Lord Justice Jackson

Review of Fixed Recoverable Costs

A response by the Association of Personal Injury Lawyers

January 2017

The Association of Personal Injury Lawyers (APIL) is a not-for-profit organisation with a 20-year history of working to help injured people gain access to justice they need and deserve. We have over 3,500 members committed to supporting the association's aims and all of which sign up to APIL's code of conduct and consumer charter. Membership comprises mostly solicitors, along with barristers, legal executives and academics.

APIL has a long history of liaison with other stakeholders, consumer representatives, governments and devolved assemblies across the UK with a view to achieving the association's aims, which are:

- To promote full and just compensation for all types of personal injury;
- To promote and develop expertise in the practice of personal injury law;
- To promote wider redress for personal injury in the legal system;
- To campaign for improvements in personal injury law;
- To promote safety and alert the public to hazards wherever they arise;
- To provide a communication network for members.

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1. Introduction

1.1 There is an injured person at the centre of the personal injury litigation process. They are not a commodity or commercial transaction, they are your relative, colleague or neighbour, injured through no fault of their own. Their bodily integrity has been harmed meaning that they should be treated differently from other types of litigation, this is because they are likely to be disadvantaged in terms of their own ability to get back to where they want to be, had the injury not happened. Injuries are unpredictable, recovery does not take a set path. More often than not injuries that fall into the multi track[1] are changeable, no two cases are the same. It is often impossible to say at the beginning of the case whether, for example, there will be a need for one or several operative interventions, whether the individual will regain function following nerve damage, whether a bone knits together or if a limb will need to be amputated. Certain types of injury, notably brain and mental health injury are notoriously unpredictable by virtue of the nature of the damage done. It is more likely than not in these cases that there be additional emergencies and breakdowns that will take the case away from a more predictable course. Unlike other types of litigation in which the loss crystallises at the point of damage or very early on, personal injury (PI) is diverse and requires a different approach. Cases of this nature also carry additional elements for consideration including, future losses based on the Ogden tables, possible periodical payments and advice on investment, including the protection of the claimant's compensation through a Personal Injury Trust.

1.2 Assessing the impact of fixed recoverable costs on access to justice is essential. The two are intrinsically linked. And whilst the argument has been made many times before, there is more to the right level of costs than simply the sums at stake. It is essential to consider the work involved in conducting litigation.

1.3 APIL recognises that efficiencies in process and procedure are important. The organisation has been instrumental in the development of the portal for RTA, EL and PL cases. These systems were designed to specifically improve the process and reduce cost. When that process was fixed all involved understood that once you went beyond £25,000 it became very difficult to fix the process. The process was intentionally created to fix the amount of work involved, once that had been developed the fees were fixed for each stage of the process based on the amount of work required. Imposing *fixed fees* without a *fixed* process creates an uneven playing field. In each and every PI case there will be a vulnerable individual taking on a well-resourced insurer. This inequality will be exacerbated in a fixed cost regime as defendants will have more "buying power" thus automatically increasing their control and the tactical advantage that an insurance company holds over an injured and potentially vulnerable individual.

1.4 Personal injury litigation has undergone radical change in the last six years. A large proportion of fast track personal injury is already subject to a fixed cost regime. At the time of writing it is expected that the Government will soon announce a consultation examining fixed costs for clinical negligence cases. Noise induced hearing loss claims are also undergoing a series of cross industry negotiations to fix costs

[1] By referring to Multi track cases we are describing cases that are valued over £25,000.

meaning the vast majority of personal injury cases are already subject to a fixed costs regime. YouGov polling data suggests a tiny fraction of all personal injury claims are valued at £25,000 - £250,000[2]. In February 2016, YouGov[3] asked 250 successful personal injury claimants how much they received in compensation. Excluding those who did not say how much compensation they received, just 3.4% of successful claimants said they received compensation of £25,000 to £250,000. Where costs are incurred outside of these parameters there is already greater certainty due to cost budgeting.

2. The right approach for the injured person

2.1 From a jurisprudential viewpoint the objective of rehabilitation is what differentiates personal injury litigation from other civil or commercial litigation. The fundamental principle applied to the assessment of an award of damages is that the claimant should be fully compensated for his loss. He is entitled to be restored to the position that he would have been in, had the accident not happened, insofar as this can be done by the payment of money[4]. Ensuring that the injured person receives early rehabilitation is one of the best ways this can be achieved and is recognised through the Rehabilitation Code[5]. A copy is attached. The purpose of the Code is to promote the collaborative use of rehabilitation and early intervention in the compensation process. It aims to help the injured claimant make the best and quickest possible medical, social, vocational and psychological recovery. There are ten 'markers' within the Code that should be referred to when assessing an injured person's rehabilitation needs these are: 1. Age (particularly children/elderly); 2. Pre-existing physical and psycho-social comorbidities; 3. Return-to-work/education issues; 4. Dependants living at home; 5. Geographic location; 6. Mental capacity; 7. Activities of daily living in the short-term and long-term; 8. Realistic goals, aspirations, attainments; 9. Fatalities/those who witness major incidence of trauma within the same accident; 10. Length of time post-accident.

2.2 Rehabilitation is a shared objective, one which is crucial to the injured person but also provides a benefit to society and government. Even now with the lack of specific provision in Costs Budgeting there is a danger that no room is made for rehabilitation to be effective and it would potentially be even worse in a fixed costs regime, proving a disincentive for both parties to get involved. It would be much easier to fix this oversight in costs budgeting than it would in a fixed cost environment. It would also ensure that the cost of the rehabilitation is identified as that. To create such a position would be fundamentally wrong, the Code like the Serious Injury Guide (discussed below) put the injured person at the centre of the process. In addition to achieving a return to work (which makes the injured person a tax payer again) the Code helps the injured claimant regain independence so far as is possible which releases the pressure on the NHS, DWP, and local authorities. Access to

[2] We have been unable to source any more definitive data on the number of claims falling within the £25,000 to £250,000 bracket.
[3] Personal Injury 2016 Report, YouGov, April 2016
[4] *Livingstone v Rawyards Coal Co* (1880) 5 App Cas 25, 39
[5] http://www.iua.co.uk/IUA_Member/Publications

rehabilitation can help a person to recover and/or return to work more quickly, or even return to work in circumstances where without rehabilitation they may have been unable to do so at all – reducing the strain on society.

2.3 It is important to encourage good litigation for all concerned in the process. APIL has been working with FOIL and a number of key insurers over the last ten years to put a process in place that meets the reasonable needs of the injured person whilst ensuring that the parties work together towards the efficient resolution of the case.

2.4 The result of this joint work is the Serious Injury Guide[6], which provides a framework for dealing with higher value cases that encourages collaboration resulting in continued liaison, case planning and the narrowing of issues in dispute. This ensures that issues over experts, costs etc are dealt with at each stage of the process leading to resolution of the issue, concluding the case at the earliest opportunity and at an appropriate and proportionate cost. A copy of the Guide is attached.

2.5 The premise of the guide is an important one, as it enables the injured consumer who is reliant on legal services to obtain the assistance they need, ahead of the costs regime whilst reducing the costs involved in a case. By the parties agreeing to the steps to be taken in the case, they in turn agree to the level of costs being incurred at each stage of the pre-litigation process. It also allows for the proper level of specialist fee earner to conduct the case. It also ensures that the client's rehabilitation needs and the process involved with that is put before a one size fits all fixed costs figure. On one view rehabilitation is like mediation. The dispute is about the injuries not the value of a contractual dispute, and the rehabilitation goal is for the parties to mitigate losses, put the wrong right, and narrow issues before resorting to litigation. The Serious Injury Guide approach takes that analogy a logical step further and seeks to force parties to address liability issues at an early stage and without recourse to litigation

2.6 Whilst the initial scope for this best practice guide was set for cases valued over £250,000[7] there is no reason why this cannot be extended to the lower realms of the multi track. The benefits would remain the same, namely:

- Early contact. The guide is designed to ensure notification of the claim to the relevant insurer and claims handler within a short period of time from initial instruction. This saves time locating the correct handler reducing cost and effort on both sides whilst ensuring that dialogue commences more quickly, and this is better for the injured person.
- Ongoing regular dialogue, this promotes forward planning and ongoing agreement as to the steps that need to be taken. It ensures that the case progresses, prevents duplication of work and means that the parties will commit to certain timeframes within which to progress particular issues e.g resolving liability.
- Resolve liability as quickly as possible. In all cases handled under the Guide there is a commitment to resolve liability by agreement, with a view to this being finalised

[6] Previously known as "the Multi-Track Code", which Lord Justice Jackson expressed support for in his Final Report on Civil Litigation Costs

[7] This lower threshold was set for administrative reasons. Insurance companies advised that it would be easier for them to train staff and administer these claims initially in cases over £250,000.

within a maximum period of six months from the date of first notification. Where this is not possible, to identify the barriers that are stopping liability being resolved and to agree an action plan to conclude the issue at the earliest opportunity.

- Access to rehabilitation. The guide includes a commitment to early discussions about the claimant's rehabilitation needs. Where necessary, the parties are encouraged to try to agree an appropriate case manager for the claimant's needs.
- Dispute resolution. Ongoing dialogue is encouraged to resolve any disagreements arising throughout the claim. If discussions fail to resolve issues, there are nominated escalation points for each signatory. These are more senior claims handlers who will act as a contact point in order to try and resolve an issue. If the escalation process is unsuccessful, parties are encouraged to consider all methods of alternative dispute resolution.
- A commitment to early interim payments. Defendants participating in the guide have expressed a willingness to make early and continuing interim payments of damages where appropriate. Those participating in the guide also recognise the benefits of making interim payments of disbursements and base costs relating to liability once that issue is resolved.

2.7 The guide has been well received, with 61 claimant firms conducting serious injury work, 13 major insurers and the Motor Insurers' Bureau all committed to working in accordance with the guide. Recent surveys by both APIL and FOIL showed an increased commitment to collaborative working amongst signatories[8]. The Civil Procedure Rule Committee has also recently supported a proposal to amend the Pre-action Protocol for Personal Injury Claims to include a web-link to the guide, recognising that the approach set out in the guide would be beneficial for cases other than those over £250,000.

Case Study

- ***Case conducted in the spirit of the Guide.***
- ***This case is valued at over £250,000 and is a clinical negligence case but shows the benefits of the Guide's objectives***

A clinical negligence claim was brought arising from the decision to let a patient walk out of psychiatric hospital unattended. The patient subsequently attempted suicide and was left in persistent vegetative state, sadly dying in hospital in May 2014.

An Inquest was held in August 2015. The Coroner found there had been a failure to protect the patient and decided that the death could have been preventable. Following the Inquest, the defendant made a realistic offer to settle the claim, despite not yet having been served with a letter of claim.

Subsequent negotiation led to settlement. The defendant's proactive approach following the Inquest meant that the case was settled without the costs of pre-action protocol, letter of claim, letter of response and court proceedings being incurred. The defendant's solicitor

[8] A recent survey by APIL revealed that 75% of participants said that following the guide led to greater collaboration.

explained that this approach was being taken to try and avoid further distress for the family.

This highlights how defendants can act to help resolve cases promptly whilst also minimising costs.

Case Study

- ***Case conducted in the spirit of the Guide.***
- ***This case is valued at under £250,000 but shows the benefits of the Guide's objectives***

GB, a 64 year old single lady, sustained very serious lower limb/orthopaedic injuries in a road traffic accident in 2016. She was in hospital for several months and it was clear that she was going to need a great deal of assistance in relation to returning home, particularly she was going to need care and support whilst she started to learn to mobilise, she was going to need to live downstairs in her property initially and then when her mobility increased she would need alterations to upstairs bathroom, the installation of a stair lift and additional physiotherapy. She would need the appointment of a case manager to help her coordinate the discharge process and ongoing care and support, liaising with builders etc.

The likelihood was that this particular client would make a good recovery, her care needs in the long term future were likely to be limited and the total value of the case is likely to be in the region of £100,000 to £250,000 and therefore not normally covered by the Serious Injury Guide.

