdiction referred to in CPR 11 is ‘jurisdiction to try the claim’, not jurisdiction to deal with the claim at all. Although the rules do permit the court to grant a stay when it does not have jurisdiction to currently try the claim, this only refers to cases where the court has some jurisdiction over the claim (even if it is not jurisdiction to currently try it). For example, say that proceedings are validly issued against a defendant, but they are then defectively served. Since the proceedings were validly created, the court has jurisdiction over them; however, it does not have jurisdiction to currently try the claim because the service of the proceedings was defective.
The extant scenario is different however; the proceedings are null. Therefore the court cannot have jurisdiction over something that does not exist, save for declaring that the proceedings do not exist and that it has no jurisdiction to deal with them at all. It is logically inconsistent to suggest that the court can grant a stay over proceedings which have not yet come into existence. Indeed, how can the court exercise powers over something that does not exist? The court’s powers may be broad and far reaching, but, it is submitted, they surely cannot extend to powers over something which is not in existence. Therefore CPR 11(6)(d) does not apply in a case where the proceedings are null. The court can only declare that it cannot deal with the (null) proceedings at all and set aside the purported claim.

III. An Alternative Way: The Approach in Practice

The Approach in Practice

Notwithstanding those seemingly logical arguments, the courts have nevertheless adopted an alternative position, accepting that there is a discretion to stay the proceedings pending restoration. In Eastern Capital Holdings v Fitter, the claimant company had been dissolved after the commencement of proceedings and, before any order for restoration had been made, an application was made by the defendant for the action to be dismissed on the ground that the claimant had ceased to exist. That is to say the argument outlined above was adopted (although the defendant sought judgment in its favour as opposed to the mere setting aside of the claim form). However, Evans J disagreed, holding: ‘In my judgment, on further analysis both logic and convenience point to the action being stayed rather than dismissed. Whatever order is made now during the period of dissolution, it will be retrospectively validated when, and if, the company is restored to the register. An order of dismissal would have to be set aside because it would be inconsistent with the action being resumed. An action which may be revived should not sensibly be dismissed now. But an action which is presently “dead” may sensibly be stayed, assuming that any order can be made now, until such time as circumstances change and the action is revived’.

The decision in Eastern Capital was approved by the Court of Appeal in Steans Fashions Ltd v Legal and General Assurance Society Ltd. Referring to Evans J’s passage in Eastern Capital, Nourse LJ said: ‘In that case [referring to Eastern Capital] Evans J…took the view, with which I entirely and respectfully agree, that not only did the action not have to be dismissed but that the correct course was to stay it pending the outcome [of the application for restoration]’. He then went on to say: ‘In my view, although the matter remains one for the discretion of the judge on the facts of the particular case, the course adopted by Evans J will generally be appropriate, subject always to proper provision for costs’.

Challenging the Approach

Although the courts have adopted the position that a stay may be granted, can it really be said that Eastern Capital (approved in Steans) was the correct decision? Three points can be made about the adequacy of the decision. Firstly, logic does not, with respect, point to a stay. As we have seen above, strict logic establishes there is no claim in existence that the court can stay. Convenience might well point to a stay, but that convenience does not trump the logical position that there is no claim in existence to stay.

Secondly, although Evans J rightly noted that any order for dismissal (judgment in the defendant’s favour) would have to be set aside once restoration had been secured so that the claim could proceed, it was incorrect to proceed on the basis that the claim could be dismissed. Since the claim did not exist judgment could not be entered for either party. The decision proceeded on the basis that it would have been possible to enter judgment for the defendant.

Finally, the decision was made despite earlier authority establishing clearly that claims brought by or against a dissolved company are null. If proceeded on the basis that a stay could be granted, which implicitly adopts the position that there is something in existence to stay, even though earlier authority established otherwise. Indeed, Re Workvale was decided less than a month before Eastern Capital (on 29 November 1991) and held proceedings were null in those circumstances. That is to say it is arguable that the decisions in Eastern Capital and Steans were made per incuriam (in ignorance of other decisions). That would be a reason for the Court of Appeal to depart from the Steans decision in accordance with the rules espoused in Young v Bristol Aeroplane Co Ltd.
It is therefore suggested that the decision in *Eastern Capital*, which was approved in *Steans*, was incorrect for the above reasons. However, to make those arguments would require an appeal to the Court of Appeal, since they focus on the correctness of the decision; lower courts would be bound to follow the decision. An appeal may not be forthcoming on a relatively technical point that may simply result in the reissue of a claim following restoration. But does that mean defendant practitioners acting in claims in the lower courts are bound to accept that a stay can be granted where proceedings are issued against a dissolved company?

It is arguable that the decisions in *Eastern Capital* and *Steans* may be distinguished where a defendant is merely try to have a null claim set aside, rather than dismissed with judgment in its favour. In both *Steans* and, it appears, *Eastern Capital*, the party seeking to exploit the dissolved nature of the opposing company was seeking to secure judgment on the substantive claim in its favour. The argument was that the other party is dissolved and therefore judgment in the substantive claim ought to entered for the party that exists. However, that is a different argument from that made by defendant practitioners here. Here the defendant merely submits that the claim form must be set aside because of the null nature of the proceedings – it is not open to the court to stay the claim because there is nothing in existence to stay. The defendant here is not seeking to have the claim dismissed with judgment in its favour; it is not seeking to deny a determination of the substantive issues merely on account of procedural failure. Instead it seeks to proceed to a determination of the merits once a claim is correctly issued and served following restoration. That makes the situation narrowly, but significantly different to the position in *Steans* and *Eastern Capital*. The decisions in both of those cases appear to have been at least partially driven by the fact that dismissal would have to be set aside upon restoration in order to permit a determination of the substantive issues. However, that would not be necessary here as the defendant is not seeking dismissal by judgment, it only seeks the setting aside of a null claim. Therefore the concern about needing to set aside the claim does not arise. Accordingly, merely seeking to set aside a null claim is distinguishable from both *Steans* and *Eastern Capital*.

If the court accepted that argument then a judge (at any level) would not be bound by the decisions and would be freed from applying them. The court would then be free to accept what is suggested to be the more logical argument and set aside the claim.

What would the position be in the event that a court does consider itself bound by the decisions and they are not distinguishable? All is not lost. It should be remembered that in *Steans* Nourse LJ said: In my view, although the matter remains one for the discretion of the judge on the facts of the particular case, the course adopted by Evans J will generally be appropriate, subject always to proper provision for costs’ (emphasis added). It is therefore clear that a court has the discretion not to follow *Eastern Capital* and grant a stay. What might persuade the court to adopt such a course? It is suggested that the post-Jackson approach to non-compliance might supply the necessary leverage. The effect of CPR 6 is that the claim form must be served on the defendant. Since the intended defendant company does not exist service on the defendant is impossible. Therefore when a claimant purports to issue and serve a claim, it is unable to comply with the rules and the claim cannot logically progress because it does not exist. The claimant is, in essence, sanctioned and seeks relief from sanction in the form of a stay to allow it to restore the intended defendant.

Since there has been a sanction the *Denton v TH White Ltd* approach to relief applies. According to that approach, ensuring litigation is conducted efficiently and at proportionate cost, and enforcing compliance with rules, have particular importance. A three stage test applies in determining whether to grant relief. The court must consider firstly whether the non-compliance was serious or significant; secondly, it should consider whether there was a good reason for the non-compliance – where non-compliance is serious or significant relief is less likely in the absence of a good reason. Finally the court should consider all the circumstances of the case. Applied here, the non-compliance is plainly significant: in consequence of the claimant’s failure to restore the defendant company the proceedings are null, they do not exist; what could be a more significant failure? Therefore the court must consider if there is a good reason for the non-compliance. It is arguable that there is no good reason since the claimant simply overlooked the need to secure the restoration of the defendant before issuing proceedings. If that was accepted then relief would be unlikely. Finally, in considering all the circumstances, it is suggested that nothing in particular merits granting relief. If that was accepted, relief in the form of a stay would be refused. It is submitted that not adopting this approach would ignore the need to enforce compliance and would permit claimants to proceed at their leisure, which is not in the interests of the proportionate and efficient conduct of the claim or litigation more generally.

**IV. Costs**
In the event that any of the above arguments are successful, and the claim form is set aside, what is the position on costs?

The Default Position – Or Not?

The general rule is of course that an unsuccessful party should be ordered to pay the costs of a successful party: CPR 44.2(2)(a). One would expect, therefore, that since the defendant made a successful application, they should be entitled to their costs. However, does that apply in these circumstances? Defendant practitioners should anticipate two arguments being made by claimant representatives, both of which seek to absolve the claimant of any costs liability:

1) Since the defendant has succeeded in its application that the court does not have jurisdiction to deal with the matter, save for declaring the claim to be void and setting it aside, it cannot have jurisdiction to order costs. Therefore costs are not payable.

2) Even if the court did have jurisdiction to make an order as to costs, the defendant was dissolved, did not exist, and could not therefore incur costs. Accordingly, no costs are payable.

These are both, on the face of it, seemingly strong arguments. Can defence practitioners respond? Notwithstanding the apparent strength of the arguments, it is suggested both are specious.

Jurisdiction to Award Costs

Taking the arguments in order, the first argument contends that since the court does not have jurisdiction to deal with the matter – because it does not exist – the court similarly cannot have jurisdiction to make an award of costs in favour of the successful defendant. That the court cannot have jurisdiction in these circumstances and for those reasons cannot be doubted. Indeed, it would be illogical for the court to accept it had no jurisdiction to deal with the matter and to then determine that it retained jurisdiction to award costs. It would be to accept the very argument that the defendant had just before contended could not be made by claimants: that the court retains a jurisdiction to grant a stay when the claim does not exist.

However, although the court cannot logically retain jurisdiction in these circumstances it does not mean the court is prevented from positively being given a power/jurisdiction to award costs. It is suggested that such a power is given to the courts by section 51(1) of the Senior Courts Act 1981 which provides, so far as relevant:

‘Subject to the provisions of this or any other enactment and to rules of the court, the costs of and incidental to all proceedings in [the courts] shall be in the discretion of the court’.

The vital portion of that section is ‘incidental to all proceedings’ (emphasis added). The court is empowered to award costs outside of the costs of actual existing proceedings. That of course included pre-issue costs (where, similarly, no claim exists). This is identical to the situation where a purported claim is issued and served but is in fact a nullity because the defendant is a dissolved company: no claim exists. Therefore the non-existence of proceedings is no bar to an award of costs; the court has been given jurisdiction to deal with costs by Parliament.

What if, for example, a claimant then contends that section 51 of the 1981 Act does not apply because it only grants jurisdiction to deal with costs incidental to proceedings? The argument would be to the effect that ‘incidental to proceedings’ implies that proceedings must have at some point come into existence and since they did not do so (because the claim was null) section 51 does not apply. Two responses can be made to this argument. Firstly, costs can be ordered incidental to ‘all’ proceedings. In response to the claimant’s purported claim being set aside owing to the dissolved nature of the company, the claimant is likely to restore the company to the register and effectively commence proceedings. Those later proceedings are part of ‘all’ proceedings on the same matter. Costs can be ordered incidental to all proceedings, therefore section 51 does apply.

Secondly, if it was accepted that section 51 did not apply, a defendant could, it is suggested, in any event institute Part 8 proceedings for costs in a similar manner to costs only proceedings under CPR 46.16 following agreement on all issues except costs. CPR 46.14 explicitly applies Part 8 to a scenario where a claim has been settled except as to costs outside of any proceedings at all. If the Rules contemplate Part 8 proceedings on the issue of costs
regarding matters outside of proceedings that are in existence, it is difficult to see why a defendant could not bring Part 8 proceedings for costs in this scenario if it were necessary. This would equally supply the necessary jurisdiction to deal with costs, notwithstanding the court’s lack of jurisdiction otherwise.

Accordingly, the court does have jurisdiction to deal with costs where a defendant successfully has a claim form set aside because the defendant is dissolved and the claim is null.

**Incurring Costs**

The second argument contends that even if the court does have jurisdiction on the matter of costs, the defendant did not exist and could not therefore incur costs. Thus no costs are payable.

That the defendant does not exist and cannot consequently incur costs cannot be doubted; something that does not exist cannot possibly incur costs. Of course the costs have been incurred by the dissolved defendant company’s insurer. The issue is therefore whether the insurer can recover its costs.

The court is empowered by CPR 46.2 (backed by section 51 of the 1981 Act) to make a non-party costs order. Since proceedings do not exist there cannot be parties to them. Thus the appropriate order is a non-party costs order.

What are the applicable principles? The Court of Appeal held, in *Palmer v The Estate of Kevin Palmer (Deceased)*, that where an insurer funds, controls and directs the defence of litigation in their own interests, it is appropriate for the insurer to pay costs where it is the unsuccessful party. It is suggested that the principle is capable of reversal, so that where an insurer funds, controls and directs the defence of litigation in their own interests, it is appropriate to make a costs order in its favour where it is the successful party. Indeed, the principle that the insurer should pay costs when it funds, controls and directs the defence of litigation in its own interests and is the unsuccessful party derives from the control it has over the litigation, not the outcome of the proceedings. Consequently, when an insurer successfully funds, controls and directs the defence of litigation in its own interests it is appropriate to make a costs order in favour of the insurer. Thus it is irrelevant that the dissolved defendant does not exist. The court can nevertheless award the dissolved defendant’s insurer its costs.

**V. Practical Benefits**

It may be questioned why service against dissolved companies is challenged at all. Why incur costs and challenge null proceedings when the proposed defendant is likely to be restored and actual proceedings issued in due course? There are three potential benefits from such a challenge.

Firstly, where limitation is in issue, it should be noted that the court should not order the restoration of a company where it appears to the court that the claim would fail owing to the expiration of limitation: section 1032(2) of the Companies Act 2006. Thus, where the defendant contends limitation has expired, seeking to have the claim form set aside because the proceedings are null will necessitate an application for restoration and consideration of whether limitation has expired. Therefore it is an opportunity for the defendant to seek to have the claim dismissed before it ever comes to be issued. Where limitation has on the face of it expired, the court is empowered by section 1030(3) and 1032(3) of the Companies Act 2006 to direct that the period between the dissolution of the company and order restoring the company is not to count for limitation purposes when it orders the restoration of the company. The effect of such an order is equivalent to exercising the section 33 discretion under the Limitation Act 1980. An order that time should not count must not normally be made unless: (a) notice of the application has first been given to all those parties who may be expected to oppose the making of the such an order, including the defendant’s insurers, and (b) the court is satisfied that (i) it has before it all the evidence which the parties would wish to adduce on an application by the claimant under section 33; and (ii) that an application under section 33 would be bound to succeed: *Smith v White Knight Laundry*. In short, where limitation is in issue, having the claim form set aside will allow a determination of limitation – and potentially the dismissal of the claim – before the claim ever comes into existence.

The second potential benefit from challenging null proceedings arises merely from the circumstances of the case. Once a claim form is set aside because it is null, it is entirely possible that the additional need to restore a company will cause the claimant to withdraw their claim simply because they have failed at the first hurdle. This is especially likely where the early stages of litigation have shown the claim is not being pursued with any particular vigour. Moreover, when a legal expenses insurer is funding the action it is equally possible that funding to restore the
company and re-launch the action will be denied once the first attempt at litigation has failed. Of course, neither of these possibilities will necessarily come to fruition, but they arise simply as a result of challenging the null proceedings. It potentially yields a great benefit.

Finally, the third potential benefit from challenging null proceedings is the opportunity arises to challenge the subsequent proceedings as an abuse of process under CPR 3.4(2)(b). One category of abuse is bringing a further claim. In Atkas v Adepta the appellants appealed against the striking out of their fresh personal injury claims where in previous claims the claim forms had been served out of time. It was argued by the defendants that the failure to serve in time in the first action was so serious a misuse of procedure and so strongly regarded as an act of disrespect to the court as to constitute or be tantamount to an abuse of process, such as required the striking out of the second abuse of process. The Court of Appeal held a merely negligent failure to serve a claim form in time was not an abuse. Something further was required for an abuse, such as inordinate and inexcusable delay, intentional and contumelious default or wholesale disregard of the rules. Applied here, merely inadvertently failing to restore the proposed defendant would not be an abuse of process. However, failing to take steps to restore the company when it is clear that is necessary – such as when the proposed defendant’s representatives have raised the issue – could arguably be regarded as intentional and contumelious default and thus an abuse of process warranting the strike out of the claim.

Accordingly, there are at least three potential benefits that can arise from challenging null proceedings. Defendants should analyse each case to determine whether any of them might arise and whether issue should be taken with the null proceedings. An approach that challenges all null proceedings may not be wise, since it appears the costs of restoring the company can later be recovered from the defendant in the event of success. Therefore it may not be desirable to challenge null proceedings if one of the above mentioned benefits is unlikely to arise: that would merely serve to increase the defendant’s costs.

VI. Conclusion

We have seen that there are strong arguments for setting aside claim forms purportedly issued against dissolved defendants and valid criticisms of decisions on the topic. Where claim forms are successfully set aside because the defendant is dissolved – and the proceedings do not exist – the court has the power to award costs. Nevertheless, caution should be exercised as it will not always be desirable to challenge null proceedings. Instead, defendant practitioners should seek to challenge null proceedings where it is appropriate to do so.

