A QUANTUM UPDATE

There have been a number of themes in the case law for the past year which will continue in the long term to have profound implications for the management of high value claims. These largely, although not exclusively, derive from the evolving periodical payments order ["PPO"] regime. There are also now straws in the wind as to how insurers may more effectively, economically and publically deal with proven fraudsters.

GENERAL DAMAGES – A RARE RECENT DECISION IN A TETRAPLEGIC CLAIM

In ***Pankhurst v White and MIB***[1] C suffered catastrophic spinal injuries rendering him C4 tetraplegic. However, Macduff J. held that he did not fall to be compensated at the top of the relevant JSB Guideline bracket [as at June 2008 this was £206,750 to £257,750] because he was independently extremely mobile in an electrically operated wheelchair and his senses and ability to communicate were unimpaired. He was aged 53 years and had a further life expectancy of 19 years to age 72 years. In June 2009 he was awarded general damages of £225,000.

WHAT IS THE LEGAL TEST FOR ASSESSING THE REASONABLENESS OF THE CLAIMANT'S PROPOSED FUTURE CARE REGIME?

Over the past few years there has been a growing inclination on the part of claimants to contend, particularly where future care and case management are concerned, that the legal basis for the assessment of such damages is whether the care and treatment chosen and claimed for is reasonable and not that it is for the court to assess the benefits and disadvantages of two rival schemes and determine which the claimant reasonably requires for the future.

This inclination no doubt stems from the not unusual circumstance where an interim payment has been used prior to trial to set up a care and case management regime and the claimant is then trying to prevent the defendant upsetting what is perceived to be an established and stable arrangement which the claimant submits should be allowed to continue into the future.

In ***Massey v Tameside & Glossop Acute Services NHS Trust***[2] Teare J, relying on principles expounded by Pill LJ in ***Sowden v Lodge***[3] which in turn were said to be derived from ***Rialis v***

[1] [2009] EWHC 1117 (QB)
[2] [2007] EWHC 317 (Admin)
[3] [2004] EWCA Civ 1370

Mitchell[4], held that law is that the claimant is entitled to the reasonable cost of caring for him in the manner chosen by him, or by those responsible for the claimant, so long as that choice was reasonable. He then went on to decide that the test is that the defendant needs to show that the care regime proposed by the claimant is unreasonable. The approach in ***Massey***[5], it is suggested, runs counter to established principles that it is for a claimant to prove that he reasonably requires the care contended for and that it is reasonable in cost and that a defendant is entitled to challenge this and advance either an entirely different or alternatively finessed care regime [something much less than demonstrating that the claimant's proposals are unreasonable] and the court will then make an assessment as between the two proposals. In ***Rialis***[6] Stephenson LJ had said:

> *"But though the means of the wrongdoer are, in my judgment, irrelevant to the assessment of compensation for the injured, that assessment is properly to be moderated by what is reasonable. A judge must resist the temptation to make the wrongdoer pay for the best possible treatment, regardless of whether the injured party will in fact receive such treatment or <u>whether it is reasonable for him to receive less expensive treatment</u>"* [my emphasis].

It seems unlikely that Stephenson LJ intended his words to be taken as meaning that a defendant's suggestions as to alternative costs should be disregarded unless they demonstrated unreasonableness on a claimant's part.

The conventional approach, that it is for the court to decide between two rival regimes which is the more appropriate to meet the Claimant's reasonable needs, has been endorsed in recent years in ***Iqbal v Whipps Cross University Hospitals NHS Trust***[7] by Sir Rodger Bell, in ***Corbett v South Yorkshire Strategic HA***[8] by HHJ Bullimore. The [it is submitted] controversial approach was followed after ***Massey***[9] in ***Taylor v Cheswoth & MIB***[10] by Ramsey J, in ***Wakeling v McDonagh and MIB***[11] by HHJ Mackie QC and, in relation to future aids and equipment, in ***A v Powys Local Health Board***[12] by Lloyd Jones J where, tellingly, he observed:

> *"...I consider that the Theraposture bed reaonsbly meets A's needs. Following the approach which I have mentioned above, I consider that, in the light of this conclusion, the fact that A's needs may be satisfied by a cheaper bed is <u>irrelevant</u>"* [my emphasis].

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[4] Unreported 6 July 1984
[5] Ibid
[6] Ibid
[7] [2006] EWHC 3111 (QB)
[8] [20007] Lawtel AC0113755
[9] Ibid
[10] [2007] EWHC 1001 (QB)
[11] [2007] EWHC 1201 (QB)
[12] [2007] EWHC 2996 (QB)

In 2009 there were two decisions bearing on this as yet unresolved issue. In ***Sklair v Haycock***[13] Edwards-Stuart J. held that the question of whether a care package advanced by a claimant was appropriate and only reasonably necessary was one of fact. The test, he said, is not whether some other care or treatment is reasonable nor what might be in the claimant's best interests. In ***C v Dixon***[14] King J. said that:

> *"I accept as a matter of principle the question for the court is its assessment on all the evidence of what is reasonably necessary to meet the Claimant's likely future care needs rather than asking whether the existing regime is within the range of reasonable options. However, in making this assessment te court cannot ignore entirely aspects of the existing regime, for example the existence of an already established, committed and loyal team of support workers".*

CAN A CLAIMANT RECOVER FUTURE CARE COSTS WHIC HE AVOID IN PART IF HE ACTED REASONABLY BY SECURING LOCAL AUTHORITY CARE/DIRECT PAYMENTS?

The long running saga concerning the extent to which a defendant may seek to reduce his liability for paying the full cost of future care and case management by requiring a claimant to have take advantage of services or direct payments available to him from a local authority may now be nearing a conclusion.

In ***Peters v East Midlands SHA***[15] the Court of Appeal upheld the decision of the trial judge that, on the facts of that case, C was entitled as of right to pursue D rather than to rely on statutory funding provided that there is no double recovery. A case manager is not required to seek full public funding where the court has ordered a tortfeasor to pay 100% of the future care costs necessary to meet C's needs. Where a claimant's affairs were being administered by the court of Protection the Court of Appeal suggested that a deputy could undertake to supply a copy of the judgment in the case to the Court of Protection and apply to that court for an order that no application for public funding of the claimant's care should under the NAA 1948 should be made without further order with a provision that the defendant should be notified of that application. That, it was said, effectively abolished the risk of double recovery.