Despite this both claimant solicitors and the insurers, and their solicitors, recognised that early intervention and assistance with rehabilitation was going to be to the mutual benefit of all concerned and we agreed to run the case as if it were a higher value one under the Serious Injury Guide.

An initial meeting took place between claimant lawyers, insurers and their solicitors, the appointment of a case manager and interim funding for the provision of care, equipment, alterations to the property and ongoing needs were all agreed. Although there was initially a dispute upon liability with potentially two defendants being involved insurers agreed to immediate funding without the need to prove liability. A further case planning meeting is to take place at the client's property with the insurers and their solicitors (together with the case manager) in February and the parties will be able to agree upon further rehabilitation in the future and general case planning for the litigation process including the obtaining of medico legal evidence.

All parties in this case are in agreement that the steps taken to date have been for the considerable benefit of the Claimant and for the benefit of the insurers as effective rehabilitation at this stage will reduce long term requirements for care and assistance and therefore reduce final damages.

The current matrix does not provide for the legal costs involved in relation to the rehabilitation process, the regular meetings with insurers etc.

If extensive rehabilitation as featured in this case is not going to be possible in the future in relation to cases where the total value is potentially less than £250,000 then this would be to the very significant detriment of clients such as Mrs GB; it will also place an additional burden upon the State as clients would have a greater requirement for State funded assistance in relation to care and disability related benefits which could otherwise be avoided if appropriate and speedy rehabilitation funded by insurers was available.

Case study

- ***Benefits of collaboration***

F was injured in a road collision in November 2013. A car mounted a pavement and knocked her over. At the time she was 17 years old.

F suffered a severe brain injury with a bilateral frontal extradural haematoma requiring a left craniotomy with evacuation of the haematoma. F has suffered residual effects of her brain injury:-

1. Executive dysfunction;
    - Distractibility;
    - Difficult with sustaining attention;
    - Difficulty with organisational skills;
    - Difficulty with planning;
2. Anxiety;
    - Difficulty with adjusting to trauma;
3. Emotional liability;
4. Fatigue;

The effects of the injury has had a marked impact on F. Although she was able to return to school (6th form college) very quickly, the impact of the brain injury soon began to demonstrate itself. It took her three years to complete her A level course although she did score high marks. She is still high functioning but has the problems outlined above. She was also a signed scholar and planned to go to university to study a science degree. It was anticipated that she would go to a top university, possibly Oxford or Cambridge.

F is now at university but a local one and doing a graphic design degree. She has abandoned science. It is quite clear that this is going to impact on F's career. It is contended on her behalf that there will be a substantial loss of income throughout her career. It is also alleged that she will require support with activities of daily living in order to enable her to live as independently a lifestyle as possible. The condition is permanent. A claim was made on her behalf against the driver of the vehicle. Her insurer's response was immediate and they admitted liability.

Throughout the case, the insurers have made available interim funding in order to assist F with rehabilitation which has mainly consisted of the intervention of a neuropsychologist. The stage has been reached where it has been decided that F needs more significant intervention including the involvement of a case manager, occupational therapist as well as the neuropsychologist. Again, the insurers are making available the necessary funds to fund this to pay for this treatment.

They have also been settlement discussions. Two offers have been made. Both are very substantial. Both represent a realistic view of the potential value of the case. The defendants have received all of the medical records relating to the claimant and the medical reports have been obtained on her. Whilst there has been unilateral disclosure, the defendants have been quite prepared to formulate their offer on the basis of the evidence that has been disclosed to them.

Although the case has not yet been resolved, a real feature has been the insurance company and their solicitor's sensitivity towards the difficulties the claimant is facing. There is a significant offer on the table but the defendants are content to let F wait until the decision of the Lord Chancellor relating to the discount rate before finally deciding whether or not to accept the offer.

3. Personal injury litigation

3.1 Claims valued at more than £25,000 involve potentially life changing injuries. Imposing fixed costs on those cases reduces the amount of time and in turn the amount of work the claimant representative can afford to do to prove liability and/or causation. For example, identifying a defendant, proving liability, attending the scene of an accident (commonly in the company of experts), liaising with the CRU throughout the life of the claim to monitor accuracy of figures, complexities over proving and calculating the person's financial losses, pension loss claims, loss of employment and career prospects along with multiple medical and non-medical experts all of this work requires, skill, time and resources. They also involve dealing or engaging with social services and other public bodies such as the DWP which is an inevitable part of the evidence gathering required in every personal injury case. Together with HMRC and the NHS, the resources of these bodies are so stretched that engaging with them and relying on them to respond or provide information is time consuming and laborious.

3.2 These cases are often difficult to value at the outset because one individual's rate of recovery will be very different to that of another.

Case Study

- ***Difficulties valuing claim at outset***

Mr F was travelling as a rear seated passenger in a taxi when the driver fell asleep at the wheel and collided with a central island. C was thrown forwards and suffered a fractured skull. C was taken to hospital by ambulance but discharged later that morning with head injury advice. He had no further rehabilitation.

The claim was initially valued in the region of £30,000 3 days post accident. At this stage it was unclear what the long term consequences of his injury would be. His special damages were also unclear as he was only carrying out casual cash in hand work as a scaffolding labourer at the time of the accident. The claim was taken on and medical records obtained to get a better idea of the injury and any ongoing difficulties.

A neurology report was obtained that suggested a mild head injury but noted ongoing cognitive difficulties and suggested a report from a neuropsychologist. This report highlighted some under-functioning and recommended that we obtain a report from a neuropsychiatrist.

The neuropsychiatrist instructed considers that Mr F suffered a moderate brain injury, with ongoing cognitive impairment and behavioural changes. He also considers that he is suffering from PTSD and recommends psychological treatment. He considers that Mr F lacks capacity pursuant to the Mental Capacity Act.

It is likely that the value of this claim now exceeds £75,000 (more if a claim for future loss of earnings).

Mr F was not very forthcoming about his difficulties initially and so it was initially difficult to understand the severity of his ongoing symptoms and their impact on his daily activities. However, given the solicitors specialism in dealing with brain injury cases they were able to obtain the right information from the claimant to obtain the necessary medical needed to accurately value the claim.

Liability and causation arguments

3.3 Fixed costs risk failing to allow for the fact that a great deal of time is necessarily spent investigating negligence claims, (particularly work related) before the letter of claim can be sent. The claimant bears the full burden of proving both breach of duty and causation. Unless liability is admitted at the outset, this can be an onerous, time-consuming and a necessarily expensive task. There are often practical difficulties with getting evidence from witnesses , they may have witnesses an RTA be unknown to the claimant and be reluctant to be involved in litigation or they may for example be fellow employees who are reluctant to get involved due to fear for their own positions within the company. The legal team may not have access to their details for considerable time, the police report may not be available for some months and without a fee, there may be internal protocols, witness interviews with public officials such as police officers that are not permitted until proceedings have been commenced.

3.4 The assumption that the complexity of the claim (and therefore the number/nature of experts required to prove liability, causation, quantum) equates with the value of the claim is a common misunderstanding. In contrast with some straightforward RTA claims for example, where liability is usually reasonably obvious, this may not always be the case in other types of negligence claims where the claimant must conduct

liability investigations, usually requiring expert advice. This is exacerbated when the defendant denies liability throughout the life of the claim.

Loss of earnings

3.5 Establishing loss is often twofold: (1), past loss calculated through evidencing loss from past earnings and (2) future losses calculated following engagement with employers and co-workers. There are also then possible added issues such as career progression that will need to be factored in.

3.6 Past losses- For employed claimants a large proportion of a lawyer's job might involve reliance on helpful employers to provide documentary evidence on past earnings history, not all employers all helpful and willing to provide such information. Some maybe the defendant to the claim. Compiling details of loss of earnings if the client is self-employed is a larger exercise and it is often necessary to trace back through their accounts and tax returns which will involve greater engagement with third parties such as accountants and HMRC.

3.7 Future losses- Establishing these loses also requires co-operation from third parties such as employers in processing witness evidence about performance, promotion and career prospects, and access to comparator information. In a self-employed scenario, given the impact on a small business it might require a forensic exercise looking at the importance of the individual to that business and again a search for comparators, which is difficult given that these are likely to be competitors.

3.8 Clients are also often contractually obliged to reimburse pay to employers and this is an area that creates cost of work in identifying the amounts (often large in these cases) being satisfied about the legitimacy of the contractual basis, which sometimes results in disputes with defendants. If the sums are recovered it is necessary to then deal with the accounting.

Case Study

- ***Loss of earnings claim***

Mr A was involved in a road traffic accident in June 2011. He was knocked off his motorbike in a collision with a lorry, which had pulled out of a junction and failed to give way.

Mr A suffered a broken wrist and was placed in a plaster cast for six weeks. Following removal of the cast, he continued to experience pain and discomfort in his wrist. He finally underwent surgery in April 2012 and wore a cast again for a further two months. Mr A's symptoms in his wrist lasted for approximately one year after the accident.

Liability for the accident was admitted by the Defendant's insurers. The main point of contention in this case concerned Mr A's loss of earnings claim, which was far in excess of £20,000. Prior to the accident, Mr A had been working as a self-employed security operative for a football club, a cricket club and a security company, all of which required him to control unruly sports fans who became aggressive. Mr A had also carried out self-

employed work for a legal services company, which required him to ride his motorbike and serve people with various documents. These people could often become confrontational. Mr A was unable to continue with any of these roles without risking further pain and injury to his wrist. He was also unable to continue riding his motorbike.

Fortunately, the football and cricket clubs were able to alter Mr A's roles, so that his wrist was not put in jeopardy. However, he was unable to continue working for the security company and the legal services company. He therefore lost a significant proportion of his earnings for the first 12 months after the accident.

Gathering evidence in support of Mr A's loss of earnings and calculating those losses was complicated and very time consuming. This was because Mr A had worked for several companies on a freelance basis. Documentary evidence was collated in support of his loss of earnings, detailed witness statements were also taken from members of each company Mr A worked for in order to substantiate his claim, which was heavily contested by the Defendant.

Eventually, the parties reached a **settlement of £35,000.**

3.9 Value does not necessarily reflect the complexity of a claim, for example the effect of a loss of earnings claim should not be forgotten when looking at the value of the overall case. Fixed fees based on the value of the claim will disadvantage those who earn less- women, the young, the old. A claim for loss of earnings will have a noticeable effect on the final value of the claim.

Case study

- ***Effect of loss of earnings on value of claim***
- ***Need for liability evidence.***

K v (1) Dr Chandok (2) Dr Inthira-Raj (3) Dr Singh (4) Dr Mohan[9]

This study is taken from a case report first published on APIL's website and in PI Focus, APIL's membership publication.

Mr K, aged 50, had a history of hypertension for which he had been prescribed Olmesartan. Mr K had blood tests in January 2006 revealing normal renal function.

Routine blood tests in February 2007 showed a raised creatinine of 157 and a reduced eGFR of 43. No action was taken by the GP surgery. Following an attendance at hospital for pain in his leg in September 2007 the claimant was found to have a raised creatinine level of 179 and an eGFR of 37. A letter was sent by the hospital to the GP surgery advising of the claimant's renal problems and advising that investigations be carried out. A

[9] APIL PI Focus, vol 23, issue 7, page 28

series of consultations and appointments both with his GP and at hospital for apparently unrelated reasons followed.

On 22 April 2009 the claimant registered at a new GP surgery as his symptoms were becoming worse. Blood tests were immediately carried out revealing creatinine levels of 353 and an eGFR of 16. On 05 May 2009 the new GP referred him as an emergency to a renal physician. Advanced renal disease and renal scarring was confirmed following a biopsy. The claimant went onto renal dialysis in May 2010 and underwent a transplant in May 2011.

The opinion of a GP expert was sought to comment on liability. Following this the opinion of a consultant nephrologist was sought and it was confirmed that there were several opportunities for renal referral.

As a result of the failure to refer Mr K, his symptoms were not appropriately managed. He had two years of unnecessary pain and suffering, water retention and general lethargy and malaise. He was also unable to work.

