

CONDUCTING AN INDUSTRIAL DISEASE CLAIM

REASONS FOR DIFFERENTIATING FROM NORMAL PI CLAIM

1. Why differentiate:
 - (a) Which Pre-Action Protocol: Personal Injuries/Disease and Illness?
 - (b) Recoverable CFA uplift ("disease" claims excluded from fixed uplift rules in CPR 45.20 – likely to follow protocol definition of disease?).
 - (c) The presence of a statutory/non-statutory compensation scheme (e.g. pneumoconiosis/Iron Trades deafness).
 - (d) Issues in the claim.

THE PROTOCOL

2. The reader is left to consult the Protocol. The main differences between it and the new PI Protocol are:
 - (i) The occupational health and personnel records of the Claimant are disclosable prior to the letter of claim (section 4). Communication duties on the Claimant arise thereafter (section 5).
 - (ii) A more detailed letter of claim is envisaged.
 - (iii) There is no presumption that an admission of liability is binding
 - (iv) It acknowledges that prescriptive rules about joint selection of experts are unlikely to be appropriate.
 - (v) It recognises that limitation may require issuing proceedings before the protocol procedure is followed and suggests a solution where this is the case.

DEFINITION

3. The Disease and Illness Protocol defines its scope as

"2.1...where the injury is not the result of an accident but takes the form of an illness or disease..."

2.2...Disease for the purpose of this protocol primarily covers any illness physical or psychological, and disorder, ailment, affliction, complaint, malady, or derangement other than a physical or psychological injury solely caused by an accident or similar single event."

4. Thus, the protocol treats the manner of infliction of the injury rather than the nature of the injury as the defining factor. This creates anomalies. The Illness and Disease protocol would seem to apply to the manual handling case where

an employee injures his back as a result of several lifting incidents whereas his colleague who injures his back after lifting the same object only once must bring his claim under the PI protocol. C.f. the employee who develops occupational asthma as a result of a single exposure to a noxious fume proceeds under the PI protocol whereas the colleague who has several exposures to the same fume must use the Illness/Disease Protocol.

5. The most common examples are asbestos disease; deafness; VWF; W.R.U.L.D.; stress; dermatitis and asthma. There are then a number of industry-specific conditions: mucous membrane disorder; certain cancers; "metal spinners shoulder" etc.
6. The Illness/Disease Protocol is not restricted to claims by employees arising out of their work.

THE ISSUES

IDENTIFYING THE DEFENDANT AND INSURER

7. This can be difficult. Many claims (most obviously asbestos) may relate to events decades earlier. Employers may have been dissolved or taken over. Even when an employer is identified, they may struggle to trace the insurer on risk at the relevant time.
8. The following steps should be taken to locate an employer:
 - (i) Identify the name of the employing company at the time. This may be ascertainable from e.g. Inland Revenue records, old payslips, the Claimant's current occupational pension provider, the Claimant's former trades union.
 - (ii) Check the current status of the company by a company search (use <http://wck2.companieshouse.gov.uk/e7ae5834a77c75009f060afec15344e3//wcframe?name=accessCompanyInfo>).
 - (iii) If dissolved, restore to the Register (usually under section 651 of the Companies Act 1985, when an order that the period from dissolution to restoration shall not count for limitation purposes can be sought – see *Smith v White Knight Laundry Ltd* [2002] 1 W.L.R. for principles).
9. Identification of the insurer will normally be done by the Defendant (if active). However, where they cannot assist then an ABI inquiry or an APIL newsletter advertisement may be the only course.

LIMITATION

10. A whole separate topic! The central issues are when did the cause of action accrue; what is the Claimant's date of knowledge pursuant to section 14 Limitation Act 1980; will the court exercise its discretion under section 33, where necessary?

When did the cause of action accrue?

11. When did the cause of action accrue i.e. when was injury first suffered? May be very difficult to define and is very rarely of importance since there is nearly always a later date of knowledge under Section 14. In *Grievous v FT Everard & Sons* [2005] EWHC 88 it was held that asymptomatic pleural plaques constituted an injury. By definition a Claimant would be unaware of their existence without medical evidence.

Date of knowledge

12. By section 14, the Claimant has sufficient knowledge to start time running when he/she first knows the following facts (actual knowledge):
 - (a) that the injury was significant (which means that the Claimant would reasonably have considered it sufficiently serious to justify commencing proceedings against a Defendant who did not dispute liability and could satisfy judgment), and
 - (b) that the injury was attributable in whole or in part to the act or omission alleged to constitute negligence/breach of duty (N.B. the Claimant does not have to know that the act/omission does constitute negligence/breach), and
 - (c) the identity of the Defendant.