Peters[16] was a decision based on its facts. As to the wider principle whether claimants were generally free in all cases to reject state funding as a matter of right the Court of Appeal did express a strongly worded *obiter* opinion [para 89]:

> *"There is much to be said for the view that it is reasonable for a claimant to prefer self-funding and damages rather than provision at public expense, on the simple ground that he or she believes that the wrongdoer should pay*

[13] [2009] EWHC 3328 (QB)
[14] [2009] EWHC 708 (QB)
[15] [2009] 3 WLR 737
[16] Ibid

rather than the taxpayer and/or council tax payer. In other words, it is not open to a defendant to say that a claimant who does not wish to rely on the State cannot recover damages because he or she has acted unreasonably. In ***Freeman****, Tomlinson J. came close to embracing this view at paragraph 6. We heard no argument on this approach to the mitigation issue and we express no concluded view about it."*

For all that they had heard no argument on the point and purported to express no concluded view, the Court of Appeal as then constituted [Sir Anthony Clarke MR, May LJ and Dyson LJ] appear to have considerable sympathy with such an approach. It may be that the Court of Appeal will in the future be persuaded in a suitable case to decide as a matter of principle that the election by any claimant that the defendant should pay for the entirety of his future care in a 100% case cannot not be properly characterized as an unreasonable failure to mitigate.

SUBSEQUENT REFINEMENTS TO THE *PETERS* UNDERTAKING

Recent refinements in practice have broadened the undertaking to require the deputy [1] to notify the Court of Protection of the outcome of the proceedings in the High Court and to supply a copy of the Order [important if the Order is a consent order approved by the judge without any judgment] and [2] to apply to the Senior Judge of the Court of Protection for an Order:

- Limiting the authority of the claimant's deputy whereby no application for public funding of the claimant's care [including the care of any child or children] under both sections 21 and 29 of the National Assistance Act 1948 can be made without further order, direction or authority from the Court of Protection

- Providing for the specific circumstances in which the claimant's deputy may be permitted to apply to the Court of Protection for permission to approach the local authority, namely where the claimant's periodical payments are not sufficient to meet his reasonable needs for care and case management.

- Providing for the mechanism by which the claimant's deputy should make his application on notice to the defendant including that the application should be made to the Senior Judge of the Court of Protection and also providing that defendant is to be joined as a party to the application without any risk of a costs penalty [this preserves the right of the defendant to appeal].

- Providing that where the defendant opposes the application he may make written representations as to the appropriateness of the exercise of discretion

- Providing that the claimant will not oppose the right of the defendant to be represented at the hearing in the Court of Protection and to make oral representations

- Stipulating the documents which are to be preserved by the Court until the death of the claimant including all judgments and orders of the Court, the statements of case, the final schedule of loss and damage and the defendant's final counter schedule, the witness statements served by the parties, the expert medical evidence served by the parties, the expert care and case management evidence served by the parties and Counsel's Opinion on approval.

THE *PETERS'* UNDERTAKING – THE AMBIT OF THE UNDERTAKING

Assuming that the current system of benefits continues in its existing form unaltered, the present system of statutory care envisages that a claimant may receive assistance from his local authority in the form of welfare services or direct payments. In addition to these, he may be eligible for other state benefits including, for example, housing benefit and carer's allowance.

Care would have to be taken to ensure that the ambit and reach of the undertaking was clearly defined and understood by all parties. For example, it would be important to determine whether the wording of the undertaking embraced or excluded Disability Living Allowance [care component] receivable by the claimant more than five years after the accident. Again, it would be vital to decide whether it embraced or excluded, for example, Carer's Allowance which is currently paid not to the claimant himself, but to persons who spend over 35 hours per week caring for recipients of higher or middle rates of Care Component of Disability Care Allowance.

However, the current system of payments of benefits is likely to be changed. The system of direct payments was one indication of a trend in governmental thinking which preferred to move away from local authorities delivering social care and accommodation and instead providing money and choice to service users. The latest manifestation of that trend is the pilot programme for Individual Budgets. Manchester was one of the pilot areas. According to the *Evaluation of the Individual Budgets Pilot Programme* [October 2008] at section 1.2:

> *"Individual budgets were to bring together those resources from different funding streams [including local authority social care, housing-related support services, adaptations and equipment budgets] for which an individual is eligible into a single sum that can be spent flexibly according to the priorities and preferences of that person."*

The Individual Budget contains a single budget comprising what were formerly various local authority <u>and</u> other state funding streams. Such funding streams within the pilot programme included the following, the sources of the monies being identified in brackets:

- Adult social care [local authority]
- Access to Work [DWP]

- The Independent Living Fund [DWP]
- Supporting People [Department for Communities and Local Government]
- The Disabled Facilities Grant [DCLG]
- Local Integrated Community Equipment Services [social care and NHS]

Individual Budgets were calculated on the basis of a points score across a series of domains to give a total number of points. Each point had a cash value. The total number of points produced a total cash value and therefore the Individual Budget. The pilot programme provided that [section 1.4]:

> *"IB levels calculated through these processes may subsequently be adjusted following discussions between care managers and potential IB users."*

Returning to the issue of the ***Peters*** undertaking, it would presumably only be the intention of the claimant to give an undertaking in relation to what are current readily identifiable as welfare services/direct payments.

In practical terms it is far from clear whether it will be possible easily to identify which elements of the budget relate to the care which is the subject of the claim in the litigation and care and which to other elements of an individual's needs. The issue may be how readily could such an Individual Budget be unpicked and whether a calculation could be easily performed as to what had been allocated for care, what for equipment and what for any other needs. It may that in time other benefits may be added to the spectrum within the Individual Budget.