The NHSLA made an offer to settle the claim for £10,000 for pain and suffering which was accepted by Mr K.

Additional sums for two years' loss of earnings were also agreed in the sum of £20,000.

Total damages: £30,000.

Subrogated outlays

3.10 As with loss of earnings claims claimants often have a contractual obligation to repay outlays to health insurers in the event of a personal injury claim. Such losses are an item of special damage. Often large amounts are involved are the sums are sometimes contentious due to arguments about causation, amount and necessity of treatment etc. It would be unfair to penalise a claimant for the cost of this exercise if they were caught up within a 'fixed' regime. A claimant could be contractually obliged to pursue recovery, but then penalised in fixed costs based on value if that was unsuccessful

Multiple experts

3.11 The assumption that the complexity of the claim (and therefore the number/nature of experts required to prove liability, causation, quantum) equates with the value of the claim is a common misunderstanding in PI cases.

Case Study

- ***Multiple experts required on causation, care and occupational therapist***
- ***Acceleration injury***

X v Wye Valley NHS Trust (unreported)

The claimant was born with Spina Bifida. This caused the claimant weakness in both legs from infancy. He also had a longstanding history of urinary incontinence and a long-term supra-pubic catheter was inserted in December 2005.

In April 2011 the claimant was referred by the District Nurse to the Accident and Emergency department at the Hospital as the District Nurse had been unable to re-insert the Claimant's supra-pubic catheter. The Claimant was then admitted to the Acute Admissions Assessment Unit at the Hospital. The plan was for cystoscopy and re-insertion of the suprapubic catheter this did not happen and there was a 3 day delay during which time the claimant was incontinent of urine. After the procedure there was then a further 5 day delay in recognising that the catheter had been incorrectly placed and before it was adjusted, during which time the claimant was again incontinent of urine. It was also noted that the claimant had suffered pressure/friction injuries to his heels (thought to be as a result of his pressure stockings becoming wet from urine). These were treated in the community and were noted to have healed within 3 months.

Urology expert evidence was obtained. The allegations related to the delay in performing the procedure to re-insert the SP catheter, and subsequent delay in recognising that it was in the wrong position and rectifying that (total of 8 days of delays) – this was admitted as a breach of duty.

It was initially thought that the compensation would be claimed for the extended admission, period of incontinence and pressure injuries to the heels for which no expert evidence would be required as they had healed. Valuing the case around £10,000 to £15,000. On further investigation with the claimant, it was noted that despite the claimant's underlying condition of spina bifida, prior to the index events the claimant had been able to independently mobilise around his home with crutches and he was no longer able to do this after the admission to hospital. He underwent months of physio which did not improve the situation and also had surgery to his legs which again did not assist.

The claimant was obese and was also in the waiting list for bariatric surgery prior to the index events, which was then postponed because of his injuries but eventually took place and was successful and the he lost a lot of weight but this did not assist with his mobility as he had been 'off his legs' for some time by then.

Evidence from a spina bifida expert (of which only one expert was located that was able to assist) advised that the extended admission to hospital and subsequent pressure injuries were causative of the claimant going from a position where he could independently mobilise to not being able to and being completely reliant on a wheelchair and having additional needs accordingly. It could not however be alleged that this was a permanent injury as it is likely the claimant would have suffered such a decline in any event due to the nature and usual course of his underlying condition.

Careful consideration needed to be given to the 'acceleration period' in light of the intervening event of the bariatric surgery which would have assisted the claimant to maintain his mobility for longer had it taken place at a time when he was still mobilising. An

acceleration period of 5 years was eventually agreed and so the claimant was entitled to additional damages for his losses in this period.

Expert evidence from care and occupational therapist was required, carefully assessing what was required in any event and what additional needs resulted from the decline in mobility during the 'acceleration period'.

Total damages: £35,000.

3.12 A brain injury typically affects cognitive, intellectual and mental health functioning. That can have an impact on short and long term memory, the ability to process and speed of processing, behaviour, emotion, tiredness, frustration and irritability, aggression concentration and can result in entire personality change. Cases of this nature are likely to lead to breakdown of family relationships affecting spouses, partners and children, criminal behaviour leading to police involvement, irrational behaviours etc. which it turn result in sudden crisis. Mental health cases, for example as a result of abuse can have similar consequences. The number of experts in a brain injury case can be extensive for example, you would be considering reports from a neurosurgeon, neuroradiologist, neuropsychologist, neuropsychiatrist, educational psychology (child), ENT and opthalmology, therapies including specialist brain injury speech and language, physiotherapy, occupational therapy, CBT, counselling, nursing care and specialist equipment provision. These experts need to be reliable and competent and often need to be prepared to enter suitable financial arrangements such as the deferral of fees, given that an injured claimant and is more often than not, unable to fund a host of expensive reports.

3.13 It will also be necessary to investigate and engage with treating medical professionals which can sometimes give rise to tensions. It is also often necessary in a brain injury case, to attend case conferences and multi-disciplinary team meetings and to have meetings with appointed case managers who are part of the rehabilitation team. In many, more complex multi-track personal injury claims there will now be an appointed Case Manager and this is envisaged and agreed by both parties (see Rehabilitation Code).

3.14 The process of selection and engagement with the Case Manager is one that requires time and skill and is imperative to optimise the outcome for the injured person. That Case Manager is crucial in monitoring both home based and institutional rehabilitation regimes and the setting of goals and monitoring whether they are achieved. Defendants will be the first to recognise that. The impact of the selection of the wrong Case Manager to the client's recovery and the damages claim can be seen from the case of Loughlin v Singh[10].

Case Study

- ***Multiple experts***

[10] [2013] EWCH 1641 (QB).

Miss K involvement in a road traffic accident. On the face of it the case appeared to be a relatively straightforward rear end shunt and was being dealt with by panel solicitors instructed by the claimant's BTE insurers. The claimant underwent a medical examination by a GP and a further medical examination by a local consultant orthopaedic surgeon. Upon receipt of these reports the claimant was receiving pressure from her panel solicitors to settle her claim for a value somewhere between £5,000 and £10,000. The claimant was unsettled by this pressure hence she approached new solicitors just over 2 years post-accident.

New solicitors took instructions and it was clear on meeting with the claimant that the orthopaedic and GP evidence was not truly reflective of the ongoing nature of the symptoms that she was experiencing. She had ongoing pain fatigue and memory difficulties. Medical evidence bore no reflection of the restrictions she was experiencing in everyday life.

Fresh evidence from an orthopaedic surgeon, identified concerns regarding cognitive deficiencies, it also highlighted memory and concentration issues that the claimant suffered from. Recommendations were provided for the claimant to be referred to pain management and for neurology evidence to be commissioned. Ultimately the claim was presented using a multi disciplinary approach of experts in the following disciplines:-

- Orthopaedic surgery;
- Neurology;
- Pain management;
- Clinical psychology;
- Neuropsychology.

The claimant's medical evidence was not accepted and the case was issued. Claimant underwent examination by the defendant's experts. Following exchange of medical evidence the claim was **settled by negotiation for £250,000.**

Vulnerable claimants

3.15 Personal injury litigation by its very nature involves damaged individuals, in some cases however, this problem is exemplified. An individual who has suffered a lifetime of damage as a result of suffering sexual abuse. These cases will almost always involve detailed investigations on liability necessitating claimants recounting the traumatic emotional, physical or sexual abuses from their past causing additional distressed. These individuals will require significant guidance and support throughout the process.

Case Study

- ***Child Abuse***

The claimant was sexually abused by a teacher at his school in about 1980 when he was 12 or 13 years old. The abuse was reported to the school, but no steps were taken to report the teacher to the police. The claimant believed that the abuse had had a profound

effect upon his education, career and life in general. He was advised to report the abuse to the police which he did in 2012 and a prosecution of the offender was successful. The claimant then wished to bring a civil case. A letter of claim was sent to the responsible local authority and after disclosing GP records, an offer of £5,000 was received. Supportive psychiatric evidence was obtained but on further investigation, he had a number of other life difficulties which broke the chain of causation. The case finally settled at £20,000 which took into account the problems with causation. The case took over three years. Costs were agreed at £50,000 and had causation been established, the case would have been worth over £250,000.

3.16 During the course of a case involving brain injury or mental health injury, such as might occur following abuse, there is a duty on the conducting solicitor to monitor mental health and capacity. That can also fluctuate throughout the life of the case. It needs to be weighed at the beginning and monitored throughout in case as to whether a Court of Protection Deputy needs to be appointed. That has a bearing on the litigation and the instructions given, including the capacity to maintain a retainer.

3.17 In relation to children similar issues might arise. Changes in their educational patterns might be crucial as might the development of Special Educational Needs and Disabilities.

3.18 All infants and protected parties will have to seek approval of any settlement and this will also involve the administration of the award. It is not clear whether it is proposed that these cases should be an exception or whether there should be additional fixed costs. We would be against any proposal for there simply to be additional fixed costs. Each case may have widely differing personal circumstances and short, intermediate and long term personal and investment requirements.

3.19 Similarly in asbestos disease cases the deceased victim often leaves a widow suffering from dementia because of the age of the deceased and their partner. Even in cases where one of the children has power of attorney such cases are often very difficult and involve more time than the value of the claim might otherwise suggest. Where there are no children or attorney the positon can be even more difficult.

Defendant behaviour

3.20 Poor defendant behaviour is one of the biggest causes of disproportionate costs. A defendant who routinely fails to act proactively, takes liability points bumps up costs. This causes problems for claimants in fixed cost cases.

Case study

- ***Defendant behaviour***

Revell v MoD (unreported)

Summary:
It took three years for the Ministry of Defence (MoD) to admit the diagnosis of non freezing cold injury (NFCI) and within a month of doing so, it settled the claim. Before then, the

claim was a litany of prevarication and procrastination on the part of the MoD, running up costs and causing delay and distress to the claimant.

Detail:
First diagnosed with NFCI in November 2009. Subsequent incidents of NFCI followed. Instructed solicitors March 2012.
An informal letter of claim sent to MoD in September 2012 after medical records, HMRC records, etc had been obtained.

MoD failed to respond so formal LoC was sent January 2013. The MoD did not respond with any decision about liability, despite the claimant agreeing extension of time for the MoD's response. Eventually in July 2013 the MoD responded to the effect that it was unable to trace all the relevant documentation about the claimant or the boots with which he had been issued.

Proceedings were issued and served on the MoD in July 2013. The MoD requested multiple extensions of time in which to serve its defence, to which the claimant agreed, while at the same time inviting the MoD to agree a £10,000 interim payment. This was refused throughout the case and the claimant had been invalided out of service. He suffered mentally as a consequence.

A defence was finally served in February 2014, almost six months after proceedings had been served. The MoD completely denied any negligence, breach of duty or injury despite their very own doctors diagnosing the injury, treating the injury and discharging the claimant, with those injuries.
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Despite the claimant's best efforts to progress the claim, and offering ADR, the MoD continued to deny the claim and refused to engage with the claimant's solicitors.

By the time a CCMC had been listed for 22 September 2014, the MoD eventually (and late) filed its objections to the claimant's budget and turned up at the hearing with counsel, even though the court had directed that only the case handlers should attend. The CCMC was adjourned so that the defendant could consider whether to agree the claimant's costs budget (the claimant had agreed the MoD's budget).

The MoD made a split liability offer which was rejected. A trial was listed for June 2015 (notice served in December 2014). More extensions of time were granted to the MoD to file various documents and evidence.

The MoD's expert confirmed the NFCI diagnosis in April 2015. Shortly after this, in May 2015, a Joint Settlement Meeting took place and the MoD paid damages of £165,000.

Total Settlement: £165,000 and costs of £115,000

Case study

- ***Defendant behaviour***

- ***failure by the defendant to engage in the early stages of this claim,***
- ***failure to negotiate a settlement***

AB v NHS (unreported)

Detail:
The claimant first reported having a hoarse voice in 2008, but it was not until August 2010, after several missed opportunities, that a 'huge' granular tumour was discovered on his left vocal cord, necessitating radical surgery which could have been avoided at an earlier point in time.

