APIL NE REG MEETING

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St James Park

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Matthew Stockwell, Outer Temple Chambers

Contentious issues in brain injury litigation (including clinical evaluation, executive function and capacity)

Executive Function and Evidence

In brain injury litigation, the two most common areas of contention are (1) whether or not brain dysfunction has resulted from a traumatic event and (2) if so the nature and extent of any resulting cognitive impairment. Despite technological advances (of which the expert practitioner must keep abreast), there remain cases in which it is impossible to diagnose brain injury on the basis of physical evidence alone (e.g. brain imaging or neurophysiological assessment). Where the existence of brain injury is accepted, it will still be necessary to clarify the extent of any cognitive impairment through detailed neuropsychological evaluation, but testing is not without controversy.

The most common indicators of brain injury 'severity' are (1) depth of coma, (2) duration of coma and (3) duration of post-traumatic amnesia[1]:

Severity	**Glasgow coma scale**	**Length of unconsciousness**	**Post-traumatic amnesia**
Mild	13 to 15	Less than 15 min	Less than 1 hr
Moderate	9 to 12	15 min to 6hrs	1 to 24 hours
Severe	3 to 8	More than 6 hrs	1 to 7 days

Whilst the vast majority of people who suffer a mild brain injury make a full recovery, for a small, unfortunate subgroup recovery is either protracted or incomplete.

This subgroup may present with complex cognitive and emotional symptoms, with the potential to significantly impact upon their daily living. The prognosis is poorer in cases of moderate severity, with a typically slower recovery period and an increased possibility of persistent symptoms. The prognosis after severe injury, around 5% of cases, is poorer still.

[1] Neuropsychological presentation and treatment of traumatic brain injury, Chapter 27, The Handbook of Clinical Neuropsychology (Oxford, Second Edition).

In summary, the more significant the initial severity of the injury, the greater the likelihood of resulting brain dysfunction and the more significant the likely nature and extent of the resulting impairment, but each case falls for individual assessment.

Neuropsychological assessment is obviously an important part of the assessment process, but not always conclusive. The following cognition skills are ordinarily the subject of neuropsychological assessment:

- premorbid functioning
- current intellectual functioning
- memory
- attention and concentration
- speech, language and communication skills
- visuospatial perception and constructional skills
- executive functioning
- mood, personality and behaviour

Although the main tools of the neuropsychologist are standardised tests, an individual's performance can be affected by a multitude of factors. Therefore a critical function in neuropsychological assessment (often neglected or dogmatically ignored by some experts) is to have regard for the potential impact of individual or external factors on performance. These include:

- physical problems
- alcohol, recreational drugs or prescription medication
- psychiatric disorders or learning disability
- congenital or pre-existing neurological conditions
- language
- cultural bias
- motivation or effort

Two of the above factors, motivation and premorbid adverse lifestyle factors, require closer consideration.

Impaired motivation is a frequently described consequence of acquired brain injury. Whilst *motivation* is a commonly used term in everyday language, a myriad of related expressions are used in scientific and clinical literature. Complex and contradictory concepts are often used without definition or clarity.

Without using a clear framework (and there much to be said for goal-directed models[2]), it can be difficult to identify the different forms of motivational breakdown and implement appropriate remedies. This is a particular problem when loss of motivation can occur in different ways, to different degrees at any stage of the rehabilitation process.

Much of everyday functioning is routine. Even complex tasks, such as driving and preparing meals, are carried out with little by way of conscious attention. When a potentially dangerous or unexpected situation arises, attention can be focused on a response and then monitoring. This mixed system of automatic and consciously controlled activity can and does fail from time to time in any person, but in the brain injured individual a breakdown in the conscious control of action gives rise to more frequent errors with potentially disastrous consequences.

It is in this context that premorbid adverse lifestyle factors (or, for example, the absence of a more supportive family structure) become aggravating features, rather than the basis for a betterment argument by the defendant.

Whilst great progress has been made in the rehabilitation of executive functioning, the evidence base for the effectiveness of specific interventions remains limited[3] . This factor must be taken into account when evaluating clinical and medical legal evidence and deciding what other evidence to place before the court.

