What is the scale of the problem?

The statistics tend to be a little dated but

- Each year, an estimated 1 million people in the UK go to hospital as a result of a head injury (more than 2,500 a day).
- Of those perhaps 80% will not have been knocked out while 150,000 will have a minor brain injury resulting in unconsciousness for 15 minutes or less. Many will
have short-term loss of attention, concentration and memory: usually they recover completely within 3-6 months.

- Mortality is around 0.5% (interestingly in the USA the figure is over 3%, with African-Americans having the highest death rate from TBI. Whether this has anything to do with insurance coverage one does not know, but the uninsured rate for African Americans is around one and a half times the rate for white Americans)

- In the UK some 10,000 (1%) will suffer moderate brain damage causing unconsciousness for up to 6 hours. Some will still have physical and psychological problems after 5 years.

- Up to 11,000 (each year) will suffer severe brain injuries and be unconscious for 6 hours or more. Of these, only about 15% will return to work within 5 years. Many will not work again and around 4,500 will require full time care for the rest of their lives.

- The Royal College of Surgeons provided statistics in 1999 that showed that when moderate head injuries occur, 63% remain disabled a year after their injuries and this increases to 85% following a serious head injury. Even after a minor injury, the victim is still susceptible to suffering severe headaches and memory problems. 34% of people are unemployed 3 months following their accident.
• Headway estimate that over 120,000 people in the U.K. are currently suffering from the long-term effects of severe brain damage caused by head injury.¹

• Males are two or three times more likely to have a head injury than females and the age group most at risk is between 15 and 29 years of age. (In the USA males are about 1.5 times as likely as females to sustain a TBI. The two age groups at highest risk for TBI are 0 to 4 year olds and 15 to 19 year olds.)²

• Most moderate to severe TBI are caused by motor vehicle accidents but many result from domestic and industrial accidents (largely falls), sports and recreational injuries and from assaults.

So how is the personal injury lawyer to best help such a client?

¹ One study (Thornhill et al: BMJ. 2000 Jun 17;320(7250):1631-5) suggests that

• the annual incidence of disability in adults with head injuries admitted to hospital is 100-150 per 100,000 population.
• Survival with moderate or severe disability is common after mild (Glasgow Coma Score (GCS) 13-15) head injury, (47% of patients) and is similar to that after moderate (45%) or severe injury (48%).¹⁶ Moderate is defined as score 9-12 and severe as ≤ 8.

² Hospital Episode Statistics data for the 2000/2001 annual data set indicate that of 112,978 admissions to hospitals in England with a primary diagnosis of head injury:

• 75% were male admissions and 33% were children under 15 years of age.
• 70-88% of all people who sustain a head injury were male.
• 10-19% were aged ≥65 years.
• Severe traumatic brain injury, defined as Glasgow Coma Score (GCS) <9, occurs in 11,000 people per year and has a mortality rate reaching 50%.
First, spot the brain injury

The effects on victims and their families can be devastating, but nevertheless brain injury is often known as the “hidden disability” because the problems which arise from an injury to the brain are not always obvious to another person. Other people can see and often understand the limitations caused by a physical disability (loss of leg etc), but difficulties with thinking skills and behavioural changes are often misunderstood.

Many brain injury claims are simply missed and settled at a serious undervalue. So how can a brain injury be spotted?

Some of the most common difficulties experienced following a brain injury are:

- Lack of insight
- Personality changes – eg increase in anger, mood swings, loss of inhibitions
- Inappropriate behaviour
- Poor perception, recognition and judgement
- Lack of initiative
- Fatigue
- Physical disabilities
- Slowed responses
- Loss of physical sensations
- Poor concentration
- Poor planning and problem solving skills
- Inability to understand and communicate
- Poor memory
- Slow or slurred speech
- Overly talkative

Other indications may include eg:

- Loss of sense of taste or smell (can be an indication in particular of frontal lobe damage)
- Disorders of hearing or balance
- Interference with vision (sometimes involving a palsy of various facial nerves) can suggest damage to the occipital lobe
- Post traumatic or retrograde amnesia
- Obviously a depressed GCS will be a marker

Moreover, there may be no specific evidence of direct trauma to the head. A severe whiplash (for instance) can give rise to diffuse brain injury where there is a rapid acceleration and/or deceleration of the brain within the skull.

Any client with a history of head injury and who suffers from any of these problems should be considered as a possible victim of brain damage. In such cases it is the subtle changes that are frequently most important - and most easily missed - and careful interviewing of the victim's family, friends and
colleagues for noted changes in his presentation may be very important.

Once the nature of the problem is identified, what then?

**Maximisation of damages or maximisation of Recovery?**

Although this talk's title refers to maximising damages, the purpose of damages is to place the claimant, so far as money can do so, in the position in which he would have been but for the accident. Plainly, if he can be put in that position ‘for real' that is a more beneficial outcome.

To that end the Rehabilitation Code is crucially important. Its aim is to promote the use of rehabilitation and early intervention in the compensation process so that the injured person makes the best and quickest possible medical, social and psychological recovery. The object is to enable the injured person to recover health, quality of life, and ability to work either before or in tandem with the compensation process.

Very often early intervention, rehabilitation and/or treatment can make a significant difference to function and outcome, and so it is very important that the claimant's legal team are alive to the options which exist, and are constantly assessing, with expert advice where appropriate, the appropriateness of seeking such intervention, which is in any event an obligation which arises under Part 4 of the Pre-Action Protocol. The object is then that the claimant's solicitor shall work with the
compensator to address and assess the claimant's needs and deliver the appropriate rehabilitation.

An assessment of immediate needs (INA) will usually be carried out by an independent person (or body) whose identity should be agreed between the parties beforehand. The report will be prepared and used wholly outside the litigation process, will be covered by legal privilege and not disclosed or used within the litigation process without agreement of both parties (although this privilege does not extend to subsequent case management notes).

The compensator will pay for the report and is expected subsequently to fund the recommended measures (so far as reasonable in terms of nature, content, costs and time). Provided the claimant undergoes the treatment recommended the compensator cannot subsequently dispute its reasonableness or cost or seek to recover any funds paid (if for instance the claim subsequently fails or a substantial finding of contributory negligence is made).

Even if the Rehabilitation Code is not invoked an INA will be a valuable aid to rehabilitation and to formulating the needs which will have to be funded from the damages, and the sooner it is obtained the better. Most cases of brain damage of any severity will require the involvement of a case manager and the case manager is usually the appropriate person to carry out the INA.
There may also be a need for early assessments by a psychologist (to address emotional and psychological issues arising from the injury), physiotherapists and speech and language therapists. Admission to a rehabilitation centre (eg Collumpton or Banstead) with their intensive and holistic approaches may assist and will be preceded by an assessment, which may take some days. Such admissions for intensive rehabilitation may last for over a year and may well be funded under the Code, but if they are not then an interim payment application will be needed and for this appropriate medical and related evidence will be required.