Solicitors were instructed in 2011. Liability was fiercely denied by the defendant and so proceedings were issued and served.

Once expert evidence was exchanged it became clear that the defendant's ENT expert report was completely unsuitable: it was partisan, combative, lacking substance and failed to develop any clear argument. It spent more time itemising the expert's qualifications and membership of learned societies than on the claim. Additionally, despite the defendant having failed to provide its histopathology expert with a full set of tumour samples, that expert's report was also served.

The defendant then forwarded a research paper to the claimant in support of its defence. To the claimant solicitors' surprise, the paper completely endorsed the claimant's case. The solicitor commented, "Either they had not read it, or if they had, they had not understood it."

A round table settlement meeting (RTSM) in April 2015 was organised at which the claimant offered to settle the claim for £160,000. This was rejected and in fact, the defendant solicitor wouldn't take part in any negotiation and would not even refer back to the defendant's insurers for more instructions.

Eventually in July 2015, four years after instructing solicitors, the claim settled for £190,000.

Unfortunately, the defendant's tactics of denying liability due to their inferior expert evidence at an early stage, and then their failure to engage in negotiations meant that the costs of the case became disproportionate: the claimant solicitors were sure that the claim could have been settled pre-action, saving around 40-45 per cent of the eventual costs liability. Even if that had not happened, the defendant's refusal to accept the claimant's lower offer to settle at the RTSM meant that it eventually had to pay £30,000 more to settle the claim.

Total settlement: £190,000.

Provisional damages

3.21 In a multi-track case there is far more likelihood of the injury being such as to give rise to the possibility of a claim for provisional damages. It would be negligent not to address this with a client as soon as it becomes apparent that an injury might be sufficiently serious and be susceptible to deterioration. Injury and recovery is uncertain and the possibility of an award for provisional damages needs ongoing monitoring, possibly with a view to amending pleadings and it is another area unique to personal injury and that differentiates it.

3.22 Cases involving provisional damages for example a case on behalf of a minor involving a head injury or food poisoning do not easily fit within a fixed costs regime. What is the threshold for entry of such cases when the final value is not determined and often unknown.

Case study

- ***Infant pedestrian claim***
- ***Provisional damages due to risk of developing epilepsy.***

Hughes (a child) v Lomas and the MIB[11]

At the time of the accident the claimant was aged 12 years and at the time of the hearing 16 years. The claimant was a pedestrian and crossing a carriageway when he was struck by the first defendant's moving car. The first defendant was uninsured and the Motor Insurer's Bureau (MIB) was added as second defendant.

The claimant suffered multiple injuries. As a result of his head injury, he suffered with poor concentration and memory, fatigue and emotional disturbance. He was left with permanent tinnitus and a two per cent risk of developing post traumatic epilepsy within five years of the date of the injury. After five years, the risk will fall to that of the general population.

The MIB's defence alleged contributory negligence on the part of the claimant and refused to accept full responsibility. The MIB paid a total of £23,800 by way of interim payments over a 12 month period.

The risk of a high finding of contributory negligence meant that the claimant wanted to accept damages by way of provisional damages.

The MIB contended that settlement should be on a full and final basis and obtained evidence from the consultant neurologist which indicated that at the time of trial, the risk of the claimant developing epilepsy was some 0.2 per cent above that of the general population.

The matter proceeded to trial. The claimant argued that in this case the risk of him developing epilepsy was measurable and not fanciful.

[11] PI Focus, vol 14, issue 5, page 25

Epilepsy would constitute a very serious deterioration especially for a 16 year old and it could result in an inability to drive and compromise his ability on the labour market.

The MIB argued that the risk was trifling and fanciful, although it conceded that epilepsy was a serious deterioration.

The District Judge accepted that the risk was small but would potentially be very serious to the claimant. He did not accept that future causation difficulties should be taken into account. He approved a settlement on a provisional basis, leaving it open for the claimant to apply for a further award of damages at a future date (before a longstop of the end of the year of his 17th birthday), should he develop epilepsy.

Interim payments: £23,800
Provisional damages: £12,000

Case study

- ***In the group action of Godstone Farm over 30 children were affected by E-Coli 0157 and 10 of those attracted lifelong complications of renal failure.***
- ***Provisional damages award.***

Liability was eventually admitted, the issue of the injury was a very long and drawn out process. It was necessary to wait to see if the children showed evidence of kidney damage and in doing so each child had several reviews both for the physical and emotional consequences of being exposed to E Coli 0157.

The provisional damages aspect to this did provide a real difficult between the parties and numerous reports were commissioned by either side or a comprehensive provisional damages order agreed and ultimately approved by the Court.

This case did not go to trial but costs for each case were in the region £80,000. This covered various medical reports, both paediatric and adult as the lifelong impact of the exposure needed to be assessed. The claim involved very young children and the court needed to know that all aspects of possible future problems had been adequately dealt with. The cases were worth less than £250,000 but should the children develop kidney failure then the claims would be worth a great deal more. It is difficult therefore, to see how these cases would be adequately investigated within a fixed costs regime

3.23 Moreover in a claim for benign asbestos disease with a value of £30,000 where the respiratory disability is say 20% but where there is an increased risk of premature death by reason of asbestos induced mesothelioma or lung cancer the value would then jump potentially to £150,000 or more.

Fatal accident claims

3.24 There are additional sensitivities surrounding the conduct of fatal accident claims and this needs to be recognised. Often, instructions have to be taken from a bereaved family member who has been highly traumatised. Conducting the evidence gathering required to submit a dependency claim can be extensive, time consuming and invasive and there needs to be a recognition of the sensitivities that apply to such litigation. This can make them more costly to deal with. For example, dependency claims by families from different cultures will have additional heads of claim. Funeral and other financial arrangements will vary enormously and can have a substantial effect on the final value of the claim. There is also the cost of attendance at an inquest. Those costs are currently recoverable if the attendance benefits the civil claim, and would be reasonable and proportionate within that context[12]. If costs are fixed this balancing act could not be performed.

Case Study

- ***Fatal clinical negligence claim***

This is a claim for compensation brought by the estate and dependants of a patient who died at aged 57 as a result of medical negligence.

The deceased underwent a minimally invasive coronary artery bypass graft on 21st February 2013 at John Radcliffe Hospital to treat Coronary Artery Disease. He was recovering well. Two days after the surgery one of the chest drains was removed. Shortly after, he rapidly deteriorated.

An urgent X-ray was arranged which showed a complete white out of the left side indicative of blood in the chest cavity. The deceased went into cardiac arrest. He was rushed to theatre and a larger thoracotomy performed. Three litres of blood were found within the chest wall cavity. After 20 minutes of CPR the deceased's heart started beating again. He was taken back to the ward for close monitoring. However he continued to bleed and was taken back to theatre where the bleeding point was then found and repaired.

Sadly he deteriorated and suffered acute renal failure and sepsis. 5 days later a CT scan showed extensive hypoxic brain injury. Brain stem death was confirmed. Care was withdrawn and he died on 2nd March 2013.

The post mortem confirmed that the cause of death was due to multi-organ failure and haemorrhagic shock due to or as a consequence of traumatic cardiac injury. The coroner ruled that the death was an accident and concluded that his death was caused by removal of the chest drain which snagged on or otherwise damaged the right ventricle of the heart resulting in haemorrhage and cardiac arrest.

[12] Lynch v Chief Constable of Warwickshire SCCO 14.11.14

The claimant's solicitors approached a cardiothoracic surgeon to provide a report on liability. His report came back negative. However on further questioning we were not confident in the expert's ability to deal with the complicated surgical aspects of this case.

We instructed a second cardiothoracic surgeon. He is very supportive of a claim identifying a number of clear breaches of duty. Based on his opinion, the allegations were widened -

1. There was a failure to adequately interpret and report the angiogram;
2. Advising, recommending and performing this type of operation when it was not indicated;
3. There was a failure to advise, recommend or perform alternative surgery;
4. Inadequate surgical technique;
5. Placing the chest drains in the wrong location.

As a result of the above :

- The deceased would have undergone a different procedure which would not have resulted in a haemothorax or his subsequent death.
- Alternatively had the technique been to an acceptable standard then the stabilising suture would not have been dislodged when the chest drain was removed.
- Had the chest drain been in the correct location it would not have posed a risk on removal and the deceased would not have suffered a haemothorax.

A life expectancy expert, a Consultant Cardiologist, was instructed to consider the deceased potential life expectancy but for the negligence, so that quantum could be calculated.

Liability was disputed in the Letter of Response. Court proceedings have been issued and we are awaiting the Defence.

The initial value estimated at the outset of the claim was limited to just funeral expenses and a bereavement award, around £20,000.00. Following investigations into his work and pensions, and the dependency claim of his widow, the value increased and the Schedule of Loss is currently in the sum of £205,000.00.

Costs are currently in the region of £50,000 plus £10,000 disbursements.

Case study

- ***Claim for dependency upon a child brought by parents and siblings;***
- ***Fatal Accidents Act claim;***
- ***British Muslim Family customs;***
- ***Need for expert evidence.***

Akhtar v Moores Timber Merchants[13]

[13] APIL newsletter, vol 13, issue 1, page 22-23

A 20 year old student, Mohammed Omar Akhtar, was killed by a fork-lift truck belonging to the defendant whose premises were situated just seventy metres away from the claimant's home. The deceased was driving towards the family home when his vehicle collided with a fork-lift truck belonging to the defendant.

The front forks made contact with the windscreen on the driver's side of Omar's car, smashing the windscreen, cutting his neck and causing fatal injuries.

Immediately after the collision, the deceased's car accelerated down the street collided with a stationary vehicle and then stopped almost exactly outside the home where Omar lived with his parents and siblings. Both of Omar's parents and a number of his siblings witnessed the immediate aftermath of the accident. Omar was fatally injured and died in hospital the following day.

Dependency claim
Omar's father, as executor of the estate, brought a dependency claim under the Fatal Accidents Act 1976, for the benefit of the deceased's family claimants. This claim was based on the argument that as a traditional Pakistani Muslim family a joint family purse operated for the benefit of parents and siblings alike and that there was a reasonable expectation that the deceased would have contributed significantly to the same.

The deceased had obtained a place to study law and but for his tragic death would have obtained a degree and a training contract with a firm of solicitors.

The claim was pitched reasonably; it was contended that the deceased would have gained employment within a medium sized general law practice.

At the case management hearing the District Judge heard submissions in relation to the dependency claim and directed that an anthropological expert and an employment expert be jointly instructed to report upon British Muslim family customs relevant to this issue and the deceased's career respectively.

The anthropologist confirmed that the family operated the tradition of family members contributing to a joint family purse and concluded that on the balance of probabilities, had he lived, the deceased would have contributed. He would have been expected to contribute to the general running of the household, towards his parents' flights to Pakistan and to the marriage expenses and dowries of his sisters. Such contributions would have been made regardless of whether or not he was living at home and the amount of contributions would have increased in line with his earnings.

The report from the employment expert concluded that the deceased would have achieved a 2:1 honours degree and would subsequently have obtained a contract with a medium sized provincial or non-city firm.

Damages: Following a round table meeting the parties agreed a settlement of the dependency claim in the sum of **£70,000.**

Authority relied upon in support of dependency: *Kandalla v British European Airways* [1981] QB 158. *Aktar* case report published: apil vol 13 issue 1

3.25 There can also be difficulties with cases because at the outset of the claim the individual losses are substantially more than the fixed costs threshold but because of a dramatic change in circumstance e.g the death of the claimant, the claim becomes worth substantially less and fixed costs could be applicable.

Case Study

- ***Changing Value***

Mr D was in his 80s and was injured in a road traffic collision whilst a pedestrian. The initial value of his case was in excess of £300,000 due to the extent of his injuries, extensive care needs and adaptations required to his property. Medical evidence and immediate needs assessment was obtained as well as an interim payment to fund rehabilitation. Sadly Mr D died two years after the accident and the value of the claim therefore changed dramatically with the case settling at £70,000.