Whilst not unanimously accepted by all neuropsychologists, there is a growing acceptance amongst practitioners - and more importantly for our purposes among the judiciary - of the need to interpret neuropsychological test results with reference to real life evidence including lay witness statements, therapy assessments, case management records, clinical records, file reviews, direct observation and interview. Without placing the result of such formal testing in a wider context, there is a danger of misinterpretation or misrepresentation[4].

[2] This is the preferred model set out by Oddy and Worthington in the excellent practitioner publication, The Rehabilitation of Executive Disorders: a guide to theory and practice (2009 – OUP).
[3] See Cognitive rehabilitation for executive dysfunction in adults with stroke or other adult non-progressive acquired brain damage (Chung et al – 2013 – The Cochrane Library)
[4] See Presenting evidence of executive functions deficit in court - Issues for the expert neuropsychologist [2013] JPIL Issues 4 page 240.

As Stuart-Smith J observed in *Ali v Caton* [2013] EWHC 1730 (QB) at [230][5]:

> "…*the determinants of behaviour and effective functional ability are multi-factorial, depending upon injuries to parts of the body other than the brain, physical abilities and disabilities, perception, mood, and the ability of rehabilitation to enable the patient to function independently on a day to day basis. The presence of reliable test results is useful but not determinative; their absence does not absolve clinicians or the court from reviewing all of the available evidence in order to form an opinion*."

So it is important we consider ***ALL*** available evidence, including but not limited to the following[6]:

- Medico-legal reports
- Clinical records
- Care and case management records
- Reports or witness statements from the appointed case manager
- Reports and notes from treating therapists
- Witness evidence from family members (and friends and colleagues as appropriate)
- Witness evidence from the Deputy

[5] See also *Verlander v Rahman* [2012] EWHC 1026 (QB), *Edwards v Martin* [2010] EWHC 570 (QB) and *Siegel v Pummell* [2014] EWHC 4309 (QB) for useful examples of judicial evaluation.

[6] There also needs to be an effective process of information sharing where all of the main protagonists know about what each person has to say and has had an opportunity to reflect upon this in their contribution. Consideration also needs to be given as to how to effectively present potentially voluminous information: one good approach, which might be employed with modification is the use schedules or appendices as in *Farrugia v Burtenshaw & Ors* [2014] EWHC 1036 (QB).

Deprivation of Liberty and the Personal Injury Practitioner

Deprivation of liberty under the MCA has the same meaning as in Art 5(1) of the ECHR and the relevant principles are rooted in the Strasbourg jurisprudence. There are three necessary elements:

- The objective element: a person's confinement in a particular restricted space for a non-negligible length of time;
- The subjective element: the person has not validly consented to the confinement in question; and
- The deprivation of liberty must be imputable to the State.

It is the third element that was brought into sharp focus in *Staffordshire County Council v SRK & Anor*, but the following is provided by way of background.

What is a deprivation of liberty?

The difference between restricting a person (not all restrictions will amount to a deprivation) and depriving them of their liberty (unlawful, unless consented to or authorised) is one of degree or intensity rather than of nature or substance. Each case requires an assessment of the specific facts, e.g. the duration, effect and manner of implementation of the measure in question and its impact on the person.

Whilst the DOLS Code of Practice provided guidance on identifying a deprivation of liberty, the Courts struggled (and still do) in many cases to decide which side of the line a case falls on.

The Supreme Court gave guidance in the linked appeals of *P v Cheshire West and Cheshire Council and Another* and *P and Q v Surrey Council* [2014] UKSC 19, concerning the living arrangements of three disabled people: P, MIG and MEG ('*Cheshire West*').

P, a man with cerebral palsy and Down's syndrome, lived in a staffed bungalow with other residents, receiving one-to-one 24 hour support for daily activities, including prompting with self-care, to e.g. hygiene and continence. Interventions were sometimes required when he exhibited challenging behaviour, some of which were of an invasive nature.

MIG and MEG (otherwise known as P and Q) were sisters with learning disabilities who became the subject of care proceedings. MIG was placed with a foster mother. She never attempted to leave the foster home by herself, but would have been restrained had she tried to do so. MEG was moved from foster care to a residential home for adults with complex needs. She sometimes required physical restraint and received tranquillising medication. Upon expiry of the relevant care order, proceedings were transferred to the COP.

In each case, the Court of Appeal had ruled that P, MIG and MEG were not deprived of their liberty, when their individual circumstances where considered against a disabled comparator.