The regeneration of hearing and the potential for medical treatment costs in NIHL claims (BCDN Edition 52)

There are 2 principle forms of hearing loss: (i) Conductive hearing loss, arising from problems with the ‘conducting mechanisms’ in the outer or middle ear, and (ii) Sensori-neural hearing loss, arising as a result of damage to the hair cells of the cochlea within the inner ear and / or damage to the auditory nerve.

Cochlear hair cells degenerate as part of the ageing process giving rise to age related hearing loss. Damage to the cells may also be caused by certain infectious diseases, genetic predisposition, ototoxic drugs and of course exposure to damaging noise.
Many species, such as fish and birds, can regenerate the hair cells in the inner ear over time and create new auditory circuits. Unfortunately, the mammalian system lacks this ability leaving humans to suffer the permanent effects of hearing loss as we age or suffer NIHL.

In 2003, Anil K. Lalwani, and Anand N. Mhatre reported in Ear & Hearing on the research that was being carried out at that time with a view to the restoration of hearing in individuals who had hereditary hearing loss. It was noted that the hereditary hearing impairment genes, whose dysfunction was associated with hearing loss, represented potential targets for gene therapy using bacteriophages (a virus that infects and replicates within bacteria). The authors stated that human gene therapy trials to restore hearing would likely be conducted “in the next decade.”

Fast forward to 23 April 2014 and it was reported in the New Scientist that the University of Kansas Medical Centre would run the world’s first gene therapy trial to restore hearing in a group of profoundly deaf people before being widened to other clinical and research institutions. The University has now begun searching for around 45 volunteers who have severe hearing loss caused by the ototoxic side effects of drugs. It is noted that this group of people will have lost a large number of hair cells but will still have supporting structures, such as neurons, present in the inner ear. Those between the ages of 18 and 70 will be eligible for the trial although those with congenital deafness will be excluded (as they often lack the structures needed to support hair cells). The human trials follow successful gene therapy carried out in mice that had lost almost all of their hair cells. After two months treatment the rodents’ had re-grown hair cells and hearing had improved by around 20 dB.

The human trials will follow the same treatment as used on the rodents and involves the peeling back of the eardrum and passing a needle through a tiny hole made by a laser to inject a viral gene package into the cochlear. The only expected side-effect from this treatment is a short period of dizziness or nausea with re-growth of hair cells and improved hearing expected between a fortnight and two months later.

The advances in this field are reaching the point where restoration of human hearing appears to be just around the corner. As Lloyd Klikstein, head of translational medicine at Novartis who is collaborating on the trial says: “We’re just trying to tweak the mammalian a little bit to do what a lot of other species do naturally”.

This obviously raises the potential for medical treatment costs to arise in the future in NIHL claims—we will be reporting on the ongoing research in future editions of BCDN.

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**Tinnitus (BCDN Editions 61 and 63)**

In the first of a two-part series on tinnitus, solicitor Ashley Collins considers the nature and causes of tinnitus.

*Introduction*

Tinnitus often forms part of a personal injury claim for NIHL and where present can significantly increase the value of the claim.

It can be difficult to rebut a claim for noise-induced tinnitus as it is a subjective condition and there is no objective method of assessment. Whether tinnitus even exists and the grading of the tinnitus is essentially based on the claimant’s own evidence.

*What and Why?*
What is Tinnitus?

The British Tinnitus Association provides the following definition of tinnitus:

"The word 'tinnitus' comes from the Latin word for 'ringing' and is the perception of sound in the absence of any corresponding external sound. This noise may be heard in one ear, in both ears or the middle of the head or it may be difficult to pinpoint its exact location. The noise may be low, medium or high pitched. There may be a single noise or two or more components. The noise may be continuous or it may come and go."

The following sounds can be heard when suffering from tinnitus:

- Buzzing
- Humming
- Grinding
- Hissing
- Whistling
- Sizzling

Grading of Tinnitus

There are various classifications for the grading of tinnitus. The following guidelines for grading by McCombe et al are commonly used:

1. Slight. Only heard in a quiet environment, very easily masked. No interference with sleep or daily activities. This grading should cover most people who are experiencing but are not troubled by tinnitus.

2. Mild. Easily masked by environmental sounds and easily forgotten with activities. May occasionally interfere with sleep but not daily activities.

3. Moderate. May be noticed, even in the presence of background or environmental noise, although daily activities may still be performed. Less noticeable when concentrating. Not infrequently interferes with sleep and quiet activities.

4. Severe. Almost always heard, rarely, if ever masked. Leads to disturbed sleep pattern and can interfere with ability to carry out normal daily activities. Quiet activities affected adversely. There should be documentary evidence of the complaint having been brought to the general (or some other) practitioner (prior to any medico-legal claim). Hearing loss is likely to be present but its presence is not essential. Given the epidemiological data, grading in this group should be uncommon.

5. Catastrophic. All tinnitus symptoms at level of severe or worse. Should be documented evidence of medical consultation. Hearing loss is likely to be present but its presence is not essential. Associated psychological problems are likely to be found in hospital or general practitioner records. Given the epidemiological data, grading in this group should be extremely rare.

The majority of people suffering tinnitus will fall into the mild and moderate categories. The grading of severe tinnitus should be uncommon. In the UK, around 6 million people (10% of the population) are thought to have mild tinnitus, with about 600,000 (1%) experiencing it to a severity where it affects their quality of life. As a result, written questions under CPR 35 should always be raised to a medical expert whenever s/he grades a claimant’s tinnitus as severe (or catastrophic – although this is extremely rare), as it is more likely to fall into the mild or moderate categories.

7% of the population suffering from tinnitus in the UK consult their GP. As a matter of course, one would expect an individual suffering from tinnitus to such an extent that it affected their quality of life would fall into this percentage. Indeed, the Guidelines for the grading of tinnitus state that for tinnitus to be graded as severe there should be documentary evidence of a complaint having been brought to a general (or some other) practitioner prior to any medico legal claim. Therefore, if a claimant alleges tinnitus, which is graded as severe but the claimant has not attended his GP on the issue, such a grading should be robustly challenged and submitted that a lower grading would be more appropriate.
The Causes of Tinnitus

Hearing Loss

Tinnitus is generally associated with hearing loss. In simple terms, tinnitus is caused by the brain over-compensating for hearing loss.

There are two types of hearing loss. The first is conductive hearing loss, which arises from problems within the outer and middle ears so that sound cannot pass freely to the inner ear. A cause of conductive hearing loss can be infections in the outer ear (otitis media) or a build-up of wax.

The second is sensori-neural hearing loss which arises as a result of damage to the inner ear. Specifically, it is damage to the hair cells within the cochlea or the hearing nerve or both. This damage can occur through a number of different ways, including as part of the aging process or as a result of prolonged exposure to noise.

If the cochlea stops sending information to parts of the brain (due to noise not reaching the inner ear due to problems in the outer/middle ears or parts of the cochlea being damaged), these areas of the brain will then actively ‘seek out’ signals. These signals are over-represented in the brain and cause the sound of tinnitus.

Both types of hearing loss can be associated with tinnitus, although it is appears more common for sensori-neural hearing loss (i.e. inner ear damage) to be present when tinnitus arises.

Tinnitus can affect people of all ages but is more common in people aged over 65. This would suggest that age associated hearing loss is one of the main causes of tinnitus.

‘Hidden Hearing Loss’

In most cases, tinnitus is associated with hearing loss, but around 10% of tinnitus patients do have a normal audiogram.

A 2011 study entitled ‘Tinnitus with a Normal Audiogram: Physiological Evidence for Hidden Hearing Loss and Computational Model’ shows that there may be something termed as ‘hidden hearing loss’ causing tinnitus. This is said to arise when an individual is exposed to excessive noise for a relatively short period of time, such as exposure to noise at night clubs (i.e. 2-3 hours of 100dB(A) Leq). Although the individuals hearing threshold levels would recover to normal levels and produce the results of a normal audiogram within days, there may still be permanent damage on the inner ears. Although the damage is too minor to have an effect on an individual’s hearing, the damage may cause either temporary or permanent tinnitus.

Other Causes

Other than hearing loss or ‘hidden hearing loss’, the following are also possible causes of tinnitus:

<table>
<thead>
<tr>
<th>Acoustic Shock</th>
<th>Exposure to a sudden and/or very loud noise.</th>
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<tr>
<td>Meniere’s disease</td>
<td>A condition that affects part of the inner ear known as the labyrinth and causes balance problems.</td>
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<td>Ototoxic drugs</td>
<td>Ototoxic drugs can include:</td>
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<td></td>
<td>- Aminoglycoside antibiotics – drugs used to treat very serious infections.</td>
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<td></td>
<td>- Cytotoxic – drugs used to treat cancer.</td>
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<td></td>
<td>- Loop diuretics – drugs used to treat heart failure, high blood pressure and some kidney disorders.</td>
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<td></td>
<td>Some ototoxic drugs can cause permanent damage to an individual’s hearing loss/tinnitus, although the majority only have a temporary effect.</td>
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### Contributing Factors

Although tinnitus is not generally believed to be a direct cause of stress, in *Tinnitus in the General Population with a Focus on Noise and Stress: A Public Health Study* it was reported that an individual’s exposed to stress can increase the possibility of tinnitus.

Further, the paper purports that a connection can be made between an individual’s stress levels and the degree of discomfort they suffer due to tinnitus. In other words, if someone’s stress levels worsen, potentially so will the tinnitus. In their study involving 12,166 subjects, of the 2,024 that reported to have tinnitus, stress was calculated as being an attributable risk in 19% of cases.

A recent study from The Karolinska Institute in Sweden “found that tinnitus is 2.5 times more prevalent in people who are under long-term stress”. It is therefore widely accepted there is a link between stress and tinnitus, although it is still unclear the extent that stress increases the risk of tinnitus.

### Noise Induced Tinnitus

*Tinnitus in the absence of NIHL*

Tinnitus is often associated with hearing loss, which can include NIHL. However where an individual suffers tinnitus but no NIHL can this be related to excessive noise exposure?

A 2008 paper ‘The risk of tinnitus following occupational noise exposure in workers with hearing loss or normal hearing’ concluded from a study involving 752 noise exposed workers that tinnitus only relates to noise exposure if NIHL is also present.

This view is supported by numerous other older publications. Glorig (1987) quoted in Dobie (1993) said “tinnitus must accompany a compensable level of hearing loss” to be noise induced tinnitus. Alexelsson & Coles (1996) in ‘Scientific Basis of Noise-Induced Hearing Loss’ stated “in cases where the tinnitus is noise induced the configuration of the audiogram should be typical or compatible with NIHL”.

In their 2002 paper Occupational Deafness, the Department for Work and Pensions concluded that in cases of alleged noise exposure, tinnitus should only be considered noise induced if there is an element of NIHL. The paper states it cannot support the concept that noise induced tinnitus is a stand-alone disorder.

A more recent 2011 study ‘Tinnitus with a Normal Audiogram: Physiological Evidence for Hidden Hearing Loss and Computational Model’ states exposure to noise for a relatively short period of time may have a permanent damage

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<th>Common drugs</th>
<th>Drugs that are reported to cause tinnitus include:</th>
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<td>• Antimalarial drugs – there is no evidence of permanent damage on hearing/tinnitus when taken in the low dosage prescribed for malaria. However, if taken in high doses, such drugs can cause permanent damage.</td>
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<td></td>
<td>• Aspirin – Use of this drug does not appear to cause permanent hearing loss/tinnitus, although it may affect it temporarily.</td>
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<td>• Antihypertensives.</td>
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<td>• Antihistamines.</td>
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<td>• Anti-inflammatories.</td>
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<tr>
<td>Anaemia</td>
<td>A reduced number of red blood cells that can sometimes cause the blood to thin and circulate so rapidly that it produces a sound.</td>
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<td>Others</td>
<td>• Hypertension.</td>
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<td></td>
<td>• Hyperthyroidism (an overactive thyroid gland).</td>
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<td>• A perforated ear drum.</td>
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<td>• A head injury.</td>
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<td>• Solvent, drug and alcohol misuse.</td>
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<td>• Paget’s disease.</td>
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on an individual’s inner ears. Although such damage is too minor to have an effect on the person’s hearing, the
damage may cause either temporary or permanent tinnitus.

The 2012 paper Prevalence of leisure noise-induced tinnitus and the attitude toward noise in university students
purported that noise induced tinnitus is a common phenomenon among young adults as a result of listening to
loud music during leisure activities. The paper supports the notion that noise induced tinnitus can be present in the
absence of NIHL. This is due to noise exposure causing inner ear damage which is not always perceived by the
individual as hearing loss or measurable by an audiogram but resulting in noticeable tinnitus. Unfortunately, the
study did not convey how many of the 145 participants alleged noise induced tinnitus without any NIHL.

The 2010 HSE Research Report ‘A review of the current state of knowledge on tinnitus in relation to noise exposure
and hearing loss’ states that ‘it is far from clear whether hearing loss and tinnitus occur as independent effects of
noise exposure, or whether one is causally related to the other’. The report concludes that more research is required
to fully understand whether an individual can suffer from stand-alone tinnitus as a result of noise exposure.

Can stand-alone tinnitus from noise exposure be compensable?

This question was addressed by HHJ Inglis in his judgment in the Nottingham and Derbyshire Textile litigation. HHJ
Inglis said at paragraph 131 “what is agreed is that where there is tinnitus, but it is not possible to diagnose noise
induced hearing loss it is not possible to say that the tinnitus is caused by noise, even if there is a history of noise
exposure”.

Therefore as case law currently stands, stand-alone tinnitus allegedly arising from noise exposure is not
compensable.

Tinnitus in association with NIHL – when is it noise related?

If an individual has been diagnosed with NIHL and tinnitus - it should not be immediately assumed that the tinnitus
is as a result of the NIHL. As stated in part one of this feature, there are numerous other causes for tinnitus.

Are there any particular characteristics of noise induced tinnitus differentiating it for tinnitus caused by other
factors?

Is there a temporal association with the noise exposure and therefore NIHL?

The publication ‘Hearing Disability Assessment - Report of the Expert Hearing Group’ considers that for tinnitus to be
categorised as noise induced, the onset of tinnitus should be closely associated with the period of noise exposure.
In other words, it should start at or about the time of exposure to noise (i.e. within one year of cessation of exposure).

The Department for Work and Pensions 2002 paper ‘Occupational Deafness’ concludes tinnitus that starts more
than a year after exposure to noise has ceased is unlikely to be due to noise.

Professor Mark E Lutman, one of the authors of the ‘Coles Guidelines’ on diagnosis of NIHL, is of the opinion that if
tinnitus starts after noise exposure ends, they are not connected.

Noise induced tinnitus pitching

According to Nergi and Schorn (1991) (quoted in Hinchcliffe & King op. cit.) “tinnitus which is associated with noise
damage can be matched to a frequency of 3kHz or above. Tinnitus which is matched to a frequency of less than
1 kHz is to be attributed to factors other than noise”. In other words, noise induced tinnitus is high pitched.

Since NIHL is predominantly affecting the high frequencies at 2-8 kHz this is also where the tinnitus pitch is most
frequently found at pitch matching. The vast majority of research shows that noise induced tinnitus can be matched
to 2-8 kHz and should also be described as ringing, whistling and hissing in nature.

Often for tinnitus to be noise induced, it should match a high frequency preferably at or just below the frequency
of the maximum hearing loss.
Summary

Noise induced tinnitus should only be diagnosed if the onset of tinnitus was during or soon after the claimant’s exposure to noise and it can be matched in pitch to frequencies 2-8 kHz.

Conclusion

Stand-alone tinnitus claims, in the absence of NIHL, should be repudiated.

If an individual has NIHL and tinnitus, it should not be automatically assumed that the tinnitus is noise related, although it is certainly a possibility. The temporal association between onset of tinnitus and cessation of noise exposure should be explored. If onset is more than a year following cessation, than the tinnitus (with supportive medical evidence) should be denied as caused by noise exposure. Evidence may also be developed as to the pitch of the tinnitus and whether this correlates with the frequencies at which NIHL occurs.

In some cases the mild nature of the tinnitus will have little impact on the value of a NIHL claim such that extensive medical enquiries are not costs effective. In other cases where the tinnitus is moderate-severe, and significantly impacts on quantum, then these investigations may well be warranted.

Limitation in disease claims – part 1 (BCDN Edition 66)

Introduction

Limitation is a commonly arising issue in disease claims, particularly noise-induced hearing loss claims. This is because there is very often a latency period between the harmful exposure and the onset of disease. It is therefore vital that disease practitioners are fully conversant with the applicable principles of limitation law.

In principle, the law is straightforward. Under sections 11 and 14 of Limitation Act 1980, a claim is time barred if it is brought more than three years after the cause of action accrues or after the claimant’s date of knowledge that an injury had been caused to them in consequence of the defendant’s action or inaction (whichever is the later). If a claim is statute barred a court has the discretion to extend the limitation period to allow the claim to proceed out of time under section 33 of the Act. When making that decision the court must have regard to all the circumstances of the case, in particular six factors.

