Bulletin 162 (Other) 7
Occupational deafness -
CI/4567/99 not authority
for proposition that EAT change
to be preferred to PTA.

SOCIAL SECURITY AND CHILD SUPPORT COMMISSIONERS

Commissioner's File No.: CI/2012/2000

Starred Decision No: 22/01

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Mr P Cichosz,
Office of the Social Security and Child Support Commissioners,
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Decision:

1. My decision is that the decision of the Birmingham appeal tribunal held on 2nd December 1999 is not erroneous in point of law.

The appeal to the Commissioner

2. This is an appeal to a Commissioner against the decision of the appeal tribunal brought by the claimant with my leave. The Secretary of State does not support the appeal.

3. In view of the issues raised by the appeal, I directed an oral hearing. It was held before me in London on 30th January 2001. The claimant did not attend, but was represented by his solicitor, Mr Hoare, accompanied by Mr Atwal who had represented the claimant before the tribunal. The Secretary of State was represented by Mr Chang of the Office of the Solicitor to the Departments of Health and Social Security. I am grateful to all three for their clear submissions at the hearing.

The issue

4. This case concerns a reassessment of the disablement resulting from prescribed disease A10 (occupational deafness). It raises the issue of the forms of assessment that should be taken into account by an appeal tribunal in determining a claimant's sensorineural hearing loss.

The assessment of deafness

5. Broadly speaking, appeals against assessments of deafness fall into two groups. In one group, the claimants have appealed despite the evidence. In other words, the evidence all points one way, but the claimants maintain that it is not accurate. In the other group, the claimants have appealed because of the evidence. In other words, the evidence shows different assessments of deafness. This case is in the second group.

6. The legislation no longer specifies the means by which deafness has to be assessed. In practice, the evidence used by tribunals in assessing deafness are either direct or indirect.

7. Indirect evidence involves inferences from matters such as tuning fork tests, the use of a hearing aid and the clinical findings on examination of the claimant's ear. These are of little help in assessing the degree of deafness with the precision required by the legislation. They are only useful as a check on the results produced by the direct methods of assessment.

8. There are three methods of assessment of hearing loss that are regularly used as direct evidence.

9. The first method is to ask if the claimant can hear a conversational voice at particular distances. This is easy to do and gives an immediate result. Its drawback is obvious. It depends on the co-operation of the claimant. That is a polite way of saying that it depends on the honesty of the claimant. Also, it is not sufficiently sophisticated and discriminating to test the degree of hearing loss with the precision needed. Again, it is at best a check on other evidence.

10. The second method is pure tone audiometry (PTA). This involves the use of equipment that produces sounds at different levels. The claimant has to indicate when a sound is heard. This to some extent depends on the claimant's co-operation. There are techniques that can be used by the operators to try to catch out someone who is giving false answers, but ultimately the accuracy of the results depends on when the claimant was last exposed to noise and the only evidence for this comes from the claimant. Despite its limitations, this test is fairly easy and cheap to administer. The pattern of hearing loss can also give an indication of whether or not it is related to exposure to noise. Pure tone audiometry is the starting point for all assessments by the Secretary of State and tribunals.

11. A claimant cannot regain a permanent hearing loss. So, naturally, claimants question the accuracy of PTA that shows an improvement. Assuming that the equipment used on both occasions had been calibrated at the appropriate intervals (of one year, I believe), there are a limited number of reasons why a test would show an improvement. One possibility is that the claimant did not give accurate readings in the earlier test. Another possibility is that the claimant's report of last exposure to noise at the time of the earlier test was inaccurate, so that the readings were affected by a temporary hearing loss. A third possibility is that the change reflects the improvement in sensitivity of more modern equipment.

12. The third method is used when there is some reason to doubt the accuracy of PTA. This method is the evoked response audiometry (ERA). It is a record of a person's brain activity in response to sound.

13. In CI/4567/1999, paragraph 9, Mr Commissioner Henty quoted medical evidence that ERA provided 'objective evidence of normal hearing or hearing loss' and described PTA as 'an objective test.' I understand what he meant, but his comment and the medical evidence that he quoted must be taken in context. That context is the extent to which a claimant can influence the outcome of the test. I would put the point slightly differently in order to emphasise that context. ERA is more objective than PTA. However, the results require skill and judgment to interpret. The figures presented in papers for tribunals are not, I believe, the results of the ERA, but their interpretation after analysis of the ERA reading of brain activity. As a consequence, the results are used as a check on the results of PTA. If the ERA is close to the PTA figures, the ERA is considered as confirming them.

14. The ERA does not depend on the claimant to acknowledge that the sound has been heard, but the claimant's behaviour may affect other brain activity and make it more difficult to interpret the results.

15. There are two types of ERA. The usual one used for testing adults is the cortical or slow vertex ERA. There is also a brainstem ERA. This is used for young children, as the results are not affected by sedative or anaesthetic that is given to keep the child quiet and still while the test is carried out.

16. If a tribunal has evidence from both PTA and ERA as well as other less direct evidence of hearing loss, it has to weigh the evidence as a whole in order to determine the level of the claimant's sensorineural hearing loss. There is no rule that one type of evidence is always to be preferred to another. The evidence has to be considered as a whole. The tribunal may conclude that one type of evidence is preferable to another, but that must be a judgment reached after considering the merits of all the evidence. Lest there be any doubt,

CI/4567/1999 is not, and does not purport to be, an authority that ERA is always to be preferred to PTA.