The Supreme Court overruled the Court of Appeal, unanimously in the case of P in the case o MIG and MEG by a majority of 4 to 3. The ultimate question before the Supreme Court was summarised by Lady Hale at paragraph 33:

> '*The first and most fundamental question is whether the concept of physical liberty protected by article 5 is the same for everyone, regardless of whether or not they are mentally or physically disabled*.'

Lady Hale emphatically said that it was at paragraphs 45 and 46:

> '[It] *is axiomatic that people with disabilities, both mental and physical, have the same human rights as the rest of the human race. It may be that those rights have sometimes to be limited or restricted because of their disabilities, but the starting point should be the same as that for everyone else. This flows inexorably from the universal character of human rights, founded on the inherent dignity of all human beings, and is confirmed in the United Nations Convention on the Rights of Persons with Disabilities. Far from disability entitling the state to deny such people human rights: rather it places upon the state (and upon others) the duty to make reasonable accommodation to cater for the special needs of those with disabilities*.
>
> *Those rights include the right to physical liberty, which is guaranteed by article 5 of the European Convention. This is not a right to do or to go where one pleases. It is a more focussed right, not to be deprived of that physical liberty. But, as it seems to me, what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities. If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage*.'

Lord Kerr, who agreed with Lady Hale and Lord Neuberger, noted at paragraph 76 that:

> '*Liberty means the state or condition of being free from external constraint. It is predominantly an objective state. It does not depend on one's disposition to exploit one's freedom. Nor is it diminished by one's lack of capacity*.'

Lady Hale analysed the Strasbourg jurisprudence and identified the twin, essential ingredients of a deprivation of liberty (or the 'acid test') as being:

- The person is not free to leave; and
- Under continuous supervision and control.

The Supreme Court judgment also confirms that the following factors are irrelevant:

- A person's compliance or lack of objection;
- The relative normality of the placement (i.e. the comparison with arrangements made for other disabled people); and
- The reasons/purpose behind the placement.

No further guidance was given as to the application of the acid test, i.e. when supervision does not amount to control and when supervision and control are not complete or continuous. Nor is there any analysis of what it means to be 'free to leave' or how to determine the area and period of confinement. Until further clarification is provided by the Courts, perhaps the best way in which to approach the issue in a given case is to look at the way in which the Supreme Court applied the acid test to P and MIG and MEG, i.e. cautiously: see Baroness Hale at paragraph 57.

Staffordshire County Council v SRK & Anor

SRK is now in his late 30s. In 2005, he was the victim of a road traffic accident and sustained a severe brain injury. He received a substantial damages award which funded the purchase of his own private property, where he lives, and now funds his care. He has a professional property and affairs deputy. His care is provided by private sector providers. The LA are not involved. He is wheelchair bound and needs 24 hour care assistance 7 days a week, and is monitored constantly. He also has epilepsy and has regular seizures. He has very limited communication.

The deputy informed the LA that SRK's situation might amount to a deprivation of liberty. The LA made an application to the COP for a welfare order authorising SRK's deprivation of liberty. Charles J accepted that the evidence showed:

- SRK lacked capacity to make decisions about his care and residence.
- His care regime was the least restrictive option available to promote his best interests.
- His brother, sister and a LA SW all agreed with the above.
- The arrangements objectively gave rise to a deprivation of liberty, judged by the objective 'acid test' laid down by the Supreme Court in *Cheshire West*.
- SRK was unable to give a valid consent, so the second subjective limb of the test for an Article 5 deprivation of liberty was also met.

The issue in the case was therefore whether the care arrangements for SRK are 'imputable to the state'. There was no 'direct involvement' by the state (i.e. the LA) in SRK's care arrangements, so if his deprivation of liberty was to be 'imputable to the state' it had to be on another basis.

Charles J found that the critical issue was to ask whether, if the COP did not make a welfare order authorising detention in this class of case, the amendments to the MCA aimed at filling the 'Bournewood gap' would have achieved their purpose. His answer to that question was no - a welfare order is needed in this class of case to provide a procedure that protects P from arbitrary detention, and so avoids a violation of the State's positive obligations under Article 5 and its spirit.

Charles J's conclusion was based on the premise that the State knew or ought to have known of the situation on the ground. That knowledge was present here (and would exist in all cases of this nature), as the Court was awarding damages and appointing the deputy and the deputy should inform the LA.