Multiple defendant cases

3.26 In some cases multiple defendants have to be sued where one potential tortfeasor doesn't accept full liability. A fixed costs regime would have to account for that and it is difficult to see how all the additional costs in pursuing multiple defendants could be pre-empted and factored in to a fixed costs regime.

3.27 Industrial disease cases are a particular case in point. It is very common in asbestos disease cases for example for there to be a number of historic employers who exposed the claimant in breach of duty. In a benign asbestos disease case where the damages are apportionable the claimant must identify all of the defendants (who have usually long since ceased to exist) and then their EL insurers in order to recover 100% damages. Insurers routinely argue that their share was less than their co-insurers. The burden however remains on the claimant to prove the extent of each contribution. Often the individual insurer's liability is limited because the claimant cannot identify other EL insurers and this leads to damages recovery being very limited. Yet the claimant must continue to bring the claim if his entitlement under a provisional award to further damages in the event of subsequent asbestos induced malignancy is to be preserved since there is only one limitation period.

Case study

- ***Multiple defendants***

Carder v. University of Exeter[14]

[14] [2016] EWCA Civ 790

The defendant argued all the way to the Court of Appeal that its own 2.3% contribution to the claimant's asbestosis was not actionable as it was too small and added nothing to the other exposures he had suffered but for which he could not sue. It admitted though that it had been negligent.

The judge assessed the full liability value of the claim at £67,500 and, on the basis of the defendant's contribution of only 2.3%, awarded damages of £1,552.50.

The Court of Appeal dismissed the defendants appeal, the MR saying:

"As a postscript, I should add that I recognise that Mr Carder has been awarded a sum which is small when compared with the costs of this litigation. That is regrettable. But litigation of this kind is often necessarily factually complex. Defendants faced with claims whose costs are likely to be out of proportion to the damages likely to be awarded after a trial should try to settle them early."

A fixed costs regime would probably have precluded the bringing of this claim and would have encouraged the defendant to adopt the same behaviour.

Case study

- ***Multiple defendants***

Mayne v. Atlas Stone[15]

The claimant who was alive when the claim was brought could only identify the defendant after extensive enquiries as one of his many employers who had exposed him to asbestos. Their contribution though was only 8.16% to his overall asbestos induced condition. He wanted the protection of a provisional award in case he developed mesothelioma about which he was very worried. He died before the trial however. The defendant again argued that although it was negligent its contribution had made no difference in outcome to the defendant. Cox J disagreed and awarded 4% of the 100% award which she agreed would only have been £12,600. She awarded £1,208 and indemnity costs following the claimant's Part 36 offer of £500.

Data

3.28 A one size fits all approach to fixing costs in the lower reaches of the multitrack is unacceptable. Personal injury litigation is significantly complex as demonstrated in the paper. Cases of this value involve considerable variations regardless of the value of the claim.

3.29 The source of the data which formed the basis of the figures included in the grid should be disclosed. The data seems to ignore the fact that lawyers conduct a significant amount of work in cases pre-issue and this is not reflected in the figures.

[15] [2016] EWHC 1030 (QB)

Interlocutory Applications

3.30 This has not really been addressed in proposals so far. It is inevitable that claimants have to make applications for interim payments in these cases, most usually to fund care, property adaptations or replacement and/or income replacement. This is so, whether liability is disputed or not. There have to be costs penalties for bad behaviour by defendant in these situations. The Serious Injury Guide is only one way to deal with this.

Allocation to multi-track

3.31 From a practical point of view there are cases that can fall within the multi track because of complexity rather than value. For example if a defendant alleges fraud on the part of the claimant, the case will automatically be allocated to the multi-track. A recent example is seen in the Court of Appeal decision in Qader V Esure [2016] EWCA Civ 1109. Such cases involve a significant amount of additional work to successful defend such claims.

3.32 Additionally noise induced hearing loss cases will almost always fall within the multi-track based on complexity as would a highway tripping case or EL construction site cases where there are multiple subcontractors involved.

Counsels fees

3.33 Barristers provide a valuable role in the litigation process and there is a real danger of losing the expertise of the specialist personal injury bar. Not providing separate figures (or allow counsel as a reasonable disbursement) to recognise the involvement and significance that counsel contributes to a case means that there is a danger that they will become underused and claims underprepared. Solicitors will no longer consider whether they need to employ counsel to provide specialist advice rather than make a financial decision. This could lead to a decimation of the sector.

3.34 There is also a fear that the development of the law relating to the personal injury sector will stagnate due to restrictions in pursuing proper legal arguments.

Reviews

3.35 One criticism of fixed costs is that they are rarely properly monitored and reviewed to keep pace with rising business overheads, inflation etc. In addition to this concern is the criticism that once fixed the figures can also be subject to arbitrary reductions to suit Government agendas. Proof of this is the failure of the government over an extended period to review fixed recoverable costs and more recently the threat of judicial review to force the Government to review the Discount Rate.

Defendant's costs

3.36 The defendant solicitors' business model is wholly different to that of a claimant lawyer it is built on a commercial basis around economies of scale and bulk discounts. Defendant panel law firms are able to structure their workload around a fairly steady number of cases per annum provided quite often on a referrer basis from defendant insurers. A large part of claimant work is in screening new cases. Defendant work is paid for monthly or quarterly and interim bills are accepted and

paid by the insurers regardless. This allows defendant solicitors a steady and reliable cash flow which supports its business model. The opposite is true for claimant solicitors who have to wait to the conclusion of the claim for payment. In complex high value claims this can be many years and will often include disbursements, where the claimant solicitor's practice has had to fund them because the client could not afford to, for example court fees.

Unintended consequences

3.37 There is a danger that introducing a fixed cost regime for more complex cases will price claimants out of the market. Fixing recoverable costs does not mean fixing actual costs. Claimants' already have significant liability for court fees and introducing fixed costs will add to this burden. Fixing costs does not reduce fees it transfers them to another party in this case the claimant. They will end up contributing significantly to fees out of their damages to cover any short fall in legal fees. This automatically means that poorer clients are disadvantaged and cannot be guaranteed access to justice. Any fixed costs regime will have a far greater adverse effect on claimants.

4. Other options

4.1 APIL is keen to engage further with Lord Justice Jackson and his assessors to provide as much assistance as possible during this review. We would suggest that the objectives of any reforms here must be to work out what steps are essential to get the right answer for the genuinely injured client, and what those steps should cost to ensure the right level of specialism. Cost control rather than a costs limit should, in APIL's view, be the focus.

4.2 Injured people deserve skilled representation from competent professionals at proportionate cost. They also want good behaviour from the other side, they do not want a fight. The court service would benefit from the issues being narrowed and properly presented in these complex cases. Cost budgeting recognised that costs is not a 'one size fits all' model. The serious injury guide tackles behaviours and in turn controls cost. We would suggest other options are considered for this small number of cases and we would be happy to explore the benefits of the guide further.

4.3 Questions which may wish to be considered:

a. What impact in reality will the proposed fixed cost regime have on changing defendant behaviour? Will it address:

- Failing to admit liability early in justified cases?
- Inadequate disclosure?
- Inadequate document retention?

b. If defendant behaviour continues to run up costs and cause delay, how can claimants function effectively in a fixed cost environment?

c. Do you accept as a point of principle that claimant costs will always exceed defendant costs because the burden of proof rests with the claimant?

d. We are concerned that fixing fees is likely to deter claimants from litigating at all. Any fall in the number of claims settling would indicate an access to justice issue – what monitoring will be in place to ensure that the number of settled claims does not fall?

5 Appendices

Rehabilitation Code

Serious Injury Guide

The 2015 Rehabilitation Code

Introduction

The Code promotes the collaborative use of rehabilitation and early intervention in the compensation process. It is reviewed from time to time in response to feedback from those who use it, taking into account the changing legal and medical landscape.

The Code's purpose is to help the injured claimant make the best and quickest possible medical, social, vocational and psychological recovery. This means ensuring that his or her need for rehabilitation is assessed and addressed as a priority, and that the process is pursued on a collaborative basis. With this in mind, the claimant solicitor should always ensure that the compensator receives the earliest possible notification of the claim and its circumstances whenever rehabilitation may be beneficial.

Although the objectives of the Code apply whatever the clinical and social needs of the claimant, the best way to achieve them will vary depending on the nature of the injury and the claimant's circumstances. The Code recognises that the dynamics of lesser-injury cases are different to those further up the scale. A separate process is set out for claims below £25,000 (in line with the Civil Procedure Rules definition of low value). Separate provision is also made for soft tissue injury cases as defined in paragraph **1.1(16A)** of the Pre-Action Protocol for Low Value Personal Injury Claims in Road Traffic Accidents.

It is important to stress, however, that even low value injuries can be life-changing for some people. The projected monetary value of a claim is only a guide to the rehabilitation needs of the injured person. Each case should be taken on its individual merits, and the guidelines for higher-value injuries will sometimes be more appropriate for those in the lowest category.

Sections 1 to 3 set out the guiding principles and the obligations of the various parties, and apply to all types of injury. After that, the sections diverge significantly depending on the size of claim.

Although the Code deals mainly with the Immediate Needs Assessment, it encourages all parties to adopt the same principles and collaborative approach right up until the case is concluded. In doing so, it does not stipulate a detailed process. Rather, it assumes that the parties will have established the collaborative working relationships that render a prescriptive document unnecessary.

Ten 'markers' that can affect the rehabilitation assessment, and therefore the treatment, are to be found in the Glossary at the end of the Code. They should be considered in all cases.

With the more serious injuries, it is envisaged that Case Managers will have an essential role to play in assessing the claimant's needs and then overseeing treatment. This Code should be read in conjunction with the Guide for Case Managers and those who Commission them, published separately.

1. Role of the Code

1.1 The purpose of the personal injury claims process is to restore the individual as much as possible to the position they were in before the accident. The Code provides a framework for the claimant solicitor and compensator to work together to ensure that the claimant's health, quality of life, independence and ability to work are restored before, or simultaneously with, the process of assessing compensation.

1.2 Although the Code is recognised by the relevant CPR Pre-Action Protocols, achieving the aims are more important than strict adherence to its terms. Therefore, it is open to the parties to agree an alternative framework to achieve the early rehabilitation of the claimant.

1.3 Where there is no agreement on liability, the parties may still agree to use the Code. The health and economic benefits of proceeding with rehabilitation at an early stage, regardless of agreement on liability, may be especially strong in catastrophic and other severe cases. Compensators should consider from the outset whether there is a possibility or likelihood of at least partial admission later on in the process so as not to compromise the prospects for rehabilitation.

1.4 In this Code, the expression 'the compensator' includes any person acting on behalf of the compensator. 'Claimant solicitor' includes any legal representative acting on behalf of the claimant. 'Case Manager' means a suitably qualified rehabilitation case manager.

2. The Claimant Solicitor

2.1 The claimant solicitor's obligation to act in the best interests of their client extends beyond securing reasonable financial compensation, vital as that may be. Their duty also includes considering, as soon as practicable, whether additional medical or rehabilitative intervention would improve the claimant's present and/or longer-term physical and mental well-being. In doing so, there should be full consultation with the claimant and/or their family and any treating practitioner where doing so is proportionate and reasonable. This duty continues throughout the life of the case, but is most important in the early stages.

2.2 It is the duty of a claimant solicitor to have an initial discussion with the claimant and/or their family to identify:
1) Whether there is an immediate need for aids, adaptations, adjustments to employment to enable the claimant to perform their existing job, obtain a suitable alternative role with the same employer or retrain for new employment. They should, where practical and proportionate, work with the claimant's employers to ensure that the position is kept open for them as long as possible.
2) The need to alleviate any problems related to their injuries.

2.3 The claimant solicitor should then communicate these needs to the compensator by telephone or email, together with all other relevant information, as soon as practicable. It is the intention of this Code that both parties will work to address all rehabilitation needs on a collaborative basis.