(a) Significance

13. This issue turns upon the extent of the symptoms. In *Mountenay v Bernard Matthews Plc* [1994] 5 Med. L.R. 293 (a W.R.U.L.D. case) the judge held that it was only a condition going beyond the ordinary aches and pains of everyday life that was actionable. In those circumstances, not every twinge will fix a Claimant with knowledge of significance. Similarly, it may be arguable that a Claimant with pleural plaques and without knowledge of the fact that they bring with them more serious connotations does not have actual knowledge of a significant injury. An extreme case is *Harding v P.D.S.A.* [1994] P.I.Q.R. P270, where despite recurrent visits to a G.P. with back problems, the Claimant was not fixed with knowledge of significance.
14. Where the limitation period may not have expired, it is always safest to treat a Claimant who seeks medical assistance for their condition as fixed with knowledge of its significance from that date. If it is significant enough to see a doctor, assume it is significant enough to claim for!
15. Once a Claimant is fixed with knowledge of significance, later deterioration does not affect the position (although that **may** be a valid basis for a section 33 application).

(b) Attributability

16. There are at least two different strands of authority. First, *Spargo v North Essex District H.A* [1997] P.I.Q.R. 235 where it was held that knowledge of attributability was satisfied (a) where the Claimant had broad knowledge of the essence of the causally relevant act (i.e. it was connected with his work) and (b) where the Claimant had sufficient belief as to the cause of his condition to lead him to consult solicitors with a view to bringing a claim.
17. The second strand of authority includes *Heyes v Pilkington Glass Ltd* [1998] P.I.Q.R. P303 and *Ali v Courtaulds Textiles Ltd* [1999] Lloyd's Rep. Med. 301, where in VWF and deafness cases respectively, the Court of Appeal held that only when medical evidence substantiates the Claimant's belief as to the cause of their problem does he/she have knowledge within section 14.

(c) The identity of the Defendant

18. In disease cases where the Claimant will often long-since have ceased being employed by the Defendant and the Defendant may have been taken over, merged or changed its name, knowledge of the Defendant's identity may only come after a little research. Note *Copeland v Smith* [2000] 1 W.L.R. 1371 citing *Henderson v Temple Pier Co. Ltd* [1998] 1 W.L.R. 1540 as to the relevance of legal advice in determining whether the Claimant has constructive knowledge of the identity of a Defendant.

Section 33

19. The Court's discretion is wide. Factors relevant to an industrial disease case are:
 - (i) Ignorance of entitlement to sue may avail a Claimant (*Coad v Cornwall and Isles of Scilly Health Authority* [1997] 1 W.L.R. 189).
 - (ii) Delay between accrual of the cause of action and prior to the Claimant acquiring section 14 knowledge and any prejudice caused to the Defendant therefrom should not be held against the Claimant (see *Doughty v North Staffordshire Health Authority* [1992] 3 Med LR 81)
 - (iii) Erroneous advice/negligent conduct by lawyers is not to be held against the Claimant (*Corbin v Penfold Metallising Co Ltd* [2000] Lloyd's Rep. Med. 247 and *Steeds v Peverel Management Services Ltd* [2001] EWCA Civ 149).
 - (iv) The fact that other claims of a similar kind have been settled by the insurers and/or the presence of a settlement scheme are not to be held against insurers (*Beattie v British Steel plc* CA 6/3/1997 and *Bytheway v British Steel plc* CA 26/6/1997).

Practical considerations

20. Limitation should always be considered at the earliest opportunity. GP, works and any hospital records should be examined and the Claimant questioned on

them. Questionnaires are generally inadvisable since they are insufficiently precise. Claimant should be questioned as to what he thought was causing his symptoms, how they changed when away from work, whether colleagues suffered similar symptoms/brought claims, whether there was any medical surveillance and with what result, was there a Trades Union and was the Claimant a member – what did it do? What prompted the Claimant to claim?