The evidence in this case

17. The claimant claimed disablement benefit in respect of prescribed disease A10 in 1992. His deafness was assessed in 1993. PTA showed a high degree of hearing loss. If it was accurate, the claimant had no useful hearing at all. Cortical ERA was carried out by Dr Jones, which showed a much lower degree of hearing loss. That showed that the PTA was unreliable and this was confirmed, if confirmation was needed, by the fact that the claimant was able to hear a conversational voice in each ear from 3 metres. His hearing loss was determined, using the ERA figures as the only reliable ones available, at 66dB in the right ear and 53dB in the left ear. The assessment ran for 5 years.

18. The claimant's hearing loss was reassessed in 1997. PTA again showed a high degree of hearing loss, although not quite as high as the PTA in 1993. Cortical ERA was carried out by Professor Harding. It showed a lower degree of hearing loss than both the 1997 PTA and the 1993 ERA. This time, the claimant was able to hear a conversational voice in each ear from 3½ metres. As in 1993, the claimant's hearing loss was based on the ERA, as the only reliable evidence available. In accordance with the legislation, his disablement was assessed as less than 20% and no award of disablement benefit was made.

19. The claimant appealed against the assessment to a medical appeal tribunal. The case came before a tribunal on 29th April 1998. The claimant was represented by Mr Atwal, who told me that he asked the tribunal to order brainstem ERA. However, the tribunal did not do that. Instead it adjourned with a request that Professor Harding carry out another cortical ERA and a bone conduction test. (Bone conduction readings show only sensorineural hearing loss, whereas air conduction readings show also conductive hearing loss. So, the former are more relevant to prescribed disease A10, but as they are the more difficult to obtain, the latter are used if the difference is only small.) It also asked him to comment on the variation between his ERA and that carried out by Dr Jones in 1993.

20. Professor Harding carried out a further ERA and a bone conduction test, which showed a slightly lower degree of hearing loss than his previous test. On the variation between the tests, he made these comments: (a) Dr Jones had used different and less up-to-date equipment than his; (b) the 1993 ERA was carried out within 5 days of exposure to noise compared with 2½ years for his tests; (c) his tests were always carried out blind of any other test results, including his own earlier tests; (d) there was a high degree of consistency between his two tests.

The tribunal's decision

21. At the resumed hearing, the tribunal accepted Professor Harding's second ERA and adopted his explanation for the difference in results.

The ground of appeal

22. As explained by Mr Hoare at the oral hearing, the claimant's ground of appeal was that the tribunal had excluded from consideration the best evidence that could be obtained, which was that provided by brainstem ERA.

23. Mr Hoare conceded that (a) the tribunal's decision was correct on the evidence before it and (b) the claimant could not argue that the PTA assessments should be accepted. Those were realistic concessions. The level of hearing loss shown by the PTA assessments is so high as alone to cast doubt on their accuracy, and this is confirmed by the conversational voice tests. Also, the claimant's hearing loss had been assessed in 1996 and 1997 in connection with (I assume) a civil claim. ERA in 1997 showed a much lower hearing loss than PTA in 1996. The Consultant ENT Surgeon's advice could not have been plainer:

> 'If this gentleman is going to proceed further with his claim he will have to perform much better than he did in October 1996 when I first saw him and if his claim is to proceed further he will probably need to undergo a further conventional hearing test but on this occasion provide true hearing thresholds and this may enable an accurate diagnostic test to be obtained.'

24. So, the tribunal was right to rely on ERA as giving the most reliable results in this case. The issue for me to decide can be put in these two questions. Did the tribunal exclude evidence of brainstem ERA? Did the tribunal decide that cortical ERA is always the best evidence of hearing loss? The answer to both those questions is: no.

25. There is nothing whatsoever to suggest that the tribunal excluded evidence of brainstem ERA. All it did was to decide that it was not going to obtain this on the claimant's behalf at public expense. The claimant could have arranged for himself brainstem ERA and presented the results to the tribunal. The tribunal did not rule in advance that this evidence could not be presented. Nor is there anything to suggest that the tribunal would have refused to consider that evidence if it had been produced. Of course, the claimant may not have been able to afford brainstem ERA, but of itself that is not a sufficient reason for a tribunal to order it.

26. Nor is there anything to suggest that the tribunal considered that cortical ERA is always the best evidence of hearing loss. The tribunal did not say that and it is not implicit in its reasons. Its reasoning shows that it considered all the available evidence, but preferred the ERAs carried out by Professor Harding. It explained why by referring to a comparison of the air and bone conduction readings.

Reasons

27. That leaves only one possible error of law. Should the tribunal have explained why it did not order brainstem ERA?

28. When a tribunal directs that cortical ERA be undertaken, the reason is usually obvious. The request in this case for brainstem ERA is, in my experience, very unusual. Looking at the case as it came before the tribunal at the first hearing, its reason for giving the directions that it did are to me obvious. The evidence appeared to show an improvement in hearing. That is not uncommon in appeals involving reassessments for prescribed disease A10. It is a tribunal's responsibility to make a decision on the evidence available. It is always tempting to think that a third piece of evidence will save a tribunal from having to resolve a conflict between two other pieces of evidence. All too often, the third piece merely produces more conflicts for the tribunal to resolve. However, out of fairness to the claimant, it is understandable that the tribunal wanted to check the evidence before it. The best source was Professor Harding. There were two obvious questions he could be asked. Are you sure that the ERA was accurate? Can you explain the apparent improvement in hearing? In other

words, the tribunal sought to check at its source the quality and significance of the evidence against the claimant. That was a sensible and rational course for the tribunal to take. It was a proper exercise of its discretion. As I have said, in the state of the evidence at the first hearing, the reason for the tribunal adjourning with the directions that it did are obvious and did not need to be stated. As the claimant was left free to obtain for himself, if he wanted and could afford it, brainstem ERA, there was no need for the tribunal to explain why it exercised its judgment against obtaining that evidence.

Conclusion

29. The appeal is dismissed.

Signed on original

Edward Jacobs
Commissioner
2nd February 2001