This is not to assert that ***Peters*** is not the answer to the double recovery issue. It may be. However, whether under the current system or any reformed system involving the introduction of Individual Budgets it will probably be necessary to consider carefully and, in the case of an Individual Budget, also with an experienced welfare benefits expert, whether such an undertaking is readily workable or not. It may be that the Individual Budgets will be sufficiently particularised such that the elements on which the undertaking is intended to bite can be identified without difficulty. If not, then the idea of the ***Peters*** undertaking may have a relatively short shelf life.

THE *PETERS'* UNDERTAKING – ITS LIMITATIONS

Peters concerned a protected party who was entitled to 100% of his damages and whose form of Order was to be a PPO. It does not resolve all the issues.

What of the non-protected party who is receiving 100% of his claim in the form of a PPO?

- Where the parties can agree then in theory, and subject to the caveats about the ambit and precision of the undertaking, a variant may be possible in such a case whereby a claimant with capacity could offer a similar undertaking not to apply to the local authority without first applying to the High Court [as opposed to the Court of Protection] with the undertaking and the judgment setting out *"the intendment of the assessment of damages"* being lodged with his current local authority and he could also be placed under an obligation to notify the defendant should he move local authority area. Any unscrupulous claimant who moved area without notifying the defendant and then made a successful application for local authority welfare services or direct payments would then be in contempt of court. There could be inserted provision for accounting to the Defendant for any local authority monies received. It could be made to be workable.

- Where the parties cannot agree then the only option is a ***Burton v Kingsbury*** topping up order – if in fact the court has power to make such a variable periodical payment – or an unsatisfactory ***Crofton v NHSLA*** assessment, which is highly undesirable since it makes involves speculating on the level of local authority annual payments that a claimant is likely to receive in the future and on the longevity without substantial alteration of the current charging regimes.

What of the non-protected party where he recovers 100% in the form of a lump sum?

- Where the parties cannot agree then the court will consider the risk of double recovery and will presumably perform a ***Crofton*** assessment with the pitfalls and uncertainties involved.

What of the protected party who recovers less than 100% [for example] say, 50% of the full value of his claim in the form of a lump sum?

- Where the parties can agree:

  One option to avoid the double recovery argument is for his deputy to provide an undertaking as per ***Peters*** until his funds are exhausted. Because he will have a deputy who will be husbanding his resources there will be no argument about over-speedy dissipation and double recovery. Some deputies are not in favour of this solution. However, it has the advantage of simplicity.

  There is also the possibility of the "light touch" reverse indemnity. The difficult here is that there is a developing argument as to what the meaning is of double recovery. Suppose a claimant recovers 80% of the full value of his claim. His reasonable care needs are assessed at 100 hours of care each week. The defendant therefore funds 80 hours

of care per week. The claimant applies to the local authority and his overall needs [irrespective of contributory negligence] are assessed at 20 hours of direct payments. The defendant may argue that the claimant should credit the defendant with anything more than 80% of those 20 hours of direct payments since that is what he has been assessed as being entitled to. 20 hours x 80% = 16 hours. If successful, the defendant would then seek from the claimant 4 hours of direct payments and the claimant would only be able to fund 96 hours of the 100 which he requires.

- Where the parties cannot agree the court has, once again, little option but to perform a ***Crofton*** calculation

DOES A CLAIMANT WITH PRE-EXISTING CARE NEEDS HAVE TO GIVE CREDIT FOR THE "COST" OF THE GRATUITOUS AND PAID CARE WHICH HE WOULD HAVE RECEIVED UNINJURED?

In ***Sklair v Haycock***[17] C, aged 49, had Asperger's Syndrome and OCD. Prior to his accident he was looked after by his 80 year old father and, in due course, would have required some care from the local authority. C contended for a 24 hour private care regime which Edwards-Stuart J accepted that he required. However, the judge had to decide whether he should reduce the claim to reflect the care which, uninjured, C would have received. He declined to place any value on the care which would have been provided by the father out of love and affection. He held that C had not gained by the absence of his father's care and attention and was indeed worse off without it. However, the situation was different where, in the uninjured scenario, future care would have been paid for. There was no difference in principle between the situation where C himself would have purchased care in the absence of his father and the situation where generous family members would have paid for such care themselves. In both situations, expenditure on care which will now be avoided should be taken into account when assessing the net value of future care.

CAN A LOCAL AUTHORITY LAWFULLY CHARGE A PROTECTED BENEFICIARY FOR NON-RESIDENTIAL CARE SERVICES?

In ***Collins v Plymouth City Council***[18] C, who had sustained injuries resulting in paraplegia and cerebral palsy and who lacked capacity as a result, sought a declaration that his local authority was acting unlawfully in charging him £20 per week for non-residential care services. The local authority's charging policy was determined by having regard to, but not directly applying, a DOH guideline for residential services which disregarded income from a trust derived from a personal injury award where the income was to be used to purchase

[17] [2009] EWHC 3328 (QB)
[18] [2009] EWHC 3279 (Admin)

care not provided by the authority but only disregarded £20 where the payments were to be made for local authority care. Holman J. held that the policy was rational and appropriate and no less generous than for residential services.

DOES A CLAIMANT'S NEED FOR A 24 HOUR CARE REGIME MEAN THAT HE WILL RECOVER THE COST OF A FULLY STAFFED PRIVATE CARE REGIME FOR THE REST OF HIS LIFE?

