BRAIN INJURIES – CURRENT ISSUES

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Why do brain injuries warrant specific consideration?

Head injury is common. It is estimated that one million people in Britain attend hospital every year as a result of having a head injury.

Out of every one thousand of the population there is likely to be between ten and fifteen people suffering a severe head injury, fifteen to twenty people suffering a moderate head injury and between two hundred and fifty and three hundred people with a mild head injury. Over the last few decades, the number of people suffering from injuries has increased so much that it has been described as a "silent epidemic". The technical ability of doctors has improved enabling them to recognise and treat blood clots in the brain and reduce death. However, the speed of life has increased and a large percentage of the survivors are young and left with permanent acute care needs.

For insurance companies receiving a claim for damages which includes a brain injury, you could be facing a claim of maximum severity with a claimant suffering from multiple physical and cognitive difficulties and an inability to work or care for themselves in the future. At the other range of the spectrum, you could be dealing with a head injury categorised as mild, but with an array of initial symptoms often referred to as post concussion syndrome such as nausea, headaches and dizziness. These symptoms are often followed by impaired concentration and memory problems. Such symptoms are also often accompanied later by anxiety and depression but many such claimants are able to return to work and look after themselves.

Setting reserves in brain injury cases is therefore challenging, particularly as the full extent of the disability and impairment will not be clear for two to three years.

At the outset of the case, when setting reserves bear in mind that the three best indicators of the severity of the injury are:-

1. The length of time in coma
2. The period of post traumatic amnesia

and/or

3. Glasgow Coma Scale - hospitals will record the Glasgow Coma Score when treating serious brain injury patients. This is universally used to rate the severity of the coma by looking at the patients ability to open his eyes, move and speak. The minimum possible score is 3 and the maximum is 15. Obviously, the more severe the injury, the lower the performance. Someone with persistent vegetative state will have a score below 9, but equally, I must warn that I have seen people who have been assessed with a near perfect score suffer ongoing cognitive problems from the head injury.

When seeking a summary of injuries from the claimant's lawyer it may be worth asking what information they have available on these issues to enable you to categorise the injury and likely valuation. I would also recommend making enquiries about early radiology to see what x-rays/scans confirm.

Mild head injury

The person experiences a brief loss of consciousness (less than fifteen minutes) or has not been unconscious at all with a period of post traumatic amnesia of less than one hour. Standard neurological examinations are often normal in such cases ultimately but there may be some small microscopic nerve damage evidence on MRI scanning.

The results of a mild head injury – numerous symptoms such as post concussion syndrome. Claimants suffer initial symptoms of nausea, head aches and dizziness

followed by impaired concentration. They complain of memory problems and difficulty processing new information, extreme tiredness and irritability. Many find a reduced tolerance to alcohol and intolerance of any loud noises and bright lights. Such people often become anxious and depressed as the symptoms resolve.

A moderate head injury

Loss of consciousness of between fifteen minutes and six hours and a period of post traumatic amnesia of up to twenty four hours. Many of these claimants will be kept in hospital for observation during the acute phase and discharged if there are no other obvious medical injuries. The residual symptoms suffered by those who have a moderate head injury are similar to those of the mild head injury particularly dizziness, headaches, tiredness, difficulty with thinking, attention, memory and planning, organisation and concentration, word finding problems and irritability.

Severe head injury

A coma for six hours or more and a post traumatic amnesia of twenty four hours or more. These claimants are more likely to be hospitalised and receive post acute rehabilitation. These are the claimants who are likely to have more serious physical deficits.

Essentially, the point to bear in mind is that the longer the length of the coma and the post traumatic amnesia, the poorer will be the outcome. However, there are exceptions to this rule and there are a small group of people who have a mild head injury and make a poor recovery as well as a small group of individuals who will have one of the severest injuries who do exceptionally well.

Medical Records

Early access to the admitting Hospital medical records and access to a full set of GP records setting out pre-accident history is essential for any claimant lawyer. I would therefore expect to be in a position to identify the risk factors for the future to insurers, but unfortunately hospitals do sometimes “miss” head injuries, particularly when there are complex orthopaedic injuries. Such claimants are often nursed on orthopaedic wards and their nursing staff may not recognise, for example that

disinhibited, aggressive and abusive behaviour could be an indication of underlying brain injury.