However caution must be exercised before applying for too much by way of interim payments too soon especially where periodical payments are possible/likely, or where there are issues over contributory negligence. Beware the *Eeles* trap³.

There will be a need also to assess the home into which the injured person is to be discharged from hospital or from the rehabilitation centre. The case manager or an occupational therapist can usually deal with this in the first instance although, of course, if major alterations (or a new property) are required an architect well experienced in such work for disabled persons will be necessary. By this stage it is likely that the instruction of such an expert will be part of the litigation process.

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³ *Eeles v Cobham Hire Services Ltd* (2009), EWCA Civ 204, (2010) 1 WLR 409
Despite the funding cuts it is important not to overlook the availability of statutory resources whether through the PCT or Social Services and this will be particularly important where, for instance, there will be a reduction of the damages due to contributory negligence. A s.47\(^4\) Report once sought must be delivered within a set time and the local authority must then consider it and decide on what type of service (if any) they will provide (whether under s.29 National Assistance Act 1948 (services) or s.21 (residential care))

Local authorities are also a source of grants which can be employed to render accommodation more accessible and appropriate for an injured person.

In addition it is important to research and secure all relevant statutory benefits (Incapacity Benefit, DLA, etc etc)

All this will be enabled by a competent case manager

**Getting the best deal for the Claimant**

This is perhaps the more appropriate aspiration, rather than simply concentrating on maximising the damages. As we have seen, rehabilitation and recovery are likely to be of greater real value to an injured claimant than simply large sums of cash. Where there has been an apportionment of liability there will be a need to maximise the power of the money that is

\(^4\) S.47 National Health Service and Community Care Act 1990
recovered, and that may mean accessing as much state provision as possible and negotiating indemnity agreements and top-up arrangements with the insurers. The funds that are recovered will need to be protected, and careful thought will need to be given to the form of award which best meets the claimant's needs.

All of this requires a team approach, and to maximise the claimant's benefit from the process that team needs to be built from an early stage with a clear idea of who will need to be recruited

**Case Managers**

The role of case managers first developed in the USA and has been prevalent here over the last decade and a half. The responsibilities of a clinical case manager include:

i. advocating for and on behalf of a client;
ii. protecting a client from vulnerability and abuse;
iii. maintaining effective communication systems for, amongst others, the client;
iv. co-ordinating a package of rehabilitation and care/support relevant to his/her needs;
v. managing such package using evidence-based practice and in line with National standards;
vi. undertaking an appropriate full needs and risks assessment;
vii. designing a case management plan to meet the assessed needs;
viii. implementing the plan taking account of quality, safety, efficiency and cost effectiveness;

ix. monitoring progress/deterioration and updating goals and related documentation. It is very important to ensure that the records which are kept, not only by the case manager but under his/her direction by the support workers, are well structured, and of a uniform pattern. The only way that progress (or deterioration) can be assessed reliably is if one is comparing like with like so far as notes from day to day are concerned, and if specific and measureable and measured goals are set and progress is recorded against them.

The role of the case manager has been one that has exercised the courts and the leading case on how they fit into the litigation process is Wright v Sullivan [2005] EWCA Civ 656. That case decided that the role of a clinical case manager, if called to give evidence at trial, was clearly one of a witness of fact, as the BABICM\(^5\) guidelines suggested. She would not be giving evidence of expert opinion. Further, she should owe her duties to her patient alone. To that end a case manager is not usually 'jointly instructed' but it is usual for her identity to be arrived at by mutual agreement.

Whilst any communications which the clinical case manager might have with the claimant’s expert witnesses, whose dominant purpose was not one which attracted litigation privilege (as explained in Waugh v BRB [1980] AC 521), would be disclosed as a matter of course, if the clinical case manager

\(^5\) the British Association of Brain Injury Case Managers
considered that it was in her client's interests that she should attend a conference with legal advisers at which advice was being sought, then the privilege was not hers to waive, and the court would not have the power to direct such waiver. That was not to say (said Brooke LJ):

"that it is not desirable to encourage as much openness in the exchange of information and views as possible in the spirit of CPR 1.3, so long as everyone concerned is acting sensibly and reasonably and is not reverting to pre-1999 trench warfare."

In that respect it was recognised in that case that the clinical case manager's case records should be made available to the defendant's solicitors and this is now (or should be) common practice.

The spirit of Wright v Sullivan is now embodied in the 2nd edition of the Guidelines published by the CMSUK.

Because of the specific defined role of the case manager, she must not be confused with the nursing/care/rehabilitation expert (see below).

**Keeping Records**

To maximise recovery of the many expenses which will be incurred it is essential to advise family and friends to record
and evidence all expenditure attributable to the consequences of the injury. Frequently, in drafting schedules of loss lawyers have to make estimates (usually underestimates) of expenses that have been incurred and recovery is significantly reduced as a result of lack of evidence. Start files for the collection of invoices and receipts, immediately upon instruction and make sure they are kept up to date.

Advise the family (etc) to commence the keeping of diaries which can evidence the (gratuitous) care being provided - not merely when care was being given but what was being done and why.

Secure bills from prior to the accident so that comparisons can be made between pre-accident and post accident charges for utilities (heat, light, phone).

**Medical records**

From an early stage create separate and paginated files of medical records and keep them up-dated. Whenever an expert is instructed ensure that s/he is provided with a set of the records so that page numbers can be referred to and clarity and uniformity can be achieved. You will also get plenty of Brownie points from the experts! Share the records thus paginated with the defendants so that their experts are also using the same references. (See below re preparation for trial).
**What experts?**

Ensure that the correct experts are engaged for the correct topic. A correct fit is essential to ensure the team is ‘fit for purpose’.

A neuro-surgeon may be appropriate to deal with the gross injury but more subtle injuries and sequelae will require other expertise.

A neuro-radiologist may be essential to identify from CT scans and especially the more sensitive MRIs exactly what damage has been done in the brain itself.

A neurologist will be relevant if the problem is (or includes) a physical one - eg there is some loss of feeling or sensation. Nonetheless it may also be necessary to consult (eg) an ophthalmologist for visual problems even though arising from nerve palsy. A neuro-otologist may be required where there is damage to the balancing mechanisms or the ear and symptoms of dizziness, vertigo, deafness or tinnitus. Sometimes brain injury leads to movement disorder, in which case it will be necessary to find a specialist in this particular field who may well be a neuro-physiologist. A neurologist is not appropriate for psychiatric or psychological issues, nor is a neuro-surgeon ideal for problems of neurology. Frequently neurologists are asked to opine on life expectancy, and
they will, but this may be a question better directed to a general physician or an expert specifically in life expectancy.