However, and quite unsatisfactorily, a considerable body of case law has been appended to the words of the statute, significantly complicating the area. This series therefore sets out to succinctly review the relevant legal principles and how a limitation defence should be prepared in a disease claim. This first part focuses on the law.

The Limitation Period

1. The period is 3 years: section 11(1), (3), (4) of the Limitation Act 1980.

2. The three year period runs from the date on which the cause of action accrued, or, if it is later, the date of knowledge of the person injured: section 11(4).

‘Date of Knowledge’ – Section 14

3. ‘Date of knowledge’ refers to the date on which the injured person first had knowledge:
   -that the injury was significant; and
that it was attributable in whole or part to the alleged breach of duty; and
-of the identity of the defendant or any other person alleged to have been in breach of duty: section 14(1)
of the 1980 Act.

4. Knowledge that the alleged breach of duty did or did not, as a matter of law, involve a tort is irrelevant:
section 14(1). A claimant’s knowledge (or ignorance) of his right to bring a legal claim forms no part of the
statutory test under section 14.

5. ‘Knowledge’ includes actual and constructive knowledge. Actual knowledge is acquired when a claimant
has a belief (that is more than a mere suspicion) which is held with sufficient confidence such that he
should reasonably begin investigation as to whether he has a claim: Ministry of Defence v AB [2012] UKSC
9.

6. Constructive knowledge is knowledge which the claimant might reasonably have been expected to
acquire:
-from facts observable or ascertainable by him; or
-from facts ascertainable by him with the help of expert advice which it is reasonable for him to seek.
But a claimant will not be fixed with knowledge of a fact ascertainable only with the help of expert advice
so long as he has taken all reasonable steps to obtain and act on that advice: section 14(3).

7. The test for constructive knowledge is an objective one: would a reasonable adult in the position of the
claimant (with the same age and mental capacity) have sought expert advice about the cause of their
condition? Particular characteristics or the intelligence of the claimant are irrelevant. An individual who
has suffered a significant injury should be assumed to be sufficiently curious to seek expert advice unless
there are reasons why a reasonable person in that position would not seek advice. For example, an
individual may be used to a condition from birth and may not therefore be curious. On the other hand,
the unexpected removal of a leg would excite a high degree of curiosity. The degree of curiosity depends
upon the seriousness of the condition: Adams v Bracknell Forest Borough Council [2004] UKHL 29; Johnson

8. An injury is ‘significant’ if the claimant would reasonably have considered it sufficiently serious to justify his
instituting proceedings against a defendant who conceded liability and was able to satisfy a judgment
for damages: section 14(2) of the 1980 Act. The test of what is a significant injury is concerned only with
the matter of quantum of damage; issues of the cause are not relevant: Dobbie v Medway Health Authority
[1994] 1 WLR 1234. It is not difficult to show that an injury is significant; provided it is more than de minimis
then it satisfies the test under s.14(2): Rothwell v Chemical and Insulating Company [2006] ICR 158. Further
the question of whether the injury is significant is decided by the seriousness of the injury and not by
reference to its effect on the claimant’s private life or career: McCoubrey v Ministry of Defence [2007]
EWCA Civ 17 [39]. The test is an entirely impersonal standard – what did the claimant know or ought to
have known about the injury, and would the reasonable person armed with such combined knowledge
have considered the injury significant: A v Hoare [2008] 1 AC 844 [34].

9. In the context of NIHL (and a male aged 61) a year is allowed as ‘thinking time’ between the time of
realising there is a significant condition and the date on which a person ought reasonably to have taken
expert advice: Johnson v Ministry of Defence [2012] EWCA Civ 1505. In the context of both NIHL and HAVS,
it is assumed that if a claimant had specifically sought medical advice in respect of those symptoms then
a correct diagnosis would have been made: Johnson [13] and [29], and Norton v Corus [2006] EWCA Civ
1630 [16] and [20].

10. As to the issue of what is ‘attributable’ for the purposes of section 14(1)(b), attributable means ‘capable of
being attributed to’, in the sense of being a real possibility rather than knowledge that injury was in fact
caused. It is knowledge of possibilities that matters; a claimant only needs enough knowledge for it to be
reasonable for him to set about an investigation: Spargo v N Essex District Health Authority [1997] PIQR P235

11. Once there is knowledge the limitation period begins to run, even if harm of the kind already inflicted (such
as noise-induced hearing loss) continues to be inflicted during a later period. The continuation of harm
does not postpone the limitation period in relation to the initial harm. Rather, two limitation periods should be identified: one for the initial harm which begins to run once there is knowledge, constructive or otherwise, of that harm, and one for the later continuing harm once there is knowledge of that later harm: *Malone v Reylon Heating Engineering Ltd* [2014] EWCA Civ 904.

**Disapplying the limitation period – Section 33**

12. Where the three year limitation period has expired, the court may disapply the limitation period and allow an action to proceed if it is equitable to do so having regard to the degree to which the limitation period prejudices the claimant and the degree to which disapplying the period would prejudice the defendant: section 33(1) of the 1980 Act.

13. The court must have regard to all the circumstances of the case in deciding whether to exercise its discretion, and in particular to:

- the length of, and reasons for, the claimant’s delay;
- the extent to which the cogency of the evidence has been affected by the delay;
- the conduct of the defendant after the cause of action arose;
- the duration of any disability of the claimant arising after the date of the accrual of the cause of action;
- the extent to which the claimant acted promptly and reasonably once he knew whether an alleged breach of duty might be capable of giving rise to a claim; and
- the steps taken by the claimant to obtain expert advice and the nature of any advice received.

14. Delay before the commencement of the primary limitation period can be considered as part of all the circumstances of the case: *Collins v Secretary of State for Business, Innovation and Skills* [2014] EWCA 717. Particular consideration may be given to the period between the claimant’s date of knowledge and expiry of the limitation period: *Beattie v British Steel, Monk v British Steel* (Court of Appeal, 3 June 1997).

15. The broad merits of the claim can also be considered. If a claim is weak, it militates against the exercise of the discretion: *Collins v Secretary of State for Business, Innovation and Skills* [2013] EWHC 1177 (QB).

16. Proportionality and the value of the claim are also important considerations. The court should consider the proportionality between the value of the claim and the costs of running it. Further if the claim is limited in value there is less prejudice to the claimant in the court not exercising its discretion than if the claim has significant value: *McGhie v British Telecommunications PLC* [2005] EWCA Civ 48 [31]-[38], and *Robinson v St Helens Metropolitan Borough Council* [2002] EWCA Civ 1099.

17. The burden is on the claimant to satisfy the court that the discretion should be exercised. It is wrong to describe it as a heavy burden. Nevertheless, the claimant is seeking the indulgence of the court and such indulgence is exceptional in the sense that the claimant is seeking an exemption from the normal consequences of failing to commence proceedings in time. How difficult or easy it is for the claimant to discharge the burden will depend upon the facts of the particular case: *Sayers v Hunters* [2012] EWCA Civ 1715, [2013] 1 WLR 1695.

18. Ultimately, section 33 asks if it is fair and just to allow the claim to proceed out of time. The burden is on the claimant to show it would be fair and just to allow the claim to proceed, but the defendant does have to show what efforts have been made to obtain evidence and that the evidence is less cogent due to the delay: *Davies v Secretary of State for Energy and Climate Change* [2012] EWCA Civ 1380. The issue of ‘paramount importance’ is the effect of the delay on the defendant’s ability to resist the claim. But a defendant should not be able to take advantage of its tortious acts when the decision to delay the issue of proceedings is the consequence of illness caused by the defendant’s tort itself: *Nicholas v Ministry of Defence* [2013] EWHC 2351 (QB).

19. Finally, it should also be noted there is no longer a bar on the exercise of the section 33 discretion where a second action is brought out of time following a first action brought in time that is subsequently discontinued: *Horton v Sadler* [2007] 1 AC 307.
Conclusion

Limitation law has been significantly obfuscated by the case law. It is, as Lady Hale said in *Ministry of Defence v AB* at [163], ‘complicated and incoherent’. However, principles can be distilled from examination of the cases. When the principles are known, limitation becomes less a matter of law and more a matter of evidence. It is with evidence that the second part of this series will be concerned with. We will consider how a limitation defence should be prepared in practice in disease claims.

**Limitation in disease claims – part 2 (BCDN Edition 67)**

**Introduction**

In last week’s edition we considered the principles of limitation law that are applicable to disease claims. In this practical article we consider how to determine whether limitation is in issue and how to run a limitation defence.

**Determining whether limitation is an issue**

1. In many NIHL cases limitation may be an issue because of the latency between exposure and onset of perceived disability. Claimants invariably provide a history of recent onset of symptoms despite historic exposure to noise. It is important to check that such a history is compatible with the extent of overall hearing loss (age associated loss + NIHL).

2. There is a ‘reservoir’ of hearing which can be lost before there is any subjective disability. Subjective disability typically arises at around 20-25dB of loss (the ‘low fence threshold’). Often, the effects of NIHL are not perceptible until age associated loss begins to increase and/or hearing loss caused by other exposures exceeds this reservoir of hearing.

3. NIHL is a non-progressive condition. Once exposure to noise ceases so does any NIHL – there is no progressive deterioration other than arising as a result of natural ageing or some other pathology. The NIHL that exists today is the same as existed at the time exposure ceased.

4. If the claimant’s overall loss is significantly greater than the low fence threshold then it is likely there has been long-standing disability or there is a third, recent cause of hearing loss which has caused disability to only recently onset. It is important to check that the degree of loss is ‘compatible’ with the history of onset of disability:

   a. Estimate the claimant’s likely hearing loss at the time exposure ceased (AAHL+NIHL).
   b. Would the overall binaural loss at this time exceed 20-25dB and so represent first disability?
   c. If the overall loss at this time would not exceed the low fence threshold at what point would this happen?

5. Questions may need to be put to the claimant’s medical expert to establish the likely onset of disability. This exercise can also often assist on quantum as the medical expert may introduce a third, later cause of hearing loss to explain any incompatibility between the degree of loss and recent onset of symptoms. Even though this will not assist in any limitation defence, it will reduce the overall value of the claim.
Running a Limitation Defence

Determining likely onset of symptoms

1. In any case where limitation may be in issue you will need to obtain full GP, hospital and occupational health records (if in existence). Occupational health records may also need to be obtained from other employers. The records may show/assist in determining the claimant’s actual date of knowledge.

2. Questions will need to be asked of the claimant in respect of limitation – sending template letters should be avoided and questions should always be relevant and tailored to each individual case.

3. Questions may need to be put to the claimant’s medical expert regarding the development of NIHL, the extent of overall hearing loss at the time exposure ceased, likely onset of symptoms/inconsistency between (typically recent) onset and degree of loss and apportionment (quantum). Again questions should always be relevant and tailored to each individual case.

4. Once you have determined likely onset of symptoms then it is reasonable to assume that primary limitation starts at least within a year. The Court will assume that the claimant would be sufficiently curious about the
causes of loss to explore the reasons for the same and so acquire knowledge. The claimant effectively has a year ‘thinking time’. Primary limitation starts at the end of this thinking time.

Length and reason for delay

5. Explore the length and reasons for any delay by the claimant (and solicitors) in proceeding with the claim by way of questions/Part 18 requests.

6. Be pro-active in how you handle the claim. Do not add to any delay in the claim by not responding promptly to the claimant’s requests for information/documentation or investigating matters. Any such delay will adversely affect your limitation defence.

Cogency of evidence

7. Examine the claimant’s evidence to identify and highlight all inconsistencies and ambiguity. This shows how delay has affected the cogency of the claimant’s evidence.

8. Examine the claimant’s disclosure. Are there relevant documents which can no longer be obtained? This may include occupational health screening/testing of hearing with other employers. This shows how delay has affected the cogency of the claimant’s evidence.

9. Examine and adduce evidence on how delay – not just since the expiration of limitation, but since employment ceased – has affected the cogency of the defendant’s evidence:
   a. Does the defendant still exist?
   b. If so have there been changes in corporate structure/ownership?
   c. Do the premises/place of work still exist? If so has this changed and how?
   d. Do the source(s) of noise still exist? Is the same plant/machinery available? Has the system of work materially changed?
   e. Are witnesses still available? If so how has their recollection of events and evidence been affected? If there are no witnesses you should show reasonable attempts have been made to identify and locate them;
   f. How has the defendant’s disclosure been adversely affected? You should show that documents existed but can no longer be located and why and what attempts have been made to locate the same – rather simply saying no documentation exists;
   g. Even if there are relevant noise surveys which show a noisy workplace do not concede any issues on breach. If you cannot say where, or how long the claimant may have been exposed to noise or what (if any) hearing conservation programme was in place, then breach remains a live issue. If necessary you can admit that if the claimant’s evidence on these issues is accepted by the court then breach would attach but you are simply unable to make any proper determination of these issues given the paucity of evidence;
   h. Consider the strength of the claimant’s case on breach and diagnosis/causation. If there is a genuine argument on any of these issues then there is less prejudice to the claimant in the court refusing to allow a claim to proceed out of time. Questions may need to be put to the claimant’s medical expert to at least highlight genuine issues on diagnosis/causation – even if the medical expert is unlikely to change their position;
   i. Consider the value of the claim. The lower the value the less the prejudice to the claimant if the court refuses to allow the claim to proceed out of time. Is there pre-negligent exposure or exposure with other employers who are not pursued? Introduce evidence on apportionment to reduce the value of the claim. Are there de minimis arguments?
   j. Are there gaps in insurance cover which mean a defendant/their insurers have to pick up the shortfall on costs? This increases the prejudice to the defendant in allowing the claim to proceed out of time.

Finally adduce evidence
10. Whilst the onus rests on the claimant to persuade the court to disapply the limitation period, the defendant must provide evidence by way of a witness statement on the above issues and the prejudice to the defendant in allowing the claim to proceed out of time.

11. Be aware of misplaced claimant arguments relying on *Keefe v The Isle of Man Steam Packet Company Ltd* [2010] EWCA Civ 683, to the effect that incomplete evidence resulting from delay does not cause prejudice to the defendant because the claimant’s evidence should be judged benevolently – and the defendant’s judged critically – in any event. This is incorrect: the Keefe principle only applies when the defendant’s breach of duty causes a gap in the evidence.

**Conclusion**

As we noted in the first part of this series, limitation has become a complicated area. However, applying the distilled principles in a methodical way to the evidence can yield much improved odds of succeeding with a limitation defence.

**Limitation in disease claims – part 3 (BCDN Edition 67)**

**Introduction**

Limitation is a commonly arising issue in disease claims. This is because there is very often a latency period between the harmful exposure and the onset of disease. It is therefore vital that disease practitioners are fully conversant with the applicable principles of limitation law. In the first part of this series we summarised the relevant principles of limitation law. In the second part we considered running a limitation defence in practice. In this final part we consider if there is a new limitation issue in disease claims.

**Malone v Relyon Heating Engineering**

The potential issue arises from the case of *Malone v Relyon Heating Engineering Ltd* [2014] EWCA Civ 904, which requires some explanation. In Malone, the claimant, M, had worked for R between 1977 and 2004. His work involved the use of power tools, including a jackhammer. He claimed he was exposed to excessive noise for up to 8 hours a day and was often not given adequate hearing protection. His claim for NIHL and moderate tinnitus was notified in 2009 and made in 2011. He accepted he had constructive knowledge within the meaning of sections 11 and 14 of the Limitation Act 1980 in January 2001, and asked for the limitation period to be disapplied under section 33 of the Act on the basis that it would be equitable to allow the action to proceed. The judge found M had been exposed to injurious levels of noise without adequate protection. She also found the cause of action regarding the entire period of employment had accrued when the injury was ‘completed’, namely when M ceased working in 2004, with limitation expiring in 2007 (although there was constructive knowledge in 2001 it was contended the damage continued until the end of employment in 2004). The judge held that the determination of whether the limitation period expired in 2004 or 2007 was critical to the exercise of the section 33 discretion. She concluded the delay between 2007 and 2009 had not materially compromised the defendant’s ability to defend the claim and exercised her section 33 discretion.

The defendant appealed, contending the judge’s approach led to the unsustainable result that the start of a limitation period was indefinitely postponed if harm of the kind already inflicted continued during a later period.

The Court of Appeal held at [39]:

‘The judge identified only one limitation period, which she applied to the entirety of the respondent’s employment and she failed to reflect the divisible nature of this form of injury. As a consequence, the judge’s approach to section 33 of the Limitation Act is vitiated because she erroneously decided that the only relevant period of delay was between 2007 and 2009. Instead, she should have identified the two periods of delay: 2004 – 2009 for the pre-2001 damage and 2007 – 2009 for the post-2001 damage...[T]here was no proper basis for the judge to suspend or put back the limitation period for the earlier period or to treat the injury for the entirety of the respondent’s
employment as being indivisible, given that apportionment is possible in hearing loss cases and was appropriate in the present case.’