In ***C v Dixon***[19] King J. accepted that C, who had suffered a severe brain injury with resulting permanent organic personality disorder and dysexecutive syndrome, reasonably required 24 hour care. C contended that this included some double-up time and extensive case management. D contended that such an intensive package would be positively harmful in promoting the independence to which he was entitled. C resented the care provided and had been given some periods without care in his care package in the past which had been successful. The judge found that the 24 hour package could be satisfied by some non-commercial support from his partner overnight and in the evenings, some free time while his partner was at work with a commercial carer available on the telephone and, when the partner would not in the future be available [assessed likely to be case in 10 years' time], a light sleeper would be required and some free time/telephone support could still be incorporated in the 14 hours of daytime care. The upshot was that C's future 24 hour care package was significantly less costly than C had contended for. The judge discussed the balance of risk in these terms [paragraph 35]:

> *"The Claimant must be entitled to adequate protection from the real risks, even if small, if the effects if they materialise would be potentially catastrophic for him. I have no doubt that such risks are very real in this case given the inherent unpredictability of the Claimant's behaviour arising out of his permanent cognitive impairments and personality disorders if suddenly confronted by the unfamiliar or that which makes him angry. As Dr Scheepers said in one telling piece of evidence in my judgment, it is not a question of numbers, and all the good days can be negatived by one very bad day. "One cannot wrap up [the Claimant] in cotton wool but the risk are very high"* [my emphasis].

IN WHAT CIRCUMSTANCES WILL A COURT SCRUTINISE PAST EXPENDITURE ON THE PURCHASE AND ADAPTATION OF A PROPERTY?

In **Pankhurst v White and MIB**[20] C, who was not a protected party or protected beneficiary, suffered spinal injuries resulting in tetraplegia. He purchased a property costing £450,000. It was known to be subject to subsidence prior to purchase. C demolished it and re-built it with expensive fittings and with twice the floor space originally specified as reasonable by

[19] [2009] EWHC 708 (QB)
[20] [2009] EWHC 1117 (QB)

his own expert witness. The cost of adaptation [if that is the right description] was eventually £924,000 as against the original estimate of £190,000. MacDuff J. disallowed the figures as claimed. He held that £500,000 was a reasonable hypothetical purchase price with £235,000 for adaptations and £20,000 enhancement in value.

WHAT IS THE PROPER APPROACH TO THE COST OF THE MASTER BOND SECURITY IN THE COURT OF PROTECTION?

This is an area where there has been much uncertainty since the Mental Capacity Act 2005 came into force in 2007. Although the Court of Protection is now a court of record, there are no formal law reports publicising decisions concerning decided principle. There have been a number of occasions on which it has been apparent that there is no settled approach among the Court of Protection judges at Archway or regionally as to the proper approach to some important issues. Recently, two Court of Protection judges at the principal court centre at Archway declined not to accede to applications by deputies made pursuant to undertakings given to the High Court in catastrophic brain injury cases following the decision of the Court of Appeal in ***Peters*** to fetter their right to apply for public funding for care from a local authority. In one case the judge issued a Notice to Show Cause why he should make the order sought on the ground that it was not in the best interests of the protected beneficiary. The defendant in the litigation [the NHSLA] sought to intervene on the basis that the expectation of all parties [the Queen's Bench High Court judge included] was being frustrated. Senior Judge Lush became involved and granted the order sought.

One persistent problematic, and until recently unresolved, issue since the 2005 Act came into force has been the level at which security should be set where the claimant has a professional receiver.

In ***Re H***[21] P's [P = protected beneficiary in the Court of Protection] professional deputy [Niall Baker of Irwin Mitchell's Court of Protection team] sought a reconsideration under rule 89 of the Court of Protection Rules 2007 of the decision of DJ Jackson to obtain and maintain security in the sum of £750,000 on the grounds that security of this level was unnecessary and excessive and caused costs to be borne. P had received a final award of £1,211,714 and a PPO of £25,000 rising to £32,000 at age 11 years and £85,000 at age 18 years. The Court of Protection permitted by order the purchase of a house in the sum of £819,274 but required security to be given for £750,000 in the annual sum of £1,875. This compared unfavourably with the basis of the settlement which assumed that the annual premium would be £765 pa to provide security of £300,000.

The reconsideration was determined by HHJ Hazel Marshall QC who held that, amongst other matters, that the Court of Protection should consider whether the deputy carries professional indemnity insurance which should be effective to replace P's assets in his hands in the event of a total default by the deputy; this consideration should extend to reviewing

[21] Court of Protection Case No: 11461874

the level of aggregation of assets in the hands of a single deputy relative to his insurance. In the absence of adequate insurance cover the starting point will be the value of assets in or passing through the deputy's hands, which could lead to a review of the terms of the deputyship order with a view to limiting the value of vulnerable assets to which he can have access and even possibly considering whether the deputy was unsuitable and should be substituted. Where the deputy has adequate and effective professional indemnity insurance, then the court:

- Should require him to deposit a copy of his insurance with the OPG and inform the OPG/the court immediately if its level is reduced;
- Should aim to set a level of security which will provide adequate resources to meet C's immediate expenditure need for a period related to the time it may take to settle the insurance claim [perhaps 2 to 3 years], the costs of making such a claim and an allowance in case immediate debts of P may have been left unpaid, applying a suitable margin for error.

Having formed the provisional view as to the appropriate level of security, the court should finally consider the level of premium and whether this would cause P undue financial hardship or would otherwise in all the circumstances [including the apparent status of the deputy] appear to be an unjustifiable or wasteful use of P's resources, when balanced against the benefit of having that security. Special circumstances [eg husband/wife deputyships, or lay deputies of obvious stature or situations in which the real risk would appear to be merely negligence rather than total default] may mitigate this, but must provide some real justification for taking the view that such a level of security is not reasonably necessary. The court will then decide whether it is in P's best interest to maintain the level of security originally assessed, or to reduce it to any extent.

On the facts of the specific case, the judge found that the applicant [Niall Baker] was greatly experienced and a reliable deputy, that he had very substantial professional insurance cover which would cover any nature of default or actual negligence by him during the course of his deputyship and that the risk of there being a level of default which might enable a sufficient aggregation of claims by insurers to reduce any recovery for P individually to be so remote that it could safely be disregarded. The judge then reviewed P's annual need for expenditure and an allowance for one-off possibilities. She held that, whilst the professional deputy's probity and reliability were not in doubt, nevertheless security had been budgeted for and purchasing security at £150,000 - £200,000 was not disproportionate to P's situation and security. Ultimately, she determined that an adequate level of security would be £175,000 which would command a fee for between £375 - £460 pa rather than the £1,875 originally set.

