PI FOCUS

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apil

Deciding factor

Assessing capacity in brain injured claimants

OPINION

'I would strongly encourage members who are interested to take the bold step of seeking election'

I say all the time that APIL is a fantastic organisation. For over 30 years, it has been at the heart of all that has happened in personal injury law, and it will continue in that way.

The strength of APIL is threefold. First, the membership, for obvious reasons. Second, the full-time staff who ensure the smooth running of the organisation from head office. Third, the volunteer officers (president, vice presidents, treasurer and secretary) and additional officers of the executive committee who all give their time and commitment.

At this time of year, APIL turns its thoughts to elections; and this time there will be elections for both officer and additional officer positions. I would strongly encourage members who are interested to take the bold step of seeking election. There has never been a better time to help invigorate the organisation and bring new ideas to the table. It would also help individual members to develop new skills which can only help with their work.

This is a very exciting and challenging time for APIL, and the profession.

The association's approach to equality, diversity and inclusion is a proactive and exciting commitment to increasing recruitment and retention of groups currently under-represented in our organisation. Next year, our first layperson will be appointed to the executive committee to help us in putting injured people first in all that we do.

Our campaign work is focused on rebuilding trust in PI and ensuring fairness for injured people by getting involved in discussion and debate about clinical negligence reform, bereavement damages, and inquests, among other issues.

There is lots to do, and plenty to get our teeth into.

All organisations need new faces, and new ideas can only enhance our arguments. I know that firms worry about the time commitment involved, but be assured that the APIL staff provide every assistance. Please think about standing. It will be exciting. You will make a difference and help APIL to progress.

Merry Christmas!

Neil McKinley
President

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NEWS

High Court applies Scots law for 'loss of society' award

The High Court last month awarded more than £600,000 to the family of a man who died of mesothelioma, in what is believed to be the first time that a senior judge in England has applied the Scottish law concept of 'loss of society'.

In *Haggerty & Ors v Imperial Chemical Industries Ltd* [2021] EWHC 2924 (QB), Mr Justice Ritchie gave judgment based on Scots law for the family of David Haggerty, who was exposed to asbestos while employed at the ICI factory in Ardeer, Scotland in the 1970s. The ICI factory manufactured explosives, and Mr Haggerty was required to handle asbestos without adequate warning or protection.

Mr Haggerty was diagnosed with mesothelioma in 2018 and died in January 2019. He met his future wife, Charmaine Haggerty, in 2015, and they married in July 2018. Mrs Haggerty had three children from previous relationships and Mr Haggerty had two. Mr Haggerty became a step-father to Mrs Haggerty's children.

As the illness progressed, Mrs Haggerty looked after her husband at home as he became increasingly unwell and later died. She gave up her job as a teacher to care for her husband.

Although the defendant originally denied liability, it later accepted that Mr Haggerty had been exposed to asbestos at the factory. Solicitors Fieldfisher brought a claim on behalf of Mrs Haggerty and her three children. Two days before the trial, further family members joined Mrs Haggerty's claim for damages. Mr Haggerty's two children, his two sisters and one grandchild sought an award for the loss of society, which is permitted by Scots law but not English law. These further claims were settled before trial.

Lawyers for Mrs Haggerty argued that the claim should be based on Scots law even though the claimants reside in England. The defendant originally objected to the application of Scots law, but a few days before the trial, conceded that Scots law should apply.

A complicating factor in the case was that for claims dating back to the 1970s, the common law rule is that while Scots law would determine the heads of loss, the assessment of those heads of loss would be determined by English law. However, the claimant's approach to the assessment was agreed by the defendant, which meant Scottish case law could be taken into account in determining loss of society awards.

Despite the fact that Mr and Mrs Haggerty had not been together for long, the judge said he accepted they would probably have been together for the rest of their lives had Mr Haggerty not contracted mesothelioma. He had lost more than 20 years because of the illness.

Mr Justice Ritchie awarded £115,000 to Mrs Haggerty for loss of society, with £40,000 awarded to two of her sons, and £35,000 to a third son, under the same head. The judgment also included £97,250 awarded to Mrs Haggerty for solatium, and £138,687 for future financial dependency. The total award including interest amounted to more than £600,000.

John-Paul Swoboda, barrister at 12 King's Bench Walk, appeared for the claimant, instructed by Dushal Mehta, partner at Fieldfisher.

APIL NEWS

Positive impact of Serious Injury Guide

Easier access to rehabilitation and an improved experience for claimants are just some of the benefits of following the Serious Injury Guide, a survey of claimant and insurer participants has found.

Entering its sixth year of operation, the guide continues to achieve its aims, with over 80% of respondents agreeing that it leads to greater collaboration between the parties. Some 75% of respondents said that the guide helps the claimant to obtain earlier rehabilitation. Three quarters of respondents agreed that following the guide improves the claimant's 'claim journey'. Trust is built between the parties, friction is removed, and the open dialogue facilitated by the guide means that the claimant's needs can be understood by all sides.

While liability may not necessarily be resolved more quickly under the guide due to external issues such as police investigations, it still provides for collaboration and allows the parties to narrow the issues in dispute. It is clear from the survey that the 'ongoing dialogue' and route planning aspect of the process is key to the success of the guide, and that all parties find this very beneficial. Meetings between the claimant and insurer representatives can enable proper discussions about key issues such as interim payments, and allow parties to agree an action plan to keep the case moving forward.

When asked about 'sticking points' or areas that were working less well, some respondents pointed to a lack of sanctions, and that the success of the guide is dependent on buy-in from both sides. It is important to note, however, that the guide is not a substitute for the court process, and that agreement may not always be reached. The Serious Injury Guide steering committee is currently developing supporting material to help participants to get the most out of the guide.

Following the success of the Serious Injury Guide for cases above £250,000, a pilot is underway to assess whether the existing guide is workable for all multi-track personal injury cases involving serious injuries and which involve a claim for future continuing loss, regardless of value. Some informal positive feedback has been received so far. It is very early days in the life of those cases, however, and it is difficult to assess properly at this stage the impact that using the guide has had. The pilot will be extended until at least June next year, with a potential further extension if needed.

APIL members who would like more information about the Serious Injury Guide should contact Alice Taylor: alice.taylor@apil.org.uk.

Medical device warning

APIL has warned of a missed opportunity to improve patient safety in its response to the Medicines and Healthcare Products Regulatory Agency (MHRA) consultation on the future regulation of medical devices.

Despite the fact that the ministerial foreword refers to the failures that were the catalyst for the Cumberlege review, only passing references are made throughout the consultation to patient safety. Baroness Cumberlege recommended that the MHRA needs to work for patients and with them, yet there are no proposals in the consultation which address this.

Further, there is a lack of consideration for the post-Brexit impact of having a separate regulatory regime for medical devices in the UK, as the EU 'CE' mark will no longer apply. Some manufacturers may decide to comply only with the EU regime, to keep costs down, leading to fewer and potentially less-safe devices available for patients based in the UK.

APIL agrees with proposals in the consultation to broaden the definition of implantable devices to include products with a non-medical purpose. It is also right that hip implants and surgical mesh should be moved to the highest risk class within the Medical Devices Regulations 2002.

Recommendations that manufacturers should hold adequate liability insurance and that, where a manufacturer is based abroad, a nominated person based in the UK should be liable on the same basis as the manufacturer, are also welcomed. These proposals are not a panacea, however, and as the ministerial foreword states, when it comes to the safety of medical devices, we can and must do better.

Policy on choice of provider

APIL has responded to a Legal Services Board consultation on a draft statement of policy to legal regulators about the information that should be made available to consumers to help them make an informed choice of legal provider.

APIL strongly believes that accreditation schemes are the best way to ensure a quality service.

Success rates and price do not necessarily reflect a legal provider's competence and standard of work.

TIME WILL TELL

Alan Collins on limitation in child sexual abuse claims

In this article I explore the direction of travel in child sexual abuse litigation. I do so against the backdrop of the Independent Inquiry into Child Sexual Abuse (IICSA), and the recent Scottish case of *B v Sailors' Society* [2021] CSOH 62.

As part of its reparations and accountability strand, IICSA took a considerable body of evidence from victims and survivors, claimant and defendant lawyers, and insurers on the issue of limitation. In light of that evidence, the Inquiry is considering 'whether the law of limitation [in England and Wales] should be reformed to make it easier for victims and survivors to bring claims in respect of non-recent child sexual abuse'.

It was argued that the law of limitation should be reformed to the extent that it is abolished in child sexual abuse (CSA) claims, because it is a potent defence deployed by defendants with potentially devastating consequences for CSA survivors.

By the time they cross the lawyer's doorstep, the overwhelming majority of CSA survivors are invariably out-of-time, the three-year limitation period having long expired. The delay in coming forward is intrinsically entwined with the sexual abuse suffered and the harm caused. The perversity, of course, is that the abusers or those responsible for them benefit from that delay, as a defence falls immediately into their laps. The burden is on the claimant to persuade the court to exercise discretion pursuant to s. 33 Limitation Act 1980 to allow their claim to proceed out-of-time.

Reform in Scotland

To address this barrier to justice, proponents of reform point to legislation recently passed by the Scottish Parliament, and by other legislatures amending limitation laws not dissimilar to that in England and Wales. The rationale is to make it fairer for victims and survivors to bring claims, who are invariably out-of-time by the time they do so.

It is argued that limitation laws are needed to make sure that stale claims are not brought before the courts, and to provide commercial certainty for institutions and lawyers. But is it right that a law that has its roots in medieval times should inhibit access to justice in the 21st century?

The Limitation (Child Abuse) Scotland Act 2017 provides for the lifting of the three-year time limit, in Scotland, in compensation claims arising from childhood abuse. Inserting the new ss 17A-17D in the Prescription and Limitation (Scotland) Act 1973, it represents a sea change in societal attitudes towards child abuse, and in appreciation of the consequences not just for the victims, but the wider community.

The Act's objective in lifting the time bar is to ensure that victims of childhood abuse, by virtue of the particular nature of the harm suffered, are not debarred from obtaining justice simply because of the effluxion of time. But the new s.17D provides the court with the power to stay an action brought by a pursuer if a fair hearing is not possible, or if the defender would be substantially prejudiced if the case were to proceed. The question to be asked is, what does s.17D mean in practice?

An Australian example

A starting point is to examine an Australian case from Victoria, which has enacted legislation not dissimilar to the 2017 Act.