A psychiatrist and/or a neuro-psychiatrist:

Note the importance of the psychiatric assessment to identify eg any depressive illness. Disease (or mental illness) is the province of the psychiatrist, not the psychologist (although they may seek to venture into that territory). Thus, for example, if you have a suspected case of PTSD, that is a case for a psychiatrist not a psychologist.

A psychologist or a neuro-psychologist:

The neuro-psychologist, with the battery of psychometric testing, will best be able to assess the most subtle deficits. With children consider the need for an educational psychologist.

A consultant in neuro-rehabilitation - may be useful.

He or she may come from a number of backgrounds (typically neurology or neuro-psychology) but their specialism is in rehabilitation.

We are not here considering catastrophic claims (eg catastrophic birth) where other experts including (eg) paediatricians, developmental specialists, experts on life expectancy etc might be needed. Obviously, where there are other injuries other experts (orthopaedic surgeons, urologists etc) may be needed too.
In addition consider the therapists required. Again specialism is essential, in particular as the needs and deficits become more complex and specific. Thus physiotherapists, speech and language therapists, and occupational therapists must have experience of dealing with the brain injured. Ensure that the physiotherapist is a "neuro-physiotherapist" (and so on).

The crucial expert in any large case is, of course, the care expert who will assess the care needs and design the regime that is required to meet the claimant's specific needs. Once again it is essential that this expert has particular experience of brain injuries. He or she will frequently be a brain injury case manager.

Sometimes the care expert also advises on OT and equipment, sometimes their expertise is limited to care and a separate expert is required for equipment. A sound approach to such equipment, however, is to ensure that the proposals of the expert are not simply taken at face value but that the pieces of equipment, especially the more expensive or person-specific ones are tried out before being purchased. This means liaising with the case manager and the manufacturers (or attending exhibitions).

Depending on the nature and extent of the injury many other experts or therapies or assistance may of course be required, eg:

Chiropody - especially where (eg) brain damage causes hemiplegia
Skin care specialist - (especially where there is risk of pressure sores)

Diabetologist/endocrinologist - diabetes insipidus can be a frequent result of brain injury, but immobility also results in weight gain which can predispose to diabetes, and although brain injury is not a direct cause of diabetes mellitus, it can accelerate its onset while cognitive deficits can render its management much more difficult

Accommodation - ensure that the expert consulted is specifically familiar with the nature of the disabilities in the case, and has experience of designing for such disabilities. Beware the 'one-size-fits-all' report. Each case is different and a report which is clearly directed to this case and this claimant's needs (and not simply generated from a word processor, sometimes without even the names changed) will be more effective. It should also be realistic, and so should be the choice of property (see eg Pankhurst v White [2009] EWHC 1117 (QB)). Allow for OT input at the time of a move to new accommodation and consider the possibility (especially with younger claimants) that there may need to be more than one move. Ensure appropriate liaison with an expert on technology so far as environmental controls are concerned.

Technology - depending on the cognitive damage and the physical difficulties, different needs will arise. Thus memory problems may require memory aids and the humble i-phone may be of very real assistance. There are many apps which can assist. Damage to the left side of the brain may result in partial or total loss of language and various technological equipment can assist with ‘total communication’ - for instance pictures of commonly purchased items can be displayed on an i-phone and
shown to shop assistants, or artificial speech can be generated by a computer.

Where the brain damage has caused physical disability (as in strokes) then many of the types of technological assistance that might be expected in SCI cases will be equally applicable. In particular where the brain damage has caused physical disability technology may provide a means of exercising a greater degree of independence, although it is worth recalling that the equipment is there to maximise independence and not to foster dependence.

However, always be realistic. If the cognitive damage is such as to prevent the claimant learning or operating the equipment it will not assist the case to put forward aspirational claims which have no practical application.

Enablement - these elements of the claim are all designed to enable the claimant to live as full a life as possible. Where brain damage has affected initiation or initiative (for instance) it may be necessary to replace the functions of the brain (mainly frontal lobe functions in this instance) and so provide a ‘buddy’ or enabler who can find activities and make them happen and engender some purpose into the injured person’s life. Recommendations for such companions should be forthcoming from the care expert and/or the case manager.

The cost of therapies

It goes without saying that there will need to be included in the schedule of loss provision for future therapies. Physiotherapy, although most intense in the earlier years is likely to be a life long element, while SLT may be limited to a couple of years,
but the equipment needed for therapies will need to be provided for, and an allowance must be made for future changes in needs, eg deterioration with age, or the natural history of the condition. With brain injuries there may well be a place for psychotherapy, or for input from a clinical psychologist, whether for the claimant him/herself or for the team of carers. It is particularly important to ensure that training for the carers to administer aspects of all therapies is included in costings.

Where brain damage causes neurological impairment frequently there will be a need for orthotic devices to support joints etc. Frequently these will not be adequately funded through the NHS and private provision must be costed.

Depending on the nature of the damage provision for future input from an occupational therapist may be necessary.

Privilege
Care must be taken in selecting experts to advise, following the recent decision Edwards-Tubb v JD Wetherspoon PLC [2011] EWCA Civ 136. If a claimant wants to instruct a new expert following an unsatisfactory report from a first expert, he will in future be faced with an almost inevitable obligation to disclose the first report where that has been obtained after the protocol letter (but not before). It would seem to follow that you must be confident in your expert before you nominate him.
The non-medical team and preparation for trial

Getting the best result for the client is a matter of preparation, preparation, preparation. The trial process, and the period leading to it, is and must be a team effort. Preparation for trial should be considered to be starting right at the outset and not something left until after final directions have been given!

The forensic presentation of the case is or may be a very different process from simply gathering the evidence to make the case, and the gathering of the evidence needs to be geared to how it will eventually be presented in court. The advocate must consider how the case will develop before the judge, what the issues are likely to be and how the other side are likely to attack the case you are presenting. The advocate will have that forensic experience and must be involved from an early stage so that (s)he can advise on evidence as it is gathered, with an eye on the trial

Let the advocate see the draft experts’ reports and comment on them and ensure that there is provision for consultation with the experts before the reports are disclosed, so that ambiguities can be ironed out and weak points identified. The team approach includes the experts in these cases so try and get all experts whose evidence is likely to impinge on the others’ to attend one meeting, so as to ensure that the experts are mutually consistent in their recommendations. A joint conference with the experts on care and OT, accommodation and technology will be worth the investment. A medical expert
may also be a useful member of the discussion group. The object is to ensure that each expert's recommendations fit with the others. It may be important (for instance) to obtain a medical view on prognosis, in particular possible future deterioration (and, of course, its impact on the need for care, equipment and accommodation). Similarly, such a conference between the medical expert and the therapists may be valuable. Having these discussions facilitated by the advocate who is to present the case and who can therefore direct discussions with a view to marshalling the necessary evidence to be presented to support the claim in law, will be important.