This is an important case for defendants. In recent times, and particularly since the Mental Capacity Act 2005 came into force, the costs of professional deputyships have crept ever

higher. Each year's costs comprise several different elements some of which are costs prescribed by the Court of Protection. Others are at large. The cost of the Master Bond is still variously asserted. The decision in ***Re H*** should help to bring a more principled approach to this. Insurers making an interim payment prior to trial where C will be a protected beneficiary would be well advised to insist that an early and timely application is made to the Court of Protection for the appointment of a deputy and for the immediate determination prior to trial of the level of security which will be required since this will fix the annual premium. At present there is a delay of in excess of 20 week between lodging an application for the appointment of a professional deputy and the First General Order being made. There are many cases where the deputyship has been running for some years prior to trial and yet no assessment has been made by the Court of Protection of the annual deputyship fees; these often appear in the claimant's Schedule as estimates. There is no reason why these should not already have been assessed. The cynic would say that the assessed figures will be significantly lower than the estimates and that a policy has been adopted not to seek any assessment prior to trial.

The only scientific way in which a defendant can attack the asserted annual costs of a professional deputyship is to take such stapes as it can to see the First General Order addresses the issue of the level of security [such an Order is a discloseable document], that C's solicitors are reminded on the first and subsequent anniversaries of the deputy's appointment that D requires C to produce as soon as possible an assessed bill of costs and not merely to read about estimates in the schedule and to ensure that the pre-trial directions provide for the sequential service of evidence as to future deputyship costs starting with supporting evidence to be adduced by the claimant in the form of a statement from his professional deputy which should be served first so that the defendant can then obtain a statement in response from another professional deputy which can address the issue of the work to be done and the likely costs involved, taking into account any particular features which may affect this such as family dynamics and personalities, geographical location and any other matters concerning C or his lifestyle or presentation which may tilt the costs level one way or the other. If a defendant does not evidence his objection to the asserted and evidenced deputyship costs claimed by the claimant he should not subsequently complain.

HOW SHOULD MULTIPLIERS FOR AN IMPAIRED LIFE BE CALCULATED?

In **Smith v L C Window Fashions Ltd**[22] C claimed damages from a brain injury resulting in cognitive impairment and behavioural changes. It was agreed that his life expectancy had been reduced by 6.5 years. C contended that, in order to avoid double counting, the court should use Ogden table 28 [used for terms certain] to calculate the life multiplier whereas D contended that table 1 should be used. Cranston J. held, applying ***Crofts v Murton***[23] and

[22] [2009] EWHC 1532 (QB)
[23] [2008] 152(35) SJLB 31 QBD

considering ***RVI v B***[24], that Ogden table 28 was only appropriate where, on the medical evidence the court could determine exactly how long an individual in a particular case could be expected to live. Here, the evidence did not determine how long he would live but by how much his pre-morbid statistical life expectancy had been shortened. Ogden table 1 should be used because there would be no double counting.

This is an unresolved issue with neither side really wanting a definitive decision. It is of greater importance in cases where the final order will be a conventional lump sum than where a PPO is made.

THE INTER-RELATIONSHIP BETWEEN THEN INTERIM PAYMENT JURISDICTION AND PPOS

In **Cobham Hire Services v Eeles**[25] the Court of Appeal endorsed the approach of Swift J. in ***Mealing v Chelsea and Westminster NHS Trust***[26] and Stanley Burton J. in ***Braithwaite v Homerton University Hospital NHS Foundation Trust***[27] as to the correct approach to the size of interim payment awards to be made where the trial judge may ultimately have it in mind to make a PPO for future heads of loss. C, who had been seriously injured in a RTA, bought a claim for damages. Liability was admitted. Life expectancy was not impaired. He received £450,000 by way of voluntary interim payments. He then applied for a further interim of £1.2 million to purchase and adapt a suitable property. The judge's conservative value of the conventional value of the claim was £3.5 million and he noted that, if he acceded to the application, the total of the interims would not exceed 50% of the conservative valuation and, on the footing that this did not exceed more than a reasonable amount of the damages which C was likely to recover, he made the order sought. In doing so, he rejected D's submission that this might tie the hands of the trial judge who might want to make a PPO.

The Court of Appeal allowed D's appeal, holding that the correct approach was to decide whether the trial judge might want to make a PPO and, if so, to assess on a conservative basis the likely amount of the final judgment, leaving out of account the heads of future loss which the trial judge might wish to deal with by a PPO. Such an assessment would usually only comprise only general damages plus interest, special damages to date plus interest and the entirety of the accommodation claim including future running costs. The judge should normally not begin not speculate about how the trial judge will allocate any other future heads of loss. The interim payment should not exceed a reasonable [possibly high] proportion of that assessment. The judge was not to have regard to how the claimant might spend the money [re-affirming ***Stringman v McCardle***[28]]. Exceptionally, additional elements

[24] [2002] EWCA Civ 348
[25] [2009] EWCA Civ 204
[26] [2007] EWHC 3254
[27] [2008] EWHC 353
[28] [1994] 1 WLR 1653

of future loss could be included in the judge's assessment of the likely amount of the final judgment when the judge could confidently predict that the trial judge would wish to award a larger capital sum than that covered by general and special damages, interest and accommodation costs alone but the judge would have to be satisfied by evidence that there was a real need for the interim payment requested to a high degree of confidence and, if he was so satisfied, then he would be justified in predicting that the trial judge would take the course indicated and he would be also then be justified in assessing the likely amount of the final award at such a level as would permit the making of the necessary interim. On the facts, the Court of Appeal assessed the conservative value of the requisite heads of loss including accommodation at £590,000. All the other heads of loss were potentially the subject of a PPO. The Court held that it was not sure that D's concession made for the purposes of argument that the future costs of therapies, equipment and Court of Protection costs would probably be capitalised. In the light of C's submission that there was no other pressing need for money no further interim payment was made on appeal; the court simple allowed the appeal which had the effect of denying C the interim award made by the judge.

There have been several reported cases since ***Cobham*** which illustrate its application in practice.