In *Connellan v Murphy* [2017] VSCA 116, the defendant was granted a stay. The plaintiff, born in 1961, alleged that the defendant, born in 1954, sexually assaulted her in 'approximately 1967 or 1968'. The defendant denied the allegation.

Prior to 1 July 2015, the plaintiff's alleged cause of action was statute-barred. However, on that date, the Limitation of Actions Amendment (Child Abuse) Act 2015 commenced, with the effect that in Victoria, limitation periods no longer apply in child abuse claims.

The 2015 Act, by s 27R inserted in the principal Limitation Act, expressly does not limit a court's power to summarily dismiss or permanently stay proceedings where the lapse of time 'has a burdensome effect on the defendant that is so serious that a fair trial is not possible'.

For the Court of Appeal in Victoria, the fact that key witnesses were alive and able to give evidence was not a trump card, as might have been expected for the plaintiff. The court was required instead to look at, as it saw it, the reality - which was that the defendant was being asked to defend himself in respect of an allegation that he had sexually assaulted the plaintiff 49 years before, and 'the burdensome and oppressive nature of that task is manifest'.

That 'task' was made 'more oppressive' because the passing of time made it impossible for both parties to investigate, let alone call evidence in relation to, the surrounding circumstances. Moreover, the plaintiff's own vague recollections were more of a hindrance than an asset.

Delay, the court concluded, also hindered the investigation of quantum and causation. The plaintiff was allegedly suffering from PTSD, but the court was not satisfied that the cause could now be investigated after so many years had passed, and any conclusion would now be 'dependent upon little more than the plaintiff's assertions of her subjective recollection of events to which she now attributes importance'.

The court held that it would be unjust to permit the plaintiff's case to continue, and ordered a stay: 'The defendant cannot realistically be expected to defend a cause of action that is alleged to have accrued almost five decades ago in circumstances where so little is known about the surrounding circumstances and facts, and all of the principal witnesses who were adults at the time are now dead.

'A trial of the plaintiff's allegations would be one that proceeded on a very unsure footing with mere scraps of evidence, the reliability of which must seriously be doubted, being tendered and relied upon. As genuine as the plaintiff's recollections might be, it would be unjustifiably burdensome to require the defendant to now attempt to defend allegations made against him as a child so many years ago.'.

The lesson, perhaps, to be learned from the case is that a survivor, no matter how genuine in the telling of their account, is going to struggle to succeed in the absence of corroboration; and must be able to provide significant circumstantial details. So, for example, in a case of sexual abuse in a school, are they able to remember the names of their form teachers; do they have their school reports?

Staying in Australia, the criminal case *R v Jacobi* [2012] SASCFC 115; 114 SASR 227 serves as a useful reminder of the issues that defendants may want to raise to argue prejudice occasioned by delay:

(i) the reliability of the victim's recollections;

(ii) the risk of the possibility of reconstruction and reinterpretation of memories;

(iii) the difficulty of having to travel back in time to recall, check and verify the accuracy of events about which evidence is given; and

(iv) the difficulty confronting the defendant in endeavouring to obtain and produce documentary evidence or oral evidence from other witnesses which might put in question the evidence of a complainant as to events, times and places.

B v Sailors' Society

The same rationale will be found in the civil and criminal jurisprudence of England and Wales: *NA v Nottinghamshire County Council* ([2015] EWCA 1139), and *R v Dunlop* [2007] 1 Cr App R 8, where it was succinctly said: 'The passage of time is, of itself, no impediment to the fairness of a [re]trial'.

Case law on delay reveals that courts are again less concerned with the period of time that has elapsed, than the effect that delay can be said to have had on the defendant's ability to mount an effective case; for example, where there is evidence of collusion, or a key witness has died (see *R v TBF* [2011] EWCA Crim 726).

It is against that backdrop that the recent decision in *B v Sailors'*

Society and the judgment of Lady Carmichael needs to be considered.

The facts of the case are not unusual. The claimants (pursuers) alleged that when resident at the defendant's children's home, they were physically and sexually abused by members of staff and visitors. The allegations went back forty plus years: a scenario that practitioners in the field of CSA claims will be familiar with.

By the time the claimants' claims were intimated, the alleged abusers were dead; as indeed were other potentially key witnesses. Nevertheless, the claims were pursued. It seems there was supporting if not corroborating evidence from other former residents, as well as what could be considered similar fact evidence.

The defendant sought a preliminary hearing at which it successfully applied to have the case dismissed on the basis that a fair trial was no longer possible, or in the alternative that it was substantially prejudiced by the passage of time. It relied on the reformed legislation which can be found in the Prescription and Limitation (Scotland) Act 1973 as amended by the Limitation (Child Abuse) (Scotland) Act 2017.

By section 17A limitation is abolished viz abuse claims, but there is, from a defendant perspective, a safety valve which provides as follows:

'17D Childhood abuse actions: circumstances in which an action may not proceed

'(1) The court may not allow an action which is brought by virtue of section 17A(1) to proceed if either of subsections (2) or (3) apply.

'(2) This subsection applies where the defender satisfies the court that it is not possible for a fair hearing to take place.

'(3) This subsection applies where -

'(a) the defender satisfies the court that, as a result of the operation of section 17B or (as the case may be) 17C, the defender would be substantially prejudiced were the action to proceed, and

'(b) having had regard to the pursuer's interest in the action proceeding, the court is satisfied that the prejudice is such that the action should not proceed.'

The application was heard without oral evidence. Instead, it was considered on the content of the affidavits of the claimants and other witnesses. This has an echo from the past, where in the relatively early days of child abuse litigation, it was considered appropriate for limitation to be tried as a preliminary issue.

It was a practice that came to be frowned upon by the English courts and is now very much an exception to the rule. It was recognised that it ran the risk of victims having to give evidence twice, and trial judges effectively deciding on what could be a relatively narrow but crucial issue without having had the benefit of hearing all of the evidence.

It represents a sea change in societal attitudes towards child abuse

Dismissing the claimants' claims, Lady Carmichael found that a fair trial was no longer possible, and she did so on the basis that the alleged abusers were dead, as were other potential witnesses. This, she considered to be fundamental, because the defendant was deprived of the ability to obtain potential evidence to refute, if necessary, the allegations. Its ability to question and cross-examine was seriously compromised.

The argument that alleged abusers would simply deny matters was not sustainable because they may arguably have information that was pertinent to the issues in the case.

The Court's attention was drawn to English cases where the claimants had succeeded where the alleged abuser was dead, but they could be distinguished on the basis that they had either been convicted of child abuse or had made admissions (*Raggett v Society of Jesus* [2010] EWCA 1002; *DSN v Blackpool Football Club* [2020] EWHC 595). The alleged abusers in *B v Sailors' Society* had died unconvicted and without any kind of admission having been made. This distinction was considered significant.

Comment

If it was thought that the weight of claimant evidence would suffice under s.17A, then this was mistaken. The decision in *B v Sailors' Society* makes it clear that a fair trial is not possible if the alleged abuser is dead, absent a conviction or admission.

In one sense the burden is clearly placed on the defendant's shoulders to demonstrate that a fair trial is impossible, but that is only part of the story. Claimants who have a credible account of abuse would face an impossible burden to discharge if the alleged abuser, without a conviction or admission, is dead - regardless of similar fact evidence being available. This is a very common scenario, and claimants south of the border have succeeded to-date under the current 1980 Act because they have been able to rely on evidence that corroborates their allegations.

Had the *B v Sailors' Society* case been tried in an English court, would the outcome have been different? That is of course difficult to answer, but the likelihood is that it would not have been disposed of at a preliminary hearing. Instead, it would have proceeded to a full trial, with the judge having the benefit of hearing from the witnesses, whose credibility no doubt would have been challenged and tested.

It can be argued that the claimants' prospects under s.33 if the evidence stacked-up, and withstood cross-examination, would have been better than under s.17A. No doubt the defendant would have argued prejudice given the demise of the alleged abusers, but that would have been weighed under s.33. The outcome may have been the same; which begs a question as to the usefulness of s.17A?

In conclusion, it is submitted that the *B v Sailors' Society* judgment demonstrates that the Scottish reforms are not a panacea. Whereas it might have been seen as a radical reform in relation to the abolition of limitation for abuse claims, the reality is sobering.

Alan Collins is a partner at Hugh James

DECIDING FACTOR

Dr Linda Monaci, Richard Dew and David Stokes on mental capacity in PI claims

Section 1(2) of The Mental Capacity Act 2005 (MCA) sets out the core principle that 'A person must be assumed to have capacity unless it is established that he lacks capacity'.

Applying this to personal injury (PI) claims, it is easy to see how PI lawyers will conduct litigation on the instruction of the injured party unless and until there is clear evidence to show that their client lacks capacity to litigate. This is particularly so where the lawyer initially forms their own opinion that their client does have capacity to litigate.

Unfortunately, significant problems can then arise if it comes to light later on that the injured party did not in fact have capacity to litigate.

Evans v Betesh Partnership

This was highlighted in the recent case of *Evans v Betesh Partnership & Ors* [2021] EWCA Civ 1194, in which Ms Evans suffered injuries following a car accident. The defendant made a Part 36 offer to settle, and in early November 2011, Ms Evans accepted the offer (against the advice of her solicitor). It was particularly relevant that Ms Evans had been due to attend an appointment with a consultant neuropsychologist on 15 November 2011, but as the Part 36 offer had been accepted, the appointment was cancelled.

Some six years after the offer was accepted, Ms Evans commenced a claim for breach of contract and professional negligence against the firm of solicitors who had advised her during her personal injury claim, on the basis that she had under settled the claim at a time when she had lacked capacity to litigate and had in fact been a protected party - something her solicitor would most likely have known, had Ms Evans' appointment with the consultant neuropsychologist gone ahead.

If Ms Evans had in fact lacked capacity to litigate, then by virtue of CPR 21, she would have been a protected party; and CPR part 21.10 makes clear that 'no settlement, compromise or payment (including any voluntary interim payment) and no acceptance of money paid into court shall be valid, so far as it relates to the claim by, on behalf of or against the child or protected party, without the approval of the court'.

The acceptance of the Part 36 offer had not been approved by the Court, and as such, if Ms Evans did in fact lack capacity to litigate, then the acceptance of the Part 36 offer was null and void.

