Catastrophic Claims Guide
Foreword

The catastrophic injury sector continues to evolve at a rapid pace, reflecting the high financial and human costs involved when attempting to provide for the most seriously injured accident victims.

Our national Catastrophic Injury Unit represents a wide range of leading insurance, healthcare and other clients. We are currently managing claim reserves in the region of £2 billion and have been involved in many of the leading cases in this sector.

This first edition of our catastrophic claims guide reviews the main issues that case handlers will encounter, examines their practical implications, and draws on our experiences of dealing with similar cases.

This is intended as a simple guide to the main issues that are encountered in catastrophic injury claims. It is not possible to set out comprehensively all of the legal and practical matters. Nevertheless, I hope that you will find the guide helpful. We intend updating the guide from time to time and would welcome your feedback, including comments or suggestions for future editions.

Finally, I must give special mention to my co-editors Caroline Craigie and Deborah Newberry and to the various other team members who contributed sections to the guide.

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Traumatic brain injury (TBI) is damage to the brain resulting from external mechanical force, such as rapid acceleration or deceleration; impact or penetration by an object.

ANATOMY OF THE BRAIN
The brain is divided into a number of areas; roughly in the following areas:

PATHOLOGICAL FEATURES
The type of TBI sustained can be defined by its pathological features. Lesions can occur within the skull but outside of the brain (extra-axial) or within the brain tissue (intra-axial).

Damage from TBI can also be focal, i.e. confined to specific areas and/or diffuse. Diffuse injuries include swelling (oedema) and concussion. Focal injuries include those to the frontal and temporal lobes, cerebral lacerations and haematomas.

Haematomas are collections of blood in or around the brain that can result from haemorrhage. Intracerebral haemorrhage (with bleeding in the brain tissue itself) is an intra-axial lesion. Extra-axial lesions include haemorrhages between the three membranes surrounding the brain (the dura, arachnoid and pia mater): epidural, subdural and subarachnoid haematomas.

Primary brain injury is caused at the moment of trauma, when blood vessels are ruptured/haemorrhage and brain tissue is damaged (contusions). There can then follow secondary injury including insufficient blood flow (ischemia), insufficient oxygen to the brain (cerebral hypoxia), swelling of the brain (cerebral oedema) and pressure within the skull (intracranial pressure).

SEVERITY
The most commonly used system for classifying TBI is the Glasgow Coma Scale (GCS) which grades a person’s consciousness on a scale of three to 15, based on verbal, motor and eye opening reactions to stimuli. Duration of post-traumatic amnesia (PTA) and of loss of consciousness (LOC) also indicate severity.

<table>
<thead>
<tr>
<th>Glasgow Coma Scale (GCS)</th>
<th>Traumatic Brain Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 or above</td>
<td>Mild</td>
</tr>
<tr>
<td>9 – 12</td>
<td>Moderate</td>
</tr>
<tr>
<td>8 or below</td>
<td>Severe</td>
</tr>
</tbody>
</table>

The GCS classification is used in the JSB Guidelines. It does, however, have limited application to children.
Spinal Cord Injury

SYMPTOMS

TBI can result in a wide range of symptoms which are largely dependent on the type of TBI sustained, the part of the brain affected and the severity of the injury.

Symptoms include:

- Prolonged or permanent effects on consciousness, e.g. coma, brain death and persistent vegetative state (PVS).
- Movement disorders, e.g. tremor, ataxia (uncoordinated muscle movements) and myoclonus (contractions of muscles).
- Altered vision, smell, taste, speech, hearing, dizziness and nausea.
- Cognitive deficits including impaired attention, insight, intellect and executive function, e.g. problem solving.
- Emotional, behavioural and personality problems including disinhibition, hypomania, sleep disturbance, anger and aggression. There may also follow psychiatric problems including depression, phobias and obsessive behaviour.

QUANTUM

Damages for pain, suffering and loss of amenity will reflect the severity of the injury and the symptoms present. Awards can range from £1,450 to £265,000 and largely depend on the extent of symptoms listed above.

The severity of the TBI will determine the extent to which care and support is required and this can translate into significant damages awards. TBI may result in the need for assistance with activities of daily living, domestic tasks, mobility, employment and financial management.

SPINAL CORD

The spinal cord is part of the central nervous system (CNS), which runs from the brain, down the back, and is surrounded and protected by vertebrae. Spinal nerves come off the spinal cord and pass between the vertebrae to carry information from the spinal cord to the rest of the body.

Spinal nerves fall into three categories:

<table>
<thead>
<tr>
<th>NERVE TYPE</th>
<th>LOCATION</th>
<th>SUPPLY FUNCTION</th>
<th>VERTEBRAE CLASSIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical</td>
<td>Neck</td>
<td>Movement and feeling to arms, neck and upper trunk.</td>
<td>C1 – C8</td>
</tr>
<tr>
<td>Thoracic</td>
<td>Upper back</td>
<td>Trunk and abdomen.</td>
<td>T1 – T12</td>
</tr>
<tr>
<td>Lumbar &amp; sacral</td>
<td>Lower back</td>
<td>Legs, bladder, bowel and sexual organs.</td>
<td>S1 – S5</td>
</tr>
</tbody>
</table>

SPINAL CORD INJURY LEADING TO PARALYSIS

With spinal cord injury, the spinal nerves joining the spinal cord below the level of injury will either be completely or partially cut off from the brain resulting in quadraplegia, tetraplegia or paraplegia:

- **Quadrplegia/tetraplegia** – a spinal cord injury above the first thoracic vertebra, which usually causes paralysis of all four limbs. The abdominal and chest muscles will also be affected resulting in weakened breathing and the inability to properly cough and clear the chest.
- **Paraplegia** – a spinal cord injury below the first thoracic vertebra. The extent of the injury can vary from impairment of leg movement to the complete paralysis of the legs and abdomen up to the nipple line. The individual retains the full use of their arms and hands.
EXTENT OF PARALYSIS

C1 – C3 Tetraplegia  Complete paralysis of all limbs and in many cases ventilation required to aid breathing. (C3 patients may be able to breathe unaided.)

C4 – C5 Tetraplegia  Complete paralysis below chest level. Limited shoulder and arm movement including lack of tricep muscles, wrist extensors and finger movement.

C6 – C7 Tetraplegia  Partial paralysis of hands and arms and lower body.

T4 Paraplegia  Paralysis below the chest.

L1 Paraplegia  Paralysis below the waist.

INCOMPLETE SPINAL CORD INJURIES

These occur where the spinal nerves are only partially cut off from the brain. The location of the damage dictates the type of paralysis/level of sensation as follows:

- **Anterior cord syndrome** – damage towards the front of the spinal cord can result in the loss or impaired ability to sense pain, temperature and touch sensations below the level of injury. Pressure and joint sensation may be preserved and some patients with this form of injury may recover some movement later.

- **Central cord syndrome** – damage to the centre of the spinal cord, which can result in loss of function in the arms. Some leg movement and control over the bowel and bladder may be preserved. Some recovery may be possible, usually starting in the legs and moving upwards.

- **Posterior cord syndrome** – damage is towards the back of the spinal cord and may leave the patient with good muscle power, pain and temperature sensation. Difficulty in the co-ordination of limbs may occur.

- **Cauda equina lesion** – cauda equina is a mass of nerves, which fan out of the spinal cord between the first and second lumbar region of the spine. Injury to these nerves will cause partial or complete loss of movement and sensation. If the nerves are not too badly damaged, nerve re-growth and recovered function is possible.

GENERAL DAMAGES

The Judicial Studies Board Guidelines’ brackets are:

- **Quadruplegia** – £212,500 to £265,000
- **Paraplegia** – £144,000 to £186,500

The level of the award within each of the above brackets will be affected by the extent of any residual movement, the presence and extent of pain, the degree of independence, depression, age and life expectancy.

SPECIAL DAMAGES

The level of injury and extent of paralysis will determine the heads of loss. The following heads of damage are likely to be claimed:

- **Care** (likely to be substantial)
- **Aids and equipment**
- **Therapies** (often including the cost and maintenance of a hydrotherapy pool*)
- **Accommodation**
- **Holidays**
- **Transport**
- **Medical costs**
- **Increased heating and laundry costs**
- **Loss of earnings**.

* Claims for hydrotherapy pools have often been disputed on the basis that appropriate facilities are situated close to the claimant negating the need for his own pool. Another helpful argument relates to the expertise required to maintain the pool temperature and the danger of worsening symptoms if this is not done correctly.
GENERAL DAMAGES FOR PAIN, SUFFERING AND LOSS OF AMENITY

Compensation awards for amputations reflect the very serious effect on an individual’s lifestyle and ability to work caused by the partial or complete loss of a limb:

<table>
<thead>
<tr>
<th>Amputation</th>
<th>Compensation Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amputation of both legs</td>
<td>£158,000 – £185,000</td>
</tr>
<tr>
<td>Above knee amputation of one leg</td>
<td>£63,000 – £92,000</td>
</tr>
<tr>
<td>Below knee amputation of one leg</td>
<td>£60,000 – £86,000</td>
</tr>
<tr>
<td>Amputation of both arms</td>
<td>£158,000 – £197,000</td>
</tr>
<tr>
<td>Above the elbow amputation (one arm)</td>
<td>£72,000 – £86,000</td>
</tr>
<tr>
<td>Below the elbow amputation (one arm)</td>
<td>£63,000 – £72,000</td>
</tr>
<tr>
<td>Amputation of both hands</td>
<td>£92,000 – £132,000</td>
</tr>
<tr>
<td>Amputation of one hand</td>
<td>£63,000 – £72,000</td>
</tr>
</tbody>
</table>

The amount of the award will depend on:
- The severity of ongoing organic and phantom pains.
- Whether or not the amputation was of a dominant arm.
- The existence of any problems with the prosthesis.
- Psychological issues arising from the injury.