Pre-action Protocols for Personal Injury Claims – New Emphasis on Rehabilitation

Everyone is now familiar with the pre-action protocol for personal injury claims which must be followed if there are not to be cost consequences under the Civil Procedure Rules. From 1st April 2005 the pre-action protocol was amended and up dated to include a specific section referring to rehabilitation. The revised Rehabilitation Code is now annexed to the protocol.

The Rehabilitation Code was first introduced in 1999 to promote the use of rehabilitation and early intervention in the claims process to ensure that the injured person makes the best possible and the speediest "medical, social and psychological recover." This should improve the lives of the injured claimant, whilst also ensuring from the claims perspective that ultimately the claimant will achieve the maximum independence of which he or she is capable and return to employment in appropriate cases. Clearly this should impact on quantum.

Section 4 of the Pre-Action Protocol – Rehabilitation

4.1 The claimant or the defendant or both shall consider as early as possible whether the claimant has reasonable needs that could be met by rehabilitation or other measures .

4.2 The parties shall consider, in such cases, how those needs might be addressed. The Rehabilitation Code (which is attached as an annexe D) may be helpful in considering how to identify the claimant's needs and how to address the costs of providing for those needs.

4.3 The time limit set out in paragraph 3.7 of this protocol shall not be shortened, except by consent to allow these issues to be addressed.

4.4 The provision of any report obtained for the purposes of assessment are provisional upon the parties rehabilitation needs shall not be used in any litigation arising out the accident, the subject matter of the claim save by

consent and shall in any event be exempt from the provisions of paragraph 3.15 to 3.21 inclusive of this protocol.

Paragraph 3.7 is of course the time limit of three months which the insurers have to investigate a claim and to respond regarding liability from the date of the acknowledgement of the letter of claim. You obviously are fully entitled to undertake full investigations in to breach of duty and causation initially.

Paragraph 3.15 to 3.21 are the provisions relating to information to be provided between the parties as to nominated experts.

The introduction of rehabilitation into the protocol means that Judges involved with case management may ask questions about rehabilitation, whether it has been considered and whether or not it has been implemented. I understand that Lord Phillips the Marshall of the Rolls is keen on emphasis being placed on rehabilitation and has asked for the Civil Justice Council to look into developing rehab within the civil justice system.

The Rehabilitation Code was actually first introduced in 1999, but I personally feel that its practical implementation has been slow. The Association of Personal Injury Lawyers would probably place the blame for this on insurers for failing to embrace the concept. However, I have spoken to senior claims officers in cases where I have worked with them to use early rehabilitation successfully and they tell me that they still come across claimant lawyers who are distrustful and reluctant to work with them in the implementation of a suitable programme.

Both the claimant's solicitors duty and the insurers duty is set out in the Code annexed to the Pre-action Protocol.

<u>Concentrating today on the Duties of the Insurer</u>

The Code of Practice indicates that:-

3.1 It shall be the duty of the insurer to consider, from the earliest practical stage in any appropriate case, whether it is likely that the claimant will benefit in

the immediate, medium or longer terms from further medical treatment, rehabilitation or early intervention. This duty is on going throughout the life of the case but is most important in the early stages.

3.2 If the insurer considers that a particular claim might be suitable for intervention, rehabilitation or treatment, the insurer will communicate this to the claimant's solicitor as soon as practicable.

3.3 On receipt of such communication, the claimant's solicitor will immediately discuss these issues with the claimant and/or the claimant's family pursuant to his duty as set out above and, where appropriate, will seek advice from the claimant's treating physicians/surgeons.

3.4 Nothing in this or any other Code of Practice shall in any way modify the obligations of the insurer under the Protocol to investigate claims rapidly and in any event within three months (except where time is extended by the claimant's solicitor) from the date of the formal claim letter. It is recognised that, although the rehabilitation assessment can be done even where liability investigations are outstanding, it is essential that such investigations proceed with the appropriate speed.