The *Evans* case is very similar to the earlier case of *Dunhill v Burgin* [2012] EWHC 3163 (QB), in which Ms Dunhill's claim was settled at a time when it was not known that she lacked capacity to litigate. Unfortunately, some time after settling the claim, 'doubts emerged about the claimant's capacity' and Ms Dunhill, then acting by her litigation friend, issued proceedings in negligence against her counsel and solicitors on the basis that the settlement was at a significant under-value. The case went to the Supreme Court (*Dunhill v Burgin* [2014] 1 WLR 933).

By implication, doubts had not arisen as to Ms Dunhill's capacity during the claim, but she was still deemed to have lacked capacity to litigate, and it was the failure of the personal injury lawyer in not investigating Ms Dunhill's capacity that lead to the significant under-settlement.

Investigate capacity at the outset

As can hopefully be seen, both in terms of acting in a client's best interests and from a law firm's risk management perspective, the best course of action is to fully investigate a client's capacity at the outset of a personal injury claim and (as capacity can fluctuate) to monitor and review the position throughout the claim.

We suggest that a personal injury lawyer should only be comfortable not taking any steps to investigate their client's mental capacity if it is abundantly clear to them that the client does have capacity to make all decisions.

As the person with conduct of the claim, the personal injury lawyer plays a crucial role in investigating their client's mental capacity. It is they who must initially assess whether their client's mental capacity may well be an issue that needs investigating. Often this will be clear cut, but in many instances it is not; and it can be difficult to spot those clients who appear to be capable of litigating, but may in fact be relying on others to make key decisions on their behalf, such as close family members or friends.

The capacity issues

Capacity is specific to the decision that is being made - see MCA section 3. This means a client may have the capacity to make one decision, but may lack the capacity to make other decisions, or to make the same decision but at a different time.

For example, an individual who has suffered a brain injury may be able to cope with managing their money while it is limited to the receipt of means tested benefits, or an otherwise limited income; but may not be able to make complex strategic decisions regarding their litigation, or to make the complex decisions involved in the management of a substantial amount of money intended to last them their lifetime.

In other circumstances, the effect of tiredness or an inability to concentrate may mean (for example) that some people are better at making decisions in the morning or in 'small chunks' rather than all at once.

In any assessment of a client's capacity, it is therefore important to identify what decision (or decisions) capacity is being tested for. A simple assessment that a client 'lacks capacity' is both common place, and completely wrong.

In addition to the presumption of capacity referred to above, the MCA says:

- A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success (s1(3)).
- A person is not to be treated as unable to make a decision merely because they make an unwise decision (s1(4)).
- A person is unable to make a decision for themselves if they are unable (a) to understand the information relevant to the decision (b) to retain that information (c) to use or weight that information as part of the process of making the decision or (d) to communicate the decision (s3(1)).
- A person cannot be regarded as unable to understand the information relevant to a decision if they are able to understand an explanation given to them in a way that is appropriate to their circumstances (such as the use of simple language or visual aids) (MCA s3(2))

For the personal injury lawyer, the most important question is likely to be whether the individual has the capacity to conduct litigation. The case law shows that in order to have capacity to conduct litigation, a person must have the capacity to conduct their particular claim with the advice and assistance of a lawyer (see the *Dunhill* case). In the unreported case of *White v Fell*, it was said:

'To have that capacity she requires first the insight and understanding of the fact that she has a problem in respect of which she needs advice... Secondly, having identified the problem, it will be necessary for her to seek an appropriate adviser and to instruct him with sufficient clarity to enable him to understand the problem and to advise her appropriately... Finally, she needs sufficient mental capacity to understand and make decisions based upon, or otherwise give effect to, such advice as she may receive.'

Having capacity to conduct litigation is not the same as having the capacity to manage an award resulting from that capacity; see *Masterman-Lister v Brutton & Co* [2003] 1 WLR 1511. So a client may be capable of giving instructions for their litigation, but then be incapable of managing their property and affairs at the conclusion of the litigation (or vice versa).

There is no single case setting out what a person must understand in order to be able to manage their property and affairs, but where the decision concerned is the management of a large award over a period of time, that must include the ability to (a) understand the need to plan and manage the money over a long period of time (b) formulate, with assistance, those plans and (c) be able to implement those plans over the long term (and so, for example, resist treaties for large gifts or expensive holidays). Every effort must be given to assist the individual with this, including the assistance of lawyers, accountants and investment advisers.

At this point, a distinction needs to be made between a person who lacks the capacity to manage a large sum of money, and a person who lacks the capacity to decide how that money should be managed. In other words, a person may have sufficient capacity to realise that they themselves cannot manage a large financial award, but be able to make a capacitous decision regarding how that money is

managed. In such circumstances, the person must be assisted in making that decision, with such aids as are appropriate to their circumstances.

It follows that in assessing capacity, there are a number of different decisions to consider, and each will require a process of considering what the client is and is not able to do, and the availability of - and likelihood of their accessing - assistance for those decisions. It is at this point that the role of the expert becomes critical.

The expert's perspective

Every expert instructed benefits from detailed instructions, for instance the specific aspects to be considered in order to determine whether a claimant has capacity, and whether any issue has been observed or reported by friends, a partner or other family members, which triggers the need for a formal capacity assessment.

In selecting the relevant expert, it is important to consider that a single one-hour consultation (or even briefer) is unlikely to be sufficient, as typically one needs to establish the nature and severity of any cognitive problems, understand the circumstances in which a claimant lives and makes his / her choices, and obtain information on this from a third-party informant.

Mental capacity assessments that lack these components are typically insufficient and so are not recommended, particularly in cases where the individual to be assessed lacks insight into their difficulties. Psychological defence mechanisms may also be involved, which may mean that the individual assessed may be avoiding recognising the full extent of their difficulties in an effort to preserve their self-esteem and sense of self.

There is also typically a mismatch between what someone says and what someone does in individuals with executive problems (the 'talk the talk but does not walk the walk' paradox), and so it is not possible to just take at face value what someone says they would do in a certain situation in cases of executive dysfunction, particularly where there is a history of mismatch between stated intentions and behaviours.

The situation becomes complex when relationships and pre-morbid behaviours, and the need to explain the reasoning behind a choice, are taken into account. For instance, an individual may have pre-morbid tendencies to enter abusive relationships which the individual is set at maintaining, even though this creates considerable difficulty; for instance, lending a partner money even though money previously lent has not been repaid, or concealing a weapon or stolen goods in an attempt to preserve the relationship.

Although one can make unwise decisions, there is clearly an issue when pre-existing emotional vulnerability and tendency to undertake actions that are not in one's best interests (for instance remaining in abusive relationships) are co-existing with acquired cognitive problems, which are likely to negatively impact the ability to make informed decisions.

However, it is also important that all reasonable steps are taken to enable an individual to have capacity to make particular decisions, for instance explaining the possible consequences in terms of pros and cons of their possible choices.

Case study

Ms F suffered a preventable subarachnoid haemorrhage (SAH) at age 45, which left her with a degree of cognitive, physical and emotional symptoms. At the time of the index event, she lived with her partner and her children (all from previous relationships): a son aged eight, a daughter aged 14 and twin daughters aged 18.

At the time of the index event, she was off work with depression, but was employed as a receptionist in a dental practice. She brought a claim for negligence against the healthcare provider due to a delayed diagnosis of the SAH.

On discharge from hospital she was reported to require assistance with washing and dressing, and she was unable to safely cook a meal in the kitchen. Subsequently she had community neurorehabilitation input. On numerous occasions she was referred for psychological support due to mood disturbances and was prescribed antidepressants.

Neuropsychological assessment

Two years' post-index event, Ms F reported that since the index event she had progressed and required minimal help with day-to-day assistance, but still could not drive. She reported that she was able to organise and carry out shopping, cooking and dressing.

Her partner attended the appointment with her, and he indicated that she required minimal day-to-day assistance. He reported that he had had to give up his job as an electrician to become her carer, but he had not returned to work. Ms F, now medically retired, receives a small work pension and state benefits. When assessed by the neuropsychologist they reported the intention to marry, having been living together in her house for the last three years.

The cognitive assessment found that following the SAH, Ms F had severe memory problems and executive difficulties. Her intellectual abilities were largely in keeping with expectation, apart from a reduced speed of processing. She had passed symptom validity testing, and so the results obtained could be taken as a valid representation of her abilities. Ms F's mood was found to be low, and she appeared depressed and socially isolated.

When the neuropsychologist asked questions aimed at understanding her ability to manage her finances, Ms F and her partner reported that Ms F was completely independent and had no problems in relation to managing her finances and handling money. But the rehabilitation records highlighted that Ms F needed support with money management which her partner now took complete responsibility for, saying she was unable to even calculate the change given back in a shop.

The rehabilitation records included concerns that Ms F's children were becoming increasingly unhappy with what they perceived as the intrusion of Ms F's partner in their and their mother's lives. They felt that he made unilateral decisions and often did not take into account Ms F's view and preferences.

In order to try to establish her cognitive problems, the neuropsychologist considered data on the prevalence of cognitive problems following a SAH, cognitive test data, behavioural observations, interview, third-party reports and information contained in the medical and occupational records. All information (apart from that which appeared offered at interview by Ms F and her partner) consistently indicated that since the index event, Ms F had difficulty remembering information and focusing her behaviour on set goals, and this was consistent with executive problems, impacting also on her social and interpersonal functioning.

There were also abundant observations that since the SAH, Ms F was less socially aware (for example, often making socially inappropriate comments) and she was considerably more anxious, vulnerable and dependent than she had been before the SAH.

Conclusion of the assessment

The neuropsychologist raised the issue of discrepancy of information between what was reported by Ms F and her partner at interview, and the content of the rehabilitation records.

The neuropsychologist felt that due to pre-existing emotional vulnerability, social isolation, and problems with memory and executive functioning since the SAH, Ms F was more vulnerable to being exploited and manipulated by others, and at high risk that the substantial damages awarded may be mismanaged.

In these circumstances, she was not just likely to make a bad financial decision, as she was entitled to do under the mental capacity test, but she was deemed to likely lack capacity to manage her own financial affairs.

Practice points

The case-study illustrates the complexity of the assessment that must take place, and the need to carry it out sooner rather than later (after the receipt of the award would be far too late).

Developing and incorporating policies and checklists to help fee-earners form a view as to their client's capacity to litigate, and to identify warning signs, can be very helpful in putting this issue at the forefront of a personal injury lawyer's mind; as well as helping to justify the steps taken after the event.