**Schedules** form the basis of the quantum claim and must correlate with the evidence (medical, expert and lay) to be called, so it is best if the advocate either drafts or has the opportunity to review the schedules in good time to remedy any gaps in the supporting evidence and to ensure that all the evidence interlocks.

**Witness statements**: CPR 32.5(2) provides that the statement shall stand as the evidence in chief unless the court orders otherwise. It is therefore important to ensure all relevant material is included, structured in a logical (usually chronological) way, and includes the personal detail which the claimant and her carers want the judge to understand. It may be quite a long document but that may be appropriate so as to convey what is relevant (and assuming it is not to be found elsewhere in medical or care reports). Nevertheless bear in mind that the Queens Bench Guide (White Book vol 2, section 1B) at para 7.10.4 observes:
“(3) a witness statement should be as concise as the circumstances allow, inadmissible or irrelevant material should not be included,”

and

“(4) the cost of preparation of an over-elaborate witness statement may not be allowed.”

Again the advocate must have the opportunity before exchange of witness statements to review the material.

**Bundles and Medical Records**: It is impossible to overemphasize the crucial importance to the efficient presentation of a case (and thus to the maximisation of the damages recovered) of well organised bundles, delivered and agreed in good time, logically prepared, properly paginated, and each party (and the judge and witnesses) having exactly the same material in the same place. This may seem obvious but the sad reality is that day after day in the courts, bundles are defective and the presentation of the case suffers or unnecessary delay follows. Presentation is a crucial part of any case, and a crucial part of maximising the recovery of the claimant’s award.

The QB Guide at para 7.11.7 states:

“The efficient preparation of bundles is very important. Where bundles have been properly prepared, the claim will be easier to understand and present, and time and costs are likely to be saved. Where documents are copied unnecessarily or bundled incompetently, the costs may be disallowed.
Paragraph 3 of the Part 39 Practice Direction sets out in full the requirements for compiling bundles of documents for hearings or trial.”

Para 7.11.8 adds:

“The trial bundle must be filed not more than 7 and not less than 3 days before the start of the trial. ..... The contents of the trial bundle should be agreed where possible, and it should be made clear whether in addition, they are agreeing that the documents in the bundle are authentic even if not previously disclosed and are evidence of the facts stated in them even if a notice under the Civil Evidence Act 1995 has not been served. If the trial/hearing bundles are extensive and either party wishes the judge to read certain documents in advance of the hearing, a reading list should be provided.”

This is all-important in serious injury cases where a substantial part of the bundles will be medical notes, whose provenance and status must be established. Para 27 of Practice Direction to CPR 32 provides:

27.2 All documents contained in bundles which have been agreed for use at a hearing shall be admissible at that hearing as evidence of their contents, unless—

(1) the court orders otherwise; or
(2) a party gives written notice of objection to the admissibility of particular documents.

But beware of the trap that what is recorded in (eg) GP notes has only limited admissibility as evidence of what a patient is reported to have said (Fifield v Denton Hall Legal Services and others [2006] EWCA Civ 169)

In respect of **medical notes and scans**: ensure that these are in a logical order. Almost always this will be chronological but where a patient is moved from hospital to hospital (or from hospital A to hospital B and then back to A) it will be important to separate out the hospitals and to identify separate stays in any one hospital. Best practice is to create a paginated and fully indexed medical records bundle at an early stage and ensure that each party and each expert has a matching set so that all references are common and can be easily found both in court but also before hand. The standard direction in clinical negligence cases in London (and I would suggest it is good practice in any complex case) provides:

Legible copies of the medical records of the [Claimant or Deceased or Claimant's Mother etc] are to be placed in a separate paginated bundle at the earliest opportunity by the Claimant's Solicitors and kept up to date. All references to medical notes in any report are to be made by reference to the pages in that bundle.

All reports coming into existence for the purpose of the case disclosed by any party are to be placed in a separate paginated bundle at the earliest opportunity by the Claimant’s Solicitors and kept up to date. Upon reports being added to such bundle the Claimants are to serve a revised index to such bundle upon all other parties. All references to such reports in subsequent reports shall include a reference to the relevant pages in that bundle.
When you get to trial, brain scans and similar need to be available to the Court, preferably on a large screen, so that neuro-radiologists can demonstrate relevant issues, and if an expert is giving evidence by video-link it is essential

a) that they have a fully paginated bundle which is the same as the one being used in court; and

b) that they have the means to refer to aspects of the scan so that the judge and parties in court can see (this can be a challenge and is a good reason for not agreeing to the video-links).

Liaise with the experts ahead of the hearing to see if they need any such facilities, if this has not already been covered in pre-hearing conferences.

**Skeleton arguments:** The QB Guide gives the following direction:

7.11.9 Lists of authorities for use at trial or at substantial hearings before a Judge should be provided to the usher by 9.00am on the first day of the hearing. For other applications before a Judge, or applications before a Master, copies of the authorities should be included in the bundle or in a separate bundle.

[Outside London you cannot rely on the Court having the authorities, especially the specialist law reports - bring your own and ensure the other side have copies]
7.11.10 For trial and most hearings before a Judge, and substantial hearings before a Master, a chronology, a list of the persons involved and a list of the issues should be prepared and filed with the skeleton argument. A chronology should be non-contentious and agreed with the other parties if possible. If there is a material dispute about any event stated in the chronology, that should be stated.

[Obviously the same applies in District Registries]

7.11.11 Skeleton arguments should be prepared, filed and served;

(1) for trials, not less than 2 days before the trial in the Listing Office, and

(2) for substantial applications or appeals, not later than 1 day before the hearing in the Listing Office and, where the Master has requested papers in advance of the hearing, in the Masters’ Support Unit Room E16 or directly with the Master. Parties should avoid handing skeleton arguments to the other party at the door of the court even for less substantial hearings, so that each party has time to consider the other party’s case.

[And again obviously the same applies in District Registries. However, while you can put your faith in e-filing, check it happened and ensure your opponents have received their]
copy – as a judge there is nothing more annoying than receiving a skeleton argument at 10.15 for 10.30 with an “essential reading list” of 1 hour’s material]

7.11.12 A skeleton argument should;

(1) concisely summarise the party’s submissions in relation to each of the issues,

(2) cite the main authorities relied on, which may be attached,

(3) contain a reading list and an estimate of the time it will take the Judge to read,

(4) be as brief as the issues allow and not normally be longer than 20 pages of double-spaced A4 paper,

(5) be divided into numbered paragraphs and paged consecutively,

(6) avoid formality and use understandable abbreviations, and

(7) identify any core documents which it would be helpful to read beforehand.

[For counsel to be able to comply with these directions it is important to brief in time – ideally at least 14 days before trial]

Above all (and no apology for repetition) liaise with the advocate and ensure (s)he has adequate time to advise on
any last minute evidential issues and for them to be addressed, and so that (s)he has time to comply with the Practice Directions.