2.4 The compensator will need to receive from the claimant solicitor sufficient information to make a well-informed decision about the need for rehabilitation assistance, including detailed and adequate information on the functional impact of the claimant's injuries. There is no requirement for an expert report at this early stage. The information should, however, include the nature and extent of any likely continuing disability and any suggestions that may have already been made concerning rehabilitation and/or early intervention. It should be communicated within 21 days of becoming aware of those injuries or needs once the compensator is known.

2.5 Upon receiving a rehabilitation suggestion from the compensator, the claimant solicitor should discuss it with the claimant and/or their family as soon as practical and reply within 21 days.

2.6 Many cases will be considered under this Code before medical evidence has actually been commissioned or obtained. It is important in these situations that rehabilitation steps are not undertaken that might conflict with the recommendations of treating clinical teams. It is equally important that unnecessary delay is avoided in implementing steps that could make a material difference to the injured person or their family. Early engagement with the compensator is crucial to discuss such issues.

2.7 Whilst generally in catastrophic and other particularly severe cases, it is recommended that an appropriately qualified Case Manager should be appointed before any rehabilitation commences, this may not always be possible even though it should be a priority. Methods of selecting Case Managers are described in paragraphs 7.3 and 7.4. The aim when appointing a Case Manager should be to ensure that any proposed rehabilitation plan they recommend is appropriate and that the goals set are specific and attainable. The Case Manager should, before undertaking an Immediate Needs Assessment (INA) as part of the claims process, make every attempt to liaise with NHS clinicians and others involved in the claimant's treatment, and to work collaboratively with them, provided this does not unduly delay the process. If possible, they should obtain the claimant's rehabilitation prescription, discharge summary or similar, including any A&E records and/or treating consultant's report and medical records.

3. The Compensator

3.1 It is the duty of the compensator, from the earliest practicable stage, to consider whether the claimant would benefit from additional medical or rehabilitative treatment. This duty continues throughout the life of the case, but is most important in the early stages.

3.2 If the claimant may have rehabilitation needs, the compensator should contact the claimant solicitor as soon as practicable to seek to work collaboratively on addressing those needs. As set out in paragraph 2.5, the claimant solicitor should respond within 21 days.

3.3 Where a request to consider rehabilitation has been communicated by the claimant solicitor, the compensator should respond within 21 days, or earlier if possible, either confirming their agreement or giving reasons for rejecting the request.

3.4 Nothing in this Code modifies the obligations of the compensator under the Protocols to investigate claims rapidly and, in any event, within the relevant liability response period.

LOWER-VALUE INJURIES

4. The Assessment Process – lower-value injuries

4.1 Different considerations apply for soft-tissue injury cases compared to other lower-value cases of £25,000 or below. In all cases, the claimant's solicitor should consider, with the claimant and/or the claimant's family, whether there is a need for early rehabilitation. The results of that discussion should be recorded in section C of the electronic Claims Notification Form, which will be transmitted through the Ministry of Justice Claims Portal to commence the claim. That form requires details of any professional treatment recommendations, treatment already received (including name of provider) and ongoing rehabilitation needs.

4.2 For lower-value injuries generally, this might involve physiotherapy, diagnostics and consultant follow-up, psychological intervention or other services to alleviate problems caused by the injury. In soft-tissue injury cases, in particular, it is understood that there is not always necessarily a requirement for a rehabilitation intervention. It is considered likely that, where there is an initial intervention, it will focus on treating any physical need, for example through physiotherapy.

In all cases, the claimant solicitor should communicate with the compensator as soon as practical about any rehabilitation needs, preferably by electronic means. The mechanism of completion and transmission of the Claims Notification Form should facilitate this process and should take place before any significant treatment has been commenced, subject always to any overriding medical need for urgent treatment.

4.3 Nothing in this Code alters the legal principles that:

1. Until there has been a liability admission by a compensator (through the Compensator's Response in the Claims Portal), the claimant can have no certainty about the prospect of recovery of any treatment sums incurred.
2. Until the compensator has accepted a treatment regime in which the number and price of sessions have been agreed, the level of recovery of any such sums will always be a matter for negotiation (most likely through exchange of offers in the portal system), unless the subject of a Court order.
3. Where a claimant has decided not to take up a form of treatment that is readily available in favour of a more expensive option, the reasonableness of that decision may be a factor that is taken into account on the assessment of damages.

4.4 Unless there is a medico-legal report containing full recommendations for rehabilitation, which both parties are happy to adopt, an initial Triage Report (TR) should be obtained to establish the type of treatment needed. In most cases, the Triage Report will be the only report required. Where both the claimant's solicitor and the compensator agree that further reports are required, the assessment process is likely to have two further stages:

(i) A subsequent Assessment Report (AR) provided by the healthcare professional who is actually treating the claimant;

(ii) A Discharge Report (DR) from the treating healthcare professional to summarise the treatment provided.

It is, however, understood within the Code that a treatment discharge summary should routinely be included within the claimant's treatment records.

It is always possible for the Assessment Report (AR) and Discharge Report (DR) to be combined into one document.

4.5 The Triage Report (TR) assessment should be undertaken by an appropriately qualified and experienced person who is subject to appropriate clinical governance structures. Guidance on this may be obtained by reading the British Standards Institute standard PAS 150 or the UKRC Standards. It is permissible under the Code that the assessor providing the Triage Report could also be appointed to implement the recommendations.

4.6 The person or organisation that prepares the Triage and, if appropriate, Assessment and Discharge Reports and/or undertakes treatment should, save in exceptional circumstances, be entirely independent of the person or organisation that provided any medico-legal report to the claimant. In soft-tissue injury cases, the parties are referred to Part 45.29I of the Civil Procedure Rules.

4.7 The Triage and the preparation of any subsequent Assessment and Discharge Report and/or the provision of any treatment may be carried out or provided by a person or organisation having a direct or indirect business connection with the solicitor or compensator only if the other party agrees. The solicitor or compensator will be expected to reveal to the other party the existence and nature of such a business connection before instructing the connected organisation.

4.8 The assessment agency will be asked to carry out the Triage Report in a way that is appropriate to the needs of the case, which will in most cases be a telephone interview within seven days of the referral being received by the agency. It is expected that the TR will be very simple, usually just an email.

4.9 In all cases, the TR should be published simultaneously or made available immediately by the instructing party to the other side. This applies also to treatment reports (AR and DR) where the parties have agreed that they are required. Both parties will have the right to raise questions on the report(s), disclosing such correspondence to the other party.

4.10 It is recognised that, for the Triage Report to be of benefit to the parties, it should be prepared and used wholly outside the litigation process. Neither side can rely on the report in any subsequent litigation unless both parties agree in writing. Likewise, any notes, correspondence or documents created in connection with the triage assessment process will not be disclosed in any litigation. Anyone involved in preparing the Triage Report or in the assessment process shall not be a compellable witness at court. This principle is also set out in the Protocols.

4.11 The compensator will usually only consider rehabilitation that deals with the effects of the injuries that have been caused in the relevant accident. They will not normally fund treatment for other conditions that do not directly relate to the accident unless these conditions have been exacerbated by it or will impede recovery.

5. The Reports – lower-value injuries

5.1 It is expected under the Code that all treatment reporting described in this section will be concise and proportionate to the severity of the injuries and likely value of the claim.

5.2 The Triage Report should consider, where relevant, the ten 'markers' identified at the end of this Code and will normally cover the following headings:

1. The injuries sustained by the claimant;
2. The current impact on their activities of daily living, their domestic circumstances and, where relevant, their employment;
3. Any other relevant medical conditions not arising from the accident;
4. The past provision and current availability of treatment to the claimant via the NHS, their employer or health insurance schemes;
5. The type of intervention or treatment recommended;
6. The likely cost and duration of treatment;
7. The expected outcome of such intervention or treatment.

5.3 The Triage Report will not provide a prognosis or a diagnosis.

5.4 The assessment reports (TR, or any AR or DR) should not deal with issues relating to legal liability and should therefore not contain a detailed account of the accident circumstances, though they should enable the parties to understand the mechanism by which the injury occurred.

5.5 Where agreed as needed, any Assessment Report (AR) will normally have the following minimum headings:

1. Nature, symptoms and severity of injury(ies);
2. Relevance of any pre-existing conditions or injuries;
3. Primary rehabilitation goal and anticipated outcome;
4. Expected duration, number, type and length of treatment sessions;
5. Impact of injuries upon work and or activities of daily living and barriers to recovery and return to work.

5.6 Where agreed as needed, such as where a treatment discharge summary is considered inadequate, any Discharge Report (DR) will normally have the following minimum headings:

1. Current nature, symptoms and severity of injury(ies);
2. Whether the primary rehabilitation goal has been attained;
3. Number, type and length of treatment sessions/appointments attended or missed/DNAs (Did Not Attend);
4. Current impact of injuries on work or activities of daily living;
5. Whether the claimant has achieved, as far as possible, a full functional recovery;
6. Whether additional treatment is required to address the claimant's symptoms.

In cases where no AR or DR has been agreed, it is expected that the notes and discharge summary of the treatment provider will contain the necessary information.

5.7 The provision as to the report being outside the litigation process is limited to the Triage Report and any notes or correspondence relating to it. Any notes and reports created during the subsequent treatment process will be covered by the usual principle in relation to disclosure of documents and medical records relating to the claimant.

5.8 The compensator will normally pay for the TR within 28 days of receipt. Where the claimant's solicitor and the compensator have agreed that such reports are required, the compensator will also pay for any AR and DR within 28 days of receipt. In either case, the compensator may challenge bills that they believe to be excessive or disproportionate.

5.9 The reporting agency should ensure that all invoices are within reasonable market rates, are clear and provide the following detail:

1. Type of treatment provided, e.g. telephonic CBT, face-to-face physiotherapy;
2. Dates of treatments/sessions attended and DNAs of treatment sessions;
3. Total number of treatments delivered and whether those treatments were provided remotely or in person;
4. Total cost and whether this is for treatment provided or an estimate of future cost.

5.10. Where any treatment has been organised prior to notification to or approval by the compensator, any invoice submitted to the compensator will also need to be accompanied by a discharge summary recording treatment outcome in addition to the information contained in paragraph 5.9 The need for the discharge summary to be included in the treatment records is covered in paragraph 4.4.

5.11 The parties should continue to work together to ensure that the recommended rehabilitation proceeds smoothly and that any further rehabilitation needs continue to be assessed.

6. Recommendations – lower-value injuries

6.1 The compensator will be under a duty to consider the recommendations made and the extent to which funds will be made available to implement the recommendations. The claimant will be under no obligation to undergo intervention, medical or investigation treatment. Where intervention treatment has taken place, the compensator will not be required to pay for treatment that is unreasonable in nature, content or cost.

6.2 The compensator should provide a response to the claimant's solicitor within15 business days from the date when the TR is disclosed. If the Insurer's Response Form is transmitted via the portal earlier than 15 business days from receipt of the CNF and the TR, the response should be included in the Response Form. The response should include: (i) the extent to which the recommendations have been accepted and rehabilitation treatment will be funded; (ii) justifications for any refusal to meet the cost of recommended rehabilitation and (if appropriate) alternative recommendations. As stated in paragraph 4.3, the claimant may start treatment without waiting for the compensator's response, but at their own risk as to recovering the cost.

6.3 The compensator agrees that, in any legal proceedings connected with the claim, they will not dispute the reasonableness or costs of the treatment they have funded, provided the claimant has undertaken the treatment and it has been expressly agreed and/or the treatment provider has been jointly instructed. If the claim later fails, is discontinued or contributory negligence is an issue, it is not within the Code to seek to recover such funding from the claimant unless it can be proven that there has been fraud/fundamental dishonesty.

6.4 Following on from implementation of the assessment process, the parties should consider and agree at the earliest opportunity a process for ensuring that the ongoing rehabilitation needs of the claimant are met in a collaborative manner.

MEDIUM, SEVERE AND CATASTROPHIC INJURIES

7. The Assessment Process – medium, severe and catastrophic injuries

7.1 The need for and type of rehabilitation assistance will be considered by means of an Immediate Needs Assessment (INA) carried out by a Case Manager or appropriate rehabilitation professional, e.g. an NHS Rehabilitation Consultant. (For further information about Case Managers, refer to the Glossary and The Guide for Case Managers and those who Commission them, published separately.)