The personal injury lawyer is also often the person with the most day-to-day contact with their client, and they will usually have a holistic view of the claim including the opinions provided by the various medical experts. As such, not only do they play a crucial part in identifying and then investigating capacity issues, they can also offer a great deal of background information when instructing the medical expert that will help them to form their own view as to a client's mental capacity.

Personal injury lawyers must therefore have an understanding of the Mental Capacity Act 2005 and Part 21 of the CPR, of the relevant considerations in assessing capacity to make different decisions, and of the need to involve a relevant expert at an early stage.

If they do so, they will be well positioned to identify those clients who may lack capacity to litigate or to manage their award, and to act accordingly.

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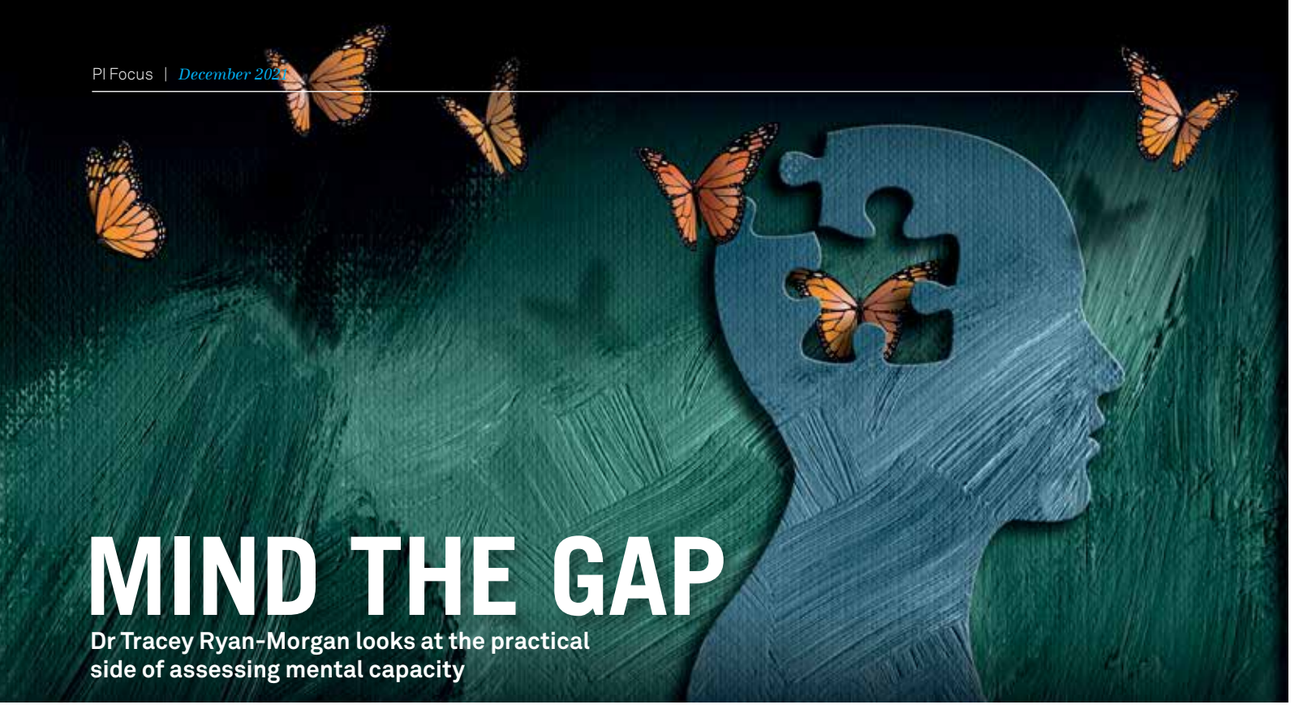

MIND THE GAP

Dr Tracey Ryan-Morgan looks at the practical side of assessing mental capacity

This article looks at assessing mental capacity from a medical and practical perspective.

As touched upon in the previous article (see page 10), the Mental Capacity Act (2005) is underpinned by five key principles:

1. Everyone is presumed to retain mental capacity at the outset – the burden of proof is on the enquirer, who has to have a good reason for questioning the person's capacity at the outset
2. Every effort should be made to maximise a person's capacity to make decisions for themselves
3. Everyone has the right to make 'unwise' decisions (eat that cake, buy those shoes, sign up for that race)
4. Anything that you do on behalf of someone who has been assessed as lacking mental capacity should be the least restrictive of their rights and freedoms
5. Anything that you do on behalf of someone who has been assessed as lacking mental capacity should be in their best interests

Greater minds than mine have wrestled with the subtleties and nuances contained within these principles, but it is true to say that there are many professionals who miss the point in such assessments: 'They were able to tell me their name and where they lived, so they have capacity' or 'We're going to have trouble discharging this person, so we'd better do a capacity assessment' are just a couple of common phrases that are bandied about with some frequency.

Other common mistakes are to assume that 'capacity' is a *general* concept, and to assume that because a person is deprived of their liberty, that they lack capacity for other things.

The decision-making process

So, we have a clear roadmap to assessing mental capacity, right?

We have the two-stage test. The first, *diagnostic* test, is where the assessor has to establish that the person has an impairment of mind or brain, whether temporary or permanent.

The second, *functional* test, is where the assessor must make sure that the person has the relevant and necessary materials, resources, time and support to try to make the decision in question for themselves, and then finds out whether they can understand, remember, use or weigh information in order to decide and then to communicate their decision, once made.

The key here is referred to as the 'causative nexus', as it requires that a link is clearly established between the diagnostic and functional; in other words, the person is unable to make the decision *because of* the impairment.

Do we know how we make decisions? Being a consultant clinical neuropsychologist, I am of course interested in which parts of our brain support decision making. We know that the very front of our brains (prefrontal cortices) are key here.

There are three key areas involved. Not in any particular order, we have the part that is impulsive, the 'gut feeling' that only thinks of the reward (orbitofrontal cortex). Then comes the rational, reflective, some might say sensible, part (dorsolateral prefrontal cortex). Finally, we get the mediator – the part that decides which one of the two former systems effectively 'wins' by considering past experiences and working out risk (the ventromedial prefrontal cortex).

So, are there different kinds of decisions that we need to assess differently? A useful distinction is between a one-off decision versus a more performative, continuous process of decision-making, as in the context of managing ones' finances.

What kind of interruptions can there be to decision-making abilities? Acquired brain injury is a common one, and encompasses strokes, infections, bleeds, tumours, lack of oxygen, among other things. Changes as a result of these tend to be permanent.

But we can also have temporary changes where the brain is affected, such as with a urinary tract infection in the elderly, or being under the influence of medication or substances. There are many scenarios where the brain may not retain the capacity to make decisions due to interruptions to the front of brain systems described above.

In certain cases of brain injury, an individual may *seem* to have retained capacity because they have retained verbal skills and can communicate fluently. Their responses to superficial questions may seem completely plausible. But, and here's the rub, they are expressing what is referred to as a dissociation between 'knowing' (awareness) and 'doing' (applying insight).

An example might be where someone recovering from the acute phase of a brain injury on a rehabilitation ward in hospital might express the desire to go home. This is perfectly reasonable and understandable. However, they may have no understanding of their injury, how it has affected them and what their care and support needs might be on discharge. They may hold a completely unrealistic view of such matters.

The conversation about mental capacity needs to ensure that there is sufficient depth

A ward environment is highly structured and supportive. It is a place where routines are set as scaffolding for a patient's day, where they do not need to think about getting showered and dressed, or eating a meal, or having a rehab session with a physiotherapist, for example, because the environmental prompts are provided invisibly, and sessions are timetabled.

Assessing the person's capacity in this context cannot rely on interview alone. Observations of how much support the person needs in practice as well as conversations with key relatives to obtain a wider view are essential. Awareness tends to develop alongside physical recovery, but it may be incomplete, and the person may require verbal and behavioural feedback in order to assist the unfolding process.

The conversation about mental capacity needs to ensure that there is sufficient depth. For example, asking a patient, 'what help do you feel you might need when you get discharged?' might elicit a response along the lines of, 'I'll be fine if I take it easy'. This is a vague and non-committal answer, that does not evidence a level of understanding. So it should be followed up by offering concrete scenarios to the person, to draw out potential difficulties or challenges, so that they might be discussed.

For example, the assessor might ask, 'what difficulties might there be in getting your shopping done?' or 'tell me how you might prepare your dinner?'. The idea is to follow a pattern of Socratic questioning along the lines of, 'and what then?' as this will help to uncover any potential difficulties, and also help to gather evidence as to mental capacity to make the decision around discharge support.

Good practice tips

What is good practice in terms of assessing mental capacity? The following tips can help:

- Be thorough – speak to people around the patient. Make observations. Prepare beforehand. Provide the patient with resources, time and support to assist them in the process. Take your time.
- Be balanced – do not form views before the information is in.
- Have a clear justification – there should always be a clear justification for an assessment of capacity. It should never be conducted 'just in case...'.
- Set an appropriate level of expectation of the person.
- Be transparent in terms of process and conclusion
- Take into account any fluctuations of capacity and if these occur, only assess the person when they are at their best
- Be respectful of the person, their expressed beliefs and wishes.
- And finally, ask the right questions, to the right depth.

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WHO NEEDS TO KNOW?

Rob Hunter and Bethany Sanders on disclosure of interim payments and offers

When a judge is asked to award an interim payment, should they be told about negotiations to settle?

In *Fryer v London Transport Executive* [1982] 11 WLUK 247 Times, December 4, 1982 [1982] C.L.Y. 2585, the evidence in support of an application for an interim payment included the amount that had been paid into court by the defendant. The Court of Appeal expressed the view that it was appropriate for the lower Courts to be told of the payment.

More recently, in *Handyside v Lowery* (Newcastle upon Tyne District Registry, 2 April 2015, unreported), HHJ Freedman refused to admit evidence of two Calderbank offers made by the defendant when deciding an application for an interim payment.

This article examines what led to the different outcomes in the above cases, and considers whether there are grounds for treating different types of offers differently.

Fryer v London Transport Executive

Fryer was an application for leave to appeal from the Court of Appeal. The appellant was a defendant in a personal injury case who sought to challenge an interim payment that had been ordered by a deputy judge of the High Court on appeal from a master.