LOSS OF EARNINGS

There is likely to be a claim for both past and future loss of earnings. When using the 6th Edition of the Ogden Tables, most (if not all) amputation cases are likely to satisfy the disability test, with amputees being categorised as disabled.

NURSING CARE

As a result of an amputation, the injured party is likely to need assistance. Care needs will depend on the remaining function of the limb and the type of prosthesis fitted. With upper limbs, more care will be required following the loss of a dominant limb. The loss of a thumb may also attract a care claim, given that many tasks depend on an adequate grasp between finger and thumb.
With leg amputations, the higher the level of amputation the greater the claimant’s care needs will be.

PROSTHETICS
An artificial limb or part of it is known as a prosthesis.

Many upper limb prostheses are mainly cosmetic, although some have a relatively good degree of functional capabilities. Lower limbs are generally functional, but their effective use depends on the level of amputation and the person’s age, build and motivation.

Whilst the NHS provision of prosthesis has improved, an amputation claim will usually include a claim for the cost of prosthetics. This will normally be for two or three limbs, which will need to be replaced at approximately five-year intervals.

The number of limbs, the frequency of replacement and the cost of maintenance are often the subject of dispute between the parties, and expert evidence on this issue is crucial. Claimants often obtain their prosthetics evidence from a provider. Where appropriate, it should be argued that a provider is not an impartial expert.

The provision of prosthetics is expensive and these claims can exceed £200,000, depending on the age of the injured party.

ACCOMMODATION
It is not unusual to see claims for accommodation being advanced in lower limb amputation claims, on the basis that the amputee needs access to a downstairs toilet and, even with the prosthesis, there may be a need for occasional wheelchair use, requiring wider doors etc.

From a defendant’s perspective, it is useful to seek the advice of medical and nursing care experts to establish if there is a genuine need for a new property or whether adaptations could be made to an existing property.

If a new property is necessary, then the Roberts v Johnson formula should be used.

AIDS AND APPLIANCES
Claims in relation to aids and appliances can be sizeable in a typical amputation claim. Frequent recommendations include both manual and electric wheelchairs, recliner chairs and kitchen and household equipment.

A larger car may also be required to facilitate wheelchair access and movement.

Again, advice from medical experts should be sought. Additional expertise may also be necessary in the form of an occupational therapist (although aids and equipment can often be dealt with by the care expert).

SUMMARY
Amputation claims need to be handled sensitively and careful consideration needs to be given to valuing such claims, which on occasion can be worth seven figures. In the case of a well motivated claimant, it should be possible for them to make a good recovery from an amputation and consideration should be given, at the outset, to rehabilitation where appropriate.
Rehabilitation

Catastrophic claims are nearly always appropriate for rehabilitation intervention because of their devastating effect on the claimant’s health and lifestyle.

The usual starting point is to jointly select and instruct a specialist case manager to undertake an initial needs assessment (INA) pursuant to the Rehabilitation Code. The Code aims to ensure that the management of rehabilitation is a collaborative process.

The main role of the case manager is to coordinate the available services. Rehabilitation can take many forms, including arranging private medical referrals or treatment, securing benefits or other public funding, purchasing aids and equipment, adapting the claimant’s home, organising transport solutions, coordinating a carer regime, or seeking alternative job opportunities accommodating the acquired disability.

**CHOICE OF CASE MANAGER**

There is a growing choice of case management companies offering a panel of case managers, although some geographical areas are better served than others.

We recommend selecting a case manager on a case by case basis. The main criteria are:

- Availability and waiting time for an INA.
- The right qualifications and experience for the injuries concerned.
- Geographical proximity and ease of travel for home visits.
- Charging rates.

The Code provides that neither party can impose their choice of case manager if the other objects on reasonable grounds.

**FUNDING**

The main barrier to rehabilitation funding is a complete denial of liability. In cases where the defendant’s denial is necessarily motivated by a lack of liability evidence and need for further investigations, one interim option for the parties to consider is for the defendant to fund a case manager to maximise public funding and health services.

The Code envisages that in most cases the defendant will provide funding for the case manager and for implementing their recommendations. The defendant will have to justify any refusal to fund the recommendations. Once funding is agreed, the defendant should neither dispute the expenditure nor seek to recover this from the claimant.

In some cases, the claimant’s solicitor may seek an interim payment to privately fund rehabilitation outside the Code. This is to be discouraged, because this can build mistrust between the parties and leave the claimant vulnerable to challenge over the reasonableness of the expenditure.

**ASSESSMENT**

The INA should generally be carried out as soon as possible following the accident, although in some cases it may still be beneficial years later. The case manager should report on the injuries sustained, their effect on lifestyle, the claimant’s domestic and family circumstances, the recommended intervention and its likely cost, the availability of public funding and state benefits, and the rehabilitation objectives.

The main complaint by defendants relates to exaggerated recommendations or occasional abuse of agreed funding. To safeguard against this and put the INA in its proper context, the defendant is entitled to sufficient information from the claimant to reach a proper decision about funding.

The case manager is unlikely to be an expert in all the relevant disciplines and the parties may sometimes require a second opinion. For example, the parties may consult a treating practitioner or medico-legal expert about very costly items such as home adaptations or vehicle purchases, or refer employment issues to a vocational rehabilitation specialist.

**CLAIM IMPLICATIONS**

The INA itself is privileged from disclosure in any subsequent litigation, unless the parties agree otherwise, whereas by comparison, all subsequent case manager updates and other rehabilitation materials are not privileged and should be disclosed.

The items funded directly by the defendant should be excluded from the claim. When a claim is eventually settled, the usual arrangement is for the defendant to stop payments and for the claimant to fund rehabilitation directly, using damages specifically awarded for that purpose.
Control of the cost of claims for care and case management can be achieved by following some basic principles.

Active engagement on care at an early stage in catastrophic cases through rehabilitation case conferences is essential otherwise claimants may be encouraged by their advisers to set up an early and comprehensive care package based on their own experts’ views. It is difficult to persuade a Judge to unravel a care package that is already in place and appears to suit the claimant, even if on the defendant’s evidence it goes beyond the claimant’s needs.

**CARE PROVIDED BY FAMILY AND FRIENDS**

Only care which has been provided “beyond the call of duty” and which would not have been provided by a relative in any event is recoverable. It is not appropriate to award damages for care for hospital visits unless the visitors actually provided nursing care during those visits (Evans v Pontypridd Roofing Ltd [2001]).

Rates are usually based on the salaries recommended by the National Joint Council for Local Government Services for a home help/home carer. Aggregate rates are increasingly being claimed to reflect that gratuitous care is provided around the clock and often at night or weekends. For example:

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TIME OF DAY</th>
<th>HOURLY RATE</th>
<th>AGGREGATE RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2010 onwards (estimated)</td>
<td>Basic</td>
<td>£7.05</td>
<td>£9.24</td>
</tr>
<tr>
<td></td>
<td>Evening</td>
<td>£8.81</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Saturday</td>
<td>£10.58</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sunday</td>
<td>£14.11</td>
<td></td>
</tr>
</tbody>
</table>

Normal practice is to award gratuitous care at 75% of the commercial rate. However, discounts of up to 33% have been applied, to reflect that the care is not being provided commercially and that tax or national insurance contributions will not be deducted. Factors to take into account include the hourly rate used, the quality of care provided, the identity of the person providing the care, the nature of the claimant’s disability and the claimant’s age.

Alternatively, if a carer has given up full-time employment to provide care, he/she may be entitled to claim for loss of earnings, provided those earnings do not exceed the commercial value of the care provided before any discount is applied. It must also be reasonable for the carer to give up work to provide the care.

**COMMERCIALLY PROVIDED CARE**

Commercial carers can be retained on a direct hire basis or via an agency. Where an agency is involved, the agency is contracted to provide care at defined times during the week. Although most agencies will try and provide the same carer to the claimant each week, this may not always be achievable. Nevertheless, use of an agency does ensure that cover can be provided at short notice for carers who are on holiday or off sick. If a claimant employs carers on a direct hire basis then he is responsible for paying national insurance and has to manage recruitment and holiday and sickness cover himself.

Hourly rates have historically been an area of disagreement between the parties. However, that gap is narrowing. Staff employed on a direct hire basis will be paid a higher rate, but are often a higher calibre of carer and have higher retention rates, which can give a claimant greater continuity of care. This can keep costs down in the long term. The applicable rates for direct hire are aggregate market rates plus add on costs such as employers’ national insurance, annual leave and insurance, which usually total about 31% of the aggregate rate.

However, courts may be persuaded not to award aggregate rates for gratuitous carers if there is a very significant element of night time care (Noble v Owens [2008]).
HEALTH AUTHORITY [2008] (which involved a claimant with cerebral palsy following a premature birth), Mr Justice Jack held that the Claimant should have two carers for the whole day save the eight hours whilst he was sleeping.

Defendants should look at ways of reducing unnecessary double up care by allowing for overlap of the night carer assisting with the evening and breakfast routines, with a further overlap between the day carers. Use of hoists, assistive technology and adapted vehicles can increase a claimant’s independence and reduce the need for double up care; be it on a constant basis or at certain times in the claimant’s life.

The position as regards night care must be carefully thought through in conjunction with the medical and care experts. Waking night care is rarely required over a sleeping night carer. The former is usually only required where a claimant has a need for regular attendance (usually more than twice) during the night; for example to assist with toileting needs, turning etc.

59 or 60 week year
Care experts have previously calculated care based on either 58 or 59 weeks to take into account holidays, training and sick leave. However, on 1 April 2009, the Working Time Regulations 2008 (SI 1998/1833) were amended to increase employee holiday entitlement from four weeks per annum to 5.6 weeks per annum including Bank Holidays (28 days for someone working five days per week). In X v A Strategic Health Authority, professional care was awarded on the basis of 60 weeks per year (i.e. 52 weeks plus four weeks holiday, bank holidays, 10 days sickness/absence and 10 days training). Some experts have increased their costings to take account of this decision.