In ***Kirby v Ashford & St Peter's Hospital***[29] C, a 3 year old child with cerebral palsy as a result of clinical negligence, who had already received £850,000 by way of a voluntary interim payment, applied for a second interim payment of £350,000 which, if granted, would have brought the total of interims to £1.2 million. C was in temporary bungalow accommodation which the judge accepted she needed to move from prior to trial. C adduced expert evidence that the cost of purchasing and adapting a suitable property [then not identified] was £907,590 [of which the purchase costs was said to be £635,000]. However, C's parents wanted to buy a property costing £815,000 plus adaptations. This was £180,000 more expensive than the expert evidence supported. Swift J. assessed the likely award on a conservative basis at £900,000. The judge accepted that this was a case the need for a suitably adapted property would merit making total interim payments greater than a reasonable proportion of her assessment. However, she considered that the cost of relocating to a suitable adapted property was only £875,000 but she recognised the need to pay for continuing care to trial. She therefore made a further award of £150,000 bringing the interim payments to £1 million.

In ***Johnson v Chesterfield and Derbyshire Royal Hospitals NHS Trust***[30] HHJ Bullimore made a top-up interim payment of £200,000 on top of a first interim payment of £700,000 where the house had been purchased but the existing funds had been exhausted because he accepted that there was a pressing need for the house adaptations to be completed if the whole objective of the purchase was not to be frustrated. He considered that this was an

[29] [2209] EWHC 1320

[30] [2009] Lawtel AC121426

exceptional case where he could be satisfied that the trial judge would order a significant lump sum.

In ***FP v Taunton & Somerset NHS Trust***[31] ***C was the mother of a severely disabled 5 year old son who*** brought a wrongful birth claim. The son had an impaired life expectancy; the range was between to age 20 and to age 60 years. C sought a second interim payment of £1.5 million to purchase and adapt accommodation and to purchase private care for 2 years up to trial. Blair J. assessed the likely final judgment at £1.3 million and ordered an interim payment of £1.2 million which, although a high proportion, would allow C to purchase and adapt suitable accommodation and to purchase care. C had a right to spend the money as she wished [***Cobham v Eeles***] but the judge made it a condition of the interim award that the interim monies should be expended only for items identified in the schedule of loss to protect the son, C and the public.

In ***Patel v Patel***[32] C, who suffered permanent brain injury in a RTA, had received interim payment of £545,000. By consent the court ordered that there should be a trial of various preliminary issues including the nature of C's special educational needs and what educational provision was required to meet them. C was in a state school and it was intended that the trial should take place in good time before C was due to start school at the beginning of the new school year. In the event this was not possible and the trial of the preliminary issues had to be postponed, it being agreed that C should not be moved from her state school in the interim. C then made an application for a further interim of £100,000 to fund a placement at a private residential school as soon as possible. Underhill J refused to set aside the consent orders. In any event C was not yet in a position to prove that she needed to go to a private school.

In ***Johnson v Compton-Cooke***[33] C, who had severe brain injuries, had already received and almost exhausted interim payments of £913,000. She applied for a further interim of £1.67 million to cover a period of 12 months which included £1.1 million for accommodation. C also contended that only the future care costs would be the subject of a PPO, that the other heads of future loss would be capitalised and that the final sum awarded would be £3.25 million. D contended that the claim was greatly exaggerated, that there was no pressing need for an alternative property at this juncture and that C was only entitled to a reasonable proportion of the likely final award. MacDuff J. decided that he could not predict that the trial judge would capitalise all those various heads of future loss as C contended because it was impossible to invest a large capital sum and achieve the rates of growth assumed by the courts [applying the 2.5% discount rate multipliers] and therefore prudence may dictate that, whatever current practice, damages for a whole range of future losses should be protected by a PPO. He rejected D's submission that C's reasonable need for care could be

[31] [2009] EWHC 1965 (QB)
[32] [2009] EWHC 3110 (QB)
[33] [2009] EWHC 2582 (QB)

provided by public funding but considered that the true cost of care lay somewhere between C's and D's figures. He was not satisfied that there was a real need for a payment now for accommodation because it was much better than adequate even if not ideal. Ultimately he assessed the capitalised final award on a conservative basis at £1.75 million and awarded a further interim payment of £600,000 [making the total of interim payments £1.513 million].

In ***Preston v City Electrical Factors Ltd and anor***[34] C sustained severe brain damage in a RTA when he was knocked down while drunk. Liability was agreed at 50% to reflect C's contributory negligence. There was an issue as to whether the brain injury was responsible for his alcohol dependence syndrome and whether his injury or the alcohol dependency syndrome had created the need for care and case management. D had already made a voluntary interim payment of £100,000. C contended that the claim was worth over £1 million even on a 50% basis. C applied for a second interim payment of £100,000 and argued that this would not exceed a reasonable proportion of the amount likely to be recovered at trial. D argued that this would adversely affect the ability of the trial judge to make a PPO for future care and case management, which D contended was the likely outcome. Walker J held that, on D's figures, any PPO for future care would be low. C had a strong preference for a lump sum. Whether or not all C's care needs were attributable to the accident a PPO would be too rigid to provide for his variable care needs. He required the maximum flexibility. A PPO was not in his best interest and a further interim payment was reasonably necessary.

IN WHAT EXCEPTIONAL CIRCUMSTANCES MAY A JUDGE CONCLUDE TO A HIGH DEGREE OF CONFIDENCE THAT HE SHOULD CAPITALISE OTHER ADDITIONAL ELEMENTS OF THE FUTURE LOSS?

- Where a PPO may not be the correct form of order because C is recovering or is likely, because of alleged contributory negligence, only to recover a percentage of the full value of his claim and his needs require him to use up a significant proportion of this immediately: see ***Preston***[35].
- Where, on any view, C has a significantly foreshortened, if uncertain, life expectancy and yet needs an adapted property now in order to accommodate the required care regime. Although the Court of Appeal considered that it would have to be an exceptional case to justify proceeding to the second stage of the assessment it should not be thought to represent only a relatively small minority of cases. It is not unusual to find that the aggregate sum of general and special damages plus interest together with the full accommodation claim fails to approach anywhere near the full cost of purchasing and adapting a property and providing for care to the trial date

[34] [2009] EWHC 2907 (QB)
[35] Ibid

and this is even before the court determines what a reasonable proportion of that figure might be.