Unless medical reports have been obtained which already identify the need for and the extent of what is needed, an independent assessment is likely to be required either from one of the treating physicians or surgeons or from an agency suitably qualified but independent of the claimant's solicitors and the insurers. The Code sets out how the assessment process works. The medical agency interviewing the claimant would be reporting under the following headings:-

1. The injuries sustained by the claimant
2. The claimant's present medical condition (medical conditions that do not arise from the accident should also be noted where relevant to the overall picture of the claimant's needs)
3. The claimant's domestic circumstances (including mobility, accommodation and employment), where relevant
4. The injuries/disability in respect of which early intervention or early rehabilitation is suggested
5. The type of intervention or treatment envisaged

6. The likely cost
7. The likely short/medium-term benefit to the claimant

Both parties receive the report from the assessing agency simultaneously and can raise queries. The insurers must pay for the report within twenty eight days. You then have to consider the recommendations and the extent to which funds can be made available.

"The insurers will not be required to pay for intervention or treatment that is unreasonable in nature, content or costs. The claimant will be under no obligation to undergo intervention, medical investigation or treatment that is unreasonable in all the circumstances of the case".

Everyone who works in serious injury claims appreciates that there has to be a material benefit to both parties from rehabilitation and that the client needs to be well motivated and to have confidence in the whole process.

In serious cases, rehabilitation as an inpatient may be recommended which can be very expensive. Clearly, there will be issues for yourselves as to whether the fees are justified. There are often also issues with the claimant lawyers to deal with because many may be willing to participate in such rehabilitation which means them leaving home.

The fact that the Courts are becoming more involved in rehabilitation is evident from case law.

Rebecca White (by her litigation friend Karen Fay) –v- Kevin Sullivan 2005 EWCA civ 656

The Court of Appeal considered an appeal by the defendant against a decision not to make an interim damages award to the claimant conditional on the joint appointment of a clinical case manager. The claimant then cross appealed against the Judges direction that the evidence of the clinical case manager should be treated as that of an expert.

The facts

W had been knocked down by a motor car driven by S. S had accepted 70% of the responsibility for the accident. The medical evidence provided by W was that she had suffered a severe concussive head injury resulting in brain damage which meant that she would not be capable of independent living and that her chances of finding work on the open labour market were extremely limited. W applied for an interim payment of £50,0000 to enable a clinical case manager to be appointed with a view to setting up an appropriate care regime.

The Defendant's insurers proposed that a clinical case manager should be instructed jointly to consider W's needs and prepare a report. The case manager had been agreed between the parties and she had agreed to make her case records available to S's solicitors. S contended on appeal that the trial Judge had been wrong to reject his argument that the instruction of the clinical case manager should be a joint instruction, that neither party should be entitled to have "behind close doors" access to the clinical case manager, and that S was entitled to the disclosure of communications between the claimant's representatives and the case manager which would ordinarily be the subject of litigation privilege.

The Court of Appeal held that:-

1. Representatives of both parties and their expert witnesses should have liberty to communicate with the case manager in relation to matters relevant to likely issues in the claim.
2. The clinical case manager owed duties to patient alone and had to make decisions in the best interests of the patient. The Judge was right in holding that the manager should not be jointly appointed.
3. If the clinical case manager considered that it was in the client's interests that she should attend conference with legal advisors at which advice was being sought, then the privilege would not have be hers to waive and the Court had no power to direct such a waiver. Nor could the Court prevent the manager

attending conferences with lawyers and experts whose contents were privileged.

4. The role of the clinical case manager, if she was called to give evidence, would clearly be one of a witness of fact. She would not be giving evidence of expert opinion.

I have annexed to this paper a copy of the Judgment which you may find useful. I think that it is entirely reasonable that any case manager looking after a claimant has to consider what is in the best interests of the client first of all, but equally the Judge did encourage "as much openness in the exchange of information and views as possible in the spirit of CPR 1.13".

So, from the insurers perspective rehabilitation is a key issue which should be raised by the claimant's solicitor at the outset in the letter of claim if they feel that it is appropriate and which the insurers should raise if they recognise that a case might be suitable for intervention.