TEAM LEADER
Where more than one carer is employed, claimants are arguing that one of the carers should be the designated team leader, who is responsible for undertaking risk assessments, drawing up care plans and rotas and addressing any general issues arising out of the care package. In X v A Strategic Health Authority the Claimant asked for four additional "non-contact" hours per week. The Defendants argued that the team leader usually has sufficient time for such tasks, particularly as rotas rarely change from week to week. The court allowed an additional two hours per month and accepted £2 extra per hour solely for the team leader but with the duties being carried out within the normal care time. However, the court did recognise that there may be times when out of hours work is needed.

CARE COSTS
Care costs are rising not just because of increases in the hourly rate.

Number of carers/"double up"
The number of carers needed depends on the extent of the claimant’s disability and more particularly on whether the Claimant requires two carers for all transfers. Claimants often argue that two carers are needed for anywhere up to 12 to 16 hours per day to aid transfers, to enable the claimant to be changed in the event of a bladder or bowel accident, to allow repositioning for comfort and prevent pressure sores and increase independence. In the case of X v A Strategic

<table>
<thead>
<tr>
<th>TETRAPLEGIC CARE</th>
<th>CARE COSTS</th>
<th>ADD ON COSTS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency basis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live-in carers (two required to prevent contravention of the Working Time Directive)</td>
<td>£1,350 per week x 52 weeks x two carers</td>
<td>£8,320 p.a. representing additional food, heat, light and carers’ expenses</td>
<td>£148,720</td>
</tr>
<tr>
<td>Direct hire basis</td>
<td>16 hours per day x £11 per hour x 365 days plus four hours per day double up (where two carers required)</td>
<td>31% uplift £32,360.90 p.a. Plus additional household costs and carers’ expenses £2,106 p.a.</td>
<td>£138,857</td>
</tr>
<tr>
<td>Plus night sleeper £66 per night x 365 nights</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Much will depend on the extent of the claimant’s disability and his ability to manage his carers. A direct hire care team requires a greater level of case management (discussed below) than an agency care team. If a claimant needs to go into hospital for an extended period, agency care can be more easily suspended on a minimal retainer. If direct hire carers are employed, the claimant remains responsible for their salaries unless annual leave can be negotiated during that time or the carers released on a retainer. The relative merits of carers hired on a direct care basis or via an agency will have to be considered in each case, but agency care is often preferred.

CARE COSTS

Number of carers/"double up"
The number of carers needed depends on the extent of the claimant’s disability and more particularly on whether the Claimant requires two carers for all transfers. Claimants often argue that two carers are needed for anywhere up to 12 to 16 hours per day to aid transfers, to enable the claimant to be changed in the event of a bladder or bowel accident, to allow repositioning for comfort and prevent pressure sores and increase independence. In the case of X v A Strategic Health Authority the Claimant asked for four additional “non-contact” hours per week. The Defendants argued that the team leader usually has sufficient time for such tasks, particularly as rotas rarely change from week to week. The court allowed an additional two hours per month and accepted £2 extra per hour solely for the team leader but with the duties being carried out within the normal care time. However, the court did recognise that there may be times when out of hours work is needed.
**Example future care calculation:**
The claimant was rendered paraplegic following a road traffic accident. Using a life expectancy to age 76 with a multiplier of 22.94, the defendant’s calculation was as follows:

*a. To age 52.5 years:*

<table>
<thead>
<tr>
<th>Domestic assistance</th>
<th>8 hours per week @ £10 per hour x 52 weeks</th>
<th>£4,160</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contingency fund</td>
<td>Live in carer @ £1,100 x 2 weeks</td>
<td>£2,200</td>
</tr>
<tr>
<td></td>
<td>Carer expenses @ £50 x 2 weeks</td>
<td>£100</td>
</tr>
<tr>
<td></td>
<td>Increased household costs @ £20.50 x 2</td>
<td>£41</td>
</tr>
<tr>
<td>Annual sum</td>
<td></td>
<td>£6,50</td>
</tr>
<tr>
<td>Multiplier</td>
<td></td>
<td>10.75</td>
</tr>
<tr>
<td></td>
<td></td>
<td>£69,885.75</td>
</tr>
</tbody>
</table>

**b. From age 52.5 to age 62.5 years:**

In addition to the above annual sum of £6,501 it is reasonable to allow for a privately employed carer/PA. The claimant will be able to arrange this without the assistance of a case manager.

<table>
<thead>
<tr>
<th>Provision of annual sum as above</th>
<th>£6,501</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 hours per week x £10 x 52 weeks</td>
<td>£10,920</td>
</tr>
<tr>
<td>Add on costs of 30%</td>
<td>£3,276</td>
</tr>
<tr>
<td></td>
<td>£20,697</td>
</tr>
<tr>
<td>Multiplier (for 10 years)</td>
<td>7.9</td>
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<tr>
<td></td>
<td>£163,506</td>
</tr>
</tbody>
</table>

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**Domestic assistance**
Claims for assistance with domestic tasks such as cleaning, washing and ironing are becoming commonplace (even when two day carers are employed). Courts are increasingly allowing such claims to free carers up to undertake their caring role, which in turn assists with retention of carers. It also recognises that domestic tasks can only be undertaken when the claimant is at home. Placing such tasks onto the carer might, therefore, limit the claimant’s independence. Awards can be as low as four hours per week as allowed in *X v A Strategic Health Authority*.

**Insurance**
Some claimants are arguing that they need to take out indemnity insurance to cover the negligence of carers, and employers’ liability and personnel insurance, which can add up to an extra £1,000 per annum. Such a claim has never been allowed by the courts and in *X v A Strategic Health Authority* the court stated that the costs were not reasonable. Some household contents policies will include employers’ liability cover for domestic staff.

**Pension contributions**
From 2012 employers will have to contribute 3% of pay into a workplace pension scheme.

**CASE MANAGEMENT**
A case manager’s role is to develop, implement and co-ordinate the care plan. Rates vary and can be up to £90-£95 per hour plus travelling time and mileage.

Increased work is usually required in the first six months to establish the care package. Where direct hire carers are employed, there may be a greater need for case management than when agency carers are employed.

Thereafter, there may be periods in a claimant’s life when additional case management is appropriate, for example, following a relationship change or during a house move.

Case managers can be avoided or their use minimised through the use of agency carers and by enlisting the support of an occupational therapist and manufacturers of equipment who will often provide free delivery, installation and instruction. Claimants with capacity can build up a vast knowledge of sources of assistance and care. In one case a claimant has commented that he will not pay for a case manager as he knows more than they do! This also gives the claimant a feeling of control and independence.
c. From age 62.5 to 74 years:

In addition to the above annual sum of £6,501 it is reasonable to allow for a privately employed carer/PA. The claimant will be able to arrange this without the assistance of a case manager.

<table>
<thead>
<tr>
<th>Provision of annual sum as above</th>
<th>£6,501</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 hours per week x £10 x 52 weeks</td>
<td>£18,200</td>
</tr>
<tr>
<td>Add on costs of 30%</td>
<td>£5,460</td>
</tr>
<tr>
<td>Carer expenses £20 per week x 52 weeks</td>
<td>£1,040</td>
</tr>
<tr>
<td>Annual sum</td>
<td>£6,501</td>
</tr>
<tr>
<td>Multiplier (rem. of life)</td>
<td>3.45</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£107,643</strong></td>
</tr>
</tbody>
</table>

d. From age 74 years:

- Live-in carer @ £1,100 per week x 52 weeks: £57,200
- Carer expenses £50 x 52 weeks: £2,600
- Increased household costs £20.50 per week x 52 weeks: £1,066
- Domestic assistance 3 hours per week x £10 per hour x 52 weeks: £1,560
- Annual sum: £6,501
- Multiplier (remainder of life): 0.84

**Total £393,472.59**

In the majority of catastrophic claims, loss of earnings will be a significant part of the claim, particularly in the case of a young claimant or high-earner.

The claimant’s full employment details should be obtained including wages, overtime, and bonuses. If specific information is not available, then the Annual Survey of Hours and Earnings (ASHE) can be used to obtain statistical average earnings for a range of occupations. ASHE provides a range of earnings (gross, net and weekly) for both males and females.

The majority of catastrophically injured claimants are unlikely to return to their pre-accident employment and will claim a full loss of earnings until retirement age.

Nevertheless, it may be possible to return the claimant to meaningful employment and mitigate the earnings claim. This will depend on a number of factors, including the nature of the claimant’s injuries, their age and their skills or qualifications.

A return to meaningful employment in this situation is often in a lower paid role than before the accident, because of reduced hours, reduced responsibility etc. If the claimant is not employed at the date of settlement or trial, or satisfies the Ogden definition of disabled, then the multiplier for residual earnings may be relatively modest.

To calculate future loss of earnings when a claimant has returned to meaningful employment, a multiplier/multiplicand approach should usually be adopted. The loss of earnings multiplier must be adjusted to take account of contingencies other than mortality (qualifications, disability and employment status) using Tables A – D as set shown below:

**EXAMPLE**

The claimant is a male aged 41 at the date of trial. He has a degree and was employed at the date of the accident, earning £45,000 net per annum. He was not disabled pre-accident. As a result of the accident, the claimant is disabled and only works on a part-time basis, earning £15,000 net a year. His retirement age is 65.

Table 9, discount rate of 2.5%*, gives a loss of earnings multiplier of 17.47 for a 41-year-old male (retirement age of 65)

Factor in risks other than mortality by using figure of 0.88 taken from Table A (41-year-old male, employed, not disabled, degree level education): 17.47 x 0.88 = 15.3736
Damages for future loss of earnings: £45,000 x 15.3736 = £691,812

Allow for residual earning capacity by calculating a revised multiplier using Table B to reflect the claimant’s post accident status (employed, disabled, degree level education): 17.47 x 0.57 = 9.9579

The claimant’s residual earning capacity is: £149,368.50 (9.9579 x £15,000)

The claimant’s future loss of earnings claim allowing for mitigation would be: £542,443.50 (£691,812 – £149,368.50)

If the claimant alleges that, but for the accident, he would have started a higher paid job elsewhere or been promoted within the same organisation, then further investigations will be required to quantify the percentage "loss of chance", including the claimant’s performance record, the organisation’s promotion criteria, the reliability of any alternative job offer etc.

