

C1 169/1981

DGR/AG

SOCIAL SECURITY ACTS 1975 TO 1981

CLAIM FOR INDUSTRIAL DEATH BENEFIT

DECISION OF THE SOCIAL SECURITY COMMISSIONER

~~21 169/1981~~

1. My decision is that industrial death benefit is not payable because the deceased's death did not result from, nor was it accelerated by, pneumoconiosis.

2. On 3 February 1980 the claimant's husband ("the deceased"), then aged 73, died. He had been employed in the mining industry throughout his working life. He retired at the age of 65 on 19 May 1971. From 13 July 1955 he had been in receipt of an industrial disablement pension by reason of pneumoconiosis accompanied by emphysema and bronchitis, and the degree of disablement had been assessed by successive medical boards at 20% from 13 July 1955 to 7 October 1980. The death certificate certified the death as having arisen from 1(a) carcinoma of the bronchus and 1(b) pneumoconiosis and went on to add "Caused through the Industrial Disease of Pneumoconiosis". A post-mortem examination was conducted by Dr D G Miller MB, BChir, MRCPATH, a consultant pathologist, who found that death was caused by (1) carcinoma of the bronchus and (2) pneumoconiosis. The cause of death was considered by two members of the pneumoconiosis medical panel, and in their report dated 21 May 1980 they stated that in their opinion death was due to carcinoma of the bronchus and that there was insufficient pneumoconiosis present to have played a material part in causing or accelerating the death.

3. In the light of the evidence the insurance officer disallowed the plaintiff's claim for industrial death benefit. Thereupon the claimant appealed to the local tribunal, who unanimously upheld the insurance officer. Apparently Dr D G Miller had been willing to give evidence on behalf of the claimant, but ill-health prevented his attending the hearing before the local tribunal. Nevertheless, after the local tribunal had given their decision, he intimated to the National Union of Mine Workers, who were representing the claimant, that he would be prepared to give evidence before the Commissioner, and went on to state that he could not believe "that by its very presence the industrial disease pneumoconiosis was entirely without influence on the outcome". The claimant's association lodged an appeal to the Commissioner, and asked for an oral hearing, a request to which I acceded. At the hearing the claimant was represented by Mr B Donaghy of the National Union of Mine Workers and the insurance officer by Mr D J Ellis of the Chief Insurance Officer's Office.

4. To be entitled to industrial death benefit the claimant must prove on the balance of probability that the deceased's death resulted from pneumoconiosis. She will establish this if she can show that death was caused or was materially accelerated by this disease. It is not in dispute in this case that the claimant was at the date of death, and had for many years before been, suffering from pneumoconiosis. The question at issue is whether or not this was a factor in causing his death. It is not in dispute that the immediate cause of death was carcinoma of the bronchus. However, Dr D G Miller had, as a result of his post-mortem examination, given as a secondary cause of death pneumoconiosis.

5. Mr Donaghy called him to give evidence. He told me that the immediate cause of death was carcinoma of the lung, but he entertained suspicions, to put it no higher, that pneumoconiosis had also played a part. I invited him to explain on what basis he reached this conclusion. He stated, in effect, that he supported the approach of Dr F S Mooney, MD BSc FCPATH who in a letter published in the Lancet on 4 January 1975 had set out certain conclusions, which he had arrived at from 300 necropsies undertaken by him since 1967 on miners suffering from pneumoconiosis. His findings related to miners in the north-west area of the country. Dr Mooney had concluded, from the statistical information he had provided, that there was a link between pneumoconiosis and lung cancer, but apparently he had failed to carry with him the general body of informed medical opinion. Nevertheless, Dr Miller was inclined to side with Dr Mooney.

6. Evidence was also given by Dr T J G Phillips MB MRCP MFOM DCh, a senior medical officer of the Department, who had been associated with the study of pneumoconiosis for some 30 years, and had been for the last 20 of them solely employed in this area by the Department. He strongly rejected Dr Mooney's thesis, and contended that, although the latter's findings were doubtlessly accurate, his conclusions were erroneous. Dr Mooney had failed to carry informed opinion at the time he published his researches, but since then the matter had really been put beyond dispute by a careful report compiled by Drs G B Rooke, F G Ward, A N Dempsey, J B Dowler and C J Whitaker, published under the heading "Carcinoma of the lung in Lancashire Coal Miners", in Thorax 1979, Vol No. 2, 229-233." These doctors had described the results of an analysis of 1,003 deaths of miners and ex-miners occurring in 1974, 1975 and 1976, and whose lungs were examined by doctors of the pneumoconiosis panel. Of the 1,003 cases, 11.4% showed carcinoma of the lung. There were 475 men without pneumoconiosis, of whom carcinoma of the lung was found in 13.1%. Of the 528 with pneumoconiosis, 9.8% had carcinoma of the lung. When compared with the figures for male deaths in the population of the North-West and Merseyside, there was no significant excess of deaths from carcinoma of the lungs amongst the miners and ex-miners of South Lancashire. Moreover, no significant excess of lung carcinoma was found in those with pneumoconiosis.

7. Apparently, Dr Mooney had challenged the findings and conclusions of Dr Rooke and his associates in the correspondence columns of Thorax, but an answer was given in the following terms:-

"... Dr Mooney lays stress on the microscopic demonstration of

pneumoconiotic foci in lung tissue and implies that more cases in our series should have been diagnosed as having some degree of pneumoconiosis. As pointed out in the discussion section of the paper, even if all our cases were assumed to have pneumoconiosis the overall prevalence of carcinoma in the whole group was 11.4%, which is still no greater than in all male deaths in the area.

A higher proportion of miners' deaths are investigated at necropsy than in the general population because compensation is at stake. As Heasman (1962) showed, the relative infrequency of necropsies may lead to an underestimate of 20% of deaths due to lung cancer in the general population. For reasons given in the text of our paper we do not claim to have a complete sample of all miners who died in South Lancashire but Dr Mooney's sample is even less complete, and he makes no mention of the prevalence of carcinoma of the lung he found in coal miners without pneumoconiosis.

His mention of Liverpool as having one of the highest incidences of lung cancer in the British Isles, but having no coal miners, is surely a point in favour of our findings rather than of his. With regard to his criticism of the statistics we used for comparison we refer him to page 233 of our paper to show that we also made use of local as well as national sources.

With reference to smoking we showed that in those whose smoking history was known 91.8% had smoked and that of the 64 lung cancer cases where smoking history was known, 98.8% had smoked. Our series was relatively small, but considerably larger than Dr Mooney's for the years studied; a much larger study (Jacobsen, 1976) of more than 11,000 British miners found that cigarette smokers had a nearly 8-fold excess of lung cancer deaths when compared with non-smoking miners."

8. Having heard Dr Phillips and examined the medical literature which was put in evidence, I have no doubt that on the balance of probability there is no connection between lung cancer and pneumoconiosis. Incidentally in Decision R(I) 10/75 the learned Commissioner, who considered the researches of Dr Mooney, was not persuaded that they should prevail over the general consensus of medical opinion. Since then, there has, of course been the report of Dr Rooke and his colleagues, which, in my view, for the time being at any rate, **concludes the matter.**

9. Accordingly, as no connection has been established from which it could be inferred that death from lung cancer was brought about or accelerated by pneumoconiosis, and as no other evidence has been produced to show that pneumoconiosis played any part in bringing about the deceased's death, this appeal must necessarily fail.

10. The appeal is therefore dismissed.

(Signed) D G Rice  
Commissioner

Date: 11 January 1983

Commissioner's File: C.I. 169/1981  
C I O File: I.O. 5120/I/81  
Region: Merseyside