The independent assessment report is prepared and essentially used wholly outside the litigation process but you are not required to pay for interventional treatment that is unreasonable in nature, content or cost.

The expert opinion and the assessment of injury

In brain injury cases with ongoing disabilities, the probability is that you will be facing a multi-track claim. Civil procedure rules regarding the appointment and use of experts are set out in Part 35 introduced as part of the Woolf Reforms. Expert evidence must be the independent product of the expert uninfluenced by the pressures of litigation. It is the duty of the expert to help the Court on matters within his own expertise and this duty is paramount and overrides any obligation to the person for whom the expert has received instructions or by whom he is to be paid.

The positive development from the overriding duty of the expert to the Court is that there has been a reduced incidence of partisan experts. Even so, in brain injury cases, I would anticipate that the main experts identifying the injury and assessing its true

affects are likely to be appointed by one party alone. Where there are long term cognitive problems that need assessing and analysing from appropriate tests, the parties need to discuss issues with their experts in conference.

Generally, I would expect to see reports from:-

1. The Consultant Neurosurgeon/Consultant Neurologist
2. The Consultant Neuropsychologist
3. The Consultant Neuropsychiatrist
4. The Consultant in Rehabilitation Medicine

Undoubtedly, you and your solicitors will have Expert Registers which are regularly updated, appraising expert's performance which will be used to nominate appropriate experts. Where there is likely to be a dispute as to whether a claimant actually suffered a brain injury with an enormous affect on the ultimate quantum of the claim, it is vital that you ensure that any expert instructed has the knowledge, practical experience and reputation in the field to maintain his or her arguments on paper, in experts meetings and at trial. I suspect that many CV's are glanced at cursorily to see how many instructions the expert receives from either a claimant or a defendant. Personally, in a brain injury case, I would advise looking to see if the expert has come from a teaching hospital setting and has written papers and published material on brain injury which indicates his knowledge and reputation in the field.

The neurologist or neurosurgeon would be expected to deal with the identification and assessment of the brain injury and its long term consequences, including the risks of epilepsy and meningitis.

The neurologist or neurosurgeon would expect to have sight of a neuropsychological assessment of the claimant where accepted tests have been carried out and interpreted. This report will identify problems with such cognitive matters as memory, attention and concentration, speed of information processing, executive functioning, visual, spatial and perceptual skills and language skills.

Frequently, relationships are disrupted by emotional, behavioural and psycho-social problems which follow from a brain injury. In many such cases, you certainly would expect to see a report produced by the claimants from a neuropsychiatrist. I have also made specific mention of a rehabilitation expert who may identify early treatment or intervention to start the rehabilitation process discussed earlier.

Serious brain injuries can also affect the senses. Personally, if I require a report on ophthalmic or hearing/balance problems, then I prefer to instruct experts who work specifically within the brain injury context based at neurological centres of excellence throughout the country, such as Queens Square in London.

The majority of these experts will not just want to see the claimant on their own but will want to talk to members of their family. The head injured person may be the last person to realise the full extent of his problems.

There are many cases where the physical injuries take priority over a brain injury initially in hospital. In those cases, CT scanning or MRI scanning may not have taken place at all. Most of the neurosurgeons who I deal with will want to see such a scan and if necessary, these will need to be interpreted by a neuroradiologist. MRI scans can be very useful in showing signs of organic damage, but equally the fact that there is no visible signs of an injury on the scan does not rule out a head injury, which can be severe enough to impact on day to day living. This is because such injuries known as axonal brain injuries occur at cell level.

I have concentrated in this section largely on the medical expert evidence that is required to define the nature of the brain injury. To quantify day to day needs, the parties will require non-medical expert reports from case managers, care experts and occupational therapists. In serious brain injury cases with physical disabilities, a report of a physiotherapist is likely to be essential along with a report from speech and language therapist and experts in information technology. Obviously, in the cases of maximum severity, there will be specialist accommodation and equipment needs which will require input from an architect.