Conversely, to avoid over-compensation, the defendant should investigate any contingencies impacting on employment prospects, including pre-accident ill health, a poor disciplinary or attendance record, vulnerability to redundancy etc.

A helpful (and topical argument) is to adduce evidence that with the current economic downturn, there are fewer promotion and job opportunities and substantial salary increases are unlikely. Building and haulage firms have been particularly hard hit. The government spending plans will also provide arguments in relation to public sector jobs.

There can be particular difficulties when investigating self-employed claimants. Full copies of their tax returns and business accounts should be obtained. Expert evidence may also be required from a forensic accountant if the claimant was a particularly high earner, or there is significant variation of earnings between financial years.

**BIAMIRE AWARDS**

A Blamire award (Blamire v South Cumbria Health Authority [1993]) is appropriate where the evidence shows that there is a continuing loss of earnings but there are too many uncertainties to adopt the conventional multiplier/multiplicand approach; for example, a claimant who has had a patchy pre-accident employment history with periods of unexplained unemployment. In such cases, the court may make a lump sum/Blamire award.

**RETRIEVAL AGE**

Claimants will often plead a retirement age beyond 65, including arguments that, for younger claimants, the state pension age is increasing as follows:

- From 65 to 66 between April 2024 and April 2026
- From 66 to 67 between April 2034 and April 2036
- From 67 to 68 between April 2044 and April 2046.

Disclosure of the claimant’s pension records or personnel file may reveal details of their retirement planning.

**HANDICAP ON THE LABOUR MARKET**

A claimant may also seek an award of damages for handicap on the open labour market (Smith v Manchester Corporation [1974] CA). A claimant must prove:

- There is a real or substantial risk that he/she will lose his/her current employment during his/her working life; and
- He/she would be at a disadvantage in obtaining alternative employment as a result of the injuries he/she sustained.

*Smith v Manchester* claims are often made speculatively and/or without the appropriate evidence to support them. Tactically, therefore, the claimant must be made to provide evidence to satisfy the two requirements set out above.

**REHABILITATION**

If a claimant has not returned to employment despite an arguable residual earnings capacity, then it may be appropriate to consider funding vocational rehabilitation to assist him back to work and mitigate the earnings claim.

Many claimants nominate an expert employment consultant to comment on expected earnings and opportunities in the claimant’s job sector but for the accident. These experts should mostly be resisted because the majority of trial judges will be comfortable making findings in relation to factual issues such as future earnings; aided by witness statements from the claimant, former colleagues, senior managers from his previous employer, or sector comparators.

*The discount rate of 2.5% currently set under s.1 of the Damages Act 1996 is to be reviewed later this year. This may see the introduction of a lower discount rate. Claimants may, therefore, seek to delay settlement to await the review decision.*
**EXISTING ACCOMMODATION – ALTERATIONS**

Seriously injured claimants will often need alterations to their home to promote their independence and mobility and/or to assist their carers. The cost of alterations will form part of the claim for special damages, if those alterations are a necessary consequence of the disability.

In addition, it is usually more expensive to run and maintain a home with a disabled person in a wheelchair or requiring other aids and equipment and/or carers. Consequently, claims will be made for additional wear and tear on carpets and floor surfaces, additional heating and extra insurance.

In the more serious cases, extensive equipment may be required which requires additional space beyond that available in the claimant's existing home. Resident carers may be required, making additional rooms essential. This raises the necessity for either an extension to an existing property or an alternative and more expensive house/bungalow.

If the existing house can be adapted by way of an extension to accommodate the claimant, his aids and equipment and his carers, claims will be made for surveys/architects' fees for adaptations, building costs for the adaptations and extensions, costs of additional furnishings and fittings for the extension.

In addition, a claim for alterations to the claimant’s parents’ home may be allowed. In *Biesheuvel v Birrell* [1998] the trial Judge concluded that a claim for adaptations to the Claimant’s parents’ house in order to allow regular visits from the Claimant were “reasonably recoverable as part of the compensation exercise”.

**ALTERNATIVE ACCOMMODATION**

The capital cost of purchasing alternative accommodation does not form part of the claim for special damage as it is an asset with value rather than an expense. *Roberts v Johnstone* [1988] provides a formula to enable a claimant to purchase suitably enhanced accommodation whilst depriving his estate of any windfall element on death.

The formula treats the loss to the claimant as an annual sum representing "the net additional capital cost of the suitable enhanced alternative accommodation”.

**ROBERTS V JOHNSTONE CALCULATION – WHAT IS RECOVERABLE?**

The cost of the new house, less any proceeds of sale from the former house, turned into a figure representing the annual cost of loss of use of capital, multiplied by the life multiplier.

As with alterations to the claimant’s existing home, alterations and any incidental costs are recoverable in full. If such alterations add to the value of the property (existing or new) the claimant will only be able to recover the expenditure over and above the enhancement of the value of the property. Credit must be given for the increase in value.

**Example**

A paraplegic claimant lives in an unsuitable house with a market value of £100,000. A more suitable bungalow has a price of £150,000. Alterations costing £50,000 are required. The alterations will increase the value by £15,000. The claimant will live in the adapted house for the rest of her life. The agreed life multiplier is 10.

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value of new property, including value added by alterations:</td>
<td>£165,000</td>
</tr>
<tr>
<td>Less value of former house (if any):</td>
<td>£100,000</td>
</tr>
<tr>
<td>Additional capital cost is:</td>
<td>£65,000</td>
</tr>
<tr>
<td>Annual cost of loss of use of capital is £65,000 x 2.5% = £1,625 p.a. This is a continuing loss for the rest of the claimant’s life, so the agreed multiplier of 10 is applied:</td>
<td>£16,250</td>
</tr>
<tr>
<td>Add: Cost of extension and adaptations:</td>
<td>£50,000</td>
</tr>
<tr>
<td>Add: Cost of moving [recovered in full if claimant would not have moved house but for the accident]:</td>
<td>£7,500</td>
</tr>
<tr>
<td>Add: Extra annual cost of living in larger more expensive house (£500 x 10) e.g. higher council tax, decorating:</td>
<td>£5,000</td>
</tr>
<tr>
<td>Less: Value added by adaptations and extension:</td>
<td>£15,000</td>
</tr>
<tr>
<td>Accommodation loss is:</td>
<td>£63,750</td>
</tr>
</tbody>
</table>

**WHAT IF THE CLAIMANT DOES NOT HAVE A PROPERTY TO SELL?**

No deduction is made from the cost of the new house when calculating the additional annual capital cost. However, an adjustment can be made to the multiplier on the assumption that, within a certain period of time, the claimant would probably have bought a house in any event.
For example, consider a claimant living with his parents at the time of the accident who, because of his injuries, needs to buy a bungalow costing £100,000. If he had not been injured, he would probably have brought a house costing about £70,000 within eight years of the accident. The appropriate life multiplier is 20. The calculation is as follows:

\[
\begin{array}{|c|c|}
\hline
\text{£100,000 x 6 [8 reduced to 6 for accelerated receipt] x 2.5%:} & \text{£15,000} \\
\hline
\text{£30,000 x 14 x 2.5%:} & \text{£10,500} \\
\hline
\text{Total claim:} & \text{£25,500} \\
\hline
\end{array}
\]

**WHAT IS THE CLAIMANT WAS LIKELY TO HAVE BEEN MOVED HOUSE REGARDLESS OF INJURY?**

Credit needs to be given for certain expenses associated with buying a property, such as surveyor’s fees, legal fees and estate agent’s commission, which would have been incurred in any event. Credit can also be taken for the additional capital cost the claimant would have incurred in any event by adjusting the multiplier, as above.

**ALTERNATIVE ACCOMMODATION FOR PARENTS**

Where the claimant is a child and new accommodation is purchased by the parents, credit should be given for the housing expenses that would have been incurred by them in any event.

**TIME FOR A CHANGE?**

*Roberts v Johnstone* has been under scrutiny for many years by claimant lawyers because of the hardship that can arise; for example, where there is contributory negligence or the claimant has a greatly reduced life expectancy. With increasingly higher house prices, the calculation may produce only a small proportion of the sum required to purchase/adapt a property. In such cases, a claimant has to apply sums allocated to other heads of loss such as earnings, therapies or care.

There have been a few (unreported) cases where the defendant/insurer has been prepared to innovate by purchasing a property and granting a life interest to the claimant. At present, such arrangements have been possible only where there is a consensual approach and a defendant volunteers to fund. There is a place, therefore, for defendants to work together with the claimant and their advisors to find innovative solutions that suit all parties concerned.

Some claimant lawyers believe that arguments can be advanced that will enable courts to order full funding, subject to a charge over the property so that the sum advanced reverts to the defendant on the claimant’s death.

As an alternative, claimant lawyers are also exploring the legal scope to widen the rules on periodical payments and indexation of these to allow for an order for annual periodical payments to cover interest on a bank loan applied to purchase suitable accommodation.

Overall, however, legal challenges to *Roberts v Johnstone* should be anticipated.
There are a number of heads of loss in catastrophic claims which are not seen in lower value injury claims, which include:

**GARDENING/DIY/CAR SERVICING/DOMESTIC CHORES**

A claimant must prove that he would have provided such services in the absence of his injuries and that he can no longer do so because of his injuries. Medical evidence will be required to show that the claimant is no longer able to carry out the tasks, although this is usually fairly self-evident. These types of “service” claim are usually quantified by the care/occupational therapy experts.