- Since *Cheshire West* (a) a Court awarding damages and/or approving settlement, (b) the COP appointing a deputy and/or (c) a trustee or attorney to whom damages are paid should all be aware that the regime of care for a person in an equivalent position to SRK creates a (private) deprivation of liberty.
- The knowledge of the Court means the State has knowledge.
- The deputy (and the Court awarding/approving damages, a COP appointed deputy and trustee or attorney) should in P's best interests inform the LA with statutory safeguarding responsibilities (paragraphs 56 to 59 & 136).
- The LA's obligations to investigate, support and sometimes make an application to Court would be triggered.

Charles J compared the procedural regime that would apply if a welfare order authorising detention was made by the Court, or was not made by the Court (paragraphs 140 to 141).

If no order was made there would be a decision by decision-maker on the ground under section 5 MCA and oversight by the LA and CQC.

If an order was made there would be:

- 'DOLS like' assessments in the preparation of evidence for the Court.
- An independent decision maker with P's 'voice' heard by the Court
- A system of review by an independent decision-maker at no more than yearly intervals

Charles J stated at paragraph 143:

> '*…the central issue in this case is whether, absent the making of a welfare order by the COP, the lack of a defined decision making procedure for the initial decision and its review under which defined assessments have to be carried out means that there are insufficient procedural safeguards*.'

At paragraph 144, he assumed the decision-makers on the ground and the LAs and other public authorities would act properly. But, he asked at paragraphs 145, was that:

> '[*a*] *sufficient decision making process and independent check to guard against arbitrary detention and so to satisfy the positive obligations [of] Article 5 and its spirit?*'

> '*I have concluded that it is not in cases within the class represented by SRK's case where the envisaged and actual application of a damages award creates a (private) deprivation of liberty within Article 5. This has the result that a failure to make a welfare order in such case would, on the backwards looking approach taken by the ECtHR, be a violation of the positive obligations imposed on the State by and the spirit, of Article 5 and mean that the State was responsible for that deprivation of liberty*.'

He reached this conclusion with 'real reluctance' as [he considered] the involvement of the COP was likely to add nothing and would divert resources. But his conclusion did apply the cautious approach in *Cheshire West* and would focus minds on deprivation of liberty. Not all LAs might act in the same way, and not all Ps have family or friends.

Whilst Charles J considered that a streamlined paper review procedure is likely to be appropriate, a review by the deputy alone would suffer from the same procedural defects as the original decision and was insufficient under Art 5.

For essentially the same reasons, the Court of Appeal upheld Charles J's decision on appeal by the Secretary of State for Justice: *Staffordshire County Council v K and others* [2017] 2 W.L.R. 1131.

Implications for PI lawyers and deputies

No formal guidance has yet been given by the Court of Protection (COP) and no case has yet grappled with the application of SRK on a prospective basis (i.e. addressing the issues raised prior to settlement). The follow issues are likely to be pertinent

- Additional costs arising from the decision in principle give rise to a recoverable loss.
- SRK envisages the deputy will inform the LA of the existence of a care package amounting to a deprivation of liberty and then LA will make an application to the Court of Protection (COP).
- This reflects the circumstances in SRK. Will this always be so?
- No case is likely to be cost free.
- How much time is required in each case and the value to be put on it is a matter for individual consideration.
- This has a knock on effect both in relation to the costs of the litigation and the damages award.
- It influences budgeting, case preparation and planning and settlement, including form of award.
- Care plans will have to be kept under review and, if changed in a way that is more restrictive, the local authority will need to be informed and a court application made.
- The judgments refer to the Re X procedure, which does not involve an attended hearing and is relatively low cost (but no, "no cost").
- However, if the care arrangements become contentious the COP will make directions for the case to proceed outside the Re X streamlined procedure and the case may become significantly more complex and costly, possibly with a number of attended hearings.
- Even if there is no significant dispute of this kind, the COP may ask for s.49 MCA expert reports or make other queries which again may involve time and costs.
- This will be more likely where the care plan or accommodation are changed.
- Costs and legal expenses will need to be provided for. These are likely to broadly mirror the original litigation or LA roles (litigation friend, litigation solicitor, case manager / care coordinator, deputy / appointee etc).
- Will these begin to look and feel like annual approvals of settlement?
- Disbursements will need to be considered.
- Who is best placed to provide costings?
- Consider if a care plan involves objective deprivation of liberty and if the claimant can give valid consent.
- Consider modifying care plan to avoid objective deprivation of liberty.