WHAT ARE THE PRACTICAL CONSEQUENCES OF THE DECISION IN COBHAM?

The approach in ***Cobham*** has the potential to redress the balance as between claimants and defendants over pre-trial expenditure. However, much depends on D making sure he keeps himself evidentially abreast from the outset of C's condition and disabilities, and any credibility issues and of his accommodation and care needs. One route to this is to use a shadow case manager who would be deployed solely to gather information for the defendant's insurers and solicitors and to advise them but not to engage directly with any care regime or treatment plan. D would do well to consider whether to recruit a shadow case manager to star work even before entertaining the first interim payment request.

C may be forced to make a fully evidenced application at an early stage and disclose and detailed schedule and valuation of his case.

C may often find that the high cost of purchasing and adapting accommodation in some cases is greater than a reasonable proportion of the aggregate of general and special damages to date and interest thereon together with all future accommodation costs. In such cases C has a heavy burden to discharge that the court can have a high degree of confidence that the trial judge will capitalise other heads of future loss at the expenses of PPOs. To do this, a claimant may have to [and, if he does not do so, a defendant may point to the fact that he has not done so]:

- Prove his current accommodation is wholly unsuitable and that there is a pressing immediate need for an alternative;
- Prove that there is no prospect of renting a suitable alternative;
- Prove that a suitable property is available and the reasonableness of the purchase price and adaptation costs;
- Prove that other heads of future claim than care and case management will almost certainly be capitalised. This may be difficult in a 100% case after the concern expressed by MacDuff J In ***Johnson***[36] about the effect of inflation on the value of damages for future heads of loss if they were to be capitalised;
- Adduce expert evidence from an Independent Financial Advisor on the needs and advantages and disadvantages of capitalising heads of future loss other than care and case management

[36] Ibid

C may now find that the choice of house is severely constrained because of the available capital from an interim payment. However, D would be wise to investigate and advance a positive case on this. D may wish to get in "on the ground" when C is selecting a property and making enquiries of C's solicitors as to the geographical area where C is looking to purchase and then to make his own immediate enquiries whether there are other properties on the market in the chosen locality which may provide equally suitable facilities at a significantly lower cost.

PPOS – OTHER RECENT ISSUES

Refinements of the standard Orders now include such matters as:

- Providing, upon the death of the claimant, for the calculation of the repayment of any periodical payment due and for repayment with accrued interest within a certain period of days of the grant of probate [I have seen a period as short as 21 days and as long as 56 days].

- Providing for the means by which proof of continuing life is to be satisfied and for the right of an insurer to withhold payment in the event that such proof is not forthcoming and only to pay interest from 14 days after late proof is provided if the PPO has not been made in the meanwhile. In ***Long v Norwich Union Insurance Ltd***[37] the court had before it a proposed draft PPO reflecting the terms of a settlement which was agreed in all material respects including a provision that proof of continuing life would be accepted in the form of a letter from C's professional deputy. C proposed an additional sentence, namely that D should reimburse her in respect of reasonable costs, if any, of providing such documentation as the administrative burden of administering the PPO was D's. D argued that C would receive substantial costs from D which ought to cover all the duties which a deputy might reasonably be expected to have performed including the obligation to provide proof of life. Mackay J held that there were benefits and burdens i for both sides in a PPO. The standard order did not make any separate provision for payment of the costs of proof of continuing life. The obligation of the execution of the order did not all rest on the paying party. If the costs of proof of life were significant then these should be included within the deputy's costs in each case or elsewhere as appropriate in the damage if it was thought worthwhile.

IN WHAT CIRCUMSTANCES WILL A COURT EXERCISE ITS DISCRETION TO MAKE A PROVISIONAL DAMAGES AWARD?

In **Chewings v Williams and Abertawe Bro Morgannwg University NHS Trust**[38] C sustained serious injuries to his right lower leg in a RTA. He also claimed that his persisting symptoms and disabilities had been compounded by clinical negligence as a result of treatment received at hospital. Liability and damages were agreed. The extant issue was whether the

[37] [2009] EWHC 715 (QB)
[38] [2009] EWHC 2490 (QB)

sum should be paid as final damages or as provisional damages to take account of the possibility that C would undergo a fusion operation on his ankle at some pint which could lead to a below knee amputation. C claimed that there was a chance that he would have fusion surgery, a serious risk of complications, some of which could result in the need for an amputation which was a risk which was real and not fanciful. Ds contended that it was unlikely that C would be advised to undergo fusion surgery because of the risks and amputation was a remote possibility anyway. Slade J held that an award of provisional damages was appropriate where there was a real and not just a fanciful chance that despite the risk to his limb, C would undertake a fusion operation and, although the chance of an amputation occurring afterwards was small, it was not negligible. The judge estimated that the risk was about 2%. Given that that 5 years had elapsed since the accident the award would be provisional for a period of 3 years only.

Relatively few provisional damages orders are made. Claimants want an end to litigation. Insurers dislike such orders. Claimants want an end to litigation. It is probably the case that this is a much underused jurisdiction and, if they were invited to do so, the courts would make many more such orders awards than are currently made.

COSTS AND PART 36 OFFERS

In ***Whitstance v Valgrove***[39] C made a Part 36 offer. D rejected this. C later made a revised Part 36 offer. D purported to accept the original Part 36 offer. At first instance the judge held that then original Part 36 offer had not been withdrawn and had been accepted by D. On appeal the decision was reversed the Designated Civil Judge [HHJ Holman] holding that the second revised Part 36 offer was plainly intended to operate as a withdrawal of the original offer. It was therefore not open to D to have accepted the earlier offer when he purported to do so. It would have been better if, when making his revised offer, C had said that the previous offer was withdrawn or amended

In ***Gibbon v Manchester CC***[40] [a conjoined appeal] C made a Part 36 offer. D rejected this. C did not make any revised offer and rejected D's offer. D later accepted C's only Part 36 offer. The judge held that C's offer had never been withdrawn and could be accepted. Upholding the decision the Designated Civil Judge [HHJ Holman] held that the onus was on C to take a positive step to withdraw the offer as required by CPR rule 36.9(2). C had not put forward a revised Part 36 offer or stated that his own Part 36 offer had been withdrawn. It was therefore lawfully accepted by D.