7.2 The Case Manager must be professionally and suitably qualified, experienced and skilled to carry out the task, and they must comply with appropriate clinical governance. With the most severe life-changing injuries, a Case Manager should normally be registered with a professional body appropriate to the severity of the claimant's injuries. The individual or organisation should not, save in exceptional circumstances, have provided a medico-legal report to the claimant nor be associated with any person or organisation that has done so.

7.3 The claimant solicitor and the compensator should have discussions at the outset to agree the person or organisation to conduct the INA, as well as topics to include in the letter of instruction. The INA should go ahead whether or not the claimant is still being treated by NHS physicians, who should nonetheless be consulted about their recommendations for short-term and longer-term rehabilitation. A fundamental part of the Case Manager's role is to make immediate contact with the treating clinical lead to assess whether any proposed rehabilitation plan is appropriate.

7.4. The parties are encouraged to try to agree the selection of an appropriately qualified independent Case Manager best suited to the claimant's needs to undertake the INA. The parties should then endeavour to agree the method of instruction and how the referral will be made. When considering options with the claimant, a joint referral to the chosen Case Manager may maximise the benefits of collaborative working. Any option chosen by the parties is subject to the claimant's agreement. In all situations, the parties should seek to agree early implementation of reasonable recommendations and secure funding. In circumstances where trust has been built, it is recommended that the parties agree to retain the Case Manager to co-ordinate the implementation of the agreed rehabilitation plan.

7.5 With catastrophic injuries, it is especially important to achieve good early communication between the parties and an agreement to share information that could aid recovery. This will normally involve telephone or face-to-face meetings to discuss what is already known, and to plan how to gain further information on the claimant's health, vocational and social requirements. The fact that the claimant may be an NHS in-patient should not be a barrier to carrying out an INA.

7.6 No solicitor or compensator may insist on the INA being carried out by a particular person or organisation if the other party raises a reasonable objection within 21 days of the nomination. Where alternative providers are offered, the claimant and/or their family should be personally informed of the options and the associated benefits and costs of each option.

7.7 Objections to a particular person or organisation should include possible remedies such as additional information requirements or alternative solutions. If the discussion is not resolved within 21 days, responsibility for commissioning the provider lies ultimately with the claimant as long as they can demonstrate that full and timely co-operation has been provided.

7.8 A rehabilitation provider's overriding duty is to the claimant. Their relationship with the claimant is therapeutic, and they should act totally independently of the instructing party.

7.9 The assessment may be carried out by a person or organisation having a direct or indirect business connection with the solicitor or compensator only if the other party agrees. The solicitor and compensator must always reveal any business connection at the earliest opportunity.

7.10 The assessment process should provide information and analysis as to the rehabilitation assistance that would maximise recovery and mitigate the loss. Further assessments of rehabilitation needs may be required as the claimant recovers.

7.11 The compensator will usually only consider rehabilitation that deals with the effects of injuries for which they are liable. Treatment for other conditions will not normally be included unless it is agreed that they have been exacerbated by the accident or are impeding the claimant's recovery.

8. The Immediate Needs Assessment (INA) Report – medium, severe and catastrophic injuries

8.1 The Case Manager will be asked to carry out the INA in a way appropriate to the case, taking into account the importance of acting promptly. This may include, by prior appointment, a telephone interview. In more complex and catastrophic cases, a face-to-face discussion with the claimant is likely.

8.2 As well as the ten 'markers' identified in the Glossary at the end of this Code, the INA should consider the following points, provided doing so does not unduly delay the process:

a. The physical and psychological injuries sustained by the claimant and the subsequent care received or planned;
b. The symptoms, disability/incapacity arising from those injuries. Where relevant to the overall picture of the claimant's rehabilitation needs, any other medical conditions not arising from the accident should also be separately noted;
c. The availability or planned delivery of interventions or treatment via the NHS, their employer or health insurance schemes;
d. Any impact upon the claimant's domestic and social circumstances, including mobility, accommodation and employment, and whether therapies such as gym training or swimming would be beneficial;
e. The injuries/disability for which early intervention or early rehabilitation is suggested;
f. The type of clinical intervention or treatment required in both the short and medium term, and its rationale;
g. The likely cost and duration of recommended interventions or treatment, their goals and duration, with anticipated outcomes;
h. The anticipated clinical and return-to-work outcome of such intervention or treatment.

8.3 The INA report will not provide a medical prognosis or diagnosis, but should include any clinically justifiable recommendations for further medical investigation, compliant with NICE guidelines and, where possible, aligned to the NHS Rehabilitation prescription, discharge report or similar. Where recommendations are in addition to or deviate from the NHS recommendations, these should be explained with appropriate justification provided.

8.4 The INA report should not deal with issues relating to legal liability, such as a detailed account of the accident circumstances, though it should enable the parties to understand the mechanism by which the injury occurred.

8.5 The Case Manager will, on completion of the report, send copies to the claimant solicitor and compensator simultaneously. Both parties will have the right to raise questions on the report, disclosing such correspondence to the other party. It is, however, anticipated that the parties will discuss the recommendations and agree the appropriate action to be taken. Subject to the

claimant's consent, their GP and/or treating clinical team will also be informed of the INA and its recommendations once funding to proceed has been obtained. In most cases, the INA will be conducted, and the report provided, within 21 days from the date of the letter of referral to the Case Manager.

8.6 For this assessment report to be of benefit to the parties, it should be prepared and used wholly outside the litigation process, unless both parties agree otherwise in writing.

8.7 The report, any correspondence related to it and any notes created by the assessing agency will be deemed to be covered by legal privilege and not disclosed in any proceedings unless the parties agree. The same applies to notes or documents related to the INA, either during or after the report submission. Anyone involved in preparing the report or in the assessment process will not be a compellable witness at court. (This principle is also set out in the Protocols.)

8.8 Any notes and reports created during the subsequent case management process post-INA will be covered by the usual principle in relation to disclosure of documents and medical records relating to the claimant. However, it is open to the parties to agree to extend the provisions of the Code beyond the INA to subsequent reports.

8.9 The compensator will pay for the INA report within 28 days of receipt.

9. Recommendations – medium, severe and catastrophic injuries

9.1 When the Immediate Needs Assessment (INA) report is received, the compensator has a duty to consider the recommendations and the extent to which funds are made available to implement them. The compensator is not required to pay for treatment that is unreasonable in nature, content or cost. The claimant will be under no obligation to undergo treatment.

9.2 The compensator should respond to the claimant solicitor within 21 days of receiving the INA report. The response should include: (i) the extent to which it accepts the recommendations and is willing to fund treatment; and (ii) justifications for any refusal, with alternative recommendations.

9.3 The compensator will not dispute the reasonableness or costs of the treatment, as long as the claimant has undertaken the treatment and it was expressly agreed in advance (or the treatment provider had been jointly instructed). Where there is disagreement, general interim payments are recommended to provide continuity of services with an understanding that recovery of such sums is not guaranteed and will always be a matter for negotiation or determination by a court. Where a claimant has decided not to take up a form of treatment that is readily available in favour of a more expensive option, the reasonableness of that decision may be a factor that is taken into account on the assessment of damages. If the claim later fails or is discontinued or contributory negligence is an issue, the compensator will not seek to recover any agreed rehabilitation funding it has already provided unless it can be proven that there has been fraud/fundamental dishonesty.

9.4 Following implementation of the INA, the parties should consider and attempt to agree, as soon as possible, a collaborative process for meeting the claimant's ongoing rehabilitation needs.

9.5 The overriding purpose of the INA should be to assess the claimant's medical and social needs with a view to recommending treatment rather than to obtain information to settle the claim.

GLOSSARY – THE TEN 'MARKERS'

The ten ‘markers’ referred to in this Code that should be taken into account when assessing an injured person’s rehabilitation needs are summarised below:

1. Age (particularly children/elderly);
2. Pre-existing physical and psycho-social comorbidities;
3. Return-to-work/education issues;
4. Dependants living at home;
5. Geographic location;
6. Mental capacity;
7. Activities of daily living in the short-term and long-term;
8. Realistic goals, aspirations, attainments;
9. Fatalities/those who witness major incidence of trauma within the same accident;
10. Length of time post-accident.

September 2015

The working parties that drew up the 2015 Rehabilitation Code included representatives of ABI, APIL, CMSUK, FOIL, IUA, MASS and PIBA. Although it is for the parties involved in personal injury claims to decide when and how to use the Code, it is envisaged that it should become operational from December 1, 2015.

A GUIDE TO THE CONDUCT OF CASES INVOLVING SERIOUS INJURY

Updated 26 September 2016

INTRODUCTION

This best practice Guide is designed to assist with the conduct of personal injury cases involving complex injuries, specifically cases with a potential value on a full liability basis of £250,000 and above and that are likely to involve a claim for an element of future continuing loss. The parties may well agree to operate the Guide in relation to lower value multi track cases. The Guide excludes clinical negligence and asbestos related disease cases.

The Guide is intended to help parties involved in these multi track claims resolve any/all issues whilst putting the claimant at the centre of the process. It puts in place a system that meets the reasonable needs of the injured claimant whilst ensuring the parties work together towards resolving the case by cooperating and narrowing the issues.

This Guide creates an environment that encourages positive collaborative behaviour from both sides, and will work in parallel with the Civil Procedure Rules.

Nothing within this document affects a solicitor's duty to act in the best interests of the client and upon their instructions.

It is recognised that there will be occasions when the defendant[1] insurer and or agent cannot commit a commercial client for whom they are handling agents to comply with the Guide. The claimant representative will be notified of this issue immediately.

It is recognised that there will be occasions where either the claimant or the defendant insurer /and or the claims handling agent are unable to comply with the Guide. Where this occurs it is expected that notification of this fact to the opposing party should be made immediately.

This Guide comprises the following:

- Objectives
- Guidance

    - Collaboration
    - Early notification
    - First contact
    - Rehabilitation
    - Ongoing review and case planning
    - Dispute resolution and escalation
    - Costs

[1] Any reference to defendant or defendant insurer can be taken to be singular or pleural when more than one defendant or insurer is involved or potentially involved.

OBJECTIVES

The principal aims are as follows:

- to resolve liability as quickly as possible;
- where beneficial to the claimant to provide early access to rehabilitation to maximise their recovery;
- to resolve claims in a cost appropriate and proportionate manner;
- to resolve claims within an appropriate agreed time frame;
- resolution through an environment of mutual trust, transparency and collaboration;

To achieve the above the parties agree to work collaboratively bringing tangible benefits to all parties.

The key objectives are:

i. **Notification**

Early notification of claims to defendants and their insurers when known, with a view to achieving resolution of the case as quickly as possible and where liability is admitted or established, providing compensation.

ii. **Case planning**

Collaboration and dialogue are a central objective to achieve efficient case progression through an agreed action plan, dealing with but not limited to liability resolution, rehabilitation, quantum evidence and overall settlement.

iii. **Liability**

In all cases handled under the Guide a commitment to resolve liability by agreement, with a view to this being finalised within a maximum period of six months from the date of first notification. Where this is not possible, to identify the barriers that are stopping liability being resolved and to agree an action plan to conclude the issue at the earliest opportunity. The plan can include trial or alternative dispute resolution as appropriate.

For cases handled in accordance with this Guide the withdrawal of an admission would only be in exceptional circumstances and an admission made by any party may well be binding on that party in the litigation. The rules concerning admissions at CPR 14.1A continue to apply.

iv. **Considerations on resolution of liability**

A commitment to an early interim payment of disbursements (the subject matter of which has been disclosed) in addition to base costs related to liability once resolved. If the parties are unable to agree the amount of contribution an action plan will be developed to conclude the issue at the earliest opportunity.

The objectives and processes set within the Guide do not prevent the parties agreeing to additional items such as payment of interest on general damages, stay of proceedings or on any other issue in the course of the claim, all such discussions being in the spirit of the Guide.

v. **Rehabilitation**

Discussion at the earliest opportunity by all parties to consider effective rehabilitation where reasonably required.