Consequently, given that the judge had identified the determining factor in deciding whether to allow the claim to proceed as whether the limitation period had expired in 2004-2007, together with her acceptance that the defendant had a strong case regarding prejudice if the relevant period of delay was between 2004-2009, the Court of Appeal held her conclusion that it was equitable to exercise the section 33 discretion was unsustainable. She should have considered whether to allow the case to proceed for pre-2001 loss, bearing in mind the prejudice cause by the delay since 2004, and whether to allow it to proceed for the post-2001 injury. The Court of Appeal went on to decide that it would not be equitable to exercise the section 33 discretion and allow the claim to proceed. The appeal was allowed.

Paragraph [39] of Malone is potentially of significant consequence to disease practitioners. What it sanctions, indeed mandates, is the division of different periods of harm in the case of divisible injuries for the purposes of determining the limitation issue. This raises an interesting prospect for divisible disease claims.

Imagine for a moment an individual making a claim for NIHL. They have been exposed to tortious levels of noise since 1994 and continue to be so exposed. By June 2004, the individual had significant difficulty with their hearing and was diagnosed with NIHL. Assume that it is settled that at this point the individual has knowledge and the three-year limitation period begins to run. A claim must therefore be brought by June 2007. However no claim is brought until June 2014. The claim is on the face of it 7 years out of time. Imagine also that it is determined to be inequitable to disapply the limitation period. The individual has at first glance lost the ability to make a claim. However, defendants conventionally have not taken a limitation point with such claims. Traditionally, defendants have not taken limitation points in divisible disease cases where symptoms continue developing during a period of ongoing exposure. Instead, it has been assumed that there has been a ‘refreshing’ of the limitation period with each new ongoing tort. Therefore it has been thought that the harm only accrues – and the date of knowledge only begins to run – from the end of exposure. Thus in our imagined scenario the injury had not yet accrued because the individual continues to be exposed. This approach has been fuelled by cases such as McManus v Mannings Marine Ltd [2001] EWCA Civ 1668. In that case the claimant had worked for the defendant for 12 days in June 1989 and for a further 14 days in January 1990. In September 1992, he submitted a claim for vibration white finger (VWF) to the Department of Social Security (DSS), the injury at that time being in two fingers of the left hand. The claimant then resumed employment with the defendants from August 1993 to November 1999 and his condition worsened to the point that it affected all his fingers and thumbs. He issued proceedings on 2 December 1999 and at first instance his case was found to be time barred on the basis that he had suffered earlier injury in 1992. The Court of Appeal allowed the claimant’s appeal and remitted the case for re-hearing. The court held that the claimant’s claim was not for the vibration white finger that had been caused before 1993 but, rather, for the additional injury that had occurred since. The injury in question, within the meaning of s 14, was the exacerbation of the VWF that had occurred and which had been contributed to by the later exposure within the period 1993 to November 1999. Some of that period of employment may have caused the exacerbation and accordingly there was a continuing cause of action so that part the damage was not statute barred.

Cases such as McManus fuelled the notion that there can be a refreshing of the limitation period. However, Malone changes this position. It mandates the division of different periods of harm. Since NIHL is divisible there is nothing in principle which prevents defendants contending in our scenario above that most of the loss in unrecoverable since there was knowledge in June 2004 and limitation expired in 2007. Of course, this approach would still permit the claimant, in principle, to recover any loss arising from June 2011 (up to the issue of proceedings in June 2014), since loss in that period is still within the three year limitation period during which the claimant may bring an action as of right; that conclusion is also supported by Berry v Stone Manganese Marine [1972] 1 Lloyd’s Rep 182. It is for that reason that defendants must be wary of running limitation defences in such circumstances if it will still result in them having to pay a small percentage of the claim.

How likely is it that defendants will have to pay a small percentage of the claim? Will defendants really be liable for significant sums in relation to the last three years of harm? In the case of NIHL for example, it is known that under stable exposure conditions, losses at 3.000Hz, 4.000Hz and 6.000Hz will usually reach a maximum level in around 10-15 years. It is also known that as hearing thresholds increase, the rate of loss decreases. Accordingly, in a claim made for continuing hearing damage where there has been exposure for 10-15 years, it could be argued that the loss will have stabilised at a maximal level, or increased in a only a minor way, such that any loss sustained in the
last three years is in the de minimis range and not compensable. Of course, it might be expected that claimant’s
would argue that even though the loss at those frequencies has stabilised, the loss will have ‘leaked’ into other
frequencies – particularly the lower frequencies vital for hearing speech – thus resulting in material damage that is
capable of being compensated. In response to this argument, it should be noted that it takes 30 years or more of
ongoing noise exposure to affect frequencies of 1,000Hz and below (the lower speech frequencies); it will therefore
only be in a limited number of cases – where there has been very long exposure – that this argument by claimants
might succeed. Indeed most claims for NIHL concern modest exposures of short duration. In short, a Malone type
argument may assist defendants considerably, with it being unlikely that defendants will be found liable for small
portions of claims owing to the last three years of exposure.

Conclusion

Defendant practitioners may in future rely on Malone type arguments to furnish limitation defences. However,
caution must be exercised. Defendants must present evidence which shows that damage in the last three years of
exposure has not materially contributed to the harm and is within the de minimis range. Where that can be shown,
defendants may have limitation defences where they have not done previously.

Are ‘Coles’ notches an unreliable marker of NIHL? The Norwegian Railway Workers Study (BCDN Edition 88)

Introduction

The presence of noise-induced hearing loss (NIHL) in an individual is determined for medico-legal purposes by the
framework application of the ‘Coles Guidelines’. A key aspect of making a diagnosis under those guidelines is the
presence of an audiometric notch, where the hearing threshold level at 3 or 4 or 6kHz is a least 10dB greater
compared with the hearing threshold level at 1 or 2kHz and at 6 or 8 kHz (or an equivalent “bulge”). But how reliable
are audiometric notches as a marker of noise-induced hearing loss? And if they are not reliable, why might that be?

In this article we consider those issues by examining a soon-to-be published study of 12,055 Norwegian railway
workers.

Background

In their research, Arve Lie, Marit Skogstad, Torstein Johnson, Bo Engdahl and Kristian Tambs, start with the proposition
that audiometric notches are emphasised in both American and European guidelines for the diagnosis of NIHL, but
that it is known NIHL may exist without the presence of a notch. More importantly, they note that notches may
appear on an individual’s audiogram without them ever having been exposed to noise, and that there are still
some practitioners who consider a notch to be proof of the existence of NIHL, which can lead to exaggerated
notions of the prevalence of NIHL. They therefore set out to describe the prevalence of notched audiograms among
railway personnel with and without noise exposure to better assess the usefulness of such notches in the diagnosis
of NIHL.

Method

Three groups of Norwegian railway workers were chosen: train drivers and conductors (TDCs), train and track
maintenance workers (TMWs), and a reference group (RG) doing traffic controlling and other types of work. All are
required to undergo periodic audiometric testing.

An extensive noise assessment program showed that the mean (8-hour Leq) noise exposure of TDCs was 70 to 85
dB(A). The mean noise exposure of TMWs was 75-90dB(A). The mean noise exposure of the RG was <70dB(A).
Exposure time was estimated as the age of worker, minus 20, since many workers are recruited at 20+ years with
little turnover in employees.
Statistical analysis was undertaken on the most recent audiogram, obtained in the period 1994-2011, of 12,055 workers comprised of 9,881 men and 2,174 women. That analysis was based on the Coles definition of a notch, alongside other definitions of notches.

Results

The analysis showed, by way of background, that TMWs had the greatest noise exposure and more hearing loss in the noise sensitive area (3-6kHz) and also at lower frequencies (0.5 to 4kHz) compared with the RG. The hearing of TDCs was approximately equal to the RG.

As to the presence of notches, the mean hearing threshold for the right ear of all workers showed that the average depth of notch according to the Coles guidelines was less than 10dB for the frequencies 3-6kHz. A Coles notch was observed in 4,690 of the audiograms compared with no notch being observed in 7,365 audiograms. That is shown in the following graph:

In respect of the prevalence of notched audiograms, a Coles notch appeared more often in the group with the highest noise exposure (TMWs). Crucially, however, although there were significantly more notches in the highest exposed group, the occurrence of notches was also highly prevalent in the non-noise exposed RG. Indeed, in either ear, a Coles notch was present in 63% of male TMWs but was also present in 53% of the RG, as shown in the following table:

<table>
<thead>
<tr>
<th>TABLE 2. Prevalence of audiometric notches (%) in either ear in relation to occupation and sex</th>
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<tr>
<td>Train and Track Maintenance (%)</td>
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The table also shows that the prevalence of notched audiograms among TDCs was in between the prevalence in TMWs and the RG. This showed, the authors said, a dose-response relationship between noise exposure and the occurrence of notches, but the results also showed that notches are common among employees not exposed to noise. In the case of females TDCs and TMWs the prevalence of notches and the differences compared with the reference group were smaller, but still significant.

As to laterality of notches, in the case of men bilateral notches were most common, being present in 25% of all men across all ages, while unilateral notches were present in the left and right ear in 18% and 16% of men.
respectively. That was different to the position with women, with bilateral notches only being present in 13% of all women, compared with unilateral left and right ear notches of 14% and 15% respectively.

Noise exposure was significantly associated with the present of audiometric notches. Notches were 1.5 times more likely to be present in the group with the highest exposures, TMWs. They were 1.4 times more likely in the group with the second highest exposure, TDCs. Age was also associated with the presence of audiometric notches, with the likelihood of notches increasing with age such that a notch was 1.8 times more likely to be present in an individual aged 45-54. However, notches were only 1.4 times likely to be present in those aged 55-64; this decline in probability was attributed to the possible diminution of notches as a result of presbycusis (age associated hearing loss). Sex was also associated with the presence of notches – men were 1.6 times more likely to display a notch compared with women.

Finally, having compared the hearing thresholds between the three occupational groups adjusted for age and sex in relation to the occurrence of notched audiograms or not, the authors noted that the hearing loss of TMWs compared with the RG was about 1-3dB for both those workers with and without notches, suggesting that the noise-related hearing loss was independent of notched audiograms.

**Discussion of the Results**

The authors noted that their study had strengths: it had a large number of participants and the participation rate was believed to be close to 100% because hearing tests were compulsory for the workers. Indeed, it was thought that there have been no other studies of a similar size looking at the prevalence of notches in relation to age, sex and noise exposure. Moreover, the noise exposure data made it possible to provide good estimates of the prevalence of notches at different exposure levels. Further, there was a large group of non-exposed workers with hearing acuity comparable with international normal values.

However, the authors do note that they lacked important information, including the number of years of employment and other important risk factors for hearing loss, such as use of hearing protection, exposure to leisure noise, smoking, hypertension, and diabetes. Therefore the authors could not rule out that factors other than railway noise may have influenced the prevalence of notched audiograms.

A discussion of the authors’ results records their surprise in finding an increased prevalence of notches among TDCs because they had a hearing acuity highly similar to the RG and a noise exposure level that is unlikely to have any significant effect on hearing. They also note the high prevalence of asymmetric notches is peculiar because noise should have an equal effect on both ears; they posit this indicates that noise is just one of several factors that may be responsible for audiometric notches.

Most importantly, they noted that notched audiograms are commonly occurring in both workers exposed and not exposed to noise, particularly in the case of men. The prevalence of Coles notches was approximately 60% in the exposed workers and 50% in the non-exposed workers. This implies, the authors said, that the precision of one notch as a criterion for the diagnosis of NIHL is very low, as 5 in every 6 notches may be unrelated to occupational noise exposure. Accordingly, the authors said the general rule that a hearing loss with a notch indicates NIHL and the lack of a notch indicates otherwise ‘must be used with great caution’. Indeed they concluded that: ‘audiometric notches commonly occur among noise-exposed and non-noise-exposed workers in a Norwegian train company. Age and sex also play a certain role for the prevalence of audiometric notches. The usefulness of audiometric notches as a criterion of the diagnosis of NIHL is therefore of limited value’.

**Further Discussion and Conclusion**

It is clear, then, that notched audiograms – the primary marker in diagnosing NIHL – are common in both those that are exposed to harmful levels of noise and those that are not. Why might this be? In short, the high prevalence of notched audiograms in those not exposed to noise is the consequence of either those workers having in fact been exposed to harmful levels of noise, either occupationally or elsewhere, or the Coles guidelines are indicating a higher prevalence of NIHL than is actually the case – that is to say the guidelines may be over-diagnosing noise induced hearing loss.
That the Coles Guidelines may be over-diagnosing NIHL is a real possibility. That is so for the following reasons:

Firstly, requirement R1 of the guidelines – that the hearing threshold level at 3, 4 or 6kHz should be at least 10dB greater than the level at 1 or 2kHz – is largely ineffective as a diagnostic requirement. That is because most males over 40 and most females over 50 years of age who have not been exposed to noise will satisfy that requirement in any event.

Secondly, the notch of at least 10dB which is required by requirement R(3)(a) of the guidelines is within typical audiometric error and the threshold is set too low in any event; it is too readily satisfied. This is of particular concern in the current medico-legal climate where poor audiometry is widespread which results in measurements of worse than actual hearing thresholds.

Thirdly, a diagnosis of NIHL based on a notch or bulge at 6kHz only is flawed.

Finally, the age data applied in the guidelines against which a claimant’s hearing is compared is inappropriate. It sets the ‘normal’ baseline of hearing too low for the non-exposed population, so that ‘normal’ hearing is regarded as better than it actually is. In consequence, more people will be diagnosed as having diminished hearing against that standard – it over-diagnoses NIHL.

In conclusion, and as the authors identify, great caution must be exercised around notches in audiograms. They are not a reliable marker of NIHL: the Norwegian study shows that noise-induced hearing loss may be independent of notched audiograms, notches are highly prevalent even where there is exposure to noise levels unlikely to cause hearing damage, and that notches are often asymmetric, which is untypical of noise-induced hearing loss. But most importantly, notches are prevalent even where there has been no hazardous noise exposure. Moreover, even where there is a history of noise exposure that does not prove a diagnosis of NIHL. As we have seen, satisfying the Coles guidelines cannot be said to conclusively show the existence of NIHL. They are some measure away from being sufficiently robust. We will be exploring these issues in more detail in a series of feature articles in the coming months.

Why NIHL is not a ‘disease’: The judgment in Dalton v British Telecommunications (BCDN Edition 93)

Introduction

In edition 29 of Disease News, we explored in detail the issue of whether NIHL is a ‘disease’ or an ‘injury’. It will be recalled that this is of importance because it determines the level of the recoverable success fee when a claim is compromised by settlement in those cases that are subject to the pre-1 April 2013 costs recovery regime. If NIHL is a disease then it falls within the pre-April 2013 CPR 45, section V, which determines a fixed success fee of 62.5%. If, however, NIHL is an injury and was ‘sustained’ on or after 1 October 2004, it would fall within section IV of the pre-April 2013 CPR 45 and attract a success fee of 25%. If sustained before that date, the success fee would fall to be determined by the court.

Traditionally, defendants had accepted that NIHL was a disease and attracted the 62.5% success fee. However, following the decision of Males J in Patterson v Ministry of Defence [2012] EWHC 2767 (QB), which held that the term ‘disease’ must be construed according to its natural and ordinary meaning, defendants began to contend that NIHL was in fact an injury owing to its process of development, which is more akin to an injury, and therefore attracted a success fee of only 25%.

Following a number of inconsistent District Judge level decisions, the Regional Costs Judge directed on 4 April 2013 the determination of the issue as a preliminary issue in four test cases. That determination has now been provided by Phillips J in Dalton v British Telecommunications Plc [2015] EWHC 616 (QB), with the result that NIHL is a ‘disease’ We reported on the outcome in edition 88 of Disease News. In this article, we consider the judgement in detail, reaction to it, and look to future developments.

Dalton v British Telecommunications
In his judgment, Phillips J starts by considering the classification of NIHL for medical purposes. Having considered a variety of sources he held that NIHL may properly be categorised as a disease ([13]).

His Lordship then turned to the legislative history of the relevant terms. Following a comprehensive analysis, he concluded that the concept of ‘disease’ was introduced to ‘cover symptoms and injuries…which were not caused by accident’, accidents being single incidents ([20]). ‘Disease’ was used in contra-distinction to the term ‘accident’, not ‘injury’ ([16]). Moreover, NIHL had been expressly defined as a ‘disease’ in subordinate legislation for about 30 years and had been so defined for around 20 years at the time of the introduction of the fixed success fees in 2005 ([25]).

Phillips J then paid considerable attention to the provenance of the fixed success fee rules, noting that they were the product of research and negotiation. There had been no suggestion that NIHL was encompassed by the fixed success fees for injuries ([30]). Indeed the report on fixed success fees for disease claims proceeded on the ‘unquestioned assumption’ that NIHL was a disease and concluded that a revenue neutral success fee for NIHL claims would be 64.07% ([31]), and a subsequent press release confirmed that a success fee of 62.5% had been adopted in NIHL cases ([33]). It could not have been clearer, said Phillips J, that it was intended that NIHL would be included as a disease ([34]). The ‘clear and obvious conclusion’ was that NIHL was a Type C disease within section V of CPR 45, attracting a success fee of 62.5%. If that were not the case the scheme had miscarried ([35]).