Defendants should ensure that only the labour costs are paid, and that the overall claim is reasonable, taking into account whether, in reality, the claimant would have had the time, skill and/or inclination to carry out such tasks.

The value of these claims differs from case to case, but claimants are generally awarded between £1,000 p.a. and £2,500 per annum.

**MEDICAL TREATMENT AND EXPENSES**

A claimant is entitled to recover any reasonable and necessary medical/treatment costs incurred. Such claims should be supported by medical evidence.

Private or NHS provision? This should be decided purely on the balance of probabilities. The argument usually put forward on behalf of claimants is that such treatment will happen much sooner if carried out privately. However, defendants should consider the prospects of the claimant’s condition requiring the necessity of NHS treatment.

Claims are often made for rehabilitation treatments such as cognitive behaviour therapy, future operation/hospitalisation costs, occupational therapy, physiotherapy, psychotherapy and speech and language therapy. These are often capable of agreement, subject to rates, frequency of treatment and the period they are to be provided being agreed.

For claims for fertility and reproductive treatment, the issues to be determined are the number of children the claimant wishes to conceive, when the treatment will be provided and the likely costs involved. Given the uncertainty of such treatment, a discount is often applied. Claims for surrogacy are not reasonable.

Claims which are usually challengeable are those for alternative treatments such as, acupuncture, Alexander technique, aromatherapy, chiropractic treatment (where claimed in addition to physiotherapy), herbal remedies, massage, music therapy and reflexology.

Hydrotherapy is discussed in the spinal injuries section.

Where new or experimental treatments are being claimed and there is insufficient proof of their effectiveness, these should be disputed.

**PRESCRIPTION CHARGES**

Individual prescription charges are currently £7.20 in England (but free in Wales, and will become free in Scotland by April 2011). Patients in England are not required to pay prescription charges once they have reached retirement age. Certain categories of patients can obtain a prescription pre-payment certificate costing £104 per annum which would significantly reduce such claims.

**HOLIDAY COSTS**

A claimant is only entitled to claim the additional costs of holidays resulting from the injuries sustained, for example, the cost of having to take carers/support workers on holiday. Defendants should consider mitigating such costs by using locally based carers. Additional claims include increased number of flights, size of property, number of rooms required, increased vehicle hire to carry equipment or be wheelchair accessible and additional food etc. Claims for upgrades and business class travel are also usual where increased leg room is required.

Defendants should consider whether the claimant used to spend holidays to see if the increased costs are reasonable. If a claimant’s holidays were usually taken in the UK, post accident holiday claims for trips abroad should be challenged.

Defendants should argue for a reduced multiplier on the basis that the desire to holiday abroad will diminish with old age.

Courts are unimpressed where the care/OT experts simply express an estimate of such costs. Holiday costs claims typically range from £2,000 per annum to £10,000 per annum.
TRANSPORTATION COSTS
Claims are usually made for the cost of automatic/specially adapted vehicles, as well as travelling expenses.

If a claimant is in receipt of the higher level of Disability Living Allowance for Mobility (DLAM), he is eligible for the Motability Scheme. DLAM is given up in return for a fully funded, insured and serviced vehicle to suit the claimant’s needs, which is replaced every three years.

AIDS AND EQUIPMENT
Claims for wheelchairs, mobility scooters, hoists, automatic height adjustable beds, stair lifts, lifts, computers, and computer automated equipment as well as guide dogs are all commonly seen. If supported by medical evidence and reasonable they are usually allowed.

Defendants should consider whether any of the equipment is available on the NHS and whether the claimed price and replacement intervals are reasonable. A crucial test is whether the claimant will actually derive any real benefit from the equipment.

To enable the courts to correctly and conveniently calculate awards for accelerated payment of future losses, the Government Actuary’s Department publishes the Ogden Tables. These actuarial tables provide multipliers for a wide range of future time periods and assumed investment returns. The tables feature their own comprehensive guidance notes.

The discount rate for investment returns is fixed by the Lord Chancellor under the Damages Act 1996. The current rate is 2.5%, although this is to be reviewed by the Lord Chancellor. There has been a successful challenge in Guernsey taking account of local economic factors (Helmot v Simon 14.09.10).

The tables give figures for men and women for losses for life (tables 1 and 2), for loss of earnings to pension ages between 50 and 75 (tables 3 to 14), for loss of pension from ages between 50 and 75 (tables 15 to 26), for discounting by a fixed period for accelerated receipt (table 27), and for regular future payments for a fixed period (table 28).

CONTINGENCIES
Tables 1 to 26 account for mortality, whereas tables 27 to 28 do not. The multipliers are then further adjusted to reflect the contingencies other than mortality set out in tables A to D, namely whether the claimant is employed or not, disabled or not, and his educational or skill level.

A key contingency is whether the claimant is disabled or not. The guidance notes require that all three of the following conditions are met:

- A progressive illness or an illness which has lasted or is expected to last for over a year.
- The disability substantially limits the ability to carry out normal day-to-day activities.
- The disability affects the kind or the amount of paid work they can do.

Some case law supports an approach that, to avoid unfair results when assessing loss of earnings, the courts may exercise discretion as to whether a claimant should be classified as fully disabled, or whether it would be more realistic to reclassify him as only partly disabled for a less demanding job role (see for example Conner v Bradman & Company Ltd [2007]). The simplest methodology for calculating this compromise figure is to take the midpoint between the disabled and not disabled adjustments. However, the approach a court will take to any individual case cannot be guaranteed.
Life Expectancy

WORKED EXAMPLE
A 35-year-old female claimant has three A-levels, i.e. educational category GE-A. At the date of accident she was employed on a salary of £25,000 net per annum, and was not disabled. Following the accident she has lost her previous job but found alternative part-time employment on a salary of £5,000 net per annum, and she is disabled. Her loss of earnings to retirement age 60 should be assessed as follows:

| From Table 8 (loss of earnings to pension age 60 – females), the 2.5% discount rate for a 35-year-old gives a multiplier of: | 18.39 |
| From Table C (females – not disabled), the adjustment of 0.86 (employed/GE-A) gives an expected earnings multiplier of: | 15.82 |
| Her expected earnings are: | 15.82 x £25,000 = £395,500 |
| From Table D (females – disabled), the adjustment of 0.48 (employed/GE-A) gives a residual earnings multiplier of: | 8.83 |
| Her residual earnings are: | 8.83 x £5,000 = £44,150 |
| Her loss of earnings is: | £395,500 – £44,150 = £351,350 |

A reduction in life expectancy can have a major impact on the appropriate multiplier and the level of damages awarded. Increased use of periodical payments, particularly in care claims, and more accurate actuarial tables have reduced the impact of life expectancy issues. However, the question of how far the claimant’s expectation of life has reduced is often widely debated by medical experts, especially where the reduction is directly attributable to the index accident.

Professor Strauss is the Director of the Life Expectancy Project which studies the life expectancy of children with cerebral palsy, persons in a vegetative state, and those who have sustained spinal cord injuries or traumatic brain injuries. Professor Strauss provides statistical evidence on life expectancy based on one of the largest databases in the world for catastrophic cases. However, where there is conflict, clinical evidence is often preferred to statistical evidence (see Royal Victoria Infirmary & Associated Hospitals NHS Trust v B [2002]; Arden v Malcolm [2007]).

Factors that can reduce life expectancy, whether related to or consequential upon the accident or not, can include:

- Smoking
- Asthma
- Drug abuse
- Diabetes
- Obesity.

These can result in reductions in life expectancy of up to ten years, depending on the individual circumstances.

In addition, many studies show that individuals who lack mobility, or have reduced mobility, are at greater risk of mortality, for example as a result of loss of muscle tissue, decline in lung function, pressure sores that lead to infection and sepsis, and increased risk of clots through poorer circulation. Many of these problems also reduce the body’s ability to fight off routine chest infections and urinary tract infections, which can further increase the risk of mortality.

If a claimant has suffered a spinal cord injury there is a risk that they will develop a syrinx (a fluid filled cavity within the spinal cord or brain stem) which can cause a loss of strength, function, and sensation in the body systems and can reduce life expectancy further. The average risk of a spinal cord patient developing a syrinx is 30%.
Capacity

The multipliers in the sixth edition of the Ogden Tables use mortality assumptions based on the general population, and therefore arguably take account of someone who is an average smoker, for example. Therefore, unless there is clear evidence that the claimant is atypical and will experience a shorter or longer than average life, no adjustment may be required. However, an atypical individual might be a heavy smoker or someone suffering a head injury or spinal injury, and in those cases the multiplier might need adjusting to reflect a lower life expectancy.

Examples of reductions in life expectancy are as follows:

<table>
<thead>
<tr>
<th>NATURE OF THE CLAIMANT'S DISABILITY</th>
<th>PRESENT AGE</th>
<th>LIFE EXPECTANCY</th>
<th>REDUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paraplegic male</td>
<td>25</td>
<td>Between 37.6 and 44.7 years*</td>
<td>16.9 to 24 years</td>
</tr>
<tr>
<td>Paraplegic male</td>
<td>44</td>
<td>Between 30.3 and 34.3 years**</td>
<td>7.2 to 11.2 years</td>
</tr>
<tr>
<td>Low tetraplegic male</td>
<td>25</td>
<td>Between 34.7 and 36.7 years*</td>
<td>24.9 to 26.9 years</td>
</tr>
<tr>
<td>Mid tetraplegic male</td>
<td>25</td>
<td>Between 26.4 and 35.7 years*</td>
<td>25.9 to 35.2 years</td>
</tr>
<tr>
<td>High tetraplegic male</td>
<td>25</td>
<td>Between 25.4 and 32.2 years*</td>
<td>29.4 to 36.2 years</td>
</tr>
<tr>
<td>Male with severe brain injury</td>
<td>30</td>
<td>25.9 years**</td>
<td>30.3 years</td>
</tr>
</tbody>
</table>

*Based on data provided by Professor Strauss "Trends in Life Expectancy After Spinal Cord Injury" (2006).
**Based on data extracted from Kennedys’ cases.