- Consider the impact on a PI Court's decision on care option reasonably required and its award of damages (relevant matters including level of supervision, periods of supervision, use of sedation or restraint, use of assistive technology).
- Consider the addition evidence required at each stage. This will also be a relevant consideration when establishing an interim accommodation package, as will negotiations and approval.
- Consider how authorisation will be managed alongside approval.
- How will this influence timing of applications?
- Consider PPOs or Tomlin orders.
- Charles J's rough estimate of existing cases - 250 to 300 cases. Is this accurate?
- The above estimate does not include cases where care is part funded from P's assets and the balance provided by a LA or NHS body (which also now apparently need COP authorisation/annual review).
- How does P fund additional costs of authorisation/review post settlement?
- Will this give risk to under settlement and professional negligence claims?

What other bearing might COP proceedings have on a PI claim?

There are two cases, by way of example, in which both the COP and the civil courts have been seized of the same subject matter – with drastically different results.

In *Sedge v. Prime*[7], COP proceedings has preceded an application for an interim payment to establish an accommodation and care package within a personal injury claim. As part of a multidisciplinary assessment, it had been concluded that it was in P (or C)'s best interests for him to live in the community. Giving judgment in favour of the claimant, the Deputy Judge commented upon the earlier determination as follows[8]:

> '*I do not regard myself as in any way bound by that decision. At the same time I do not regard it as irrelevant. The fact that those experienced in caring for others and/or arranging such care unanimously concluded that it would be in the claimant's best interests for him to be cared for in the community suggests that a considerable body of experienced opinion did not reject community care as a potential realistic option for the claimant. But the decision offers limited support for the claimant's case since the test the court has to apply is different.*'

[7] (2013) 129 B.M.L.R. 37
[8] At [40]

Clearly an earlier '*best interests'* decision is relevant information as part of a subsequent decision in connection with a compensation claim, but is the latter assessment entirely unfettered? Are the injured party's rights (and Court's obligations) arising under Articles 5 and 8 not potentially engaged in each case? Equally, would respect for dignity in those who lack capacity to make decision regarding their own personal care arrangements not inform the assessment of what was reasonable by way of private expenditure?[9]

In *Roult v. North West SHA*[10], partial approval of settlement was made in a liability admitted birth injury claim on the basis that the claimant would be accommodated by his LA in a 'group home'.

This was news to the LA. In ignorance of the proposals for the claimant's care, the LA (with the support of the Official Solicitor, who was in a similar state of darkness) pursued a welfare application in the COP owing to safeguarding concerns.

Ultimately, the COP concluded that it was in the claimant's best interests (with the agreement of his new advisers in the clinical negligence proceedings) for him to live in his own property as part of a proposed supported living arrangement. As the terms of the partial settlement excluded any liability on the part of the defendant to meet such costs, the interested parties remained at loggerheads as to how the claimant's future care needs should be met.

Loughlin v. Singh and Others[11]

This case throws up a number of important issues and practice points, so it is worth looking at in some detail.

Firstly, an important if subtle point is the judicial evaluation of expert evidence. On a number of occasions the Judge emphasises the extent to which the experts have[12] (or have not[13]) made a detailed and careful review of the relevant material. Moreover, the Judge expressly attaches particular weight to one expert's practical experience in cases of a similar nature[14]:

[9] See *R. (on the application of A) v East Sussex CC (No.2)* [2003] EWHC 167 (Admin); (2003) 6 C.C.L. Rep. 194 - an unusual case in which Munby J considered the interrelationship between a LA's responsibility as an employer under the Manual Handling Operations Regulations 1992 and the interests of disabled people to be lifted safely with dignity.
[10] [2009] P.I.Q.R. P18
[11] [2013] COPLR 371
[12] Of Dr Schady at [22], of Dr Moss at [26] and of Dr O'Driscoll at [51]
[13] See Appendix in connection with the evidence of Professor Barnes
[14] [2013] COPLR 371 at [36] and [51] – Likewise PI practitioners can draw on the experience and guidance of those who deal with capacity issues on a more regular basis – see *Compensating elderly clients* [2012] Eld LJ 278