As to the submission that on a natural and ordinary understanding of the term ‘injury’ NIHL was an injury, Phillips J observed that such an argument assumed that if a condition is an injury it cannot be a disease. However that was incorrect; it was clear from sections IV and V that there is a degree of overlap between the two terms, they are not mutually exclusive ([43]). So the issue was solely whether NIHL was a ‘disease’ ([44]). In that respect, the legislative history showed that a ‘disease’ is anything – even an injury – that arises by a process, rather than by an accident ([46]). Though that legislative history had to be considered with circumspection, reference to it was relevant in interpreting the provisions because ‘injury’ and ‘disease’ were otherwise ambiguous and because the long standing use of those terms in antecedent legislation was reflected in the Pre-Action Protocol for Disease and Illness Claims ([47], [49]).

Accordingly, Phillips J ruled that the legislative history strongly indicated that Parliament intended the term ‘disease’ in CPR 45, sections IV and V, to include ‘any illness (whether physical or physiological), disorder, ailment, affliction, complaint, malady or derangement other than a physical or physiological injury solely caused by an accident or other similar single event’ ([50]). Although that conclusion was different from that reached by Males J in Patterson, Phillips J said that the decision there appeared to have been reached without the legislative history and its relationship with the current Pre-Action Protocol being drawn to Males J’s attention ([52]).

Applying that definition, NIHL was plainly a ‘disease’. Further, to the extent that tinnitus is a symptom of NIHL or is otherwise caused by exposure to excessive noise, it was also a disease. His Lordship also observed, obiter, that VWF was also a disease according to that definition ([53]). That conclusion was fortified by the fact that if NIHL was an injury, then Section IV of CPR 45 would only apply to NIHL ‘sustained’ on or after 1 October 2004. It would rarely be possible to identify when a condition such as NIHL was ‘sustained’, the word being more suited to single incidents. It would result in uncertainty and further argument ([51]).

Phillips J held that if he was wrong about the meaning of ‘disease’, it was nevertheless entirely clear that NIHL is a disease. Firstly, the categorisation of NIHL had its own legislative history, pointing in one direction. It had been identified as a disease in legislation since 1975. In using the term ‘disease’ in Sections IV and V without any list or definition, Parliament must be taken to have intended to include conditions such as NIHL which had been and were currently defined as a disease for the purposes of closely-related legislation ([56]).

Secondly, in the context of occupational disease claims, NIHL claims are not only recognised as such but account for a substantial majority of all such claims. NIHL is the paradigm case of such as disease. It was inconceivable, when looked at in the proper litigation context and considering the mischief being addressed, that Parliament did not intend to include NIHL (and VWF) in type C of section V ([57]).
Thirdly, the Civil Justice Council’s press release put the matter beyond any sensible argument, expressly recording that an industry agreement was to be embodied in the rules which agreed a success fee of 62.5% for NIHL and VWF claims ([58]).

Having concluded that NIHL was a disease, Phillips J declined to express an opinion on when NIHL is sustained given that the issue did not arise for determination. Indeed, it was in part because the term ‘sustained’ was inapposite to refer to a process that NIHL had been held to be a disease ([63]).

Practical Impact

The decision of Phillips J now leaves little scope for contending that NIHL is not a disease. It is a decision of the High Court that is binding on the lower courts: Howard De Walden Estates v Aggio [2007] EWCA Civ 499. Further it is a decision which, as a matter of judicial comity, would be followed in other High Court cases: Aggio.

The decision also confirms that to the extent that tinnitus is a symptom of NIHL or is otherwise caused by exposure to excessive noise, it is also a disease, removing the possibility of an argument that tinnitus is not a disease even if NIHL is.

Success fees of 62.5% will therefore be recoverable in the ordinary way in those cases that are still subject to the pre-Jackson costs recovery regime (which is a finite and diminishing pool). This should be of some relief to disease practitioners. Though that is seemingly counter-intuitive, it should be noted that many NIHL cases concern NIHL that is allegedly sustained – whatever that may mean – before 1 October 2004. Therefore the recoverable success fee would fall to be determined according to the pre-1 April 2013 Costs Practice Direction, Section 11, with the very real risk of an even higher success fee being awarded.

Aside from the issue of NIHL, Phillips J also purported to resolve the issue of whether VWF is a disease, presumably in attempt to prevent that particular question being litigated. Phillips J concluded VWF was also a disease. It should be noted that part of the judgment is obiter and would not be binding on future courts – it would merely be persuasive authority. Having said that, the decision is comprehensive and well-reasoned. It can be expected to be followed.

Further Developments and Conclusion

It has transpired that at application for permission to appeal the decision of Phillips J has been made to the Court of Appeal. The decision of the High Court expressly recognises that it adopts an alternative position to that adopted by Males J in Patterson. Should permission to appeal be granted, it is expected that the appeal will focus on the extent to which extraneous material was relied upon to construe the former Part 45; the court’s decision ascribes emphasis to the legislative history, which does provide an extended definition of disease, and the Pre-Action Protocol, which is not a part of the Civil Procedural Rules, although it does apply to disease claims and the CPR do expect compliance with it. Further, the decision placed considerable emphasis on the series of negotiations that resulted in the fixed success fees. It is at least arguable that undue weight was given to these extraneous aids when interpreting the provisions.

As to reaction to the judgment, Jonathan Wheeler, the incoming president of the Association of Personal Injury Lawyers, echoed Phillips J’s comments, saying that the attempt by defendants to have NIHL classified as an accident rather than a disease in an attempt to reduce the level of costs they would have to pay was ‘downright dishonest’.

We will update on the progress of any appeal. Until then, however, NIHL is very much a ‘disease’, as is, it appears, VWF.

De Minimis in NIHL Claims (BCDN Edition 97)

Introduction
Back in edition 3 of Disease News, we explored the issue of whether noise-induced hearing loss (NIHL) can be de minimis. That is to say we asked if hearing loss can ever be so trivial so as not to be actionable. In this article we return to the issue, probing it in light of the recent County Court decision in Holloway v Tyne Thames Technology.

Revisiting De Minimis Principles

It is trite law that negligence is actionable only of proof of damage. It is similarly trite that while such damage need not be substantial it must be more than minimal. As a matter of public policy, a claim for negligence or breach of statutory duty can only be brought where the damage caused is worth suing for, not for merely trivial injuries. If culpable action or inaction produces a physiological change that is neither visible, nor symptomatic, and it in no way impairs bodily function, it should not attract legal liability.

These principles were famously espoused in Cartledge v Jopling [1963] AC 758. Lord Pearce said, at 779: ‘...it is for a judge or jury to decide whether a man has suffered any actionable harm and in borderline cases it is a question of degree…It is a question of fact in each case whether a man has suffered material damage by any physical changes in his body. Evidence that those changes are not felt by him and may never be felt tells in favour of the damage coming within the principle of de minimis non curat lex. On the other hand evidence that in unusual exertion or the onslaught of disease he may suffer from his hidden impairment tells in favour of the damage being substantial’.

But while the principle itself is clear, it is often difficult to determine the point at which an injury or condition crosses the Rubicon from triviality to materiality.

Further guidance on the nature of de minimis was provided in the seminal decision of Rothwell v Chemical & Insulating Company Ltd [2007] UKHL 39 (otherwise known as the Pleural Plaques Litigation). In that case the majority found that asymptomatic pleural plaques which were accompanied by the usual risks for future asbestos related disease and feelings of worry did not constitute ‘personal injury’ and so no cause of action could be pursued. The test for de minimis was framed in a number of ways by their Lordships, but was perhaps best expressed by Lord Hoffman, who said the test was whether a claimant was ‘appreciably worse off’ on account of the injury or condition (at [19]).

Since asymptomatic pleural plaques were found to be de minimis in Rothwell, there is a danger of treating that decision as authority for the proposition that the presence of symptoms is sufficient alone to make an injury or condition cross the threshold of materiality. However, that is manifestly not the case. The presence of symptoms alone is not enough, as Lord Hope made clear. Instead, the symptoms must have more than a negligible effect on the victim. Lord Hope said, at [47]: ‘But the policy of the law is not to entertain a claim for damages where the physical effects of the injury are no more than negligible. Otherwise the smallest cut, or the lightest bruise, might give rise to litigation the costs of which were out of all proportion to what was in issue. The policy does not provide clear guidance as to where the line is to be drawn between effects which are and are not negligible. But it can at least be said that an injury which is without any symptoms at all because it cannot be seen or felt and which will not lead to some other event that is harmful has no consequences that will attract an award of damages’.

Thus a condition or injury will be de minimis if it is not symptomatic in a more than material way.

An additional illustration of the test in practice was provided by the Court of Appeal in Hussain v West Mercia Constabulary [2008] EWCA Civ 1205, where it was held that transient physical symptoms caused by anxiety or stress did not amount to physical or psychiatric injury and were therefore de minimis. Further, in the Northern Irish decision of Fryers v Belfast Health and Social Care Trust [2008] NIQB 123, a needle stick injury was held also to be within the de minimis principle (although this was subsequently reversed on appeal (see [2009] NICA 57)).

Finally, in Sienkiewicz v Greif (UK) Limited [2011] UKSC 10, Lord Phillips, at [108], commented that it would be impossible to define quantitatively what is de minimis. Arguably it is not the injury but the resulting disability – in the past, now or in the future – which is paramount in determining the likely success of any de minimis defence, or adopting the words of Lord Hoffman in Rothwell at [19], is the claimant ‘appreciably worse off’?

Human Hearing and Speech
Before considering whether NIHL can be de minimis according to the above principles, it is worth revisiting the topic of human hearing. The human range of hearing is between in the region of 20 Hz and 20 kHz in children and young adults but with the high range frequencies at 8 kHz and above fading with age.

The human voice produces sound within a frequency range of about 60 Hz-7 kHz but most human speech falls within a range of 250 Hz-3 kHz. The primary importance of sound within the human speech frequency range of 250 Hz-3 kHz is internationally recognised in the transmission of speech through telecommunications networks with circuitry designed to capture sound within that range only.

However, sound at 4 kHz can also play a part in speech recognition. According to an Irish Expert Hearing Group ‘each individual frequency supplies a different quantity of information for understanding speech. All frequencies between 250 Hz and 4,000 Hz contribute to speech comprehension, but some are more important than others. The most important frequency for understanding speech in a quiet environment is 2,000 Hz. The other frequencies, e.g. 250 Hz, 500 Hz and 4,000 Hz, are less important’. Importantly the same Expert Hearing Group concluded that ‘frequencies of 6,000 Hz and 8,000 Hz carry no information for speech comprehension’. This is reflected within the figure below reproduced from the Group’s report showing the frequency ranges important for understanding speech.

De Minimis NIHL?

With the nature of human hearing in place, we can now ask how the legal principles are to be applied in NIHL cases. Is hearing loss of only a few decibels actionable? Similarly, is more significant hearing loss outside of the key frequencies for human hearing – that is 250 Hz-3 kHz – actionable? These are pressing questions, for such claims are increasingly frequent in view of the profitability of NIHL claims for claimant practitioners next to other areas of personal injury following the Jackson reforms.

Early indications suggested that hearing loss of any degree, however minimal, would always be actionable. In Parkes v Meridian Ltd [2007] EWHC B1 (QB), the first instance decision in what became Baker v Quantum Clothing Group Ltd [2011] UKSC 17, Judge Inglis said the following, at [125], in respect of de minimis: ‘I do not accept, however, the argument for the Defendants based on de minimis. The smallness of a level of risk may be relevant in assessing how an employer should act in particular circumstances. It does not prevent compensation for hearing loss being appropriate where the impairment has led or will lead to some level of disability, even if only minor. For small amounts of noise damage that will lead to awards at the bottom end of the damages scale, the key decision in my judgment is whether a real degree of noise induced impairment can be confidently diagnosed on the balance of probability…I accept that such impairment will, either at the time of examination, or later with the development of presbyacusis [age-related hearing loss], result in disability that develops earlier and is more severe at the time of life it develops than would otherwise be the case’.

However, those comments were made prior to the decision in Rothwell, and in light of that decision are, with respect, wrong. Applying Rothwell, minor hearing loss should not be actionable if the claimant is not ‘appreciably’ worse off. Now it is true to say the claimant may only be appreciably worse of in time, once presbyacusis illuminates the
noise-induced hearing loss, but, fundamentally, the issue is always whether the NIHL itself materially affects the claimant, at any time. Does the NIHL alone materially affect the claimant? Does the (noise-induced) loss of hearing of a magnitude of only a few decibels, or outside of the key frequency range for hearing, materially affect the claimant? If not, if the noise-induced hearing loss itself is minimal and only affects the claimant in some very small measure, the loss falls within the de minimis principle and is not actionable.

It appears that this approach is now gaining some traction. In the first instance decision of *Hughes v Rhondda Cynon Taff County Borough Council* (Cardiff County Court, 3 August 2012), the claimant alleged NIHL arising from exposure to excessive noise during employment with the defendant as a labourer between 1969 and 1986. The claimant initially had difficulties in hearing speech against a noisy background from 2009 when aged 60. Breach of duty was admitted but causation was in dispute and it was further contended that any NIHL which may have existed was insignificant such as to be de minimis. There were 5 audiograms considered by the court, none of which showed any hearing disability within the key 1-3 kHz frequency range and applying the ‘Black Book’ method for assessment of disability. In oral evidence the claimant’s medical expert advanced for the first time the argument that losses at 4 kHz gave rise to a disability. It was common ground that there were a few decibels of loss at 4 kHz caused by noise but the issue was whether it constituted a disability?

The judge found that the NIHL at 4 kHz did not give rise to any disability. The claimant’s difficulties in hearing speech arose from age related and idiopathic (unknown) losses. The claimant’s hearing was still within a range of normal hearing for a man of his age and as such there was no ‘disability’. The claimant was not ‘appreciably worse off’ and the change in hearing fell within the de minimis principle so as not to be actionable.

**Holloway v Tyne Thames Technology**

The approach in Hughes has been followed in the recent County Court decision in *Holloway v Tyne Thames Technology*. In that case the judge was satisfied that the defendant was in breach of its common law duty care throughout the claimant’s employment from 1993 to 2006. The medical experts, Professor Homer for the Claimant and Professor Lutman for the Defendant, agreed that the claimant’s audiometry satisfied the criteria for diagnosing NIHL. Accordingly, Judge Freedman concluded the claimant had sustained NIHL during her employment. The primary issue for determination, however, was whether that NIHL should attract an award of damages or if it fell within the de minimis range. Judge Freedman accepted the test to be applied was whether the claimant was appreciably worse off on account of the NIHL, in accordance with Rothwell.

The medical experts were divided on two issues. Firstly, the quantification of the noise loss and, secondly, whether the claimant noticed her additional noise loss at 4 kHz. As to quantification, Professor Homer for the claimant said the claimant had either a 6 dB (binaural 1, 2, 3 kHz average) or 9 dB (binaural 1, 2, 4 kHz average) noise loss, by using statistics for age 60 individuals from the Modified ISO 7029 (1984) tables – the claimant was aged 68 and 5 months at the time of examination. Meanwhile, Professor Lutman contended that the noise loss was 1.3 dB (binaural 1, 2, 3 kHz average) using age 70 statistics and did not consider this loss to be significant or have a material effect on the claimant. If Professor Lutman’s approach was preferred by the court, Professor Homer agreed the claimant’s hearing loss over 1, 2, 3 kHz would not be noticeably different over those frequencies. Judge Freedman was persuaded by Professor Lutman’s evidence on this point; indeed, in his judgment he was not satisfied that even a noise loss of 3 dB was an appreciable loss. As to the additional loss at 4 kHz, but for the noise exposure, the judge accepted the claimant would have had a 30 dB loss in each ear, but noted she had a 40 and 45 dB loss in the right and left ears respectively. Professor Homer contended this loss was sufficient to show a measurable loss. Professor Lutman did not agree: while the claimant might notice the loss it would be so rarely that he could not accept that she was materially affected. Professor Lutman’s evidence was again preferred on this point. Therefore the claim failed.

**Comment**

This decision, coupled with *Hughes*, is encouraging for defendants. It shows that arguments logically derived from the law stated in *Rothwell* are now finding favour in the courts. It also accords firmly with public policy: why should negligible hearing loss attract damages when other negligible harm does not?

However, it should be borne in mind that the decision in *Holloway* is first instance in the County Court: it is not binding. But it will, as a matter of judicial comity, be followed by other judges unless they are convinced it is wrong:
Howard De Walden Estates v Aggio [2007] EWCA Civ 499. It is therefore of significant value to defendants and allows them to contend that losses of up to at least 3 dB in the key hearing range frequencies and losses of up to at least 15 dB at 4 kHz are de minimis.

This decision may well be a significant weapon in combatting the rising tide of NIHL claims.