Individuals who have suffered a severe head/brain injury may suffer from a loss of mental capacity. This may be temporary or permanent. It may affect their ability to manage their own financial affairs and make decisions in relation to their welfare. Mental health problems, strokes, alcohol or substance misuse may also affect capacity.

Capacity is both time and function specific: an individual may lack capacity to make a particular decision at a particular time. They may have capacity to make some decisions but not others. Accordingly, capacity is to be determined at the time the decision is to be made.

An individual’s capacity should be assessed to establish whether they require the appointment of the Official Solicitor or a litigation friend. The Official Solicitor may be appointed to represent adults who lack capacity to conduct litigation and proceedings in the Court Protection.

STATUTORY DEFINITION

Section 2 (1) of the Mental Capacity Act 2005 (the Act) states "a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain".

KEY STATUTORY PRINCIPLES

- There is an assumption of capacity.
- All practicable steps must be taken to help a person to make their own decision before concluding they are unable to do so.
- A person should not be treated as unable to make a decision merely because he makes an unwise decision.
- Decisions made on behalf of the person who lacks capacity must be made in their best interests.
- The decision should be the least restrictive of an individual's rights.

A diagnosis that an individual lacks the capacity to make a particular decision should be based on the balance of probabilities.
ASSESSING CAPACITY

The Code of Practice supporting the Act outlines a two stage test to assess capacity:

- Does the person have an impairment of, or disturbance in the functioning of, their mind or brain?
- Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

A person is unable to make a decision if they cannot:

1. Understand information about the decision to be made;
2. Retain that information in their mind;
3. Use or weigh that information as part of the decision-making process; or
4. Communicate their decision.

The first three criteria should be applied together. If a person cannot do any of these three things, they will be treated as unable to make a decision. The fourth criterion only applies in situations where people cannot communicate their decision in any way (for example when in a coma).

Assessing the ability to make complex or serious decisions may require a formal assessment and expert advice may be sought, e.g. from a neurologist, psychiatrist, psychologist or neuro-psychologist. Where there is concern about a person’s ability to communicate, it is important to make all practical efforts to help them communicate. This might call for the involvement of speech and language therapists or specialists in non-verbal communication.

There are also many practical ways that should be considered to help someone make a decision for themselves; for instance with regard to location, timing and seeking support from other people such as family.

Capacity should always be reviewed:

- Whenever a care plan is being developed or reviewed.
- At other relevant stages of the care planning process.
- As particular decisions need to be made.

WHO SHOULD ASSESS CAPACITY?

The person who assesses an individual’s capacity to make a decision will normally be the person who is directly concerned with the individual at the time the decision needs to be made. This is often the individual’s carer. In settings such as a hospital, this is likely to involve the multi-disciplinary team.

More complex decisions are likely to need more formal assessments, involving seeking a professional opinion from, say, a psychiatrist. However, the final decision about capacity must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks capacity.

In all cases, the findings should be recorded clearly and comprehensively in the relevant medical records.

COURT OF PROTECTION

The Court of Protection may:

- Decide whether the person has capacity to make a particular decision.
- Make a decision on financial or welfare matters affecting a person who lacks capacity.
- Appoint a Deputy, who may be a friend, relative or professional to make decisions in relation to the welfare or finance as specified by the court (The Deputy replaces the old role of the Receiver).

PERSONAL INJURY TRUST

A vulnerable claimant may be advised to implement a personal injury trust at settlement or upon receipt of a substantial interim payment. The use of a trust can ensure that income derived from a damages award is disregarded for the purposes of means testing for benefits or local authority care. Agreement from the Court of Protection must be sought where the claimant is lacking capacity to create such a trust.

EFFECTS ON CASE MANAGEMENT

The fees of the Court of Protection and Deputy will form part of the claimant’s damages. Initial commencement fees are charged on the appointment of a Deputy and the involvement of the Court of Protection. Thereafter an annual fee is charged. In our experience these annual costs are now increasing.
Experts

Use of experts in catastrophic injury cases is vital: first, in the assessment of the technical issues in a case; and second, in persuading an opponent (and ultimately the court) that one party has the stronger case.

In practice, this means that the expert evidence should sensibly inform the issue(s) at stake and proportionality should always be borne in mind (to overall cost and complexity of issues). The court is likely to (and has) restricted expert evidence that it considers is too long, unnecessarily complicated, requires onerous disclosure or carries a significant risk of disruption to the timetable/trial date.

OVERRIDING DUTY

The overriding duty of an expert witness is to the court (pursuant to CPR 35). In practice this means an expert must:

- Provide an independent opinion.
- Restrict their opinion to that which falls inside their expertise (both for the field of dispute and the time of the allegation).
- Take into account all material facts when forming their opinion.
- Inform those instructing them about a change in opinion, with reasons.

FINDING A SUITABLE EXPERT

Experts are generally chosen by insurers and lawyers on the basis of past experience and/or recommendation. Most law firms have a comprehensive “in house” database setting out the details and qualifications of experts, waiting lists and ratio of claimant/defendant instructions received.

If an expert witness has a close connection with a party or acts in a partisan way, a party may face court sanctions. These include deciding the instructing party cannot rely on the evidence (or that it should carry little weight).

CASE MANAGEMENT: AGREING EXPERTS

The court will only give permission to rely on an expert if a particular issue indicates professional expertise, outside already available expertise or, outside the inferences that the court can reasonably draw from the available evidence.

Therefore, parties should communicate their proposals about the need for experts as early as possible. It is important to avoid incurring the costs of expert evidence on uncontroversial issues or matters that are suitable for a single joint expert (SJE).

At the early stage of a claim, there are advantages and disadvantages in providing detailed information about a choice of expert(s). This is particularly applicable when completing the allocation questionnaire. If a party is confident that their expert is the best in the field (or very well regarded), naming the expert can disarm the opposing party. Conversely, a party risks naming an expert, only to discover (on receipt of his report) that the expert does not have the required depth of expertise in the relevant field.

Naming the field of expertise ensures retention of some flexibility.

TYPES OF EXPERT

A combination of medical and non-medical experts will need to be appointed to enable the parties to obtain a full picture of the injuries, the claimant’s immediate and long-term needs and the cost of those needs.

Medical and non-medical experts must work in partnership. For example, a care expert will need to consider the medical evidence before being able to assess a claimant’s care requirements. Medical experts should be asked to advise whether they agree with the recommendations made by the non-medical experts, e.g. accommodation needs.

Typically, medical experts include:

- Neurologist and neuro-psychologist (head injury/brain damage).
- Psychiatrist/neuro-psychiatrist (psychological injury).
- Spinal injuries consultant and/or neurosurgeon (paralysis).
- Consultant in rehabilitation medicine and prosthetics expert (amputation).
- Chest physician or thoracic surgeon (lungs/chest injuries).
- Cardiologist or cardiac surgeon (heart).
- Urologist and fertility expert (urinary tract).
- Gastroenterologist or colorectal surgeon (gastro-intestinal).
- Orthopaedic surgeon (musculoskeletal system).
Typical non-medical experts include:

- Care experts (to include aids and equipment).
- Accommodation experts.
- Speech and language experts.
- Physiotherapists.
- Information/assisted technology experts.
- Court of Protection fees/Deputy costs.

The issue of life expectancy will be central to the parties’ expert evidence. Please refer to chapter 10 for separate guidance.

**LEAD EXPERT**

When the CPR was first introduced the use of a lead expert in multi-track cases was mooted. It was suggested that the court would give directions to a lead expert who would coordinate the evidence of the experts from different disciplines. However, this was not formalised into CPR 35.

Nevertheless, in practice, there will sometimes be a "principal expert" who crosses different aspects of expert disciplines; for example, a neurological rehabilitation expert in a brain injury case. Similarly, in an amputation case, an expert in rehabilitation medicine will often straddle accommodation, lifestyle and prosthetics.

In addition, the expert who is instructed to provide an initial opinion on liability will often take the lead in the sense of providing an overview of the injuries, areas of concerns and the need for additional expertise; which can then determine the instruction of other experts.

**SINGLE JOINT EXPERT (SJE)**

The main purpose of a SJE is to agree or to narrow issues. They do not tend to be used on complex or controversial issues (particularly in relation to causation). As with any expert, a SJE’s overriding duty is the court. However, a SJE also owes an equal duty to all parties. This includes ensuring all instructions, questions and responses are visible to all parties.
Insurers and defendants have increasingly argued that seriously injured claimants, who are entitled to receive care and accommodation from their local authority or primary care trust (PCT), should deduct this statutory funding from their damages.

**PETERS V EAST MIDLANDS STRATEGIC HEALTH AUTHORITY [2009]**

In *Peters*, it was held at first instance that there should be no reduction in damages to reflect the local authority’s duty to provide care and accommodation.

The Court of Appeal found as follows:

- The whole of any personal injuries award would be ring-fenced from consideration and could not be taken into account when determining whether the local authority was entitled to recover the cost of any care provided.
- Provided that there was no risk of double recovery, the Claimant would be entitled to choose to pursue the tortfeasor even if matters were otherwise equal between relying on the local authority and recovering from the tortfeasor. The risk of double recovery could be addressed by an undertaking from the Claimant’s Deputy.
- On the facts of this case, it was reasonable for the Claimant to prefer her care and accommodation to be funded by the tortfeasor. The Court also provided an indication that it may be sufficient that the Claimant believed the tortfeasor should have to pay rather than the taxpayer.
- No reduction of the whole life multiplier was appropriate to reflect the possibility of future state assistance, because the Claimant was not going to receive any.

The practical impact of this judgment was that claimants could make a “Peters election”, effectively transferring the entire funding burden to the tortfeasor, regardless of the availability of state assistance.