Recent cases re experts

Beck –v- MOD 2003 EWCA civ.1043 – the Defendants were unhappy with the expert and wanted to instruct someone else. The claimant was not prepared to undergo another examination. The Court held that the defendant could have the claimant examined by a new expert subject to a significant condition. The defendant was to disclose the original report if another examination were to be allowed.

Lucas –v- Barking Havering and Redbridge Hospitals NHS Trust 2003 EWCA civ 1102 – there is no right under CPR35.10(4) to have sight of the instructions referred to by an expert in their report. In this case an earlier medical report and a witness statement were submitted to the expert who quite properly mentioned them in her summary of instructions. CPR35 empowers the Court to order disclosure of instructions where it considers that the summary is inaccurate or misleading. The Court found that this was not the case here and that the defendant was not entitled to disclosure. CPR31.14, which permits a party to call for sight of documents was subservient to the detailed provisions of CPR35.10.

The mere mention of a privileged document does not necessarily represent waiver of that privilege.

Jackson –v- Marley Davenport Limited C.A. 9904 – there was no power under CPR35.13 to order disclosure of an earlier report which was supplanted by the later, final report.

Care – What if the State pay?

In case of maximum severity, the claims for future accommodation and care will form a major part of the schedule of loss. Arguments may arise as to whether state provision of some sort should be used by the claimant to meet his or her injured needs impacting on the damages to be paid by the insurers.

This was considered by the Court of Appeal in the cases of Sowden –v- Lodge and Drury –v- Crookdake on the 21st October 2004 - 2004 EWCA civ 1370.

The position in respect of National Health Service provision (i.e., private or NHS) is covered by section 2(4) of the Law Reform (Personal Injuries) Act 1948. This provides that in an action for personal injuries, in determining the reasonableness of expenses the possibility of avoiding those expenses, or part of them, by taking advantage of facilities available under the NHS is to be disregarded. The claimant can insist on damages to cover the cost of private medical treatment even though that treatment is available free under the NHS.

There is no equivalent statutory provision in respect of local authority provision of care or residential accommodation. In Sowden, Mr Justice Andrew Smith awarded the claimant damages totalling 1.2 million (actually 2.4 million reduced for 50% recovery) but including the cost of top up private care in a residential care home paid for by the local authority.

The Court of Appeal did allow this appeal to the extent of remitting the case to the trial Judge who was to give further consideration to whether the top up regime could in practice be implemented.

In Louise Sowden's case she suffered a catastrophic head injury in a road accident in 1992 at the age of 13. Judgment was actually given on the assessment of damages just before the claimant's 24th birthday. Following the accident she had attended a residential school after rehabilitation until 1998 before transferring to a residential home. At the time of the trial her future placement was uncertain.

The claimant in her schedule of loss claimed for the cost of future care on the basis that damages would be awarded to enable her to live in her own accommodation with a privately funded care regime. The defendant argued that the future care should be assessed on the basis that it would be assumed that the claimant would be provided with accommodation and care funded by the local authority under section 21 of the National Assistance Act 1948. The defendant also argued that the very fact that the

award would be reduced by 50% made it unlikely that the private arrangement would be put in place or maintained.

It was held that a reduction in the award for contributory negligence was not a relevant factor in determining the basis on which the damages for the future care would be assessed. However, at first instance he held that a private arrangement was not in the claimants best interest because she wouldn't have the same company or space as in a residential setting and she had lived happily for 10 years in a residential home. He accepted the Defendants contention that he should assume that the local authority would in future fulfil its statutory duty to provide accommodation. He held that the scope of the Defendants liability to pay for the claimants needs was more demanding than the statutory duty of the local authority but he accepted the Defendants proposal that they should only be responsible for the shortfall, i.e., providing top up care to meet the claimants needs. He found the defendant was not obliged to pay for the main package of accommodation and care which would be provided by the local authority.

The Court of Appeal allowed the claimants appeal in Sowden but endorsed the Judges findings that in assessing the claimants reasonable needs and in assessing damages the fact that her damages would be reduced for contributory negligence and would affect what was actually purchased should be disregarded.