FORESEEABILITY

21. Liability only arises where the employer should have been aware of the risk of the disease (save in certain strict liability cases – see *Larner v British Steel plc* [1993] 4 All E.R. 102 and *Dugmore v Swansea NHS Trust* [2002] EWCA Civ 1689). In some diseases the date from which employers should have been aware of the risk has, for all practical purposes, been decided and is likely to be admitted (it should be pleaded and expert evidence only sought if expressly denied). In others, it has not and expert evidence is likely to be needed. The following is a summary of the decided decisions:
- (a) Deafness: date of knowledge is 1963 (*Thompson v Smiths Shiprepairers (North Shields) Ltd* [1984] All E.R. 881). Occasionally other big employers have been fixed with earlier dates e.g. British Rail in 1955 (*Kellett v British Rail* 3rd May 1984).
 - (b) Vibration white finger: first knowledge of risk is 1973 (coal industry and British Rail: *Armstrong v British Coal Corporation* [1997] 8 Med L.R. 259 and *Allen v British Rail Engineering Limited* October 7 1998) but first date when precautions should have been taken was 1975/6. Other industries may have a later date of knowledge (e.g. 1975 ship repair and gas: *Smith v Wright & Beyer* [2001] EWCA 1069; *Hall v British Gas plc* 7 April 1998).
 - (c) W.R.U.L.D: no single fixed date and in any event less important due to lack of latent period. From statutory/HSE material it is probably 1986 for keyboard operators and much earlier (1960s) for industry.
 - (d) Dermatitis: depends upon chemical (subject to principle in *Larner*) but otherwise 1959, when became a prescribed disease.
 - (e) Asbestos: for a thorough review of the history, see article by Jeffrey Morgan Parsons in [1997] J.P.I.L. 5. Some knowledge of risk by 1930. However, where Claimant has mesothelioma, any pre-1964 exposure must be shown to be “substantial” and over a “significant” period (*Shell Tankers v Dawson* [2001] ICR 1223). For “secondary exposure” e.g. wife washing husband’s overalls, the date is not before 1965 (*Maguire v Harland & Wolff plc* [2005] EWCA Civ 01).
22. In stress cases, foreseeability now turns on the criteria set down in *Sutherland v Hatton* [2002] All E.R. 1 although the most extreme statement of the law in that case has to some extent be abrogated by cases such as *Barber v Somerset County Council* [2004] 1 W.L.R. 1089 and *Hartman v South Essex Mental Health & Community Care NHS Trust* [2005] EWCA Civ 06.

BREACH OF DUTY

23. Nearly all cases are now covered by statutory duties (except stress, even there the Protection from Harassment Act 1997 may help) and those that are not are often difficult to prove. In some cases (classically old asbestos cases) the statutory duties may be long repealed, in which case the claim needs careful research using back-copies of Redgrave. There is no "one-size-fits-all" approach.
24. Expert evidence will always be necessary in the absence of an admission. Experts need choosing carefully to ensure that they have the appropriate expertise in the industry in question. A lot of the leading experts come from parts of the country where the disease may be more prevalent.
25. It is often necessary to prove the level of exposure in order to prove breach of duty (e.g. deafness and VWF). Ensure the experts know the actionable levels and that the lay evidence addresses the issue, where the levels can no longer be tested.
26. A careful witness statement needs to be taken, particularly where the Claimant is old and there is a risk of pre-trial death. Care needs to be taken to identify the date(s)/period, source, frequency and extent of exposure to the source of the injury. Statements from colleagues/former colleagues will be necessary.
27. It may be that there is or can be negotiated (if there are lots of Claimants) some form of payment scheme. In each case it has to be considered whether it is in the individual Claimant's interest to utilise the scheme.

CAUSATION

28. The tortious cause need only make a material contribution to the injury. However, provided the Defendant raises the issue, the Defendant will be liable only for such proportion of the damage as the tortious cause occasioned (*Holtby v Brigham & Cowan (Hull) Ltd* [2000] All E.R. 421). Any exposure by another tortfeasor or non-tortious exposure (e.g. before the relevant date of knowledge/foreseeability) will have to be quantified and apportioned/discounted. In *Rugby Joinery UK Ltd v Pamela Whitfield* [2005] EWCA Civ 561 the CA emphasised that where the Defendant alleged that the Claimant's condition was partially caused non-tortiously and would have deteriorated even absent tortious exposure, medical opinion on the issue should be sought.
29. *Fairchild v Glenhaven Funeral Services Ltd* [2002] 1 W.L.R. 1052 illustrates the proposition that causation is not simply an issue of fact but largely of law and, in that case, policy.
30. Identification of an appropriate expert is again crucial. The best are not only expert medics but have a thorough understanding of the issues in this type of litigation. The expert needs to be asked to address the issue of apportionment, where it is raised, and provided with the relevant pleadings and detailed evidence as to the relative amounts of exposure (in terms of duration, frequency,

extent and nature), since simply using a time-weighted basis is unlikely to be appropriate (although is often used for convenience, particularly in deafness cases).

QUANTUM

31. Most of the common diseases have their own JSB category and the medical expert may need to be aware of these. For example, the medical expert in a VWF case needs to ensure that he/she is aware of the classifications of severity that the court will use in determining the level of award for pain, suffering and loss of amenity.
32. The medical expert will also need to ensure that they give appropriate evidence regarding prognosis. This may often include evidence about future risks for the purpose of provisional damages (e.g. risks of mesothelioma/lung cancer/asbestosis in asbestos cases).

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