Fryer was decided under the Rules of the Supreme Court 1965, which predated the Part 36 regime under the CPR. Order 22, Rule 7 prevented disclosure of voluntary payments into court 'until all questions of liability and of the amount of debt or damages have been decided'.

At the time, a payment into court, as opposed to a written offer complying with certain formalities, was required. The Court also considered Order 29 Rule 15, which provided that unless a defendant consented, no communication of an interim payment could be made to the court 'of any question or issue as to liability or damages until all questions of liability and amount have been determined'.

The appellant in *Fryer* argued that there was an error of law because the rules did not permit the amount of money paid into court, nor the existence of a voluntary interim payment, to be disclosed to the master and the judge.

In refusing permission to appeal, Waller LJ commented that the application for an interim payment did not raise a question of damages within the meaning of the rule 7 or 15. The object of the power to make interim payments, particularly in personal injury cases, was to relieve the injured party from the worst effect of the delay in the hearing of the claim.

In his view, the question was 'what, in the interlocutory proceedings before the learned Judge, should be done to meet the justice of the case'. Waller LJ also identified what he described as an even stronger reason for refusing leave, which was that the defendant had failed to object to either payment being disclosed before the master or the judge.

Subsequent cases decided under the Supreme Court Rules

In *A Ltd v B Ltd* 29 ConLR 53, the applicant for an interim payment in a construction dispute sought to rely on a payment into court. HHJ John Davies QC held that he was not bound by *Fryer*, and that order 22, rule 7 did prohibit reference to an interim payment on an interlocutory hearing, which in his judgment *did* involve a question of damages.

In *Bowmer & Kirkland Ltd v Wilson Bowden Properties Ltd* [1995] 7 WLUK 345, the defendant had made a payment into court as well as a Calderbank offer.

HHJ Hicks QC held that evidence of a payment into court was admissible on an application for interim payment. He considered himself bound by *Fryer*. Even if not bound by *Fryer*, HHJ Hicks QC said that he would have come to the same conclusion. No separate objection was taken in relation to a Calderbank offer, and so this was also admitted in evidence. HHJ Hicks QC also observed, however, that there might be a distinction to be drawn between payments into court and Calderbank offers.

Handyside v Lowery

Handyside is the most recent judgment available concerning the admissibility of offers during an application for an interim payment, and fell to be decided in light of the Civil Procedure Rules. By CPR 36.16(2), the fact that a Part 36 offer has been made and the terms of such offer must not be communicated to the trial judge until the case has been decided. In the ordinary course of events, therefore, disclosure of a Part 36 offer to an interlocutory judge will be in order. Special circumstances could arise if the same judge was due to hear the interim payment application and trial.

The issue in *Handyside* was whether two Calderbank offers were admissible. The offers had been made in a letter that included the following assertion:

'For the avoidance of doubt this offer is made without prejudice save as to costs and should not be referred to at any hearing of an Application for an interim payment.'

HHJ Freedman noted that the point had arisen unexpectedly at the outset of the hearing. Having reserved judgment, he distinguished *Fryer* on the grounds that Calderbank offers are different from Part 36 offers (or their predecessors). It would appear that *A Ltd v B Ltd* was not drawn to his attention. He rightly observed that he was not bound by the decision in *Bowmer*, as HHJ Hicks QC had not heard argument as to whether a Calderbank offer was to be treated differently.

HHJ Freedman was influenced by the policy of encouraging settlement negotiations. He referred to the Supreme Court decision of *Ocean Bulk Shipping and Trading SA v TNT Limited and Others* [2010] UKSC 44, which concerned whether without prejudice negotiations were admissible to help interpret any agreement which results from them.

In *Ocean Bulk Shipping and Trading*, Lord Clarke emphasised that the without prejudice rule in the law of contract was founded on the public policy of encouraging litigants to settle their differences, as well as the express or implied agreement of the parties that communications in the course of their negotiations should not be admissible in evidence.

HHJ Freedman held that there was a distinction between Calderbank and Part 36 offers. He reasoned that a party who makes a Calderbank offer risked not obtaining the benefits under Part 36 but, as a quid pro quo, they should be entitled to the advantage of the offer not being known until costs fell to be decided. In his judgment, it would be unfair to the defendant to depart from the protection sought by the wording of the Calderbank offer, and to do so would also be contrary to public policy.

The downside of *Handyside*

Interim payments serve a vital role for claimants who may have needs that cannot wait. As observed in *Fryer,* the power exists to relieve the claimant from the result of the injuries caused by the defendant's negligence, and also to mitigate the delay before damages are awarded. These are important policy objectives that are supported by ensuring that the Court has the maximum information and assistance at the interlocutory stage.

It has long been the policy of the courts to promote settlement. If defendants were discouraged from making offers by the fear that they would be used for the purpose of interim payments, then that would run counter to the general policy. However, this is open to question: the costs sanctions that arise in the event that an offer is not beaten are a powerful incentive to negotiate.

At an interim payment application, the judge must determine the reasonable proportion of the likely 'final judgment' in accordance with CPR 25.7(4). Evidence of offers can help the Court in this process, and it is recognised that in certain circumstances, there are exceptions to the general exclusion of without prejudice communications for the purpose interlocutory hearings (see, for example, CPR 36.16(2) and *Family Housing Association (Manchester) Ltd v Michael Hyde and Partners* [1993] 1 WLR 354). If it is asserted that offers were motivated by commercial considerations, this is a matter the interlocutory judge will be able to weigh in the balance.

The decision in *Handyside* has the potential to do mischief. It could discourage litigants from using the Part 36 regime. It would reward defendants who unwittingly fail to comply with the formalities required by CPR 36.5 but subsequently find themselves at an advantage. If followed, *Handyside* would sanction the negotiating tactic of putting pressure on the claimant with a large financial offer while at the same time restricting access to interim funding. This ought to be deterred.

HHJ Freedman noted that he had heard comparatively brief argument on the point. Perhaps as a result, his decision does not engage with the rationale of *Fryer* or the policy objectives that underlie the power to make interim payments. The issue would benefit from further judicial consideration.

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BELT AND BRACES

Nigel Zoltie on the effect of seat belts on RTA injuries

Most injuries sustained in road traffic accidents involve occupants wearing seat belts. This article offers a medical expert's view on the issues that may arise when a seat belt was not worn, or when it is not known whether a seat belt was worn or not.

Medical evidence has overwhelmingly shown that seat belts can prevent deaths and serious injury in road traffic accidents. Wearing them is compulsory in the UK, although a medicolegal expert should be aware that a claim can be modified, usually reduced, to take into account failure to wear a seat belt.

If an issue is raised that no seat belt was worn, the expert should be prepared to consider a subsequent set of questions, to assist the court. These might include consideration as to what injuries might have been less severe or not occurred had a seat belt been worn, and also what injuries might have been greater or have occurred had a seat belt been worn. These questions are easy to pose by lawyers, but complex to consider from a medical point of view.

As a general principle, at low and moderate velocity impacts, seat belts restrain the torso, and prevent the torso and head striking the steering wheel and the windscreen. This is based on the assumption, which may of course be tested, that the seatbelt was fitted correctly and was being worn correctly. Seatbelts do not prevent injury to flailing limbs. At high velocity impacts, seat belts also normally prevent ejection from a vehicle, and affect the injuries sustained.

Also, as a general principle, seat belts do not prevent injury due to lateral deforming forces, such as caused by side impacts; nor do they prevent injury due to rotational forces, such a spinning car.

Low velocity impacts

At very low velocity, there is a contradictory concept, whereby a gentle force impact might not be sufficient to cause whiplash type injury. Wearing a seatbelt, by restraining the torso, allows a greater differential and sudden movement between the torso and the head, increasing the risk and severity of whiplash. If a seat belt has been worn in a low velocity impact accident, then it is likely that a whiplash injury might have occurred or been more severe. This concept may be important for the apparently simple fixed cost (MedCo) reports, and the legal teams need to be aware that a simple concept of financial deduction for not wearing a seatbelt may not be appropriate.

Moderate velocity impacts

For moderate velocity impact accidents, seatbelts tend to save truncal injuries and head injuries, but not necessarily limb injuries or whiplash injuries.

Without a seat belt, injuries to the trunk can be caused by the body moving forward and directly impacting on internal vehicle structures. There is an inevitable logic that these injuries would have been prevented by usage of a seat belt.

However, as the velocities increase further, then a variety of injuries can still be caused by sudden deceleration. The deceleration can occur because the torso is held in the seatbelt and decelerates with the car, or the body is projected forward without a seatbelt and strikes the internal vehicle parts, the same relative deceleration occurring when the body is stopped by the car parts. In either case, injuries due to the deceleration can occur, irrespective of seatbelt usage.

The above considerations apply to the concept of the forces involved being forwards and backwards, in which case a seat belt offers restraint. If the forces involved are sideways forces, then seatbelts are a very poor at restraint, and may not prevent injuries due to side forces even if worn.

If there is intrusion of the car frame into the passenger compartment, then the concept of moving vehicle components hitting the static body applies, and seatbelts cannot prevent injuries due to intrusion. This is most obvious in roll-over accidents, with intrusion of the car roof causing head injuries, which would not have been prevented by wearing a seat belt.

High velocity impact accidents

In high velocity impact accidents, often involving deaths, questions may arise as to whether a seat belt was being worn, and whether any medical evidence can help determine the answer. Under such circumstances, the primary evidence is engineering with respect to investigating the vehicle itself, and inspection of the seat belt. The medical aspect relates to considering the pattern of injuries actually sustained, and the possible causes for those injuries.

In high velocity impact accidents with significant vehicle damage, the position of the seat before and after impact and intrusion of vehicle body parts may be of great significance, and the medical expert may therefore need expert engineering evidence to assist in determining what injuries might have been suffered had a seat belt been worn.

When dealing with complex issues, it is important to note that engineering experts often deal with speed calculations, and calculate forces involved derived from speed calculations measured in Newtons, a measure of force. Medical literature relates injuries to G-force, a measure of acceleration - so there is often a discrepancy between the physics described in engineering reports and medical reports.

Also, injury is thought to be caused by peak G-force, not average G-force, meaning that simple considerations of apparent forces may be misleading. In scientific terms, it is usually impossible to measure the exact force applied to the body parts, and the measures used are proxies for the actual force, speed being one proxy, and damage to car / intrusion being another. These proxies are good rules of thumb, but not absolute in their accuracy.

For such high velocity impact accidents, there are patterns of injuries associated with seat belt usage. These would include truncal injuries, where the seatbelt impacts on the chest.