'*Dr O'Driscoll is a consultant neuropsychiatrist with considerable experience, both in community based rehabilitation and in the clinical tertiary setting. He emphasised that neuropsychiatrists focussed mainly on the behavioural and emotional aspects of frontal lobe injury... Not only did he have expertise that comprehensively embraced all the issues as regards capacity, he had also considerable practical experience in working with cases, such as the present one, which were at the margin between capacity and incapacity. He had before him all the information, gathered over many years, about the claimant's behaviour, and the assessments made by others.*'

Secondly, the Judge - albeit with some reticence - took into account the views of other professionals who have been in close and frequent contact with the claimant. These reservation are surprising. The importance of such evidence has been emphasised in a number of cases[15]. Moreover, it would fly in the face of the Mental Capacity Act 2005 not to take into account such evidence, as reflected in the Code[16]:

'*The Act places a duty on the decision-maker to consult other people close to a person who lacks capacity, where practical and appropriate, on decisions affecting the person and what might be in the person's best interests. This also applies to those involved in caring for the person and interested in the person's welfare. Under section 4(7), the decision-maker has a duty to take into account the views of the following people, where it is practical and appropriate to do so:*
Anyone the person has previously named as someone they want to be consulted,
Anyone involved in caring for the person,
Anyone interested in their welfare (for example, family carers, other close relatives, or an advocate already working with the person),
An attorney appointed by the person under a Lasting Power of Attorney, and
A deputy appointed for that person by the Court of Protection.'

[15] See *Saulle v. Nouvet* [2008] M.H.L.R. 59 at [53], *Bailey v. Warren* [2006] C.P. Rep. 26 at [87]-[90] and generally *Lindsay v. Wood* [2006] M.H.L.R. 341
[16] At Paragraph 5.49

Thirdly, the Judge discounted past professional care and case management services by 20% on a *broad brush* basis. The precise jurisprudential basis is unclear[17], but this is a cause of significant concern for both the lawyer and professional deputy assisting a claimant with acquired brain injury.

It is imperative that all professionals supporting an injured person understand and, if appropriate, scrutinise paid care and case management roles[18] and that all services are appropriately estimated[19].

Fourthly, and finally for these purposes, a number of issues are raised in relation to disclosure of documentation before (and/or prepared in connection with) the Court of Protection proceedings. Given the importance of the decisions under consideration, it is undoubtedly correct that *all* material which has a bearing on P's capacity should be placed before the Court of Protection[20].

[17] Arguments of a similar nature were rejected by Stuart-Smith J in the case of *Ali v. Caton & Anor* [2013] EWHC 1730 (QB) at [323h]; '*The position of a significantly brain-damaged claimant who acts on the basis of apparently reasonable advice is strong, though not always impregnable, when seeking to recover the costs of so doing from a tortfeasor. On this item, the balance of the argument strongly favours the claimant. In the event, the attempt to prepare Jubair for independent living has not been successful and should now not be maintained...While I accept that it may have been possible to do some things better (for example, a more vigorous approach to the implementation of strategies for independent journeys), that does not vitiate the general purpose and reasonableness of the strategy*.' This judgment proceeded by way of appeal: *Ali v Caton & Anor* [2014] EWCA Civ 1313. The defendants were unsuccessful, but the Court did nor grapple specifically with *Loughlin*, which remains under a cloud. For example, how is the decision of Parker J to be reconciled with case law in this context (namely mitigation) which (1) makes clear that it is the injured party's actions which are relevant in this context ('*For a supervening cause or a failure to mitigate to relieve a defendant...there must, in my judgment, be a finding of some conduct on [the claimant's] part or on the part of someone for whom the [claimant] is in law responsible*' per Beldam LJ in *Mattocks v. Mann* [1993] RTR 13) and (2) that, in any event, these actions are not to be judged harshly ('*As between a claimant and a tortfeasor the onus is on the latter to show that the former has unreasonably neglected to mitigate the damages. The standard of reasonable conduct required must take into account that a claimant in such circumstances is not to be unduly pressed at the instance of the tortfeasor...the claimant's conduct ought not to be weighed in nice scales at the instance of the party which occasioned the difficulty*' per Sachs LJ in *Melia v. Key Terrain Ltd* (1969), cited with approval in *Morris v Richards* [2004] P.I.Q.R. Q3).