The IFA

While it has in the past been usual not to bring in the IFA until quite late in the case, and while the CA have indicated (in Eeles) that they would not expect an IFA’s report to be commissioned for an interim payment application save in an exceptional case (so there might be arguments about the cost if the IFA is consulted too soon) nevertheless, especially where there is a less than 100% recovery, it may well be important to secure financial advice to ensure that damages recovered are used to their best advantage. Moreover, given the provisions of the CPR 41.6 and 7 (which require the court to give an indication "as soon as practicable" as to whether periodical payments or a lump sum are the more appropriate form of award, taking account *inter alia* of any financial advice received by the claimant - see Practice Direction 41B), and CPR 41.5 (which not only allows a party to plead in his statement of case which form of award is thought appropriate, but enables the court to direct him so to do), there should be little problem over the costs of an IFA being allowed at an early stage.

The IFA should also be able to advise on the setting up of a trust to protect the claimant (from gold diggers, and also to retain entitlement to statutory benefits - which will be especially valuable where liability has been apportioned),
and on the early setting up of trust or deputyship bank accounts (to deal, for instance, with interim payments). He or she can also advise (independently) on appropriate investment vehicles (many claimants may be advised by their banks or building societies to invest in inappropriate products).

Very crucially in the current climate an IFA will be able to advise (and to provide expert evidence) on the issue of the discount rate (if the Lord Chancellor does not amend it, it may be that the courts will revisit the issue in light of expert opinion – see further below) and whether and why any particular inflation index should be chosen for indexing periodical payments, or selecting a multiplier for a lump sum. In this context, note the decision of the Royal Court of Guernsey in *Helmot v Simon* (decided at first instance on 14th January 2010) to reduce the discount rate on lump sum damages for future losses to 1 per cent. On 14 September 2010 the Court of Appeal (Sumption, Jones and Martin JJA) allowed the appeal and dismissed the cross-appeal. In place of the 1% discount rate that had been applied to all future losses by the Royal Court it substituted a discount rate of -1.5% for earnings related losses and 0.5% for other losses. These changes may seem small in percentage terms, but the effect of the Court of Appeal’s judgment was to increase the total award of damages by about £4.5m. The Court of Appeal’s decision was upheld in the Privy Council on 7th March 2012 (see further below).
As is well known the yield obtainable on conventional and low risk investments comes nowhere near the current discount rate set by the Lord Chancellor under the Damages (Personal Injury) Order 2001 (since 28.6.2001) at 2.5%. This compares with

- The Court Special Account rate at 0.5%
  but less tax (!)

- ILGS yields
  - 1998  3.53%
  - 2001  2.46%
  - Dec 2010  0.5%\(^6\)

While periodical payments do provide some protection by indexation, there was a significant disincentive to their use when the indexation was linked to the RPI (by s.2(8) of the Damages Act). As is also well known, cost inflation (usually earnings) is likely to outstrip retail prices. It is a statistical fact that earnings have increased more quickly than prices. Between 1963 and 2003 the ONS figures show earnings increased at an average of 2% pa above RPI. Nursing and care costs tend to rise more quickly still. Manifestly where the principal cost to be met by a damages claim is the cost of care which will obviously reflect what the carers are paid, an award at to-day’s values will rapidly fall behind the real cost

\(^6\) By December 2010 the rate dipped below the 0.5% mark and the average yield for the 36 months leading up to November 2010 was only 0.84%. The rate is now said to be 0% according to the evidence in Simon.
even if indexed at RPI. After 20 years, with a differential of 2% pa the award will only meet 2/3 of the cost. The situation plainly gets worse as life expectancy increases. In these circumstances the provisions of s.2(9) which allow for the disapplying of s.2(8) or modifying its effects are crucial and it was this provision which enabled the Court to escape the constraints of subsection (8) in *Thompstone* in respect of care costs and *Sarwar v Ali & MIB* in respect of earnings. There is an interesting debate to be had as to whether further escape might be achieved, for instance in respect of funding mortgage payments for the acquisition of property, to avoid the *Roberts v Johnstone* problem where there is insufficient free capital to fund the purchase and adaptation of suitable accommodation. Expert evidence would be required to mount this argument, and it is the IFA who will be able to fuel these debates.

An IFA (and perhaps also an employment expert) will also be needed to calculate the appropriate centile of ASHE 6115 which is applicable for the particular care regime. It usually falls within the 70th to 80th centile and usually the more intense the care regime, the higher the centile, but it is not necessarily the case that the higher rates are applicable in larger conurbations. When a claimant lives in the heart of the country it is frequently more difficult to recruit and retain appropriately competent care workers and so higher rates may need to be paid. The case manager or nursing care expert can advise on the rates that have to be paid. But the IFA can then assess these against the ASHE data to fix the centile, or indeed the classification as other categories of ASHE may be appropriate (ASHE 3211 for nursing care for
instance). Moreover, current figures show that the higher centile earnings are not in fact increasing but reducing. In the short term there is therefore an argument for employing the median rate rather than a higher centile band. In the longer term the higher centiles are probably still appropriate. All these are issues upon which the IFA’s advice will be central. Once again we see how important team work is in constructing the case.

Similarly, if a future loss of earnings claim is being dealt with on the basis of a PPO, the probable index will be the relevant ASHE category at its median level, but the IFA (perhaps with the assistance of an employment expert) can advise as to the appropriate level having regard to the claimant’s pre-accident history and probable future career path but for the accident.

The IFA will also be able to advise on the post settlement investment risks and the investment strategy which will best meet the particular claimant’s needs and run practical examples to demonstrate whether a PPO or a lump sum or a mixture of the two is most appropriate in the particular case, when the needs that have to be met have been identified. The IFA will be able to feed in to the model different discount rates, different inflation assumptions and identify the sums required. The IFA can advise on the benefit of the security and guaranteed continuity of a PPO against the loss of opportunity (but heightened risk) of self investment of a lump sum award.
It may also be important for the IFA to investigate the nature and security of the insurer and whether it can satisfy the requirements for continuity of payments (s.2(3) Damages Act 1996) as some foreign based insurers cannot do so.

In short the financial advisor will be an important member of the team.

**Court of Protection costs, Professional Deputy costs, related costs of admin**

These topics merit a separate session on their own, but they manifestly must not be forgotten (they frequently represent a head of claim between £250-500,000), and a report from a professional deputy (eg a solicitor or an accountant) will assist in setting out all the one off and regular costs which will be incurred, including the issues which may arise over the level of the security bond required by the Court, the number, nature and costs of probable applications to the Court over C’s life, the necessity of establishing wills or statutory wills, the costs of replacing deputies etc etc.