1. The test to be adopted was not an objective assessment of what was in the claimant's best interests but rather the tests adopted in Rialas –v- Mitchell (unreported 06.07.1984). What first had to be considered was whether it was reasonable for the claimant to be cared for at home. If so, then the defendant had to pay the reasonable sum of caring for the claimant and a lesser sum was only appropriate if it was unreasonable for the claimant to live at home and reasonable for him to live in an institution.
2. In general terms, the correct approach was to compare what a claimant could reasonably require with what a local authority was likely to provide in discharge of their statutory duty and, if the second fell significantly short of the first to require the tort feasor or to pay.

3. It was held that it was for the Defendants to call evidence of what the local authority would provide. There is no burden on a claimant to disprove that statutory provision would be adequate although it may be prudent for evidence on that topic to be called.
4. The Judge in Sowden was entitled in the circumstances to conclude that a residential arrangement was appropriate.
5. A "top up" award to meet the shortfall between local authority care and the claimant's needs was not inappropriate in principle. But the way in which the defendants proposals developed during the course of the Sowden trial meant that the Judge was not given, and did not insist upon, an opportunity to assess the feasibility of augmenting residential care provided by the local authority in the manner proposed.
6. The claimant's appeal in Sowden was therefore allowed and remitted on a limited basis for the parties to call evidence as to the likelihood and practicability of the proposed augmentation of residential care by way of top up provision.

In summary, if as an insurer you seek to argue that the claimant should be accommodated in local authority housing you must:-

1. Raise the issue well in advance of trial
2. Investigate the extent to which the relevant local authority can provide any suitable accommodation or care
3. Investigate and cost the appropriate top up care that might be provided and how it would work
4. Plead the case for the local authority accommodation and care and give the claimant the opportunity to respond to the case in detail.

Where a claimant wishes to be cared for at home, the starting point will be to investigate if this requirement is reasonable. Following this decision, you would have to demonstrate that the local authority provision meets the claimant's reasonable requirements

The level of damages

General Damages

The Seventh Edition of the JSB Guidelines for the Assessment of General Damages is the usual starting point for this award. The range varies from the bracket for very severe brain damage of £155,000 to £220,000 to the bracket of £8,500 to £23,500 for minor brain damage. There is a separate category for epilepsy and for a head injury with minimal brain damage if any.

Provisional Damages

You can expect to see a claim for provisional damages in respect of the increased risk of epilepsy in the majority of serious brain injury cases. In my career as a claimant lawyer, I have had clients develop epilepsy after cases have been concluded and it is certainly something that I press for in appropriate cases.

It is, of course, the available evidence on loss of earnings, care and equipment needs which will increase the quantum well into seven figures.

Recent Cases

1. *Simon Nicholas Dixon (by his Mother and Litigation Friend Pauline Dixon) v. John Were 2004 – Gross J 26 10 04*. The claimant, a 28 year old man received £3,032,279.00 for the brain damage and multiple fractures sustained in a road traffic accident in July 1997. The claimant suffered from urological and sexual disfunction and required a tracheotomy. He walked with a limp and suffered from Bipolar Disorder.

   Liability – admitted. Deduction for 27.5% for contributory negligence reflected the fact that the claimant was not wearing a seatbelt and he knew that the defendant had been drinking alcohol.

Injuries – traumatic brain injury, complex and severe fractures to the left hip and pelvis, scarring, footdrop and chest and facial injuries in the accident. The claimant suffered from mood swings which are only partially controlled by medication. He found normal social interaction difficult. He had no insight into his difficulties. He was not capable of work of any kind. It was accepted by the defendant that the claimant had no residual capacity for work.

Prior to the accident, the claimant was studying economics at university and intended to obtain employment after graduation in the financial sector. He required live-in care to manage his daily life after the accident, including managing simple financial matters. A Case Manager and the Receiver for the Court of Protection managed his financial affairs. The claimant needed daily care of an average of six hours per day for seven days a week, full case management, periodic hospital admission and ongoing neuro-psychiatry and neuro-psychology treatment. The condition was permanent. Life expectancy was unaffected.