**Conclusion: Success In Running a De Minimis Defence**

Holloway and Hughes demonstrate that de minimis defences can succeed in NIHL claims. The appropriate selection criteria for running a successful de minimis defence are:

- The main speech frequencies between 1-3 kHz unaffected by any NIHL, or are only affected in a very limited way;
- NIHL of not more than 15 decibels at 4 kHz or 6 kHz. It is preferable that the NIHL is only at 6 kHz since there are studies to support the role of hearing at 4 kHz for speech recognition and it is possible to argue that any loss at 6 kHz is transient or spurious or, if the loss is permanent, does not arise as a result of NIHL. However, Holloway does indicate that even losses at 4 kHz can fall within the de minimis range.
- An elderly claimant with already significant non-noise related losses such that it can be argued that any disability from NIHL is completely subsumed by other losses/disability. Whilst the effects of NIHL and age related losses are initially additive the effect of the noise component progressively diminishes over time. By the age of 80 it is arguable that it makes virtually no difference to an individual’s hearing ability what noise exposure has arisen, though be aware of the onset of any disability being ‘brought forward’ as a result of the NIHL.
- Not all of these selection criteria need to be present for a de minimis defence but the more present the better the prospects of success. We would also emphasise the importance of developing proper medical evidence supported by authorities. There are studies which suggest that hearing at 4 kHz (see earlier) and possibly 6 kHz play some role in speech recognition. Hearing aid manufacturers are also starting to introduce ‘extended bandwidth’ hearing aids which are said to amplify sounds between 6–8 kHz (traditionally insufficient amplification at these frequencies coupled with ‘feedback’ prevented this). However we are unaware of any authorities (as yet) which show significant improvements in speech recognition with the use of extended bandwidth amplification. Having said all that, Holloway might just indicate that losses outside of the key hearing range are likely to be treated as de minimis.

**Muting NIHL Claims – The ABI’s Approach to Reform (BCDN Edition 99)**

**Introduction**

The Association of British Insurers (ABI) has set its sights firmly on noise-induced hearing loss (NIHL) claims, warning in a new report published this week that the UK’s ongoing compensation culture is resulting in thousands of people being misled into believing they are entitled to compensation for industrial deafness in consequence of claimant lawyers and claims management companies (CMCs) shifting their attention to more lucrative disease claims.

In this article we explore the ABI’s report, considering the issues that have arisen and the proposed remedial methods.

**Background**

The ABI’s report, ‘Noise Induced Hearing Loss Claims: Improving the Claims System for Everyone’, opens with a history of NIHL litigation, noting that the majority of historic NIHL claims arose from those working in heavy industries, resulting
in the promulgation of the Iron Trade Deafness Scheme in 1984. It also explains that claims were driven by the unions, with the Scheme ending in 1998 with no new claims being accepted after 1997. It recalls that during the operation of the Scheme, NIHL claims peaked at 67,054 in 1993, before settling to a low of 5,346 in 2001 after the Scheme came to a close.

More generally, the background to the report explains that public awareness of NIHL has increased over the years, with unions campaigning heavily on the effects of exposure to noise in the workplace. Indeed, in 1999, the Trade Union Congress (TUC) ran a campaign drawing attention to the issue of occupational hearing loss. In consequence, it is now a widely understood issue.

The Scale of the Issue

The report goes on to explore the magnitude of modern NIHL litigation. Despite improvements in health and safety measures and better regulation, the report notes that insurers and compensators have experienced a significant increase in NIHL claims in recent years. It attributes this to ‘the UK’s compensation culture’. In 2010, the report states, 24,352 NIHL claims were notified. But, by 2013, this had increased to 85,155 – a staggering increase of almost 250% in just three years. The total estimated cost of these claims was over £400 million. While the report concedes that claims numbers peaked in 2013 following the introduction of the Jackson reforms, it notes that claims numbers remain high, with the estimated number of claims notified in 2014 being 39% higher than in 2012. Indeed, it should be noted that the statistics for 2013 are likely to be anomalously high on account of the introduction of the Jackson reforms and the deluge of claims that were notified prior to their introduction in April 2013 to benefit from a more beneficial procedural regime. But placing 2013 aside, it is clear that claims numbers have been increasing year on year – significantly so in 2012 and 2014 – since 2006, as the following graph shows:

Furthermore the report explains that the increase in NIHL claims can be seen in the significant increase in the number of searches made through the Employers Liability Tracing Office (ELTO), figures that we have previously reported on. In 2014, there were 134,283 NIHL searches through ELTO, an increase of 40% from 2013, when 95,673 NIHL searches were made.

The report goes on to contrast the ‘dramatic increase in the number of notified NIHL claims in recent years’ with the number of settled claims which are paid, noting that settled claims have not increased at the same rate as notified claims. Indeed, in 2010, there were just over 10,000 claims that were paid, which increased to 15,632 paid claims in 2014, an increase of only 56%. The incongruence between notified claims and settled claims, the report says, shows the increasing number of unmeritorious claims that insurers and compensators are required to process. The numbers of settlements by year are shown in the following graph:
The report then notes the cost of these claims numbers, stating that the estimated overall cost of NIHL claims to insurers has risen from just under £83 million in 2010 to over £360 million in 2014 – a more than four-fold increase in just four years. This increase, the report asserts, is ‘a direct result of the UK’s compensation culture rather than a genuine increase in people experiencing NIHL. The increase cannot be explained by any change in the law, new regulations or medical practices’. The increase in costs over the years is shown below:

Alongside the astounding increase in costs, the report observes that a significant proportion of the cost of NIHL claims comprises disproportionate claimant representative fees. In 2013 the average compensation payment for a NIHL claim was £3,100, while average claimant legal costs were £10,400. Thus for every £1 paid to a claimant, over £3 was paid to their representative. It should also be noted that costs significantly in excess of £10,000 are not uncommon.

Finally in respect of the scale of modern NIHL litigation, that report observes that while insurers and compensators are having to manage the increase in claims, most of them are unsuccessful. The industry average claims failure
rate was 65% in 2013. Furthermore the rate is increasing, with one insurer reporting a failure rate of 85% in 2014. These failure rates, the report says, highlight two issues. Firstly, a significant number of submitted claims are of poor quality without any real prospect of success – there can be no doubt about this. Secondly, insurers and compensators are being forced to direct significant resources to managing these spurious claims, which results in reducing the time spent on settling genuine claims.

The Cause

What then is the cause of this increase in claims? The ABI states in the report that the Jackson reforms are to blame. In consequence of the reforms, low value road traffic (RTA) claims are less attractive to claimant lawyers and CMCs owing to the reduction in recoverable fees by around 60%. In consequence, claimant practitioners have refocused their attention to those claims, namely NIHL, where hourly fees remain potentially recoverable. Consequently, NIHL claims are aggressively farmed.

Hourly fees are only recoverable where NIHL claims proceed outside of the Claims Portal. The ABI takes issue with NIHL claims not being processed through the Claims Portal. For the ABI, all NIHL claims are suitable for resolution through the Portal. But, the ABI says, there are a number of problems with the Portal in its present format. Firstly, the Portal excludes multi-defendant claims and the majority of NIHL claims are multi-defendant, meaning most NIHL claims are excluded from the Portal. Secondly, claimant practitioners often provide insufficient information in the Claim Notification Form (CNF), prolonging investigations by the insurer; this is compounded by the absence of a requirement to supply a copy of the claimant’s HMRC schedule. Finally, the Portal does not allow sufficient time for insurers to make adequate investigations into potential liability, requiring a response within just 30 business days even though NIHL claims are difficult to investigate and often require the consideration of medical evidence, which is not provided at stage one of the Portal process. Therefore it is highly unusual for compensators to be in the position to admit liability within 30 days.

Consequently, few NIHL claims ever enter the Portal in the first place and, of those that do, very few settle in it: the report notes that only 3.6% of all 28,379 disease claims submitted to the Portal have settled within it. Coupling the small number of NIHL claims entering the Portal with the small number of disease claim settlements in the Portal, the report says that ‘it is likely that only around 1% of all NIHL claims are settled within the Portal’. It says that such a limited success rate for the Portal in respect of NIHL claims is ‘stark’. Moreover, the difference in potential claimant costs is significant – the report observes that Portal costs would be fixed at £900 plus VAT in EL claims up to £10,000 in value, and £1,600 plus VAT in those EL claims valued at between £10,000 and £25,000, while average legal costs for NIHL claims in 2013 were £10,400. The report concludes: ‘The ability for claimant lawyers to drive up excessive legal costs has led to many new entrants into the NIHL claims market including law firms that have traditionally handled RTA claims. This, together with increased claims farming, has driven the significant increase in NIHL claims that all compensators are now experiencing’. There can be little doubt about the correctness of this proposition.

Challenges in NIHL Litigation

The ABI’s report then goes on to identify three distinct issues which, it says, leave NIHL claims open to abuse for financial gain by claimant practitioners.

Firstly, it points to poor quality medical evidence, noting that it is difficult to secure high quality, independent medical evidence for these high volume, low value claims, just as it was with whiplash claims. The consequence in whiplash cases was the introduction of the MedCo portal. The ABI posits that NIHL claims are similar to whiplash claims in respect of medical evidence in that: there is a lack of independence between those commissioning audiograms and the audiologists conducting the audiometry; audiologists are insufficiently qualified; audiograms are obtained in unsuitable non-clinical surroundings; and reporting consultants are insufficiently objective in their approach.

Secondly, the ABI says there are many unmerited claims for tinnitus. Since there is no objective test for tinnitus ‘it is susceptible to exploitation for financial gain’, the report says. Furthermore, like whiplash, the diagnosis of tinnitus is dependent on the history supplied by the claimant, which makes it difficult to dispute a claim for tinnitus.
Finally, the report notes that claimant practitioners attempt to circumvent the limitation period for financial gain by arguing that claimants have only recently become aware that their hearing loss is noise induced, and that the limitation period only runs from the date that their client sought legal advice on the issue. However, the report observes that awareness of NIHL in the public consciousness has been significantly excited by heavy campaigning by the unions and advertising by claimant lawyers, therefore many arguments on limitation simply seek to circumvent the limitation period for financial gain.

Resolving the Issues

Having identified the issues the report concludes: ‘The current compensation system is failing claimants and compensators. The UK’s compensation culture is driving the increase in the number of unmeritorious NIHL claims, with claimant lawyers and CMCs chasing excessive profits from disproportionately high legal fees. The high volume of claims being submitted and the high legal costs both impact on compensators, businesses and public sector bodies alike. Consumers suffer as the additional costs feed through to higher insurance premiums, the price of goods and services and impacts on taxation.

‘Genuine claimants also lose out as the current Claims Portal cannot be used for the vast majority of NIHL claims slowing down the process. NIHL claimants are therefore not enjoying the same fast and efficient process for handling their claim as those with other injury claims’.

To remedy the issues the ABI proposes three specific reforms to NIHL litigation.

Firstly, the ABI proposes extending fixed costs to all fast track disease claims that fall outside of the Claims Portal. Noting that Lord Justice Jackson proposed fixed costs, the report says the failure to implement fixed costs has led to claimant practitioners targeting disease claims with a view to making profits, often practitioners who lack the skills and knowledge to process disease claims efficiently. The report calls for the recommendation to be implemented and for the fixed costs to be set at a level which reflects the steps required by a claimant solicitor to present and run a successful claim, ensuring they are contained and proportionate.

Secondly, the report calls for the EL/PL Protocol/Claims Portal process to be amended to bring multi-defendant claims within its scope. Alternatively, it calls for a new low value disease protocol. Any protocol should as a minimum, the report says: have a timetable appropriate to low value disease claims, require disclosure of evidence of employment (specifically a HMRC schedule), allow for multi-defendant claims and allow for liability to be admitted subject to causation. The ABI says a streamlined process with fixed costs ‘will serve to reduce the drivers behind the compensation culture which has penetrated NIHL claims so that insurers and other compensators can focus their efforts on ensuring that genuinely injured claimants receive compensation without undue delay’.

Finally, the ABI calls for extension of the MedCo portal to all NIHL claims. It says the underlying ethos of independence in medical reporting should be capable of extension to all low value claims and there are concerns around the quality and independence of medico-legal reporting for NIHL claims. The report says extending the portal would be beneficial to claimants and compensators alike ‘and has the potential to drive down the volume of unmeritorious claims presented. Access to justice would be preserved as genuine claims based on independent medical evidence of hearing loss attributable to noise exposure at work would be able to proceed quickly and efficiently; whilst those not capable of being substantiated independently would be identified at an early stage and would not proceed’.

Comment and Conclusion

The report certainly draws attention to many of the issues in NIHL litigation. It will be interesting to see what, if any, response is given by the Government and what, if any, reforms follow. More generally, it should be noted that the report is the first in the ABI’s series, ‘Tackling the Compensation Culture’. The second report in the series will be published later this year.

Next week in Disease News we analyse the ABI’s proposals in further detail and set out reasons why the proposed ABI reforms may not result in the intended desires to drive down NIHL claims volumes and curtail unmeritorious NIHL claims.
Date of Knowledge in NIHL Claims: *Baird v Latham Farms* (BCDN Edition 101)

**Introduction**

In negligence, an employer is not liable for an injury or condition which arises from dangers that are not reasonably foreseeable. The earliest NIHL claims appeared in the 1960s but were unsuccessful as a result of exposure occurring many years before the risks of exposure to excessive noise were foreseeable. Therefore a key question in any claim is: when will an employer be held to have known about the risk of excess noise? Moreover, there is the question of ‘guilty knowledge’: just because there is knowledge (actual or constructive) that exposure to excessive noise is hazardous, it does not mean that it is automatically guilty knowledge. An implementation period is normally granted before an employer will be in breach of their obligations after knowledge of the risks is present. This issue was initially discussed in edition 15 of Disease News and this article revisits the subject with reference to the decision of *Baird v Latham Farms Limited*, handed down yesterday.

**Background**

The first judicial indication of the date at which an employer would be held to know about the danger of excessive noise was provided in *Thompson v Smiths Shiprepairers (North Shields) Ltd*. In that case, concerning claims made by shipbuilders, the court held that the employer had actual knowledge by 1963, by reason of publications such as the Ministry of Labour’s ‘Noise and the Worker’ leaflet and the Wilson Committee’s report. These documents were published in 1963 and were aimed at minimising the problem of excessive noise resulting in hearing loss in the industrial/factory context. This judgment led to a widespread approach of treating the date of knowledge as 1963.

In edition 15 of BCDN we discussed the flexibility of this date and found through an analysis of previous authorities that the date of an employer’s knowledge is metamorphic, reflecting developing knowledge and the availability of that knowledge to each employer across different industries. Indeed, it was held in *Stokes v Guest, Keen and Nettlefold*, that ‘the overall test is still the conduct of the reasonable and prudent employer, taking positive thought for the safety of his workers in the light of what he knows or ought to know; where there is a recognised and general practice which has been followed for a substantial period in similar circumstances without mishap, he is entitled to follow it, unless in the light of common sense or newer knowledge it is clearly bad; but, where there is developing knowledge, he must keep reasonably abreast of it and not be too slow to apply it’.

This flexibility was recently affirmed by the decision of the Supreme Court in *Baker v Quantum Clothing Group*. There the Court held that not all employers should be fixed with the same date of knowledge in 1963. Moreover, knowledge in that year should be fixed from the middle of that year onwards thereby reflecting the publication of the two documents in the earlier part of the year. Smaller and medium sized employers, particularly in industries not associated with excessive noise, should have a later date of knowledge. This later date of knowledge could be imputed by, for example, the less obscure ‘Code of Practice for Reducing the Exposure of Employed Persons to Noise’, published in 1972. This document set out acceptable noise levels and durations of exposure whilst also advising on appropriate steps to protect the hearing of those exposed to potentially hazardous levels of noise. The Code was much more widely distributed and discussed such that even smaller companies could have been expected to be aware of its existence.

So it is established that the date of knowledge is flexible, but what has the case law up to this point told us about the period of implementation that employers are allowed? It is clear from cases such as *Bowman v Harland and Wolff, Armstrong v British Coal Corporation, Smith v Wright and Beyer Ltd, Brookes v South Yorkshire Passenger Transport Executive*, and *Maxfield v ATS North Eastern Ltd*, that the courts have traditionally held the implementation period to be two years. Whilst this was in the context of hand-arm vibration syndrome (HAVS), the same principle was applied in *Baker* which concerned noise induced hearing loss (NIHL). Significantly, in *Baker*, the Supreme Court rejected the Court of Appeal’s view that the implementation period was 6-9 months. Instead, it agreed with Judge Inglis’ view at first instance that the period was two years. So, with an implementation period of two years, the date of breach in relation to the 1963 knowledge is in the region of 1965, and in relation to 1972 knowledge the date of breach is 1974.
Having discussed the background, we can now consider these issues in light of the judgement handed down yesterday in the case of *Baird v Latham Farms Limited*. The facts of the case were as follows. Mr Baird worked in the agricultural sector for much of his life starting out as a farm worker. In 1962/3, aged about 23 years of age, he started work for the defendant, Latham Farms, as a farm foreman. He remained working there for about 12 years before moving on.