There are many professional deputies who will provide reports for proceedings and there can be merit in obtaining a report from someone other than the deputy who has been appointed, and therefore who can be seen as a disinterested expert witness. There may be an opportunity for joint instructions to a deputy acting as a SJE. However, the fact remains that the deputy who is ‘in post’ will be charging whatever they (or their partners) dictate subject to the control of the SCCO (Senior
Courts Costs Office), and as such their evidence will be important as the starting point.

Many such professional deputy witnesses have a substantial portfolio of cases from which they are able to draw comparative costings to predict the cost of managing this particular case, but do look carefully at their comparators. One brain damage case is not like another and a brain damaged person who retains some capacity, or who remains superficially articulate, or is behaviourally challenged, will probably require a lot more management and deputy’s time than someone in PVS.

**PPOs for CoP and Deputy costs?**

Should the deputy’s costs (and the projected court costs and charges) be met by a PPO? The answer will be fact specific, and reference must always be had to the test in Part 41.7 – the form of award which best meets the claimant’s needs having regard to the factors set out in the Practice Direction (41B).

If there is to be a PPO then what index is to be used? The default index is, of course, RPI (s.2(8) Damages Act 1996) but s.2(8) may be dis-applied and a different index employed (s.2(9) and see *Thompstone* and cases such as *Sarwar v Kamran Ali*).

There is an evidential burden on C to show that the RPI is not appropriate, but what other index might be?

There is no clear answer. The appropriate index might include AWE for solicitors or ASHE 2413, but at what centile? Or an index based upon CoP fixed hourly rates? Or is RPI in fact sufficient (although historically earnings tend to exceed RPI (or CPI) by about at least 1%). This is an area where (again) advice for an appropriately experienced IFA will be valuable.
Alternatively, is it better simply to take the money and invest it on the basis that this gives greater opportunity to take advantage of good investment performance, and allows greater flexibility where there may be spikes in the attention the Deputy needs to provide. There will be extra time, and therefore costs, required at possibly unpredictable times – relationships starting or ending, moving homes, making wills, contested wills, or other hearings before the CoP. All this is built in to the costings but a PPO will tend to average them out.

While this lack of flexibility is always a problem with PPOs, it is avoidable if deputy costs are taken as a lump sum BUT especially where life expectancy is an issue it is important to bear in mind that the deputy’s costs will go on being charged throughout C’s life. And if the money runs out this will be a real problem as there is no state service to fall back on to provide for C’s needs (unlike care needs, however inadequate some aspects of state care may be).

So a PPO for deputy’s costs is probably well worth pursuing, but it is a cost that insurers appear very reluctant to agree as a PPO.

Litigation friend expenses

These must be recorded and included in the schedule of loss. Where there are unpaid expenses which the Litigation Friend has incurred in his/her capacity as such, it may be appropriate for these to be provided for expressly at the time of the approval hearing in the order and paid direct from the judgment sum prior to remission to the Court of Protection (see Part 21 r.12 and 21PD.11)
Fund Management and Trusts

Where there is no loss of capacity, but C is vulnerable, the medical evidence will sometimes suggest that to protect C from his own improvidence, or from predators, the award should be secured in a trust. Experience has shown that the management of such a trust, with a professional trustee is not a lot cheaper than the costs incurred by a deputy. Indeed there is a valuable decision of HHJ Hazel Marshall QC in the CoP (Re HM (a Child) sub nom SM v HM (By the Official Solicitor as her Litigation Friend) 04.11.11: Lawtel 27/1/2012: [2012] W.T.L.R. 281) where she reaches a similar conclusion (paras 101-106).

There are significant limitations to the protection provided by a trust, in particular the claimant is entitled absolutely to the trust fund and can call for an immediate distribution of the whole fund or any part of it.

But can the costs of establishing and managing the trust be recovered?

Certainly the costs of fund management which obtain returns above the more modest returns assumed by investment in ILGS are not recoverable for similar reasons (Eagle v Chambers [2004] 1 WLR 3081).

As Lloyd-Jones J said in A v Powys Health Board [2007] EWHC 2996:

"... there can be no claim in respect of investment advice or for the costs of managing investments. This is so whether or not the claimant is a patient. (Page v Plymouth Hospitals NHS Trust [2004] 3 All ER 367; Eagle v Chambers (No. 2) [2004] 1 WLR 3081.) A
defendant is required to pay damages assessed on the basis that the return on the money would be by way of investment in gilts. The claimant is entitled to use his money as he chooses but if he chooses to invest more broadly the costs relating to that broader investment flow from the decision as to how to invest and not from the accident. (See Eagle v Chambers per Waller L.J. at paras. 95-96.) I consider that accountancy costs fall into the same category because these will arise from the choice to make investments other than in gilts."

Similarly, it is extremely unlikely that the costs of administering a PI trust would be recoverable (given that the object is (usually) to maintain means tested benefits, the value of which to the claimant can be set off against and are likely to exceed the costs of the trust) unless perhaps the claimant is a vulnerable adult but who just retains capacity (see eg the discussion in A v Powys Health Board).

Where, however, expense arises simply from administrative costs which but for the tort the claimant would not have incurred (eg the need to instruct accountants to make tax returns and so on) then this is more of a grey area. Lloyd-Jones J appeared to reject it (see above) but it must depend on the circumstances and in that case he did allow the cost of a premier banking service to assist and protect the claimant. However, where the cost of employing professionals arises from the engagement of carers (eg pay roll management), it would seem to follow that the requirements of causation and remoteness are satisfied and the costs should be recoverable and these are usually the costs of the case manager (whose costs would usually be within the PPO).
So this is one context in which the IFA should be considering a PPO. One question (among many) will be whether a PPO will enable irrecoverable costs of managing the damages to be avoided? Will it indeed mean that by indexing the care costs the risks of a poor return on investments can be obviated?

In *Re HM (a Child) – supra* – proceedings had been brought against an NHS trust and HM was to receive a lump sum, which was significantly less than the level at which her financial needs had been calculated. In order to save some of the costs involved in a deputyship, it was proposed to set up a personal injury trust to administer the damages award, even though she was a protected party. The issue was whether it was ever, and if so in what circumstances, appropriate for the Court of Protection to authorise the creation of a trust of the assets of a person who lacked capacity as the means of administering those assets, rather than appointing a deputy. The judge concluded that despite it being a CoP case, there was nothing to prevent such an order, but that it would be rare and she gave extensive guidance as to when it might be appropriate. On the facts of that case she made such an order. This is a very useful case where recovery is less than 100% and costs need to be saved but the judge makes clear that it is essential to support the costs argument with clear and compelling evidence, as in many cases there may not be much difference in the costs incurred in managing a trust, and there are many other considerations (including the protection available to the protected party)
**Divorce**

While the decision in *Pritchard v JH Cobden Ltd (No 1) [1988] Fam 22* made it clear that damages cannot be recovered for losses arising from divorce, the fact is that brain injury (and any other catastrophic injury) does impose significant strains on relationships, so that there is a real risk of relationship breakdown.