Bruising from seat belts may be evident, but not well documented in the medical records. Clinical notes tend to concentrate on the severe injuries that need treatment. Descriptions of bruising may be restricted to the nursing notes, or postmortem reports, and the medical experts should be provided with the full set of medical notes as such descriptions may be 'hidden away' on one sheet only in the notes, yet of great significance when dealing with this particular problem.

Deceleration injuries, especially internal injuries, can still occur, and a medical expert would need to consider whether such injuries might have occurred had a seat belt been worn. For a complex claim, each injury would need to be considered, and careful consideration given to whether other injuries might have occurred had a seat belt been worn.

A more contentious issue relates to injuries sustained by other occupants of the vehicle. From a medical point of view, injuries sustained by other occupants can be a proxy for the forces involved in the impact. Their injuries, and their seat belt status can influence considerations for the claimant under question. However, there is a legal challenge for the teams involved in obtaining the correct permissions to release the medical details of other injured parties to the expert.

An expert asked to address such matters for a high velocity impact accident therefore needs the full medical notes including any ambulance records, engineering evidence including police report and investigation reports, and other medical evidence - such as post-mortem reports and medical evidence of injuries to other parties. Witness statements can be of assistance, as the condition of the claimant immediately after the accident – level of consciousness, breathing, not breathing, gasping etc - can help in the consideration as to whether survival might have occurred if a seat belt had been worn.

Choice of expert

The skill and knowledge needed to prepare a report on seat belt injuries is usually the province of those doctors treating such injuries, and with the experience of the range of injuries and patterns of injuries seen in road traffic accidents. This would normally be primary responders such as doctors attending the scenes of such accidents, often as part of the ambulance service system, Accident and Emergency experts, and orthopaedic and trauma experts.

Other doctors, trained or working in vehicle research facilities, also have expertise in patterns of injury, and statistics relating to patterns of severe injury. Any expert used should be expected to have knowledge of the effects of seatbelts, and also knowledge of the patterns of injuries expected relating to the mechanism of injury, and thereby the injuries that might or might not have occurred had a seat belt been worn.

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BEYOND BELIEF

Dr Bruce Scheepers gives personal insight into functional disorders

Within the mysterious and poorly understood world of neuropsychiatry, I have had a specific interest in what probably remains the most contentious and challenging of all medical conditions - 'functional disorders'. Over the last ten years, about a quarter of my instructions have involved a functional disorder as the presenting medical condition, divided roughly 50:50 between claimant and defendant. Having now retired after more than twenty-five years as an expert witness in personal injury and medical negligence claims, I have been contemplating how the functional disorder landscape has changed and wondering what the future may hold.

Functional disorders

Historically referred to as hysteria, dissociative disorder, conversion disorder, somatoform disorder, or medically unexplained symptoms, functional disorders are among the most common clinical presentations encountered in medicine. Mainstream medical practice has avoided the subject over most of my career, and medico-legally, we seem to have tip-toed around the many challenging and complex issues that have arisen.

I now rarely encounter open hostility and frank disbelief when I suggest that physical problems might be symptoms of the mind, but I still do meet lawyers and experts who automatically assume I am talking about feigning, 'putting it on', or deliberately manufacturing symptoms for financial gain.

It has only been over the last ten years that medicine has witnessed the paradigm shift needed to develop a new conceptual framework. Both the DSM-5 (2013) and the soon to be implemented ICD-11 (due January 2022) have completely re-defined these conditions, and around the UK many NHS Trusts have established dedicated functional disorder neurology services.

That certainly does not mean that agreement or consensus has broken out among medical experts. Over the last thirty years, medicine has seen the establishment of a host of new disciplines or subspecialities such as pain medicine, audio-vestibular medicine and indeed, neuropsychiatry.

Every one of the thirty or more medical subspecialities we now have in the UK will probably have a diagnostic category that includes medical conditions recognised as functional disorders. Most share a range of associated symptoms and characteristics, and the suggestion that we should adopt a single generic functional somatic syndrome across all disciplines has been around for over twenty years.

There is disagreement and even hostility among some clinicians regarding which clinical presentations or 'named' conditions might represent functional disorders. Do we include conditions such as irritable bowel syndrome, chronic fatigue syndrome, fibromyalgia, post-concussional syndrome, post-whiplash syndrome, irritable bladder syndrome, complex regional pain syndrome, spinal cord injury without radiographic abnormality (SCIWORA) or functional dizziness - to name just a few?

With colleagues across a range of disciplines including cardiology and neurology, I helped to establish the Northwest Blackouts Group in the 1990s, because it had become apparent that we had all established our own frameworks, classifications and criteria for conditions referred to variously as syncope, fainting, non-epileptic attack disorder, or pseudo-epilepsy; but within this cohort there was large group of patients with the same condition by different names.

As science has singularly, over the years, failed to identify structural pathologies or disease processes that might explain the clinical presentation and causation of functional disorders, it appears that medicine has instead established a constantly expanding evidence base around the clinical presentation, or the appearance of the phenomena (phenomenology), but

without any significant understanding of causation.

We have identified abnormalities in new computerised scanning techniques or new physiological investigation procedures that have enabled us to speculate on what might be causal, but without establishing a clear pathology or any certainty. We know 'what' these conditions are, or the ways in which they present, but have little idea 'why' or 'how' they develop.

Indeed, looking at the literature, it is apparent that over several centuries, medicine has failed to establish a singular unifying construct or conceptual framework that enables us to explain how an apparent abnormality of the functioning of the mind might be manifested as physical or somatic symptoms. In ancient times, the Gods might have been blamed; and in some cultures, to this day, ancestors or spiritual tribal leaders might be regarded as responsible or causal. Religion historically has played a prominent role in explaining the unknown, so that the secularisation of western society and the increase in atheism appears to have left a void. This void seems to have been readily filled by pseudoscience and conspiracy theories.

Personal experiences

My own approach to functional disorders is coloured by my own personal experiences. During my second year at medical school, I developed reflex syncope associated with haemophobia. In other words, I started fainting when I saw blood! Multiple episodes later, countless failed remedial strategies and increasing avoidance behaviour saw me failing my second year in medicine, and being faced with an urgent decision about my future.

There was shame and embarrassment, because I did not really do failure, and a feeling of utter disbelief. Then there was the paranoia - that somehow, I was being punished for my sins. Being the son of missionaries in Africa, raised in a deeply religious evangelical Christian home did not help in that regard, nor did my childhood exposure to African cultures with strong beliefs in evil spirits, ancestral worship and the Sangoma.

Nonetheless, all my retrospective enquiries and reflections trying to identify a possible trigger or a cause for my fainting proved fruitless. I was not ill, probably the healthiest I had ever been. I was very happy and enjoying student life away from my restrictive family environment - until this had happened. Suddenly I had lost control of my life, my plans, and my dreams. Had anyone suggested that I was 'attention-seeking', 'play-acting' or 'putting it on', I could not have vouched for my reaction, but then few even knew of my problem, or the seriousness of my difficulties at the time - not even my parents.

My initial exposure to blood at medical school was volunteering with student colleagues to assist the A&E nurses who were inundated over the weekend with lacerations requiring suturing. Just a few months of anatomy and a few hours of practising, we were beginning to feel like 'proper doctors'. After my first episode of fainting, I tried to donate blood (unsuccessfully – only a quarter pint), assisted a family veterinary friend with animal surgeries (unsuccessfully – could not complete a surgery) and I continued to trudge the long, echoing corridor that linked the medical school to the hospital on a Friday or Saturday night for what became a ritual fainting exercise.

I did not experience a cathartic epiphany, but instead there was a gradual dawning realisation that I was not sick, or damaged in any way. These episodes of fainting when I saw blood were caused by my own thoughts. I had developed an illness belief that I would pass out every time I saw blood, and this became a self-fulfilling prophesy.

The difficulty was that, however strongly I resisted the thoughts and diligently sought to help myself, my body behaved differently, because it had established an automatic reflex, and every fainting episode just reinforced my abnormal illness belief and this reflex.

The fundamental problem was that I had lost control, and for someone with my personality, this was catastrophic. I confess to a personality where I like to feel in control, I tend to strive for perfection and I do not readily consider the possibility of failure. I have subsequently discovered that my anankastic or obsessional personality traits are shared by the vast majority of people I have encountered with functional disorders over the years, possibly because I have always made the specific enquiry!

Obsessive personalities

Most medico-legal experts and lawyers will also identify with anankastic personality traits, which are generally highly valued in western society because of the tendency to conscientiousness and scrupulousness. These traits are probably essential in certain occupations such as air traffic control, quality control, or indeed in personal injury law.

In my sample of patients and claimants with functional disorders over the years, there has been an overrepresentation of doctors, lawyers, elite sportspeople and successful businesspeople all sharing this constellation of anankastic personality traits. We are cautious individuals who tend to be organised and orderly with attention to detail, but rather stubborn and pedantic. We like to feel in control, and finding ourselves in circumstances where we feel impotent or vulnerable can result in catastrophic thinking and disproportionate reactions.

Our fear of failure and 'all or nothing' attitude to life may lead to demand avoidance behaviour, so that in psychiatry, we have long recognised that such personalities may be prone to develop substance misuse disorder, eating disorders or a range of other psychological problems. There is also a recognised association between these personality types and functional disorders.

Historically it was believed that emotional trauma including sexual abuse / assault was the trigger for many functional disorders; but we now recognise that a common trigger is also physical trauma. It is unsurprising then that in personal injury law, we will frequently encounter people with anankastic personality traits who have experienced physical or emotional trauma of some sort, causing them to feel powerless and out of control,

and subsequently developing functional disorders.

Iatrogenic perpetuation of functional disorders is also unsurprising, as doctors feel the need to thoroughly investigate, and under intense pressure to intervene. Creating a medical diagnosis, giving it a name and prescribing an intervention is usually unhelpful in functional disorders - and probably sometimes causes harm, although unintentionally. In some cases, intervention is, in my opinion, avoidable; and I have seen surgical colostomies, amputations and other radical interventions performed with the best intention, because that is what the patient demanded.

Belief in abnormal illness

So, what is it that underpins these severely debilitating and disabling conditions? From my own experience, I was unable to make progress and to continue my career until I had accepted that I did not have an illness or underlying pathology that needed fixing. There was no beneficial medication I could take. My fainting was caused by my own beliefs.

