NIHL Claims:
A Collection of Articles from BC Disease News
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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, 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.
Feature: 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?
o 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;

o 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;

o 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;

o 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?

o 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.
Feature: 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 10 dB 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 0.5-6 kHz) 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 [+/-10 dB] 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 +/- 5 dB 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 +10dB 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 100dB. 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:

‘There is a strong case for repeating audiometry routinely and recording both results. This practice is recommended, at least in the case of air conduction at frequencies 1, 2 and 3 kHz, taking the step of removing and replacing the earphone between repeats. Where such repeats differ by 5 dB the lower (more acute) threshold should be taken, and if the difference is 10dB the average should be taken; these rules implement the principle of taking the average result and rounding down to the nearest 5dB, in recognition of the essentially asymmetrical nature of subjective error in audiometry. In the event of larger differences occurring, the case merits further testing’.

It is also a recommendation within the Coles Guidelines at Note 3 page 269:

‘... 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 audiometric 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 audiology. Using such services may again result in audiograms with worse than actual thresholds and simply confirm the false positive diagnosis of NIHL.
Feature: 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.

Fig: Frequency range important for understanding speech
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 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 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 of disability.

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 in 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.
Feature: 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>JC Guidelines</td>
<td>WHO</td>
</tr>
<tr>
<td>Slight</td>
<td>0</td>
</tr>
<tr>
<td>Some</td>
<td>1</td>
</tr>
<tr>
<td>Moderate</td>
<td>2</td>
</tr>
<tr>
<td>Severe</td>
<td>3/4</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

<table>
<thead>
<tr>
<th>(i) Severe tinnitus and any noise induced hearing loss</th>
<th>£23,980-£36,850</th>
</tr>
</thead>
<tbody>
<tr>
<td>(ii) Moderate tinnitus and slight 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</td>
<td>£12,100 to £23,980</td>
</tr>
<tr>
<td>(iii) Mild tinnitus with some noise induced hearing loss of between 16-30 dB.</td>
<td>£10,175 to £12,100</td>
</tr>
<tr>
<td>(iv) Slight or occasional tinnitus with slight noise induced hearing loss of up to 15 dB</td>
<td>£5,940 to £10,175</td>
</tr>
<tr>
<td>(v) Slight noise induced hearing loss of up to 15 dB without tinnitus or slight tinnitus without hearing loss.</td>
<td>Up to £5,665</td>
</tr>
</tbody>
</table>

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.