Mr Baird at the time of the claim was aged 76 years having been born in May 1939. In later life he noticed that his hearing was gradually deteriorating and put this down to his advancing years. However things became worse and he eventually went for a hearing test in September 2011 where he was alerted to the possibility that his hearing loss was noise induced. Having considered potential causes of noise-induced hearing loss (NIHL) Mr Baird claimed that the most likely was his time working at Latham Farms. It was here that he alleged he was exposed to particularly noisy working conditions whilst driving a tractor. Mr Baird spent many of his working hours driving a Massey Ferguson tractor which had been fitted with a metal cab. The object of the metal cab was to shield the driver from the elements, but a side effect was to make it a noisier working environment for the driver due to levels of vibration and/or reverberating sound.

In order to establish whether or not the defendant had breached its duty of care, it was necessary to determine the state of knowledge within the agricultural sector of the potential for noise to cause injury, i.e. the date of knowledge of the defendant. In doing so HHJ Godsmark QC considered what industry publications were available to the defendant at the relevant time and whether or not the claimant had brought the issue to the attention of the defendant.

It was submitted by the claimant’s expert, Mr Hill, that the 1963 publication of ‘Noise and the Worker’ by the Ministry of Labour was a landmark for knowledge within industry of the dangers of industrial noise. However, in cross-examination Mr Hill conceded that 1963 was not a fixed date of knowledge for all industries and that in some industries it took longer before it became recognised that noise was a hazard within that industry. It was also accepted that Noise and the Worker was directed more at factory conditions than agriculture.

The defendant’s expert, Mr Lawton, noted that Noise and the Worker was unlikely to have been circulated through the agricultural sector and identified a research paper by C.J. Moss entitled ‘Machinery Hazards’ published in the Annals of Occupational Hygiene in 1969 but first presented at an Occupational Hygiene conference in 1968. The contents of this paper concerned the problem of increased noise levels for tractor drivers in metal cabs with noise levels of 100.5 dB(A). It was contested that this paper would not have been much circulated outside professional occupational health circles at this time.

Both experts identified the Department of Employment’s ‘Code of Practice for Reducing the Exposure of Employed Persons to Noise’, published in 1972. This document set out acceptable noise levels and durations of exposure whilst also advising on appropriate steps to protect the hearing of those exposed to potentially hazardous levels of noise.

The defendant submitted that the date of knowledge, however, should be no earlier than the Agriculture (Tractor Cab) Regulations 1974. These dealt specifically with noise levels in tractor cabs and mandated measures to protect the hearing of drivers. Alternatively, the defendant argued that the date of knowledge should be taken as a date when it might reasonably be expected to have learned of the 1972 Code of Practice and understood that it applied to noise exposure in tractor cabs. In addition, it was also submitted that there should have been a two year implementation period, in line with previous authorities. Both of these submissions, if successful, would have meant that the claimant’s exposure to noise would have been non-tortious due to the date of knowledge not being excited until the claimant had ceased working for the defendant.

When determining the defendant’s date of knowledge, HHJ Godsmark QC took into account evidence from the claimant himself, Mr Baird. Mr Baird outlined the complaints that he had made to his employer at the time and that he had insulated the cab with foam and used cotton wool as ear plugs. Whilst there was some discussion over the claimant’s credibility due to an inconsistency between his witness statement and his evidence at trial, it was accepted that on the balance of probabilities the claimant had told the defendant that he had difficulty hearing and was caused discomfort by the noise of the cab, not that he had complained officially or regularly.
Interestingly, HHJ Godsmark QC found that there was no breach of the defendant's duty between 1962 up until 1972 when the Code of Practice for Reducing the Exposure of Employed Persons to Noise was published ([31]). But this was still before the promulgation of the Agriculture (Tractor Cabs) Regulations, which addressed the hazards of noise within tractor cabs specifically, in 1974. In addition to this, HHJ Godsmark QC also held that the period of implementation expected of the defendant was 8 months.

Having outlined the decision, we can now analyse it with a particular focus on the decision regarding date of knowledge and the period of implementation and how this may affect claims in the future, if at all.

Date of Knowledge

It is plain that the 1963 regulations were not sufficient to impute knowledge to the defendant, however, HHJ Godsmark QC found that the 1972 Code, combined with the complaints made by the claimant were sufficient. An interesting, and unresolved, question for defendants is whether the 1972 Code would have been enough alone to establish knowledge without these complaints being made? Is it the case that knowledge was only excited by reason of the Code and the complaints in concert?

Assuming, for a moment, that the Code, alone, would not have been enough to impute knowledge, it is clear from the judgement in Baird that the 1974 regulations would have been accepted as having permeated the agricultural industry sufficiently for the defendant to have known of the hazards of excessive noise at that point. So, if the 1972 Code alone would not be enough, does that mean knowledge would only be found in 1974? Claimants may argue an alternative, that knowledge can be imputed in 1973 by reason of the Agriculture (Tractor Cabs) (Amendment) Regulations 1973. The purpose of these regulations was to reduce the level of noise inside new tractor safety cabs so that it could not present a threat to drivers' health. The 1974 regulations, mentioned in Baird, were only introduced as a matter of manufacturing necessity, since manufacturers were unable to produce a sufficient number of noise approved tractor cabs in the time permitted by the 1973 regulations. If the 1974 regulations were enough to impute knowledge it is certainly arguable that knowledge could be established in 1973 since it is arguably the case that a reasonable employer could be expected to be aware of legislation directly affecting them and requiring them to act. The consequence of such an argument for Baird would have been that, regardless of the complaints made by the claimant, the defendant's date of knowledge would still likely to have been within the claimant’s period of employment.

Implementation Period

Even once the date of knowledge has been established there remains the issue of what implementation period is to be accorded by the courts. As previously outlined, in Baker, the Supreme Court rejected the Court of Appeal's view that the implementation period was 6-9 months. Instead, it agreed with Judge Inglis' view at first instance that the period was two years. It would seem then that the decision in Baird in relation to the implementation period is at odds with previous authorities. HHJ Godsmark QC stated: 'I would allow six months from publication for the penny to drop for this Defendant in relation to Mr Baird in his tractor. Thereafter I would allow a further two months for the defendant to seek and obtain expert assistance, confirm the problem and identify a solution – that being the provision of ear defenders.'([35])

What effect will this have on future claims, if any? Does this mean that defendants will now be attributed guilty knowledge earlier than they have previously? Time will tell, but the following issues should be noted. This decision might be explainable on the following grounds; firstly, the industry concerned in Baird is that of agriculture and specifically tractor cabs, compared to factory noise in Baker. The shorter implementation period may have been based on the assumption that a small farm could have more easily taken measures to reduce the risk of noise exposure by providing ear defenders or modifying a small number of tractor cabs. Whereas, a larger company with more employees may have required more time to implement such measures. However, it could also be argued that larger companies, with their large health and safety departments, are better equipped to absorb this kind of shift in approach, not to mention better placed to finance it.

Secondly, even if this decision is not explainable on the above terms and it is at odds with earlier authority, it is open to defendants to argue that this decision is not binding. As a first instance decision of the County Court, judges in
the future will not be obliged to follow this decision. Judges in other County Court claims may well follow it as a matter of judicial comity, but they are not obliged to if they consider it to be incorrect.

Conclusion

The case of Baird is a useful example of the application of date of knowledge principles in NIHL claims. The decision raises some interesting questions about the date of knowledge in tractor cab noise claims and the interface between industry documents and complaints from claimants. It remains to be seen if these principles are adopted in future cases. This decision is not binding and defendants may have grounds in future claims to argue that this is an anomalous decision in respect of the implementation period accorded and therefore that a two year implementation period should be accorded.

De Minimis Revisited: The Importance of Opposing Medical Evidence (Edition 133 of BC Disease News)

Introduction

We have previously explored the issue of whether noise-induced hearing loss (NIHL) can be de minimis in editions 3, 39, 97 and 108 of disease news i.e. does NIHL of a magnitude of only a few decibels, or, outside of the key frequency range for hearing, materially affect the claimant? After some initial successes, we have seen more recent setbacks for defendants in the following 3 decisions, Lomas v London Electric Wire Company & Smiths Ltd, Roberts v Prysmian Cables and Systems Limited, and Childs v Brass & Alloy Pressings (Deritend) Ltd.

To our knowledge there have now been 7 County Court decisions which address de minimis arguments in NIHL claims (there are no doubt other decisions out there). Defendants have succeeded in 2 and claimants in 5 (although in 1 the case was defended on diagnosis and comments on de minimis were obiter). When and if the new LCB Guidelines on quantification of NIHL come to be commonly applied then de minimis will become an increasing feature of NIHL claims. We recently saw from our analysis of some 10,000 audiograms and the impact of the LCB Guidelines that around 50% of claims will broadly fall within a de minimis categorisation—see link here.

In this feature, we explore the reasons for the recent defendant setbacks, how they impact on defence strategies and what selection criteria apply to running de minimis cases.

Background

The same issues have arisen in all these cases: does the claimant suffer any NIHL and if so is the claimant ‘appreciably worse off’ as a result?

In edition 97 we considered two defendant favourable decisions of Hughes and Holloway in which it was found that NIHL at 4 kHz of up to 15 dB in conjunction with average NIHL of over the key speech frequencies 1, 2 and 3 kHz of up to 1-2dB did not give rise to any disability so that the claimant could not be considered to be ‘appreciably worse off’. It is noteworthy that in both of these claims medical evidence was heard from both the claimant and the defendant.

We then considered the further decisions of Hinchliffe and Briggs in edition 108, whereby the test of the claimant being ‘appreciably worse off’ was again endorsed and described as meaning that there must be ‘real damage as distinct from damage which is purely minimal’.

The loss in Hinchliffe was 1.7dB of NIHL between 1-3 kHz plus a loss of about 10-15dB at 4 kHz. Notwithstanding the fact that causation had not been established and so the claim failed on that basis, HHJ Gosnell went on to consider obiter the issue of de minimis. It was said that the need for hearing aids had been accelerated by between 2-5 years and on the Worgon-Coles scale of disability the claimant reached stage 1 (see paragraph 121 of the Nottinghamshire & Derbyshire Deafness judgment of HHJ Inglis for a more detailed discussion of the scale). The judge considered that the claimant was reporting symptoms caused by hearing loss which were ‘appreciable and
more than minimal’. It was agreed that an award of £2,800 would have been made had the claimant succeeded in proving NIHL.

This was followed shortly by Briggs v RHM Frozen Food Limited in which the claimant’s hearing was essentially normal between 1-3 kHz and typical for her age but with a 10-15 dB NIHL at 4 kHz. Professor Homer for the claimant argued that 4 kHz is a critical frequency for hearing whilst Mr Jones for the defendant argued the NIHL would make very little difference and would not be noticeable to the claimant. HHJ Coe preferred Professor Homer’s evidence that loss at 4 kHz was significant. This together with an accelerated need for hearing aids made the claimant appreciably worse off. Damages were valued at £4,000 but £2,000 awarded as the defendant was responsible for only half of the NIHL.

We now go on to consider three further de minimis judgments in which the defendant did not challenge the claimant’s evidence.


We turn firstly to the decision of Lomas, in which the claimant, claimed damages from the defendants in respect of his developing NIHL and tinnitus. The defendants argued that if the claimant had developed tinnitus it was not proved on the balance of probabilities that it arose as a result of his exposure to harmful levels of noise and they claimed that the hearing loss was so small that is was not compensable on the ground that it was de minimis.

The claimant’s expert, Mr Lloyd, initially calculated the claimant’s average binaural NIHL over 1-3 kHz at 11.5 dB. However, in his oral evidence Mr Lloyd, conceded that this was not a proper calculation and changed his assessment over 1, 2 and 3 kHz bilaterally to 3 decibels. In the words of Recorder Hincliffe QC, ‘that, of course, is a substantial alteration to the overall hearing loss’.

The defendants, perhaps following this concession by Mr Lloyd, decided not to call their expert, Professor Lutman, to give evidence and so the claimant’s NIHL was accepted as 3dB over 1, 2 and 3 kHz. There was no loss at any higher frequency of 4 (or 6) kHz as can typically arise a de minimis cases.

The defendant argued that this loss was de minimis and referred the judge to the authorities of Rothwell and Holloway. As well as not calling their expert to give evidence, the defendant did not provide the judge with a transcript of the latter judgment, however, although some criticisms were levied at the defendants for this, this did not prove to be fatal as Mr Lloyd conceded that the claimant would ‘have no appreciation of any harm or diminution in his hearing whatsoever’. (para 26).

The judge then considered whether, on the balance of probabilities, the tinnitus was likewise caused or materially contributed to as a result of the claimant’s exposure to the same noise. It is this issue where the defendant’s decision to not call Professor Lutman to give oral evidence proved fatal to the defence.

The joint medical report considered the causation of the tinnitus. Indeed, attention was drawn to the passage of the medical report entitled ‘Area of disagreement’ in which Mr Lloyd outlined his opinion in the following terms: ‘With regards to whether the claimant’s tinnitus is caused by his excessive noise exposure there is a range of opinion on this point. Some experts argue that the tinnitus cannot be attributed to excessive noise exposure unless it came on during or within a year of cessation of the claimant’s excessive noise exposure. Other experts argue that there is cochlear damage which by definition there is when there is noise induced hearing loss present. Then the claimant has been predisposed to developing tinnitus even if it is some years after cessation of noise exposure. I am of the latter opinion; there is no evidence in the literature to support either argument.’

Hincliffe Q.C. points out significantly at para 24 that Mr Lloyd was not challenged on this aspect of his evidence. He then went on to consider whether he should accept this unchallenged evidence. He stated:

‘It has to be said that he impressed me as a witness and I have no reason to doubt his expertise and it is his opinion, which I accept, that in this case the claimant has suffered noise induced hearing loss to the extent of 3 decibels bilaterally. Moreover that the damage to the cochlear has, in this case, played a material part in the development of the tinnitus.’
Therefore, whilst the NIHL was found to be de minimis, based upon the unchallenged oral evidence of Mr Lloyd in relation to the claimant’s tinnitus, Hincliffe QC was satisfied that as ‘it has not been seriously argued that the tinnitus should not sound in damages’ it was found to be in part or in whole, as a result of his exposure to harmful levels of noise. (para 30). The claimant was awarded £3,000 for the tinnitus.

Roberts v Prysmian Cables and Systems Limited, 30 October 2015.

In this case the medical evidence was based on 8 audiograms, 7 of which were carried out during the claimant’s employment with the defendant using Bekesy audiometry between 1986 and 2004 and one in 2012 when the claim was issued which used pure tone audiometry (PTA). The claimant also complained of tinnitus.

The claimant’s expert Mr Tomkinson provided an initial report based on the 2012 PTA only and finding NIHL (average of 10-11 dB NIHL over 1-3 kHz). Mr Tomkinson did not know of and was not provided with the workplace audiograms when producing this initial report. When Mr Tomkinson was later provided with the workplace audiograms-which showed far better hearing than the later 2012 audiogram-and asked to report on them he concluded that the NIHL over 1-3 kHz was nil or minimal though with some damage at the higher frequencies of 4 and 6 kHz, might contribute to difficulties with conversation in noisy environments. He also found that the 2012 results showed that deterioration since 2004 was due to factors other than noise. In a 3rd report however his conclusion was markedly different. He now sought to disregard the workplace audiograms as being unreliable and found a NIHL over 1-3 kHz of between 3-5 dB (having been specifically directed in instructions by the claimant solicitors that 3 dB of NIHL represented a level which would result in compensation).

HHJ Keyser found the change in Mr Tomkinson’s opinion in the 3rd report to be unexplained and felt that it was given due to the nature of the questions put by the claimant’s solicitors.

HHJ Keyser identified that Mr Tomkinson had ‘altered his position considerably’ and that ‘the terms in which he has sought to argue Mr Roberts’ case on points of evidence (notably in respect of answers recorded on the occupation health records) suggests that in doing so he has acted more as a partisan advocate than as an impartial expert’.

He therefore did not allow the claimant to rely upon the evidence within the 3rd report.

Despite this the defendant’s arguments on de minimis were doomed. They argued this without obtaining their own medical evidence or calling the claimant’s expert for cross examination. The defendant relied on the findings in Holloway to challenge the claimant’s expert evidence. His Honour Judge Keyser Q.C. was unappreciative of this approach and stated:

‘…A court should exercise very considerable caution before rejecting uncontradicted expert evidence on technical matters’.

HHJ Keyser found that the evidence adduced for the claimant does not establish that the level of hearing loss at 1, 2 and 3 kHz would have been ‘either perceptible or functionally significant’ (para 36). He noted, however, that whilst the loss at 4 and 6 kHz is not included in the calculation of average binaural hearing loss there had been no evidence adduced to ‘undermine’ the proposition that the presence of noise induced hearing loss at 4 and 6 kHz is sufficient to establish material, though very minor damage.

HHJ Keyser even went on to say that: ‘The fact that loss at 4 and 6 kHz is not included in the calculation of average binaural hearing loss would militate against this conclusion only if it were shown on the evidence that the reason for its non-inclusion was that it had no impact on function or perception. In fact, the evidence before me is, to the contrary, that it can and in the present case does have some functional significance’.