This abnormal illness belief, in my opinion, is the principal causal factor in functional disorders. I have never encountered a patient or claimant who did not fervently believe that they had an underlying physical problem that needed fixing, or that they just needed to learn to live with because it was beyond fixing. In personal injury claims, there is also usually a feeling of intense injustice because this was clearly caused by someone else's negligence or the index event.

The abnormal illness beliefs that underpin functional disorders include the belief that 'I pass out when I see blood', or 'the rear end shunt caused permanent brain damage', or 'I am confined to a wheelchair because the epidural needle damaged my spinal cord'. Even if the person cannot fully understand or explain the mechanism and how causation might have occurred, they are absolutely certain that they have been the unfortunate victim of negligence, or some condition that has been outside of their own control.

Usually their thesis has attracted powerful support from family and friends, as well as online forums. In my experience functional disorders are very seldom deliberately manufactured, however bizarre or unusual the presentation. Deliberate deception in personal injury claims is invariably only uncovered by video-surveillance and almost impossible to detect clinically. In my experience, it is the inconsistency and variability of the presentation, or specifically because of the unusual, bizarre or incongruous nature of the presentation, that makes a functional disorder more likely than not.

But most importantly, it is the certain belief and firm conviction that is fundamental and pathognomonic. Most of the functional disorder patients or claimants I have examined have been intelligent, high functioning individuals who, if so minded to deliberately deceive, could probably have done a pretty good and convincing job without inconsistencies, incongruencies or variability of symptoms.

The diagnosis of functional disorders is not just about the medically unexplained or unusual nature of the presenting symptoms, but also the catastrophic impact, the severe distress, and the disproportionate disability that is characteristic. The person's life is usually dominated by health anxiety, their disability, the sense of loss because of the profound change from their premorbid life, and persistent thoughts about the injustice of it all. This is unsurprising, because the impact has invariably been life changing. A personal injury claim in this theatre is invariably unhelpful, and assists with perpetuating and sometimes worsening the condition.

One of the reasons why there is still considerable disagreement between experts is because the scientific literature is not very helpful, not only in relation to causation, but especially when it comes to treatment and prognosis. The quality of the studies is frequently poor.

Certainly, the functional disorders associated with personal injury claims have been very poorly researched. The literature overall suggests that functional disorders have a poor prognosis. In some pain syndromes or other specific conditions, it seems that the outcome is regarded as particularly hopeless.

Psychological therapy such as cognitive behaviour therapy and a graded exercise programme are the two treatments most consistently reported to be likely to assist people with functional disorders, but the prognosis in published scientific studies ranges between 10% and 90%. That does not accord with my own experience of a 60% to 70% recovery, and I have spent some considerable time trying to determine why this is. I have concluded that, probably on account of my own experiences, I have focussed on the abnormal illness beliefs. Cognitive behaviour therapy is about trying to change someone's behaviour by changing the way that they think. I rely on my own flavour of 'conversion therapy'.

A hopeful prognosis

I did return to complete my medical studies, making a full recovery to the extent that I even at one stage contemplated specialising in reconstructive surgery. Instead, I emigrated to the UK, where I felt myself drawn to psychiatry and more specifically to the specialty of neuropsychiatry.

I changed my abnormal illness beliefs and was able to regain control of my life. In retrospect, no amount of money could have helped me to accept a new career – to accept that I just was unsuited to the study of medicine because I passed out when I saw blood. I had developed a thought in my mind; an illness belief, that was able to repeatedly, for a few seconds, cause my heart to stop and all brain activity to cease.

The narrative about my personal experience has been repeated hundreds of times to most of my functional disorder patients, and to many of the claimants I have seen in my medicolegal practice. My own experience provides me with hope and optimism, which is why my own experience is that functional disorders have a good prognosis.

There is currently a concerted attempt to radically alter functional disorder perceptions and constructs in medicine, although still very little about treatment and prognosis. If only I had discovered a simple treatment or better still, a medication. Instead, I confess that in clinical practice, I have often felt more like an evangelist or proselytiser than a medical doctor.

Dr Bruce Scheepers is a consultant neuropsychiatrist

SCREENING TEST

Rodney Peyton on clinical negligence challenges and why preliminary reports are useful

Clinical negligence is a very complex area of law. Cases can be interesting and intellectually stimulating, but also emotionally draining. It is easy to run up considerable costs, not to mention the sheer amount of time and effort required; and yet statistics from the defence unions indicate that four out of every five potential cases are successfully defended.

These are not good odds, and this article looks at the lessons learnt to navigate the clinical negligence minefield in a faster, better, more efficient way - based on personal experiences as a medical expert from over 3,000 cases.

On reviewing these, ten recurrent themes come to light, due attention to which heralds the success or otherwise of a particular case. These may be conveniently represented by the word 'SCREENING', both as one of the themes, and as an acronym for the other nine areas.

Screening

From the outset, it is of prime importance to carefully assess any complaint and determine whether, even on face value, the essential triad of duty, breach and consequential (or 'but for') damage is likely to be present; as most cases fail on the first hurdle of causation. Subsequence is not consequence. It is all too easy to get sucked into the client's story where the potential for a case may at first sight appear obvious to a lay audience.

Doctors have a duty of candour, and they may apologise if an outcome is not as expected, even though there has been no breach of their duty of care. Sometimes this has been taken by both clients and lawyers as an admission of liability; which is not necessarily the case. Any drug or procedure has an element of risk, and a poor outcome may be an unfortunate complication of a disease, injury or modality of treatment. With any medical management, nothing can be guaranteed. It is a matter of weighing up potential benefits against any possible downside, which is the central tenet in the doctrine of informed consent.

In many cases, a client's concerns are more in the nature of a complaint about behavioural issues, including attitudes of staff, lack of communication or perceived delays in the management of their case. These are best dealt with within the normal complaints procedure for the practice or institution involved, and do not usually give rise to the legal definition of 'medical negligence'.

Direct enquiries would be expected to result in a written response in a matter of months. This can clarify issues and, on some occasions, complaints may result in the instigation of a Serious Incident Review (SIR), with the potential to identify areas where medical care has been deemed to be sub-standard and could be subject to legal challenge. However, if lawyers are involved on a client's behalf before the complaints procedure or SIR has been completed, it is likely any written response would not be released as the matter would be regarded as *sub-judice*.

The key to mitigating against making an emotional decision to pursue a case is to obtain a preliminary screening report by an experienced medical expert in order to establish who, in all the circumstances, might have a duty of care, what standard should be applied, and whether or not any consequence was likely to have occurred directly due to the suggested breach.

This initial opinion does not go into great depth on the specifics of the case, and can usually be based on a detailed statement from the client; but may require perusal of some specific notes and records along with the responses to any complaint. Without clear evidence of the essential triad, putting together a case becomes more of a phishing expedition which can be very costly in terms of time, effort and also financial layout which may not be recoverable.

An early, general screening overview therefore helps to contain costs as it can be provided for a fraction of the fees that would be required for a full liability and causation plus a condition and prognosis report. Therefore, obtaining a screening report as a general overview is a vital first step in the initiation of a claim. The word 'SCREENING' is also an excellent acronym for the other nine areas where difficulties for lawyers can and do arise.

Statute

The Statute of Limitations sets a maximum time after the subject incident during which legal proceedings may be initiated. It does not automatically apply, and courts have discretionary powers to grant permission to proceed if there is a compelling reason and the basis for the case appears sound. But the Statute serves as a warning to lawyers to avoid unnecessary delays in moving forward their investigation - or they may unintentionally run out of time and find themselves at the receiving end of a claim in professional negligence.

This is another benefit from swift, initial screening, allowing early determination as to whether or not matters are likely to proceed. If a case seems weak and a firm declines to take it on, clients can be informed at an early stage so they are free to seek alternative medical or legal opinion before they run out of time.

Counsel

Barristers taking on clinical negligence cases are usually highly experienced and extremely busy. When engaging counsel, it is worth ensuring they have enough time to discuss, guide and lead through the evidence and will keep in regular contact about the case.

Having a screening report allows a more informed discussion of the medico-legal aspects and, in particular, the raising of specific questions that experienced counsel may wish to be included in the briefing for the more detailed expert reports. Regular contact allows counsel to maintain an ongoing overview as the various reports are received, so they can provide direction and ensure the case stays on track, particularly giving advice on the handling of any new issues that may arise.

In complex cases, where there are likely to be multiple medical reports on both sides of an argument, it is appropriate to obtain a secondary review when all reports have been received, whereby an experienced expert can look at all the available evidence and then work in continuity with counsel to consider the implications of the information in terms of potential strengths and weaknesses before court proceedings. It is a grave error to leave this until the day of the hearing.

Reports

The initial screening report gives an early steer on liability and causation, determining the direction of a case without spending a lot of money on multiple specialist reports. It should give advice on which specialists should be involved and in what order such reports should be obtained.

From the outset, it is important to determine exactly who has been regarded as having a duty of care towards the claimant. Normally this is easy to determine, but it may not be so obvious. At first sight, the case may appear to involve a particular consultant, but closer examination may reveal it is actually in the remit of other professionals from different medical specialities, such as general practice or accident and emergency, or indeed para-medical specialities including nursing or physiotherapy.

> *Anger is a common emotion best handled through empathy, understanding and a certainty [the client] is being listened to*

With private patients, it is necessary to name specific personnel, whereas in the public scenario, indemnity is provided by the Trust or institution. Therefore it is necessary to be clear about the duty of care and whether it is vicarious. As a rule of thumb, it is better to co-join as many defendants as possible as it is easier to remove than to add a potential defendant at a later stage.

On occasions, it is necessary to reverse the sequence and obtain a report detailing likely consequential damage which may have arisen as, if none can be determined, a report on liability and causation is likely to be superfluous.

Experts

Experts must clearly understand that their primary duty is to the court no matter who instructs them, and be a recognised expert in the specific subject matter of the case. They must be able to reason logically, both orally and on paper, setting out their opinion against relevant facts and tests without using hyperbole, in a way that lay persons in general, and the court in particular, can understand and interpret.

Experts must acknowledge that the standard required is reasonableness not perfection, and be prepared to alter their stated opinion if new evidence, which they have not previously had a chance to consider, is presented during proceedings.

Ethics

It is an expert's duty to remain independent no matter who engages them. They need to be coldly objective and demonstrate no conflict of interests or bias on behalf of the claimant, the defence or a specific line of medical therapy.