The jurisprudence within the Family Division has made it clear that damages recovered for personal injuries are not sacrosanct and along with all other assets whatever their origin, they go into the pot for potential division. However, the court will have regard to the origin of and the reason for such a resource, and in particular will have regard to the needs of the parties. Nevertheless, this can result in a substantial part of the award going to meet the other spouse's needs (or their children’s needs), with potentially adverse consequences for the injured party (see eg *Mansfield v Mansfield* [2011] EWCA Civ 1056).

One way to provide greater security for an injured party may to follow the lead of the Supreme Court in *Radmacher v Granatino* [2010] UKSC 42 where significantly greater weight was given than heretofore to nuptial agreements. These can be entered into before or after the marriage and provided that the agreement is freely entered into by each party with a full appreciation of its implications the court is likely to give effect to the agreement unless, in the circumstances prevailing, it would not be fair to hold the parties to it.

If, therefore, especially in cases where there would have been very limited assets but for the damages award, the claimant and his existing or any future partner enter into such an
agreement to avoid a squabble should they subsequently separate, then the cost of the separate independent advice that they will require, and the cost of the drafting and any associated costs, should be legitimate heads of claim.

Appropriate provision will need to be made for children, and the uninjured party’s needs will have to be met as far as possible. It may be that (as in Mansfield) the uninjured party will only have use of part of the capital during the children’s minority (to provide a home) and it can then be returned to the claimant in his later years (a Mesher order). All this will be fact dependent. Similarly, it may be more difficult to seek to ring fence resources which are attributable to loss of earnings, since that is a resource against which the other party might have had a claim in any event.

These considerations will, of course, apply both to dissolution of marriages (Matrimonial Causes Act 1973) and civil partnerships (Civil Partnership Act 2004).

Discount Rates and multipliers

The Lord Chancellor, as everyone knows, is supposed to be conducting a review of the discount rate. This review was announced in November 2010. On May 11 Jonathan Djongolay announced in the House of Commons that the LC had consulted (HM Treasury, The Government Actuary, the ABI....and APIL) and “A consultation paper will be published soon, and the review will be completed on as timely a basis as possible”. That was not May 2012, but May 2011!
The question is, what to do while the outcome of the review is awaited? One solution is simply to put as much into PPOs as possible.

Another is suggested by the NHS cases where they are quite open to the inclusion of clauses in effect allowing for a revisiting of the award after the LC’s review is complete. The following example is taken from a clinical negligence case in Wales:

5 AND IT IS FURTHER ORDERED that determination of the following issue be adjourned for future consideration on the terms set out.

   a. That the future life sum and the future earnings sum recorded in the above declaration should be varied by reference to any change to the discount rate as set in section 1(1) of the Damages Act 1996.

   b. Following the final determination of and change to the discount rate in (a) above following the review announced on the 9th of November 2010 “the present review”, the calculation of the variation shall be by application to the future life sum the percentage of increase or decrease of the change in full life multiplier following the change in discount rate (if any) and to the future earnings sum the percentage of the increase or decrease of the change in the earnings multiplier following the change in the discount rate (if any).
The terms as to the adjournment are

i. The parties agree that the basis of the agreement for the future life sum £… is a full life multiplier of … to be treated as derived from Table 28 and based upon a discount rate of … and that for the future earnings sum £…. is a multiplier of …. to be treated as derived from Table 28 and based upon a discount rate of … as recorded in the above declaration and that the calculation shall be carried out as provided for in (b) above.

ii. It is the present review including any challenge until the present review is concluded which is the “relevant event” for any calculation and in default of agreement as between the parties as to the additional capital sum (or repayment of capital sum) there is permission for the action to be listed for further directions.

iii. Insofar as the variation to the future life sum and earnings sum is agreed by the parties within a period of four months of the relevant event (in which case the Order by agreement can be dealt with on paper) the costs will be part of the costs of the action. Otherwise the costs of this adjourned issue be reserved.
There are several interesting aspects of this, including the use of Table 28 as the assumed applicable table for establishing the multiplier. In general terms this is more beneficial to claimants, and insurers frequently argue that Table 1 (or 2) should be employed. The arguments are set out in Whiten v St George’s Healthcare NHS Trust [2011] EWHC 2066 (QB) (05 August 2011) and see also Crofts v Murton [Lawtel 10.9.08]. By and large it depends whether the life expectancy has been calculated on a generic or, alternatively, on a comprehensive and specific basis. Where the estimate is on the former basis (i.e by simply estimating by how much C’s pre-morbid statistical life expectancy had been shortened) there is a good argument that Table 28 is not applicable. Where however the medical evidence enables the court to determine how long this claimant could be expected to live, the court will have already taken into account the chances of dying earlier or living longer than the predicted date and to take mortality further into account in deciding the multiplier would amount to a double discount for mortality: see Royal Victoria Infirmary & Associated Hospitals NHS Trust v B (A Child) [2002] EWCA Civ 348, [2002] P.I.Q.R. Q10 applying Wells v Wells [1999] 1 AC 345.

The short point for claimants is ‘do not accept Prof Strauss’ estimates’ without further inquiry.

Apart from these considerations, it is probably a question of wait and see, as the courts have shown no appetite for a challenge to the discount rate on a reasoned and evidence based approach, nor has there been any acceptance of the suggestion that cases should be adjourned pending the
outcome: see *Love v Dewsbury* (QBD 19.11.10) and *Day v Randhawa and MIB* (QBD 11.01.11) where Simon J held that it was wrong to adjourn issues relating to the discount rate to be applied to some of the future loss claims in a personal injury action simply on account of a prospect of a change in the law. Moreover, it was wrong to assume that the discount rate would be reduced.

Having said all that, the arguments reflected in the decision of the Privy Council in *Helmot v Simon* [2012] UKPC 5 are pretty compelling, albeit that the actual figures and applicable rates have to be seen in the context of economic conditions in the Bailiwick which are not all applicable in England and Wales..

Lord Hope summarised the issue in the case at para 14:

14. It has been assumed until very recently that it will be possible to achieve a rate of return on capital which will more than offset the effects of inflation on the amount of the award. This has led to the assumption that the choice of interest rate will always take the form of a discount for the accelerated receipt of the lump sum. One of the issues in this case is whether the law allows the court to adjust the lump sum in the other direction if the evidence shows that the rate of inflation will outpace the rate of return on capital, as the Court of Appeal did in this case in regard to the losses that must keep pace with the rate of inflation for earnings in Guernsey if the respondent is to be fully compensated. The effect of such an adjustment is to increase, rather than reduce, the number of years used as the multiplier. The use of the word “discount” is not an apt way of describing that exercise. But in principle there can be no objection to such an adjustment if the evidence shows that it is needed to ensure that the lump sum will continue to be large enough to meet losses to be incurred in the future. Otherwise the effects of accelerated receipt, which are inevitable where the award is by means of a lump sum, will not be properly recognised. [*emphasis added*]

The Royal Court had employed a flat discount rate of 1% (as opposed to D’s contention that it should be 2.5%) and the Court of Appeal (allowing the claimant’s appeal and
dismissing the defendant’s cross appeal) applied a negative rate of – 1.5% to earnings related heads of claim (including care) and 0.5% to everything else. This had the effect of increasing the award from £9.337m by about £4.5m in a case of a brain damaged man 28 at the date of the accident, 39 at the date of judgment, and with a 5 year reduction in life expectancy. The Privy Council upheld the Court of Appeal’s decision in March 2012.