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>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Up to 30</td>
<td>31-35</td>
</tr>
<tr>
<td>None</td>
<td>£5,150</td>
<td>£4,980</td>
</tr>
<tr>
<td>Slight</td>
<td>£9,250</td>
<td>£8,820</td>
</tr>
<tr>
<td>Mild</td>
<td>£11,000</td>
<td>£10,705</td>
</tr>
<tr>
<td>Moderate</td>
<td>£20,890</td>
<td>£19,690</td>
</tr>
<tr>
<td>Severe</td>
<td>£33,500</td>
<td>£32,200</td>
</tr>
<tr>
<td>None</td>
<td>£6,970</td>
<td>£6,800</td>
</tr>
<tr>
<td>Slight</td>
<td>£10,160</td>
<td>£9,835</td>
</tr>
<tr>
<td>Mild</td>
<td>£11,000</td>
<td>£10,815</td>
</tr>
<tr>
<td>Moderate</td>
<td>£21,800</td>
<td>£20,600</td>
</tr>
<tr>
<td>Severe</td>
<td>£33,500</td>
<td>£32,310</td>
</tr>
<tr>
<td>None</td>
<td>£17,255</td>
<td>£16,455</td>
</tr>
<tr>
<td>Slight</td>
<td>£18,770</td>
<td>£17,945</td>
</tr>
<tr>
<td>Mild</td>
<td>£20,280</td>
<td>£19,205</td>
</tr>
<tr>
<td>Moderate</td>
<td>£21,800</td>
<td>£20,600</td>
</tr>
<tr>
<td>Severe</td>
<td>£33,500</td>
<td>£32,420</td>
</tr>
<tr>
<td>None</td>
<td>£21,800</td>
<td>£21,290</td>
</tr>
<tr>
<td>Slight</td>
<td>£24,730</td>
<td>£24,090</td>
</tr>
<tr>
<td>Mild</td>
<td>£27,655</td>
<td>£26,890</td>
</tr>
<tr>
<td>Moderate</td>
<td>£30,580</td>
<td>£29,690</td>
</tr>
<tr>
<td>Severe</td>
<td>£33,500</td>
<td>£32,490</td>
</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>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>
<th>66-70</th>
<th>71+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Slight</strong> (up to 15 dB)</td>
<td>None</td>
<td>£5,665</td>
<td>£5,480</td>
<td>£5,305</td>
<td>£5,130</td>
<td>£4,955</td>
<td>£4,780</td>
<td>£4,605</td>
<td>£4,430</td>
<td>£4,255</td>
<td>£4,080</td>
</tr>
<tr>
<td></td>
<td>Slight/ occasional</td>
<td>£10,175</td>
<td>£9,700</td>
<td>£9,230</td>
<td>£8,760</td>
<td>£8,290</td>
<td>£7,820</td>
<td>£7,350</td>
<td>£6,880</td>
<td>£6,410</td>
<td>£5,940</td>
</tr>
<tr>
<td></td>
<td>Mild</td>
<td>£12,100</td>
<td>£11,775</td>
<td>£11,450</td>
<td>£11,125</td>
<td>£10,800</td>
<td>£10,475</td>
<td>£10,150</td>
<td>£9,825</td>
<td>£9,500</td>
<td>£9,175</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>£22,580</td>
<td>£21,660</td>
<td>£20,340</td>
<td>£19,020</td>
<td>£17,700</td>
<td>£16,380</td>
<td>£15,060</td>
<td>£13,740</td>
<td>£12,420</td>
<td>£11,100</td>
</tr>
<tr>
<td></td>
<td>Severe</td>
<td>£36,850</td>
<td>£35,420</td>
<td>£33,990</td>
<td>£32,560</td>
<td>£31,130</td>
<td>£29,700</td>
<td>£28,270</td>
<td>£26,840</td>
<td>£25,410</td>
<td>£23,980</td>
</tr>
<tr>
<td><strong>Some</strong> (16 to 30 dB)</td>
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<td>£7,665</td>
<td>£7,480</td>
<td>£7,305</td>
<td>£7,130</td>
<td>£6,955</td>
<td>£6,780</td>
<td>£6,605</td>
<td>£6,430</td>
<td>£6,255</td>
<td>£6,080</td>
</tr>
<tr>
<td></td>
<td>Slight/ occasional</td>
<td>£11,175</td>
<td>£10,820</td>
<td>£10,460</td>
<td>£10,100</td>
<td>£9,740</td>
<td>£9,380</td>
<td>£9,020</td>
<td>£8,660</td>
<td>£8,300</td>
<td>£7,940</td>
</tr>
<tr>
<td></td>
<td>Mild</td>
<td>£12,100</td>
<td>£11,775</td>
<td>£11,450</td>
<td>£11,125</td>
<td>£10,800</td>
<td>£10,475</td>
<td>£10,150</td>
<td>£9,825</td>
<td>£9,500</td>
<td>£9,175</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>£23,980</td>
<td>£22,660</td>
<td>£21,340</td>
<td>£20,020</td>
<td>£18,700</td>
<td>£17,380</td>
<td>£16,060</td>
<td>£14,740</td>
<td>£13,420</td>
<td>£12,100</td>
</tr>
<tr>
<td></td>
<td>Severe</td>
<td>£36,850</td>
<td>£35,540</td>
<td>£34,220</td>
<td>£32,900</td>
<td>£31,580</td>
<td>£30,260</td>
<td>£28,940</td>
<td>£27,620</td>
<td>£26,300.00</td>
<td>£24,980</td>
</tr>
<tr>
<td><strong>Moderate</strong> (31 to 45 dB)</td>
<td>None</td>
<td>£18,980</td>
<td>£18,100</td>
<td>£17,225</td>
<td>£16,350</td>
<td>£15,475</td>
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<td>£12,850</td>
<td>£11,975</td>
<td>£11,100</td>
</tr>
<tr>
<td></td>
<td>Slight/ occasional</td>
<td>£20,645</td>
<td>£19,630</td>
<td>£18,605</td>
<td>£17,580</td>
<td>£16,555</td>
<td>£15,530</td>
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<td>£13,480</td>
<td>£12,455</td>
<td>£11,430</td>
</tr>
<tr>
<td></td>
<td>Mild</td>
<td>£22,510</td>
<td>£21,125</td>
<td>£19,955</td>
<td>£18,785</td>
<td>£17,615</td>
<td>£16,445</td>
<td>£15,275</td>
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<td>£13,935</td>
<td>£12,765</td>
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<td></td>
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<td>£22,660</td>
<td>£21,340</td>
<td>£20,020</td>
<td>£18,700</td>
<td>£17,380</td>
<td>£16,060</td>
<td>£14,740</td>
<td>£13,420</td>
<td>£12,100</td>
</tr>
<tr>
<td></td>
<td>Severe</td>
<td>£36,850</td>
<td>£35,660</td>
<td>£34,450</td>
<td>£33,240</td>
<td>£32,030</td>
<td>£30,820</td>
<td>£29,610</td>
<td>£28,400</td>
<td>£27,190</td>
<td>£25,980</td>
</tr>
<tr>
<td><strong>Severe</strong> (46+ dB)</td>
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<td>£23,420</td>
<td>£22,865</td>
<td>£22,310</td>
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<td>£21,200</td>
<td>£20,645</td>
<td>£20,090</td>
<td>£19,535</td>
<td>£18,980</td>
</tr>
<tr>
<td></td>
<td>Slight/ occasional</td>
<td>£27,200</td>
<td>£26,500</td>
<td>£25,810</td>
<td>£25,120</td>
<td>£24,430</td>
<td>£23,740</td>
<td>£23,050</td>
<td>£22,360</td>
<td>£21,670</td>
<td>£20,980</td>
</tr>
<tr>
<td></td>
<td>Mild</td>
<td>£30,420</td>
<td>£29,580</td>
<td>£28,755</td>
<td>£27,930</td>
<td>£27,105</td>
<td>£26,280</td>
<td>£25,455</td>
<td>£24,630</td>
<td>£23,805</td>
<td>£22,980</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>£33,640</td>
<td>£32,660</td>
<td>£31,700</td>
<td>£30,740</td>
<td>£29,780</td>
<td>£28,820</td>
<td>£27,860</td>
<td>£26,900</td>
<td>£25,940</td>
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<tr>
<td></td>
<td>Severe</td>
<td>£36,850</td>
<td>£35,740</td>
<td>£34,645</td>
<td>£33,550</td>
<td>£32,455</td>
<td>£31,360</td>
<td>£30,265</td>
<td>£29,170</td>
<td>£28,075</td>
<td>£26,980</td>
</tr>
</tbody>
</table>
Feature: 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.
Feature: 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,8 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.
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>
</tr>
</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]:

...
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 21cm (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 (L_{eq,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.
Feature: 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 Vlieland-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 it 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.
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 Cortaulds 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**
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.

Notch / bulge worse ear only – ONLY POSSIBILITY
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?
Feature: 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).

**Patterson v Ministry of Defence**

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.

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 did not yet exist (if 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’.
Our new noise app ‘ABCNoise’ is now live.

The app is designed to drive up your NIHL repudiation rates and drive down indemnity spend. It is the latest generation and most comprehensive web based NIHL claims handling tool in today’s market which:

- Provides the most robust screening for non-organic hearing loss
- Estimates likely onset of disability and highlights limitation issues
- Compares and contrasts hearing in both ears with ‘normal hearing’ and identifies any material asymmetry
- Validates diagnosis of NIHL (according to either the ‘Coles Guidelines’ or MRC NSH data)
- Compares and contrasts multiple audiograms and identifies unreliable claimant responses
- Assesses the ‘compatibility’ of NIHL with the occupational exposure to noise
- Identifies potential constitutional hearing loss
- Provides a comprehensive library of template letters or repudiation
- Gives you direct access to over 50 NHS hearing test centres national wide which perform clinical audiometry under strict protocols complying with the British Society of Audiology recommended procedures for pre-tone audiometry
- Or allows you to have control over the repeat audiometry process and use your own preferred audiology providers
- Apportions NIHL
- Assesses quantum allowing you to apply different age data and tariff quantum tables
- Gives you access to a library of hundreds of key legal, scientific and medical NIHL authorities
- Allows you to control, host and retain ownership of your own claims data

The tool is free to use-please register at Click Here.

If you would like an on-site demo of the tool please contact Boris Cetnik.

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