An award of £1,500 was made on the basis that the contribution of noise damage to the overall disability was very slight. In relation to tinnitus, HHJ Keyser found that as the onset of the claimant’s tinnitus was more than 1 year after the last exposure, it could not be due to noise exposure and so no award was made for this.

Child v Brass & Alloy Pressings (Deritend) Ltd, 21 December 2015.
This is another NIHL claim whereby a de minimis defence was being run where the defendant did not have their own expert and neither did they put written questions to the claimant’s expert. Mr Manjaly was instructed by the claimant and produced a report finding average NIHL of 2.02 dB. He went on to say that:

’Mr Childs does not require hearing aids at present. However, he will benefit from the fitting of bilateral hearing aids in the future. In my opinion, the client’s need for hearing aids has been accelerated by five years as a result of the exposure to loud noise…I can confirm that Mr Childs has noise-induced hearing loss of moderate severity. This will have a moderate effect on his ability to enjoy social, domestic and recreational activities’.

DJ Kelly went on to consider the proposition of the defendant that the NIHL of 2.02 dB was de minimis. In doing so she identified the test as set out in Johnston & NEI International Combustion Limited, namely, whether or not the claimant is ‘appreciably worse off’.

DJ Kelly indicated that she had read the decisions which were referred to by the defendant, of Holloway, Hincliffe and Briggs. In doing so she noted that in Holloway;

‘Judge Freedman had the benefit of hearing medical evidence from two doctors, one on behalf of the claimant and one on behalf of the defendant. The evidence before me today is limited to the medical report from Mr Manjaly in its written form, without Mr Manjaly being here to be subject to cross-examination’.

Again, when referring to Hincliffe, she noted that HHJ Gosnell had the benefit of hearing live medical evidence. HHJ Kelly then went on to say:

‘It is apparent from those three cases that the conclusion as to whether or not the loss is de minimis is very fact specific to an individual case. Mr Manjaly’s evidence is the only medical evidence I have before me. A paragraph 16 of his report he confirms that the claimant has:

”…noise-induced hearing loss of moderate severity. This will have a moderate effect on his ability to enjoy social, domestic and recreational activities”’

In relation to the comment of Mr Manjaly regarding hearing aids, HHJ Kelly said that the proposition that there has been a five-year acceleration period remained unchallenged by the defendant. This resulted in her making the following conclusion:

’The defendant chose not to ask questions of Mr Manjaly, nor, as I understand it, to seek permission to rely on its own medical evidence. On the evidence that I have before me, I have unchallenged evidence as to Mr Manjaly’s conclusion that there is a five-year acceleration as to the need for hearing aids. Doing the best I can on the evidence before me, it seems to me that there is no evidence on which I can properly reject the conclusion of Mr Manjaly as to the five-year acceleration period. Accepting as I do, that the claimant’s need for hearing aids has been accelerated by five years, it does seem to me that the claimant is appreciably worse off.’

Therefore, the approach as to hearing aids in Briggs was followed.

In the table below we summarise the key findings in the 7 de minimis judgments:
Comment

What lessons can be learnt from these recent defendant setbacks?

Whilst it could be suggested that the most recent de minimis judgments are all claimant favourable, they are of no precedent value for the proposition that either small amounts of NIHL over 1-3 kHz alone or combined with loss at 4 kHz means that the claimant is 'appreciably worse off'. The poor outcome of these claims was largely down to failures in the defendant obtaining its own medical evidence and allowing the claimant's medical evidence to remain unchallenged. None of these county court decisions are binding. Further each decision is based on the particular evidence (or lack of it!) of each case. Findings on the evidence in one case is not a proper basis for the same finding in another case where the evidence is different.

Defendants cannot simply reply on previous favourable decisions to run de minimis cases without evidence (and equally the same applies for claimants). Where there is a genuine de minimis defence then defendants should always instruct their own medical experts and challenge those areas of the claimant's evidence in dispute.

Conclusion: Success in Running a De Minimis Defence

Therefore, despite this recent claimant success and with the major caveat that all cases are individual and fact specific we believe the appropriate selection criteria for running a de minimis defence are as follows:

<table>
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<th>THE NIHL</th>
<th>NO</th>
<th>NO</th>
<th>NO</th>
<th>NO</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
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<td>Roberts Jackson Limited / Timothy Grace</td>
<td>Roberts Jackson Limited / Alistair Wright</td>
<td>Michael Lewin Solicitors / Joe Wynn</td>
<td>Robert Jackson Limited / Mr Vanderpump</td>
<td>Slater &amp; Gordon / Elizabeth Marshall</td>
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<td>DF SOL / COUNSEL</td>
<td>Dolmans / Doug Cooper</td>
<td>Clyde &amp; Co / Doug Cooper</td>
<td>DAC Beachcroft / Doug Cooper</td>
<td>Weightmans / Richard Seabrook</td>
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<td>Clyde &amp; Co / Paul Higgins</td>
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<tr>
<td>CLAIMANT EXPERT</td>
<td>Mr Tomkinson</td>
<td>Professor Homer</td>
<td>Mr Zeitoun</td>
<td>Mr Lloyd</td>
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<td>Mr Tomkinson</td>
</tr>
<tr>
<td>DEFENDANT EXPERT</td>
<td>Mr Jones</td>
<td>Professor Lutman</td>
<td>Mr Jones</td>
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<td>No Expert</td>
</tr>
<tr>
<td>DE MINIMIS</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
</tr>
</tbody>
</table>

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- The main speech frequencies between 1-3 kHz unaffected by any NIHL, or are only affected in a very limited way-say a maximum of 3-5 dB;
- NIHL of not more than 10-15 dB at 4 kHz or 6 kHz. It is preferable that the NIHL is only at 6 kHz since there are studies to support the role of hearing at 4 kHz for speech recognition and it is possible to argue that any loss at 6 kHz is transient or spurious or, if the loss is permanent, does not arise as a result of NIHL;
- No tinnitus;
- No advanced need for hearing aids in the future;
- An elderly claimant with already significant non-noise related losses such that it can be argued that any disability from NIHL is completely subsumed by other losses/disability. Whilst the effects of NIHL and age related losses are initially additive the effect of the noise component progressively diminishes over time. By the age of 80 it is arguable that it makes virtually no difference to an individual’s hearing ability what noise exposure has arisen, though be aware of the onset of any disability being ‘brought forward’ as a result of the NIHL.

Also, as is clear from these recent decisions, if you are going to run a de minimis defence to trial you must ensure that:
- You put Part 35 questions to the claimant’s expert.
- Apply for and obtain your own medical evidence.
- You develop proper medical evidence supported by authorities.
- You do not leave any key areas of the claimant’s medical evidence unchallenged.
- You call your expert to give oral evidence at trial.

**Obtaining Medical Evidence in NIHL Claims: Further Guidance**

**(Edition 144 of BC Disease News)**

**Introduction**

We have previously featured the obtaining of medical evidence in NIHL claims in editions 32, 118 and 126 of BC Disease News. We follow up with a County Court judgment of His Honour Judge Peter Hughes QC, handed down this week, in which BC Legal, acting for the 2nd and 3rd defendants, successfully overturned an initial case management decision refusing the defendant permission to obtain its own medical evidence.

**Background**

Firstly, let us look at the protocols and rules which govern expert evidence for both pre-litigation and litigated cases. Although we have already outlined the relevant protocols and rules that govern expert evidence it is worth doing so again as familiarity with them is vital for success.

**Pre-Action Protocol on Disease and Illness Claims**

Paragraph 1.2 of the Protocol provides that its aim is to, amongst other things, settle claims ‘fairly’. [Paragraph 9.4 of the Protocol provides that where the claimant obtains a medical report prior to writing the letter of claim, the defendant will as a matter of course be entitled to obtain its own medical evidence], Paragraph 9.4 of the Protocol prescribes that a ‘flexible’ approach must be adopted to obtaining expert evidence. Further to this paragraph 9.13 provides that further guidance can be found in CPR 35, such that the principles applicable to litigated cases are also relevant to pre-litigation cases. Consequently, the following arguments are applicable to obtaining expert evidence whether at the pre-litigation stage and/or once proceedings have been issued.

**The Civil Procedure Rules**

The relevant rules are set out in Part 1 and Part 35 of the Civil Procedure Rules.
CPR PART 35

CPR 35.1 provides that expert evidence shall be restricted to ‘that which is reasonably required to resolve the proceedings’. The particular policy objective underlying this rule is that of reducing the incidence of inappropriate use of experts to bolster cases.1

Reference should also be made to Part 35.6. This provides that written questions must be proportionate, they may only be put once, unless the other party agrees or the court authorises it, and they ‘must be for the purpose only of clarification of the report’. The note in the White Book on this part of the rule reads:

‘The meaning of “clarification” is not explained in the rule or Practice Direction. However, it would seem that questions should not be used to require an expert to carry out new investigations or tests, to expand significantly on his/her report, or to conduct a form of cross-examination by post’.

CPR Part 35 should be read in conjunction with CPR Part 1 as follows:

CPR PART 1

The overriding objective is contained in Part 1 of the CPR and provides that the court must deal with all cases justly and at proportionate costs. CPR 1.1 states that this includes, so far as is practicable:

(a) Ensuring that the parties are on an equal footing;
(b) Saving expense;
(c) Dealing with cases in ways which are proportionate:
   a. To the amount of money involved
   b. To the importance of the case
   c. To the complexity of the issues
(d) Ensuring that the case is dealt with expeditiously and fairly.

In short, where medical evidence is reasonably required by the defendant, cases must be dealt with justly, fairly and ensuring that parties are on an equal footing by allowing such evidence to be obtained. At the same time there needs to be considerations of proportionality and saving expense.

Applying these rules, it becomes plain that, firstly, where there are legitimate concerns about the claimant’s medical evidence, further expert evidence is reasonably required to verify or fairly challenge the case and to ensure that the parties are on an equal footing. Further, expert evidence would also be necessary to fairly meet the case and ensure that it is dealt with justly.

This position is supported by recent NIHL case law and authority, which we have previously discussed and we will now review the most recent decision in Walton, in order to highlight how this also supports granting permission for repeat audiograms/defendant’s own expert evidence.

Facts

Mr Walton, the claimant, was 72 years of age and brought claims against three of his former employers. He worked as a maintenance worker/pipe fitter for United Utilities from 1962 to 1972; for Ready Mix Concrete as a batch man/labourer and its successor, Cemex Investments in a similar role from 1972 to 1982. The value of the claim was limited to £15,000.

The claimant solicitors obtained a medical report from a consultant ENT surgeon, Mr Manjaly who carried out audiogram testing on the 3rd November 2013 in a hotel room in Carlisle. The medical report stated that:

‘Mr Walton gave a reliable history of exposure to loud noise during his employment (R2). Audiometry carried out on the 3/11/2013 revealed bilateral high frequency sensorineural deafness (R1), with a bulge at high frequencies, characteristic of noise-induced damage (R3). Clinical examination carried out on 03/11/2013 revealed no middle

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ear disease responsible for this hearing loss. On balance of probability, Mr Walton’s hearing loss is a result of exposure to loud noise, combined with age-related hearing loss’.

Following this, the defendants wished to obtain their own medical opinion from Professor Lutman. However, their initial application was refused at the Case Management Conference on 4th August 2015 pending Part 35 questions put to Mr Manjaly. The defendants renewed this application once Part 35 replies had been obtained on 15th December 2015 which was refused by Deputy District Judge Robson. In doing so he gave permission for further Part 35 questions and allocated the claim for trial to the fast track. The reasons given for the refusal of permission were:

a) Permission was given for Part 35 questions and these were fairly detailed and searching
b) DDJ Robson was ‘impressed’ with the Part 35 replies which he felt showed a ‘very earnest effort to respond to the questions without dodging the issues’.
c) Any clarification needed could be dealt with by additional Part 35 questions honed more directly to the issues which had been raised.
d) It would be disproportionate to have two experts for such a modest case as this would force the case into the multi-track list.

The defendants appealed.

Submissions

The defendants made four main submissions:

a) The audiological evidence was not clear cut;
b) The defendants were disadvantaged by being required to pursue their case through Part 35 questions;
c) Cross-examination through Part 35 questions was not permissible and an inappropriate use of the CPR; and

d) The trial date was liable to be put at risk by delaying a decision as to whether the defendants should be allowed their own expert to see how the claimant’s expert answered the Part 35 questions.

Counsel for the claimant contended that the application for a separate medical expert was a ‘costs building exercise’ and suggested that counsel specialising in this area of litigation was capable of dealing with the medical issues on behalf of defendants without the need for a defence medical expert.

Discussion and Outcome

At para 43 in Walton, HHJ Hughes, referred to several authorities in this area, including Langley v Caterham Marble (Stoke-on-Trent County Court, 21st March 2014), Aspinall & Offermans v BT (Sheffield County Court, 10 April 2015) and Maplesden v Sarek Joinery (Middlesborough County Court, April 2015). As we have discussed these judgments in great detail in editions 118 and 126, we will not reiterate their findings here. However, these were relied upon in Walton to show that County Court judges routinely allow defendants their own medical evidence and HHJ Hughes stated at para 55:

‘I am in broad agreement with the views expressed by my colleagues in the cases quoted above. There are, though, a couple of small points on which I differ slightly, from local experience in dealing with these cases at trial in both the multi-track and fast track lists.’

HHJ Hughes then went on to provide some useful guidance for judges dealing with NIHL claims and medical evidence at the case management stage. He said at para 56:

‘From my own experience and that of my colleagues as cited above, I think that it is possible to glean a number of guiding principles:’

a) Unless the audiology is accepted to be reliable and uncomplicated, the defendant should not be required to accept the expert selected by the claimant as the sole expert;
b) The claimant’s report should include details of when, where and in what conditions the examination and audiological assessment took place. The claimant’s expert should also provide details not only of his or her experience in medico-legal work but of the proportion of this which is for claimants and defendants.
c) Part 35 questions have only a limited role to play. They should be used only for clarification as the rule stipulates. An appropriate use, for example, is by defendants, at an early stage, after initial receipt of the
report to clarify the conditions in which the audiograms were conducted and to establish whether there is likely to be any challenge to their accuracy and reliability;

d) Especially where the claimant’s audiological examination has taken place in less than ideal conditions, as for example at a ‘claim clinic’ held in a hotel or village hall, consideration ought to be given to refusing the claimant permission to rely on the report and directing that the claimant is examined by a single jointly instructed expert;

e) Where the audiology is not straightforward and significant issues as to interpretation are to be expected, the parties should be allowed to have their own experts;

f) The decision as to what order to make in respect of expert medical evidence is not necessarily determinative of the question as to the track in which to list the case for trial. Where there is a single jointly instructed expert the case is likely to remain in the fast track and the expert will only be called at trial to give oral evidence where this can be demonstrated to be necessary. Where both sides have their own experts, decisions as to whether to give permission for the experts to give oral evidence at trial are best made only after they have met and identified the points on which they disagree. It is at that stage that the court can best judge whether the case needs to go into the multi-track list. There will be cases where, with robust case management at trial, the case can still be completed in a day and hear in the fast track list.

g) It is not sensible for cases to be listed for case management conference before deputy district judges as they are likely to have little experience of such cases. It is highly desirable for NIHL cases to be dealt with by a full-time judge, and, where possible, a District Judge at a court centre who has been designated to case manage them.

h) The fact that there is such an imbalance between the value of claims and the costs of the proceedings makes it all the more essential that the parties should be expected to comply with the timetable for trial and that judges should take a robust approach in cases where this has not happened. The primary onus is on the claimant’s solicitors to ensure that the case is trial ready. They must be pro-active in ensuring that the timetable for trial is complied with. Failure which makes it impossible for the trial to proceed as listed is liable to result in the claim being struck out.’

It was subsequently found that in the first instance in Walton, DJR Robson, in exercising his discretion available to him in case management decisions, was wrong. HHJ Hughes concluded that there were issues with the audiogram which could not be determined through Part 35 questions alone and in any event this was not a proper use of the CPR.

Similarly, he rejected the claimant’s submission that it is the place of counsel to act as an expert. With respect to this point he said at para 58:

‘I do not agree with the point made by Mr. Buckley that no defence expert was needed because experienced counsel, such as Mr. O’Leary, were well-able to deal with the medical issues. It is not for counsel to act as the expert, and, neither, is it right to assume that trial counsel will necessarily have this depth of specialist knowledge and experience. The submission confuses the boundary between the role of advocate and expert’.

The defendants were granted permission to obtain their own medical evidence from Professor Lutman and the case remained in the fast track.

Conclusion

The judgment in Walton follows the trend of County Court judgments which support the granting of permission for repeat audiograms/the defendant’s own medical evidence. In edition 118 of BC Disease News, we provided a summary of some common reasons why repeat audiometry/defendant’s own medical evidence is reasonably required in NIHL claims and these should be utilised in any submissions made and be accessed here. Also, our template letter outlining the legal basis for defendants requiring their own medical evidence can be accessed here.

Further features on this topic in editions 32, 118 and 126 can be accessed here.
Next week we consider further why diagnosis of NIHL cannot be made upon a single audiogram. As a number of recent studies have shown, a single audiogram can be described as no more than a ‘best guess’ of an individual’s hearing thresholds.
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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