Breakdown of damages – on a Full Liability Basis

General damages – pain, suffering and loss of amenity (PSLA) £147,500

Interest - £11,800

Future cost of hip surgery - £20,000

Future cost of foot surgery - £3,500

Future scar revision surgery - £520

Future septoplasty - £420

Future oral surgery - £2,500

Physiotherapy - - £20,000

Future prescriptions - £1,944.

Future Urological/Erectile Disfunction - £18,768

Future loss of earnings and car allowance - £905,121

Future loss of insurance policies - £15,500

Future loss of pension - £207,184

Future cost for Court of Protection and Receiver - £169,344

Future care and case management - £2,238,578

Special damages - £345,000
Interest on past losses - £75,478

The above awards were reduced to reflect contributory negligence. You will note that £169,344 was allowed for the future costs of the Court of Protection and for the receivers costs. There are often arguments in brain injury cases as to whether or not the claimant is a "patient" by reason of mental disorder and incapable of managing his affairs in accordance with the definition of the Mental Health Act 1983. This is a critical point which needs to be addressed early on because it impacts on the conduct of the litigation (through a Litigation Friend) and on the management of interim payments. The Mental Capacity Act 2005 received the Royal Assent on 7th April 2005 and is likely to come into force in April 2007.

> A person must be assumed to have capacity unless it is established that he lacks capacity.
>
> A person is not to be treated as unable to make a decision unless all practical steps to help him to do so have been taken without success.
>
> A person is not to be treated an unable to make a decision merely because he makes an unwise decision.
>
> An act done or decision made for on behalf of the person who lacks capacity must be done and made in his best interests.
>
> Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive for the persons rights and freedom of action.
>
> An internet version of the Mental and Capacity Act 2005 can be found at http://www.dca.gov.uk-menincap-mcbdraftcode.pdf .

From the insurers prospective, clearly the terms of the Mental and Capacity Act will impact on claims and on the claim for the costs of receivership long term.

2. *Thacker –v- (1) Gary Steeples (2) Motor Insurers Bureau 2005 QBD (Cox J) 16 02 05*

The Facts

The claimant, a 26 year old man received a lump sum payment of £1,300,000 plus structured settlement for the catastrophic brain injury sustained in a road traffic accident in October 2000. The claimant was rendered a tetraplegic and would require care and assistance for the remainder of his life. The claimant suffered injury as a pillion passenger on a motor cycle driven by the first defendant who lost control of the motor cycle causing the claimant to fall off and collide with a lamp-post.

Liability disputed – MIB alleged the claimant had acquiesced to the performing of a "wheelie-type" manoeuvre. At settlement hearing on the 23rd of April an agreed liability split of 85/15 in the claimant's favour was approved by the judge.

Injuries – a severe diffuse brain injury, rendering the claimant a permanent tetraplegic. The claimant lives in a specially adapted suite in his parents' house with care partly provided by the local NHS Primary Care Trust and partly privately. The prognosis was that the claimant would require 24 hour care and assistance for the remainder of his life.

The case was settled out of court but approved with a lump sum payment of £1,300,000 plus periodic payments of £236,424 per annum RPI indexed for life.

This case is of note because it raised arguments of bringing into account local authority payments for care. The settlement terms in this case were agreed on the basis that the MIB would make periodic payments approaching 100% (despite the admitted contribution) of the likely future cost of care and case management but in

return, the claimant would obtain NHS or local authority funding towards his care and would account to the MIB for the amount of any such funding that he would not have to pay for.

An innovative approach to the issue of local authority funding.

Periodical payments

This brings me on to another area which I have been asked to address to you on,, namely, periodical payments which were agreed in this case. Tomorrow you have a full session on periodical payments and so I shall only touch upon this briefly in the context of head injuries.

References: Damages Act 1996; New CPR Part 41.6

The new Section 2 (1) of the 1996 Act provides that the court awarding damages for future pecuniary loss in respect of personal injury (a) may order that the damages are wholly or partly to take the form of periodical payments and (b) shall consider whether to make that order.