It is quite reasonable to advocate a particular view as to how a particular complaint should be managed. However, it must also be accepted that there is likely to be a reasonably held range of opinion which experts should outline and, if necessary, indicate by logical argument why their opinion should be given preference.

From a lawyer's standpoint, it is not acceptable to ask an expert to 'tweak' a report in order to place their particular client in a better light. While some attempt to justify this by stating that they are only trying to do their best for the client, they do not serve either the justice system or their profession well.

An expert who agrees to change any element of a report under such circumstances is compromised, not just for the case in hand, but for any other; and is open to being severely criticised in court. It is not unknown for both experts and lawyers, found to have breached this code of conduct, to have their professional registration to practice removed by their governing body. Such censure can have considerable implications for their personal, professional and financial well-being. If an expert does change their opinion, they must be fully open and transparent, stating logically the reasons why.

On occasion, there has been a tendency to pursue a case that has no chance of success up to the door of the court in order to get a settlement of some sort, at least to cover expenses. Recent judgements have made it clear that courts regard such behaviour as a breach of ethical duty.

Notes and records

Guided by the initial screening and comments of counsel, all appropriate notes and records need

to be expeditiously sourced, well organised chronologically, indexed and paginated for ease of both study and reference; especially as, in some cases, many thousands of pages may be involved. As well as contemporaneous medical notes, other records may be valuable, for instance letters to clients from an institution following a complaint or other internal documents such as a report resulting from a serious incident review. External documents may also be available following a post-mortem or inquest, and the client themselves may have notes in a diary or even photographs on their phone.

Medical experts should be wary if they find notes have been altered in any way or redacted, especially if this has been carried out by the legal team either for the defence or the claimant. Unless the redaction relates to the names of third parties, it is not best policy to edit notes in any way before forwarding them for an expert opinion.

Insurance

Medico-legal cases can be very expensive, and costs need to be controlled. There is no such thing as a water-tight case, and loss can result in a heavy financial burden. Any law firm should be clear how it is going to be compensated if a case does not proceed as expected.

Some form of insurance is therefore needed. Clients may self-insure or have a legal policy in place at least to cover initial advices. It may also be possible to obtain legal aid or after-the-event (ATE) insurance, if it is clear from the initial screening report and the opinion of counsel the case has a high likelihood of success.

No medical knowledge / expertise

The lawyers most likely to get in trouble are those who do not undertake these proceedings on a regular basis. There are many nuances from both a medical and legal point of view that can make cases that look similar produce markedly different outcomes.

An important understanding is that reasonableness is the standard, and not perfection. Further, no medical treatment can be guaranteed of success. It is understandable, when discussing a treatment with the patient, that there will be a tendency for doctors to be optimistic, which courts have accepted as reasonable 'therapeutic reassurance'. Downside risks must also be explained, as known complications do arise during the process of gaining informed consent.

But just because a patient has been told about the risks and signed a consent form, does not mean that when such difficulties arise, they could not be considered to be due to a negligent act. An independent medical legal expert should be in the best position to determine whether a poor outcome would reasonably be regarded as due to a known complication in all the circumstances, or represent a negligent breach of the duty of care.

Guiding client expectation

In some cases, particularly when the consequences have been devastating for the client, even the most experienced lawyers may become emotionally involved. The rule is empathy, not sympathy, and to remain objective throughout so clear, unencumbered, professional advice may be given to the client.

It is important to get to know the client in order to understand how to influence them. At an early stage, an in-depth conversation is needed, to ascertain exactly what outcome a client expects from the case. Some want to punish, others wish for monetary compensation; but on many occasions the client is primarily looking for a detailed, understandable explanation as to what happened. It is therefore important to listen to understand where the client is coming from, to ask questions and summarise what is heard in order to gain clarity. Anger is a common emotion that is best handled through empathy, understanding and a certainty they are being listened to, rather than any logical argument.

Managing a client's expectations is one of a lawyer's most important functions, and vital if the client is to feel content with the outcome, however long the process takes. There must be clarity on deliverables; what sort of timeframes are to be expected, who will have to be consulted, what the costings will be and who will be paying for it.

It is important to be totally authentic and provide a personal service, explaining the system within the office, how clients can get through and how often they will be updated. Unfortunately, on many occasions the expert may be the only person who actually has face-to-face contact with the client, especially during the recent pandemic, which can lead to misunderstandings. Clients need to understand what the expert's role is, and that they are not acting as a GP or medical specialist for the client.

The expert may often be the only person who actually has face-to-face contact with the client... which can lead to misunderstandings

Whatever is agreed, it should be written down in a letter of agreement, not relying on oral recall. The client should be clear about the steps, for instance that matters will be discussed with them once in receipt of the preliminary screening report and advice from counsel. With everything, it is about trust - which includes 'no' when necessary. At the first sign of any difficulties, communicate quickly.

Conclusion

These have been the most frequent challenges in the legal process noted in over three decades of dealing with personal injury and clinical negligence cases. The basis of a sound case is being able to show strong liability and significant harm coupled with a good, credible claimant. Legal representatives must have a deep understanding of the many complexities involved, and be aware of potential pitfalls.

Securing an early screening and proficient advices from an appropriate medical expert goes a long way to mitigating any possible financial and reputational risks.

Rodney Peyton OBE is a consultant trauma surgeon and founder of Peyton Medico Legal; www.rpeyton.com

CASE NOTES

Full reports of all cases listed are available on APIL's website at www.apil.org.uk/legal-information-search

Gul v (1) McDonagh (2) Motor Insurers Bureau [2021] EWCA Civ 1503

19 October 2021

Lord Justice Nugee

Liability: contributory negligence; low reduction

As he was crossing the road on Saturday 17 October 2015, the appellant, Saboor Gul, then aged 13 years and 8 months, was struck by a car driven by the first defendant, James McDonagh, which was travelling at about 40 mph.

As a result of the accident, McDonagh was charged with, and pleaded guilty to, a count of causing serious injury by dangerous driving, and a further count of dangerous driving arising out of his conduct after the accident, and sentenced to a term of imprisonment. He took no part in the proceedings either at first instance or on appeal.

The action was brought by the appellant against McDonagh as first defendant, and the Motor Insurers Bureau (MIB) as second defendant. McDonagh was uninsured, and the MIB was joined as having a contingent liability to satisfy any judgment against him.

The MIB admitted primary liability and judgment was entered against Mr McDonagh for damages to be assessed.

The question of contributory negligence was tried as a preliminary issue before HHJ Gargan, sitting as a Judge of the High Court, who found that the appellant had been contributorily negligent, and that it was just and equitable to reduce his damages by 10%.

HHJ Gargan refused the appellant permission to appeal, but he was granted permission by Bean LJ. In the appeal, the appellant contended that HHJ Gargan should not have made any reduction.

However, Nugee LJ dismissed the appeal, concluding that the judge had not made any error.

He said: '[HHJ Gargan] was fully alive to the egregious conduct of Mr McDonagh, and regarded it, rightly, as weighing heavily against him, but he also concluded that the appellant's culpable misjudgment could not be wholly ignored, although he selected a figure of 10% at the lower end of the suggested bracket.

'It was common ground that 10% was an unusually low reduction, but I see no basis for saying that it was not open to the Judge to adopt it. It is impossible to say that it is outside the range of reasonable determinations.'

Paul Rose QC and David Rivers appeared for the appellant, instructed by Slater and Gordon

Tim Horlock QC, instructed by Weightmans, appeared for the second respondent

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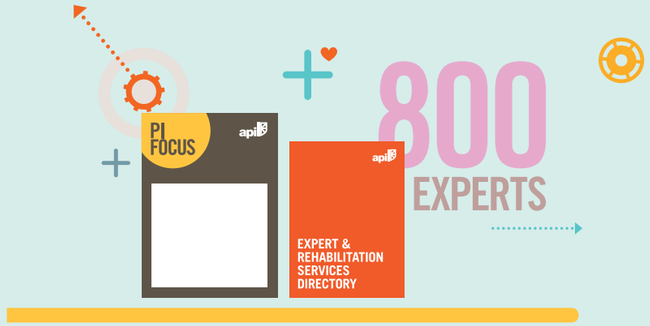

THE LAST WORD

Last month we welcomed Paul Fleming to the APIL staff team. He joins us in a new and much-needed role as Head of Business Development. It's great to add Paul to my brilliant senior management team with the skills and experience he brings from his previous roles.

Paul brings expertise in sales and business development which will help APIL respond to the evolving PI sector and the needs of injured people. There are clear signs of consolidation in the sector, along with firms looking at how they can grow their market share and improve margins by diversifying and specialising. There is lots of opportunity for us to grow our organisation and widen our appeal to more stakeholders and more firms. As a not-for-profit campaign group committed to injured people, we need to ensure we grow to fund our unique campaigning activity, and ensure the sustainability of our Association and our ability to deliver on our challenging strategic plan.

Like most organisations in the third sector, we have had to respond to the impact of the pandemic, and have invested in our ability to offer virtual training and events as we worked to continue to engage with members during the restrictions we have all faced. In many ways this has been very successful and we have, for example, seen a big increase in attendance at regional and special interest group meetings in their new virtual format.

'Growing our membership is a strategic priority and will increase our reach and influence'

As the world starts to return to some kind of normal, things have changed, and many people's priorities and perspectives have also shifted. We are balancing the benefits of virtual engagement with the importance of offering in-person networking and training opportunities at our residential conferences and training courses. Our model for training and events going forwards is to provide a hybrid approach where we can, so that we can meet the needs of as many members as possible. How demand will develop and change is difficult to predict, but we will respond quickly and effectively to future trends to ensure members can access easily the benefits they want.

Paul is a business development professional, but I am sure he would agree that, as we are a volunteer-led group and a community of like-minded people committed to needlessly injured clients, our best sales force is our members - and I hope you will champion APIL in your own firms and with other contacts in the sector. Growing our membership is a strategic priority and will increase our reach and influence to help us ensure the injured person's voice is always heard loud and clear. So, please do be an advocate for APIL.

Paul is looking forward to meeting members and will be working hard to bring new ideas and improve our relationships with firms and other stakeholders where required. In the meantime, I'm sure he would love to hear your ideas for how we can attract even more members to APIL, so why not get in touch at paul.fleming@apil.org.uk.

Have a great Christmas and New Year, and see you in 2022.

Mike Benner
Chief executive

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