While different legal and economic and fiscal considerations do apply in Guernsey (where the Damages Act does not apply and there are no PPOs) nevertheless the logic of the approach is strong. While the point has legitimately been made that D called limited evidence so that C’s evidence was not fully challenged, D’s case (at first instance) being simply that the court should apply the Lord Chancellor’s discount rate, nevertheless C’s witnesses were impressive, as Lord Hope (para 29) observed:

...Their credentials for giving evidence were, as the Court of Appeal observed in para 41 of its judgment, as impressive as they could possibly have been. Mr Hogg is a forensic accountant who has made a special study of the problems associated with the assessment of damages in cases of this type. He has given evidence in several such cases in England, including two of those that were under appeal in Wells v Wells. Mr Bootle is a professional economist and the author of numerous publications on the subject, including the impact of inflation on investment strategy. Mr Daykin was the Government Actuary for the United Kingdom from 1989 to 2007. He was consulted in that capacity by the Lord Chancellor when he was fixing his discount rate in 2001 and was responsible for preparing the second to sixth editions of the Ogden Tables. He has also advised the Social Security Department of the States of Guernsey on the funding of long term benefits.

D called only Hugh Gregory as their forensic accountant who agreed Rowland Hogg’s methodology and largely agreed or
did not dissent from his conclusions (or those of C’s other two witnesses). Crucially D did not call evidence from an actuary or an economist to challenge C’s case.

Mr Hogg’s conclusions were that:

“i) The starting point in assessing the discount rate for Guernsey should be yields from ILGS and I consider that the appropriate yield before tax is 1.25% (January report para 5.16),

ii) after allowing for Guernsey tax this would be reduced to 1% (para 5.19),

iii) higher inflation in Guernsey than in the UK reduces this to 0.5% (para 5.24) which is my proposed basic discount rate (para 5.30),

iv) for earnings-related losses there should be an additional allowance for the faster growth rate of earnings compared with prices. I propose a deduction of 2% to minus 1.5% (para 5.33) as the discount rate for such losses, which include future costs of care.”

This evidence was supported by the conclusions of Mr Bootle and Mr Daykin, specifically in the Guernsey context, albeit by reference to most Western economies over many years. It can therefore be seen, however, that the specific rates approved by the court are not immediately transferable to England and Wales.

However, what may be of more interest is that in the Privy Council (where the defendant abandoned their case that the Royal Court should have applied the Lord Chancellor’s discount rate, arguing instead that it was wrong to project forward so many years on the basis of economic data which was inadequate to the task) Lord Hope (with whom the other members of the Board agreed) took the view that the Lord Chancellor’s rate has no current evidential basis. Although Lord Irvine had purported to follow the reasoning in *Wells v Wells* in fact he took account of a number of factors which played no part of the analysis in *Wells v Wells* (including the
political considerations of the impact on the MoD and the NHS). Lord Hope implied that but for the statutory context in England and Wales our courts might well be entitled to take a fresh look at the appropriate rate.

It is also important that Lord Hope concluded that different heads of loss might attract different discount rates. The decision of the House of Lords in Wells v Wells should not be seen as an indication that a single discount rate must always be adopted. It would be wrong to do that if the evidence shows that, if that were to be done, a given head of loss would not be fully compensated.

Similarly, he concluded that it is open to the court to apply a discount rate which is not a discount rate at all. It is, in essence, simply a process of adjustment. And in principle there can be no objection to its operating in the reverse direction if the evidence shows that an adjustment which increases the multiplier is needed to ensure that the lump sum will continue to be large enough to meet losses to be incurred in the future.

The guiding principle in the court’s approach (derived from Wells v Wells) is that the victim should, so far as it is possible to do so, be fully compensated, although (as Lady Hale observed) it should be “not a penny more but not a penny less”. Over compensation is as objectionable as under-compensation.

What is clear, however, is that any challenge to the LC’s rate in England and Wales would have to be supported by very clear and careful evidence that there has been a marked
change in economic circumstances (which is likely to be projected forward for a significant period), and that in light of the attitude of the CA to date, it will be an uphill task. However, as Lord Dyson observed if the evidence of Mr Bootle were accepted “it would demonstrate that a discount rate based on the ILGS would lead to a massive under-compensation of Mr Helmot’s claim for earnings related losses” and there was no basis for rejecting that evidence.

The conclusion for claimants in this jurisdiction must be to maximise the PPO form of award for at least all earnings related losses.

**Impact on Roberts v Johnstone**
There is, however, at least one reason to pause before fully embracing all the ideas in *Helmot*. If a negative, or even a much lower discount rate is employed the effect on *Roberts v Johnstone* calculations will be to make them unworkable. A negative discount rate would mean that no recovery could be made for the loss of use of the capital tied up in the property.

There are many criticisms of the workings of *Roberts v Johnstone* but very few suggestions as to how accommodation claims might be better addressed. One is to create a PPO which is linked to an index of mortgage rates and this has attractions as it would enable monies to be borrowed to finance the purchase, and the interest element of the repayments would be protected. This however does not address the potential for capital gain (or loss).
Another potential solution lies in the tortfeasor (or the insurer standing behind him) taking the capital risk and buying the property, and the claimant renting the property with the balance of the rent (so far as it exceeds that which C would have paid in any event) being met by the tortfeasor, linked to an appropriate index. This again creates its own problems, and insurance companies are very reluctant to become involved in property ownership, but there are a few cases (on an anecdotal basis at least) of insurers doing this.

**Conclusion**

The task of the personal injury litigator may not simply be to maximise the damages, rather it should be to get the best outcome. This may involve facilitating rehabilitation or manipulating the interplay of statutory resources and compensation, or ensuring the form of the award best meets the claimant’s needs.

But whatever the objective, the task is one which will require many different skills, it will require teamwork and the exercise by the conducting solicitor of management skills to co-ordinate the team. It will require attention to detail and careful preparation right from the initial instruction, and it will require that the team has a familiarity with the particular exigencies of managing a brain injury claim.

The law continues to develop with new means being sought at every step to meet the fundamental principle – that the
claimant is entitled to full compensation for the loss which he has suffered as a result of the defendant’s tort.

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