[18] Helpful guidance on the role of the case manager can be found in the case *Wright v. Sullivan* [2006] 1 W.L.R. 172. For further detail on the clinical objectives, *Rehabilitation following ABI* (RCP & RSRM 2003) is a useful starting point. Please also see *Good Practice in Brain Injury Case Management* (2006) Jessica Kingsley Publishing (Ed. Jackie Parker).

[19] The same applies equally of deputyship costs, the Court demonstrating reluctance to assist a Protected Party in the event of an underestimate of charges; see *In the matter of GW* (decision of Master Howarth dated 19 September 2013 in the Senior Courts Cost Office).

[20] As a specialist forum, perhaps the Court of Protection is best placed to consider contentious capacity issues and brain injury cases might be transferred, for these purposes? See Gordon Ashton OBE's article in APIL PI Focus Vol 18 Issue 5.

This gives rise to the thorny question of '*what disclosure might be made of reports made available to the Court of Protection for these purposes in subsequent civil proceedings?*'[21] - No doubt this issue will fall for further judicial consideration in due course.

Matthew Stockwell

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OuterTemple Chambers

T: +44 (0)20 7353 6381
E: matthew.stockwell@outertemple.com
www.outertemple.com

[21] Historically, the Court of Protection has shown great reticence receiving applications by third parties or strangers to the original application. In the context of applications by a deputy seeking authorisation to access public assistance against the background of an earlier personal injury settlement, for example, the interested local authority has been given short thrift – see *Re Reeves* (COP 2010) Senior Judge Lush. It is always been the case that, in connection disclosure documents, the Court of Protection's primary focus has been on the best interests of the protected party - *In Re Manda* [1993] Fam. 183. Whilst awaiting definitive judgment, the prudent course for any deputy would be to treat all documents filed in connection with the application, as opposed to general accounting documentation, as being subject to the Court of Protection Rules 2007, r17.

Barrister, Outer Temple Chambers, London

Matthew is a personal injury and public law barrister who specialises in serious injury litigation & welfare related aspects of public law. His caseload is made up almost exclusively of cases with a mixture of high value (or other importance to the parties), sensitivity and complexity. He is recognised for his know-how and experience, combined with a strong work ethic and empathy with clients. He has acted for claimants and defendants at all levels up to and including the Supreme Court.

Matthew served on the national executive committee of the Association of Personal Injury Lawyers (APIL) between 2007 and 2015 – as Vice President in 2012 & President in 2013. He is co-author (with Nigel Tomkins) of the APIL Guide 'Accidents at work'. Matthew has particular knowledge and experience of head injury litigation, delivering APIL's Brain Injury training courses (with Neil Sugarman) and actively contributing to APIL's catastrophic injury training programme.

Cases of interest include *Threlfall v Hull CC* [2010] CA (guidance on determining 'suitability' of PPE), *Uren v Corporate Leisure & Others* [2011] CA (non-delegable nature of employer's risk assessment obligations – tetraplegia claim on behalf of serviceman), *Fox v Foundation Piling* [2011] CA (costs: relationship between Part 36 and Part 44.3), *Dunhill v Burgin* [2014] SC (litigation capacity and compromise) and *Pollock v Cahill* [2015] (tetraplegia claim on behalf of blind adventure athlete).

Matthew also has extensive experience of fatal accident, clinical and professional negligence claims and other cases of medical and technical complexity.

In the sphere of public law, Matthew has a longstanding academic and professional interest in health and social care provision. He obtained a masters degree from Trinity College, Dublin, following comparative research about issues of capacity and consent in the context of obstetric management, and regularly appears in the Court of Protection, Family and Administrative Courts on matters of the utmost sensitivity.

Matthew advises and lectures widely in the areas of health and social welfare decision-making, mental capacity and mental health, community care provision, learning disability and funding & charging issues. He is also a specialist contributor to Judicial Review: Law & Practice (Jordans).

Outer Temple Chambers
The Outer Temple
222 Strand
London
WC2R 1BA

Tel: 020 7353 6381
Fax: 020 7583 1786
E-mail: Matthew.Stockwell@outertemple.com
Web: www.outertemple.com

Outer Temple Chambers