The effect of this is that the court must consider in every case involving future pecuniary loss (.e.g. the loss of future earnings and cost of future care) whether periodical payments are a suitable means to pay all or part of the award, and is able to make an order to that effect without the consent of the parties.

The new power applies to claims or actions under the Fatal Accidents Act 1976 and the Law Reform (Miscellaneous Provisions) Act 1934 in respect of claims for the benefit of the deceased's estate.

The power to order periodical payments without the consent of the parties applies in all cases which have not been finalised before the 1st of April 2005 but a variation order under Section 2 would only be capable of being made in cases where the proceedings were commenced after the 1st of April 2005.

Are periodical payments appropriate?

Section 2 of the Damages Act establishes that the primary consideration in deciding whether periodical payments are appropriate is whether the continuity of the payments is believed to be secure. Part 41 of the Civil Procedure Rules requires the court to consider and indicate to the parties as soon as practicable whether periodical payments or a lump sum is likely to be a more appropriate form for all or part of the damages.

To assist the court in reaching this decision under Rule 41 of the CPR 41.5, the parties can state a view on this issue in their statement of case. Where a party does not state a view in the statement of case, Rule 41.5 allows the court to order them to do so.

CPR 41.7 requires the court on reaching a decision on whether periodical payments are likely to be suitable or on whether to make an order, to have regard to all the circumstances of the case and, in particular, the form of award which best meets the claimant's needs. The court shall have regard to a number of factors including:

- The scale of the annual payments taking into account any deduction for contributory negligence
- The form of the award preferred by the claimant, including the reasons for the claimant's preference and the nature of any financial advice received by the claimant when considering the form of the award
- The form of award preferred by the defendant, including the reasons for the defendant's preference

There is no financial threshold for the making of a periodical payment order. In any brain injury case where there is likely to be an award of damages for future pecuniary loss, periodical payments will be an issue.

To date, my own experience of periodical payment is limited to clinical negligence cases where the periodical payments are self funded and are therefore considered to be reasonably secure under the 1996 Act.

Section 2 (8) of the amended 1996 Act provides that periodical payment orders will be treated as providing for the amount of payments to vary by reference to the Retail Prices Index (RPI). However, sub-section 9 preserves the court's power to make different provisions where circumstances make it appropriate. Rule 41.8 requires the index in question to be specified in the order.

There are now a number of claimants who are arguing that linking a periodical payment to the RPI for commercial care costs will not keep up with actual care costs.

Re Y.M – There is already a case listed for trial specifically on this issue. As I understand it, the case which is a clinical negligence matter involving a patient and a child has been compromised on the basis of a lump sum and periodical payments. The issue for the Court to decide, probably in October is whether the payment should be linked to the RPI or an alternative such as the Average Earning Index or other rates – Watch This Space!!

Do insurers deal fairly with claims?

In my practice, I come across many insurers who go out of their way to develop a line of communication with the claimant's lawyer, dealing promptly and fairly with liability initially and considering reasonable requests for interim payments and input to rehabilitation. Equally, there are frustrating examples of where nothing is heard from insurance companies for many months and reasonable requests for interim payments are ignored until proceedings are issued and an application made. The longest delays in practice are usually in the cases where there is an issue regarding the validity of insurance and indemnity.

I personally detect an increasing willingness to exchange views at round table meetings. There is, of course, judicial encouragement and endorsement for the parties to consider alternative dispute resolution. I find that in high value brain injury cases, once both parties have been able to serve reasoned schedules and counter-schedules of loss, there can be enormous benefit from organising a round table discussion. If settlement cannot be reached, then it at least irons out a number of the issues relating

to quantum and usually, means that it is only the major issues upon which the parties are far apart which have to be litigated further.

A wish list from the Claimants:-

- Confirmation of liability as soon as possible or if liability is denied, a reasoned response to the protocol letter of claim and provision of disclosure.
- If there are difficulties regarding indemnity, say so as early as possible and be as open as possible with the Claimant's Solicitors.
- Prompt response for reasonable requests for interim payments.
- Sending the cheque within an agreed time scale.
- Endorsement and participation in the recommendations of the Rehabilitation Code.

Sally-Ann Robinson