**DOUBLE RECOVERY**

An undertaking was held to be an effective way of dealing with the risk of double recovery in cases where the claimant’s affairs were being administered by the Court of Protection, because control was placed in the hands of that Court. The undertaking from the Deputy was as follows:

- To notify the senior judge of the Court of Protection of the outcome of the proceedings and supply to him copies of the judgment of the Court of Appeal; and
- To seek from the Court of Protection:
  - A limit on her authority, so that no application for public funding could be made without further order, direction or authority from the Court of Protection; and
  - Provision for the defendants to be notified of any application for authority to apply for public funding, and to be given the opportunity to make representations against such authority being granted.

**CONTRIBUTORY NEGLIGENCE**

One issue not considered in *Peters* was the impact of an apportionment of liability. If a claimant’s damages are reduced for contributory negligence, there will be a shortfall in the sums required to fund future care and accommodation. Where a claimant is therefore forced to rely on some state funding, the safeguard against double recovery is a “reverse indemnity”, whereby he agrees to refund any such payments to the defendant. The courts have rejected alternative attempts to deal with this on the basis of a percentage discount from the overall care claim or multiplier.

In the rare cases where the percentage reduction for contributory negligence is so high that the claimant must rely on the state for his entire funding in relation to care and/or accommodation, these items are excluded from his compensation award and no issue of double recovery arises.

The claimant (and his representatives) must be made to appreciate the significance of the shortfall in damages, and the importance of investigating what state funding is available at the outset. If beneficial, the claimant might be persuaded to agree to the joint instruction of a “facilitator”, who can act on his behalf and liaise with the relevant agencies.
Periodical Payment Orders

INTRODUCTION

We have witnessed increased interest by claimants in non-NHS catastrophic personal injury cases to seek Periodical Payment Orders (PPOs). Claimants’ financial advisors are advising their clients to seek a PPO rather than a lump sum award to take advantage of the annual increase of the periodical payment in accordance with ASHE (Annual Survey of Hours & Earnings) 6115. Defendants and their insurers need to now embrace this new regime to ensure they are one step ahead and can offer PPOs on their own terms having implemented systems to administer PPOs effectively. Failing to take proactive action now will lead to future administrative difficulties.

The ASHE results, both current and historic, can be found on the ONS website at www.statistics.gov.uk/statbase/product.asp?vlnk=13101. We set out below the historic and most up-to-date gross hourly rates for all percentiles of 6115 from 2004 including both the “first release” and “revised” hourly rates. The 2009 “revised” hourly rates and 2010 “first release” hourly rates were published by the ONS later than expected on 6 December 2010.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MEDIAN</th>
<th>MEAN</th>
<th>10%</th>
<th>20%</th>
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STANDARDISING THE APPROACH TO PPOS: PRACTICAL CONSIDERATIONS

Self funding insurers should consider how they wish to manage PPOs. We strongly advise a unified approach to ensure the administration of PPOs in the future is efficiently managed. We set out below a number of issues to be considered in respect of PPOs.

Calculation/payment date

The parties must agree on the date for payment of the periodical payment. This could be monthly, quarterly or annually. The Model Schedule to the Order which has been judicially approved for NHS cases is based on the claimant receiving his periodical payment annually and in advance on the 15 December of each year. Of course, insurers do not need to adopt the NHS practice of paying on this date. Individual insurers or medical defence organisations must decide how they wish to fund periodical payments and could choose to pay quarterly rather than annually, in advance. It is unlikely a claimant will agree to monthly payments as it will limit his ability to manage his affairs.

The 15 December date was chosen as this is four to six weeks after the ASHE data is published by the ONS and allows the NHS Litigation Authority to undertake the calculations and arrange payment. In recent years the publication of the ASHE data has been delayed and in 2010 was published on 6 December 2010. Taking this into account a payment date in January each year would be prudent. A claimant may be reluctant to agree to payment much later than January as they will be deprived of the benefits of indexation.

Insurers considering self funding their periodical payments should consider at the outset when they would like the payments to be made. In particular, consider those managing the process in 10 years’ time who may have a significant portfolio of periodical payments to administer. It will certainly be far easier from an administrative perspective if all calculations are undertaken at the same time each year and payments made. Of course, the downside of one single payment date is this may have cash flow implications and this will also need to be taken into account.

If, however, a date is agreed to calculate the uplift there is no reason why the annual sum could not be paid quarterly over the 12-month period. This would reduce the impact on cash flow. Quarterly payments would not increase the administrative burden as automatic BACs payments can be arranged.

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A calculation and/or payment date soon after the publication of the latest ASHE data is both logical and practical. It also ensures the claimant receives the benefit of the latest data as soon as it is available. Individual insurers have different objectives and priorities. For example, payments being made at the end or beginning of a particular financial year may be significant. This needs to be taken into account at a very early stage to ensure these objectives can be achieved. If timing of periodical payments is important serious consideration should be given to PPOs now to avoid insurers being ambushed on a particular case at a later stage.

**Pro-rata payment**

If a defendant decides to pay all the PPO from a particular date, claimants will usually seek a pro-rata periodical payment from the date of settlement to payment of the first periodical payment. So, by way of example, if a claim settles on 31 January but the first periodical payment is not until 15 December a claimant will usually seek a pro-rata periodical payment from 1 February to 14 December. This should be resisted.

During negotiations, or within the terms of any Part 36 offer, it should be made clear to a claimant that the pro-rata periodical payment is included in the retained lump sum. This has been successfully argued on numerous occasions to date.

**Stepped payments**

In the majority of catastrophic personal injury cases there is a single payment which is agreed and paid throughout the duration of a claimant’s life.

In birth injury claims or cases involving young adults a periodical payment can increase or decrease over the duration of a claimant’s lifetime depending on his needs. The Schedule to the Model Order accommodates stepped payments so, for example, a claim involving a child may increase at age 12 and post 19 years of age.

It has been common practice with RPI PPOs for stepped payments to be centred around a claimant’s birthday. If an insurer has decided to adopt a particular payment date, i.e. 15 December each year all experts should assess claimant’s needs to and from the payment date rather than focusing on a claimant’s birthday.

By way of illustration, a claimant’s birthday is on 30 July, and on 30 July 2012 he reaches age 12 when his care regime increases from £50,000 to £100,000. If the insurer has chosen 15 December as the date of payment, should the increase take place on 15 December 2012, after the claimant’s twelfth birthday, which would benefit the defendant; or should the increase take place on 15 December 2011, before the claimant’s twelfth birthday, which would be more advantageous to the claimant?

As the above example shows, if a particular payment date is chosen, the defendant’s experts assessing a claimant’s needs must report based on claimant’s needs to and from the designated payment date. Adopting need based on birthday will certainly cause debate between the parties as to when the stepped payment should take place. Of course, if a birthday is close to a chosen payment date this issue is less controversial.
If the claimant is to receive a single annual payment throughout the duration of his/her life and not stepped payments, the Schedule to the Model Order for NHS cases will need to be amended as this anticipates stepped payments.

**Standard Part 36 offer**

If a unified approach is to be taken on the administration of PPOs this needs to be clearly reflected in any standard Part 36 Periodical Payment Offer. The Part 36 offer must state the following:

(i) Retained lump sum: to include all interim payments and recoverable benefits.

(ii) Amount to be paid by periodical payment: annual sum to be paid.

(iii) Payment period: set out stepped payment dates, if appropriate by dates and not birthdays.

(iv) Index: ASHE 6115.

(v) Percentile: ASHE (80) or other percentile to be offered if taking a standardised approach but avoid ASHE (90).

(vi) Payment date: the date chosen for all periodical payments to be paid.

(vii) First escalation date: will the first payment also be index linked? Ideally this should be avoided.

(viii) Confirm whether a pro-rata periodical payment is payable or included in the retained lump sum.

We can provide a bespoke service to advise on all aspects of PPOs, and by way of example, can prepare a model order and schedule and standard Part 36 PPO offers.

**WHY ARE THEY SO IMPORTANT?**

The award to a claimant of a large interim payment, frequently running to six-figures in a catastrophic injury claim, can significantly impact on case handling. The most important consequences are:

- It can unfairly upset the status quo and tie the hands of the trial judge in relation to the main issues of future care and accommodation if, by the trial date, the claimant has already established the regime contended for by his expert team.

- It can limit the trial judge’s discretion in relation to the form of award if the amount of previous interim payments leaves insufficient funds in the "pot" for periodical payments.

To address these issues, the courts have developed rules governing applications for interim payments.

**EELES V COBHAM HIRE SERVICES LTD, COURT OF APPEAL 13.03.09**

The general approach to be adopted is as follows:

- Assess the likely amount of the final judgment, excluding the heads of future loss which the trial judge might wish to award as periodical payments. This usually amounts to damages for pain, suffering and loss of amenity, past special damages, interest on past losses, and future accommodation and running costs.

- The assessment must be carried out on a conservative basis and may therefore be closer to the defendant’s estimate. The court is then entitled to award a reasonable proportion (which may be a high proportion) of the conservative assessment.

- The court can award additional elements of the final judgment as an interim payment where it is satisfied, to a high degree of confidence, that the trial judge will award this as a lump sum because of immediate needs.

- If the interim payment is to buy a house, the judge does not need to decide whether the particular house proposed is suitable; that is a matter for the Court of Protection in cases where they are involved.
THE GENERAL APPROACH IN PRACTICE

The *Eeles* criteria have been refined as follows by later cases:

- The past losses should be assessed as at the future trial date, not just up to the present date of the application.
- A reasonable proportion of the conservative assessment has generally been fixed at a high proportion; typically about 75% to 80% and up to as much as 92%.
- Future accommodation has been excluded from the analysis where there was a genuine dispute over home versus residential care, and where the case was close to trial and the trial judge would be resolving this soon.
- A higher interim payment has been awarded where the court was persuaded that periodical payments were unsuitable due to high contributory negligence, or to variable future care requiring the flexibility of a lump sum, or where the claimant’s strong preference was for a lump sum.
- A lower interim payment has been awarded where the court was persuaded that periodical payments offered greater security due to low investment returns from a lump sum.