Appointment, where necessary, of an independent clinical case manager instructed by the claimant, or subject to the claimant's agreement, on a joint basis.

vi. **Interim damages**

A willingness to make early and continuing interim payments where appropriate.

vii. **Part 36/Calderbank offers**

No Part 36/Calderbank offers unless or until the parties have tried to agree an issue through dialogue and negotiation but cannot do so.

viii. **Documents**

Commitment by all parties to obtain and disclose promptly all relevant documents, such as

a. liability documents
b. police reports in road accident cases
c. accident report documentation
d. medical notes and records
e. documents relating to past loss
f. case manager records
g. other relevant non-privileged material

Where possible, all parties are to obtain evidence in such a way as to avoid duplication of effort and cost.

GUIDANCE: ACHIEVING THE OBJECTIVES

1. COLLABORATION AND CASE PLANNING

1.1. The aims and objectives of this Guide will be achieved through the parties working together, allocating tasks where appropriate, narrowing the issues throughout the claim, leading to resolution at the earliest time.

1.2. Collaboration begins with a commitment to early notification of a claim to the potential defendant.

Collaborative working between the parties should continue throughout the life of the claim with the objective of achieving:

- early liability resolution
- maximising rehabilitation opportunities
- making provision for early interim payments
- emphasising restitution and redress, (rather than just compensation)
- early identification of issues not in dispute
- flexible approaches to resolution of issues in dispute

1.3. The parties should aim to agree a framework/timetable for engaging on a regular basis in order to bring the case to conclusion.

2. EARLY NOTIFICATION

2.1. The claimant's solicitor should ensure that the defendant and their insurers / handling agents are given early notification of the claim. The recommended contents of the early notification letter are set out below. The early notification point for each insurer can be found at www.seriousinjuryguide.co.uk.

2.2. A full formal detailed letter of claim is not expected (in the first instance). The aim is to alert the proposed defendant and insurer / handling agent to the potential claim, applicability of this Guide and to enable:

- an initial view for the purpose of understanding the nature of the claim and severity of injuries
- allocation of the case to an appropriate level of file handler within their organisation
- liability to be resolved promptly without further investigation by the proposed claimant.

2.3. The claimant's solicitors should aim to send a written notification within 7 calendar days of instruction. This should include where available but not be limited to:

- Name, address, date of birth and NI number of claimant (Such personal data should not be sent in one letter because of the risk of fraud.)
- Date, time and place of accident or date of onset of condition giving rise to the claim
- Factual outline of accident and injury if available
- Who is said to be responsible and relationship to claimant
- Any other party approached
- Occupation and approximate income
- Name and address of employer if there is one
- Current medical status in summary form (e.g. inpatient or discharged)
- Any immediate medical or rehabilitation needs if known
- The identity of the firms' escalation point of contact (see escalation section) and email address
- Protected party status on a without prejudice basis.
- A reference to the claim being conducted within the Guide

2.4. In the notification letter, the name of file hander with conduct at the claimant's solicitor's firm and immediate line manager/supervisor should be identified. Relevant e-mail addresses and telephone numbers should also be included.

2.5. The solicitors representing the claimant should take all reasonable steps to locate and notify the appropriate insurer / handling agent. Where known the letter should be sent to an established address to enable the file to be allocated at the correct handling level within the insurance company / handling agents.

2.6. If an insurer or handling agent is unknown, a short notification letter should be sent to the proposed defendant with a request to pass it on to any relevant insurer. In RTA cases, the MIB should be approached in the absence of an alternative insurer.

2.7. In the event that more than one potential defendant is identified details should be communicated to all other defendants (see section 4 below).

2.8. The reasonable costs of the solicitor in complying with this section will not be challenged for the lack of a retainer at this point in time.

3. FIRST CONTACT

3.1. At the earliest opportunity but no later than:

3.1.1. 14 calendar days of receipt of the notification letter, the defendant insurer / handling agent must acknowledge the correspondence in writing and confirm it is with the correct handler, confirming the name of the file handler, escalation contact point, as well as e-mail addresses and telephone numbers of the same.

3.1.2. 28 calendar days of receipt of the notification letter, the defendant insurer shall make contact with the claimant solicitor. The purpose of this first contact is to establish lines of communication between the parties, to include but not limited to:

- the parties' views on liability
- update on injuries
- any rehabilitation needs identified
- other potential defendants
- agreement as to when to hold further discussions.

4. CLAIMS INVOLVING MULTIPLE DEFENDANTS

4.1. The claimant solicitor must be kept informed in the event that additional defendants are identified.

4.2. In the event that there is more than one potential defendant it is expected that one defendant will coordinate correspondence with the claimant representatives. The identity of the coordinating party in such cases ought to be communicated within 28 calendar days of the last letter of claim where more than one is sent.

4.3. Where a coordinating contact point is offered the claimant representative shall restrict communication to that party, save that in the event that they consider there is a failure to make satisfactory progress in accordance with this Guide, all other known defendants should be alerted to the concern(s) raised. It is expected that this step will not be taken unless the escalation procedure has been tried first.

4.4. The defendants should confer within a maximum of 28 days in order to agree a response or to appoint a replacement coordinating defendant.

4.5. It may be that a coordinating defendant cannot be agreed between the defendants. In such cases the claimant must be notified of the fact immediately. However there is a continuing expectation that the defendants will, as soon as possible, agree a coordinating defendant.

5. ONGOING REVIEW AND FORWARD PLANNING

5.1 Regular on-going dialogue should take place between the parties with a view to agreeing the next steps required to progress the case. Material changes in circumstances should be communicated immediately (e.g. death of the claimant, loss of capacity, significant medical deterioration, material change in care regime costs, risk of loss of employment etc).

5.2 The claimant solicitor should give reasonable access for medical facilities when requested by the defence insurer. The parties should liaise on the issue of selection of any expert and the status thereof as part of the planning process.

6. REHABILITATION

6.1. One of the overriding aims of the Guide is to help claimants to access rehabilitation when appropriate. At the earliest practical stage the parties should, in consultations with the claimant and/or the claimant's family, consider whether early intervention, rehabilitation or medical treatment would improve the present or long term situation. Defendants should reply promptly to any request to rehabilitation, and in any event within 21 days.

6.2. Further guidance can be found in the following material:

6.2.1. APIL's **Think Rehab! Best Practice Guide** on rehabilitation and the parties http://www.apil.org.uk/files/pdf/rehabiliation-guide-to-best-practice.pdf

6.2.2. The **Guide to Best Practice at the Interface Between Rehabilitation the Medico-legal Process** endorsed by BSRM, APIL and the Royal College of Physicians published November 2006, http://www.bsrm.co.uk/publications/Guide2BestPracticeIntRehabMedLegal.pdf

6.2.3. The Rehabilitation Code 2015 (official implementation 1 December 2015) http://iual.informz.ca/IUAL/data/images/2015%20Circular%20Attachments/067%20REHAB%20CODE.pdf

6.2.4. The Guide to Case Managers 2015 (official implementation 1 December 2015) http://iual.informz.ca/IUAL/data/images/2015%20Circular%20Attachments/067%20CM%20GUIDE%20MASTER2.pdf

6.3. The parties are encouraged to try to agree the selection of an appropriately qualified case manager best suited to the claimant's needs.

6.4. The insurer and/or appointed solicitor will be kept up to date with rehabilitation progress as part of the case planning process, by whatever means is agreed between the parties or generally.

6.5. Rehabilitation reports and case management material should be provided to the insurer on a regular basis.

6.6. The parties should seek to agree the frequency with which records and documents should be disclosed.

6.7. The parties should seek to agree the frequency of meetings or conference calls with the case manager (if such meetings or calls are appropriate).

7. ESCALATION PROCEDURE

7.1. In the event that either party feels that the opposing handler is not acting in accordance with the spirit of the Guide the first step must always be to exhaust attempts to resolve the point of concern by dialogue or a meeting.

7.2. If such dialogue still fails to allay the concerns, contact should be made with the nominated contact point at the firm/insurer/handling agent (see notification stage above) in order to try to deal with the issue.

7.3. In circumstances where a defendant solicitor has been instructed, the signatory insurer escalation point will remain the nominated contact point for the purposes of the Serious Injury Guide. The claimant solicitor should contact the signatory insurer escalation point directly with any escalation procedure issues, and in doing so, there will be no issue raised in relation to the Code of Conduct. The defendant solicitor should be notified of the intention to escalate, and should be copied into the correspondence sent to the insurer escalation contact point.

7.4. All parties are expected to adhere to the objectives set out above.

8. DISPUTE RESOLUTION

8.1. Ongoing dialogue is fundamental to the process. The parties will continue to discuss the case on a regular basis and at the times agreed. There may be occasions when issues arise that cannot be resolved through discussion.

8.2. On those occasions the parties should consider and agree if possible how they will approach such disputes. Such an approach should be adopted when any dispute emerges in the case, whether it relates to a discrete issue or resolution of the dispute generally.

8.3. All methods of dispute resolution should be considered. Including:

- Stocktake/cooling off period before the parties re-engage
- Early Neutral Evaluation
- Joint Settlement Meeting
- Mediation
- Arbitration

8.4. Considering other methods of dispute resolution does not prevent the parties from starting legal proceedings including Detailed Assessment if needed.

9. COSTS

9.1. Where the stage has been reached in the case where it looks like there stands a good prospect of resolution, the parties should also consider how to resolve costs promptly. For example, if there is a Joint Settlement Meeting, then the Defendants are entitled to expect the Claimant to provide cost details to be served 7 days prior to the JSM; the parties should agree the manner in which the cost details will be given (by way of a schedule, some other form or draft Bill of costs). The parties should agree whether cost lawyers need to be available at the meeting in order to facilitate resolution of costs. If it is not possible to resolve costs at the meeting, the parties

should agree a 28 day period following the meeting to enable without prejudice discussions with a view to finalising the costs issues.

9.2. Where the case is resolved by acceptance of written offer, the parties should be prepared to engage immediately in discussion concerning costs. Agreement should focus on the information that is to be provided by the receiving party to the paying party, and a without prejudice timescale established, normally 28 days after acceptance of offer, to try and resolve costs once and for all prior to commencing the costs procedure.

9.3. Following resolution of liability, the Guide recognises an early commitment to pay an interim payment towards disbursements and a contribution towards base costs. See objective (iv) above.

Signatories:

The following general insurers and claimant firms and professional organisations have agreed to follow this Guide. See www.seriousinjuryguide.co.uk for a full and up-to-date list. All named firms commit that all handlers within their organisations will follow the Guide in all respects including the escalation process.

Acromas

Admiral

Allianz

Aviva

AXA

Swiftcover

Direct Line Group

Churchill

Esure

Hastings

LV/Highway

MIB

NFU Mutual

QBE

RSA

ASB Aspire LLP

Ashton KCJ Solicitors

Atherton Godfrey

Barlow Robbins LLP

Barratt Goff and Tomlinson

Blakeley Solicitors

Blaser Mills

Beardsells Solicitors

Beecham Peacock LLP

Bolt Burdon Kemp

Boyes Turner

Boys and Maughan

Brethertons LLP

Carpenters

Cartridges Law

CFG Law

Clarke Willmott LLP

Coles Miller Solicitors

Coole and Haddock

Field Fisher

Fletchers

Foot Anstey

Ford Simey LLP

Freeths LLP

George Ide LLP

Goughs Solicitors

Healys

Higgs and Sons Solicitors

Hugh James

Irwin Mitchell

JNP Legal

Liddys Solicitors

Mason Baggott and Garton

Morrish Solicitors

Nash and Co

Novum Law

Osbornes

Pattinson & Brewer

Patrick Blackmore

Peace Legal

Pierre Thomas and Partners

Potter Rees Dolan

Pudsey Legal

Serious Law

Shoosmiths (Access Legal)

Simpkins and Co Solicitors

Slater & Gordon

Smith Jones Solicitors

Stewarts

Stones Solicitors

Thomas Dunton Solicitors

Thompsons

Whitestone Solicitors

Wolferstans