The *Eeles* criteria have arguably set a higher threshold test for claimants seeking large interim payments, and by doing so have placed the parties on a more equal footing, although properly prepared and deserving cases should still qualify.

In practice, such applications now require particularisation of the relevant heads of damage, consideration of the claimant’s personal circumstances and needs, and some examination of the suitability of periodical payments.

Where an interim payment request is made pre-litigation, and refusal might result in the escalated expense of the claimant commencing proceedings for the express purpose of making an application, case handlers might wish to seek a legal opinion on its merits.

OTHER CONSIDERATIONS

- Where liability is disputed, it will be necessary for a claimant to persuade the court that his claim is very likely to succeed and that the claimant will be entitled to substantial damages against the defendant. Such an application can take the form of a “mini trial” and can prove costly.
- If contributory negligence is unresolved, the court will need to take into account the effect a finding of contributory negligence would have on the final damages award.
- The court must be satisfied that a claimant will obtain judgment for a substantial amount of money against the defendant from whom he is seeking an order for an interim payment, whether or not that defendant is the only defendant, or one of a number of defendants to the claim.
- If a claimant seeks an interim payment of a specific sum only and does not ask the court to make an alternative award as it sees fit, the claimant is taking a substantial risk as to costs. If the court does not award the sum sought by the claimant, the application will be unsuccessful and it is likely that a costs order will be made in favour of the defendant.
- Tactically, the defendant’s position is likely to be strengthened if a “reasonable” interim payment is offered to the claimant when refusing the request for a substantial interim payment. With catastrophic claims, the court is likely to allow a less substantial interim payment for on-going expenses if it does not agree that a substantial interim payment should be made to set up and fund a care regime or purchase accommodation.
- Claimant’s solicitors can often use the excuse of the need for a substantial interim payment to prematurely issue proceedings and make a formal application. This inevitably leads to significant costs for both parties. Payment of a “reasonable” interim payment can often prevent the issue of proceedings as it puts the claimant at risk as to costs.
Costs

Costs in catastrophic claims are of concern primarily due to their high value, which is compounded by the court’s willingness to allow disproportionately high costs. They are further compounded by a culture of “cost-building” which is particularly prevalent in claims funded by a conditional fee agreement (CFA). As such, it is vital to understand the avenues available to a defendant to reduce the costs to a reasonable and proportionate level.

PROPORTIONALITY

A significant element of proportionality is a comparison between the costs claimed and the damages recovered. In catastrophic claims, damages will almost always exceed the costs claimed. However, this is not the only argument for proportionality.

There is judicial guidance that proportionality is not limited to an overall comparison of costs and a single item can be disproportionate in isolation (Giambrone v JMC Holidays Limited [2004]). On assessment, the court can consider whether an individual item is disproportionate, even if it considers the costs as a whole are proportionate.

Over-pleading

Where a claimant pursues an exaggerated or inflated claim, he will suffer costs consequences of doing so on a detailed assessment (Booth v Britannia Hotels Limited [2002]).

Conduct

A paying party is able to challenge items and aspects on an issue-specific basis. A party who pursues issues that are withdrawn or abandoned, or which are unsuccessful, should not expect to seek the costs of those issues from a paying party (Shirley v Caswell [2000]).

On assessment, the court’s powers are more limited than at trial or other hearing and it is, therefore, prudent to address these issues in the final cost order or judgment. If these issues are not addressed in the final order then recent decisions have shown that a party may raise on assessment issues in respect of conduct that have not already been addressed in an order.

HIGH CHARGING RATES

Claimant lawyers are typically seeking charging rates upwards of £400 to £450 per hour. Unfortunately the courts recognise this area as specialist so as to justify an uplifted charging rate. The debate, therefore, moves to whether there has been appropriate delegation to junior staff. In practice, partner involvement is common and there is often little or no delegation. The paying party should seek to argue that the more routine or straightforward elements of a claim should be delegated to a more junior fee earner.

Similarly, recourse to using both junior and Queens’ Counsel (QC) is often seen. It is our view that a QC should only be used in the most complex of cases where there is a novel point of law or difficult questions of fact. These factors can be used to object to QC costs incurred in the conduct of the claim and the involvement of both a QC and Junior in the more straightforward cases.

COST ESTIMATES

Claimants are now obliged to file detailed estimates of costs during the life of a claim, including upon allocation of a claim and at the pre-trial stage. The estimates provide a valuable insight into what costs have already been incurred and those that will be incurred. A defendant can use estimates to potentially settle costs and damages on a global basis.

Case Law (Tribe v Southdown Gliding Club Limited [2007]) suggests that where a bill exceeds a costs estimate (in the allocation questionnaire, pre-trial checklists etc) by 20% or more then, if a paying party can prove reliance on the estimate, the court may disallow those costs claimed above the 20% discrepancy. The court may also have regard to the estimate when considering the overall proportionality of the costs claimed. It is, therefore, important to write to the claimant’s solicitors and confirm that the estimate has been noted and will be relied on at the conclusion of the claim.

COST CAPPING

The law now provides that the court has discretion to make cost capping orders. Indeed, the Court of Appeal has considered the issue on a number of occasions and advocated the benefit of the court attempting to control and budget for costs. However, in the 2007 case of Willis v Nicholson, the Court of Appeal indicated that catastrophic injury claims could be the most unlikely area where the court would be prepared to impose any limit.

When the new rules came into effect in October 2010, two impediments were created: foremost that a cap could apply to prospective costs (i.e. it cannot be made retrospectively) and second that a court would only make a cap in “exceptional” circumstances. Unfortunately, those circumstances were not defined.

Nevertheless, it is incumbent upon defendants to continue to raise the issue of costs with the court at the earliest opportunity in the litigation. Where there is a real danger of disproportionate
or excessive costs, a capping application should be considered. Capping lays down a marker for detailed assessment and encourages the parties to provide accurate estimates. Equally, it can lead the parties to a discussion on costs and even, to the offer or consideration of a voluntary cap.

SUCCESS FEES

Success fees are fixed at 12.5% (or 100% at Trial) in road traffic accident claims where damages do not exceed £500,000. Where the damages exceed £500,000, the claimant can make an application to the court to escape the fixed success fee regime and apply for an increased success fee. This can be for any amount up to 100%. However, if the claimant does not manage to successfully obtain a success fee of more than 20%, he will be limited to 12.5%. A 100% uplift applies in all claims that proceed to trial, even if a claimant may have failed to beat a Part 36 offer previously made by the defendant (Lamont v Burton [2007]). Therefore, when considering liability or quantum trials, a risk benefit analysis should be undertaken to include the fact that costs liability may double.

Where success fees are assessed by the court in non-road traffic accident claims, awards will be assessed on a case-by-case basis.

One possible approach would be to reach an agreement at the start of a case to make regular payments on account of costs and disbursements in return for the claimant not entering into a CFA.

THE COST OF INVESTMENT ADVICE

Catastrophic claims often include provision for independent financial advice about the investment of damages and setting up trusts. Whilst advice about the provisions of settlement (such as a periodic payment order) is recoverable, the cost of investing damages into the future has been ruled not to be an item of cost or damages recoverable between the parties (Eagle v Chambers No.2 [2004]). Therefore, attempts to include such items in any cost proposal should be challenged.

Tactical CAT Claims Handling

CO-OPERATION, COLLABORATION AND CONSENSUS – THE “THREE C’S”

The objective is to proceed consensually. A constructive relationship with the claimant’s solicitor is essential to enable the parties to work together to achieve a settlement.

Where liability is not going to be in serious issue, the ideal arrangement is for the insurer or its solicitor to secure a face-to-face meeting with the claimant and family as soon as possible.

The best opportunity to achieve this will usually be during discussion about immediate needs/rehabilitation, before discharge from hospital.

Where a direct relationship is achieved, it is much easier to proceed on a basis of mutual understanding, which in turn will allow agreement on the most contentious issues when they arise. The risk of the traditional adversarial exchange of ambitious schedules and counter schedules of loss during litigation can also be reduced.

THE KEY TO UNLOCKING SETTLEMENT

Usually the single defining feature of catastrophic claims is the assessment of the lifelong professional care regime.

Under a standard litigation timetable, this will not usually be formally discussed/quantified until exchange of final schedules/counter schedules of loss. This can be four to five years post accident, with the parties following directions towards trial, or consensually working towards a distant joint settlement or round table meeting (JSM/RTM). Insurers are quite reasonably concerned at the damages and costs inflation inherent in such a timetable.

Whilst the experienced catastrophic practitioner (whether for the claimant or defendant) can estimate accurately at an early stage the likely final award for standard catastrophic injuries, the advice given to a claimant will always be against final settlement until he is confident that the appropriate care regime will be put in place and maintained for life. It is difficult to challenge such advice in light of the parallel costs incentive for the lawyer to delay settlement.

So if settlement of a catastrophic claim is going to be achieved outside the five-year litigation time scale, the “Three C’s” will need to be promoted from the outset.
The cases that settle most effectively for all parties will usually be those where quantum investigation has been undertaken consensually outside litigation.

Negotiation/disposal

- Consider early neutral expert determination on specific heads of loss.
- Invite experts on each side to attempt joint determination of specific heads of loss.
- Consider early neutral evaluation of whole claim (even if not legally binding).
- Consider mediation – this is most effective where liability is in issue and/or three or more parties are involved.
- Consider without prejudice meetings without counsel, but ideally with the claimant present, to resolve individual heads of loss.
- Plan for RTM/JSM – these are of most use if arranged as a means to settlement outside litigation process. Do not fall into the trap of agreeing a directions timetable geared to RTM/JSM slotting in between schedules and trial.
- Offer staged payments of costs on account, in full settlement of costs incurred to payment date (excluding success fee).
- Always invite the claimant to include costs as part of any RTM/JSM.
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