[39] [2009] Lawtel AC0122124
[40] [2009] Lawtel AC0122124

In ***Onay v Brown***[41] where primary liability had been conceded but the issue of seat belt contributory negligence remained to be determined and D made an offer which, although not expressly stated to be such, was and was objectively intended to be a Part 36 offer to settle at 75/25 in C's favour the Court of Appeal held that the judge had been wrong to order C to pay the costs of the contributory negligence issue. C was entitled to his costs even though he had not previously been prepared to accept anything more than a 20% reduction.

In ***Sonmez v Kebabery Wholesale Ltd*** [42] where C had never been prepared to accept any reduction for contributory negligence and had refused D's Part 36 offer to settle at 75% in C's favour but was held to have been 20% the Court of Appeal held that the judge had been wrong to order C to pay D's costs of the trial. C's conduct in standing by his conviction that D was wholly responsible was not conduct which fell within CPR rule 44.3(5). The correct order was that D should pay C's costs.

COSTS AND EXAGGERATED CLAIMS

There have been a number of interesting decisions in this area in 2009. Many high value claims are advanced where, for good reason, the probity of the claimant is questioned.

In ***Cunningham v AST Express Ltd***[43] C claimed damages for personal injuries in a RTA. C initially claimed £180,000 including damages for care and assistance and loss of earnings. D made an offer to settle [at a date when D could have paid into court] in the sum of £4,700. C rejected this but made no counter offer. At trial C was awarded £4,143. D applied for an order that C pay the costs from 21 days after the offer. The recorder made an order that D pay C's costs to that date and 50% of C's costs after that date as the offer could not be a Part 36 offer because there had been no payment into court. The Court of Appeal held that the recorder should have determined who was the winning party, have noted that D had acted impeccably and that C's conduct was open to criticism not least because he had greatly exaggerated his claim. There was no reason to deprive D of an order that C should pay D's costs from 21 days after the offer was made.

In ***Hullock v East Riding of Yorks CC***[44] C sustained injuries in an accident at work. Primary liability was admitted but contributory negligence was in dispute. C alleged she had limited mobility and required substantial continuing care. D's surveillance evidence showed that C was not as disabled as she had maintained. C served a revised schedule in which a reduced claim for past care was advanced and the claim for future care was abandoned. A settlement was agreed on the basis that C would retain the interim payment. Costs were

[41] [2009] EWCA Civ 775
[42] [2009] EWCA Civ 1386
[43] [2009] EWCA Civ 767
[44] [2009] EWCA Civ 1039

argued. The judge ordered C to pay 50% of D's costs on the basis that although C had obtained a judgment she had presented an exaggerated claim. D had never made a Part 36 offer and until D acknowledged that she was entitled to the settlement amount C was entitled to continue with her claim. The Court of Appeal allowed D's appeal holding that, as liability was admitted the court was required to identify what the real issue between the parties was and reflect that in the costs order. In this case the real issue was confined to an exaggerated claim for special damages; that, was a central, if not decisive, consideration in determining who should pay the costs. The exaggerated and unsuccessful claim had real costs consequences for which C had to be made liable. The judge had failed to give effect to his important finding about C's conduct. The real winner was D. The court ordered C to pay D's costs up to the date of the interim payment but D had to pay C's costs thereafter.

In ***Shah v Ul-Haq***[45] and others D sought to strike out a claim brought by C1 for his own personal injury where the judge found that C1 had fraudulently supported a claim that C2 was in C1's car and had been injured when C1 knew that not to be true. The trial judge declined to strike out C1's claim and instead awarded him damages but ordered C1 and C2 to pay 2/3rds of D's costs of defending the action. This resulted in the event to a balance being due to D. On appeal D contended that CPR rule 3.4(2) provided the basis for striking out a claim as an abuse of process and that the judge should have made it plain that if such a supporting claimant were found out not only would the fraudulent claims be dismissed but also the claim of the supporting claimant would be struck out, even if such a claim were genuine. The Court of Appeal held that the invariable rule was that, where a claim had been dishonestly exaggerated, the judge should award the limited damages to which the claimant was entitled and he should not be deprived of them because he had fraudulently attempted to obtain more. The Court doubted the correctness of the *dicta* of Laws LJ in ***Molloy v Shell UK Ltd***[46] that the dishonest exaggeration of a genuine claim should result in the dismissal of the whole claim. There was no logical justification for suggesting that a claimant who lied about another's claim should be treated more severely than if he lied about his own. The appropriate remedy was in cost unless a fair trial became impossible due to the dishonesty in which case, exceptionally, the claim might be struck out. As a postscript, Toulson LJ said:

> *"...I would add that everyone knows that fraud is a scourge of our time. On the judge's findings the claimants were guilty of serious criminal offences, including conspiracy to defraud and conspiracy to pervert the course of justice. If, as has been suggested, such fraudulent claims have reached epidemic proportions, it may be that prosecutions are needed as a deterrent to others."*

In **Widlake v BAA Ltd**[47] C, a security guard at an airport sustained injuries when she fell down a defective staircase at work. Liability was admitted. C deliberately and dishonestly

[45] [2009] EWCA Civ 542
[46] [2001] EWCA 1272
[47] [2009] EWCA Civ 1256

sought to conceal her pre-accident history of back problems from the examining medical experts. She nonetheless beat D's Part 36 payment. C argued that D should pay her costs subject only to a reduction to reflect the extent to which the any exaggeration had resulted in increased costs. The judge ordered C to pay D's costs. Allowing the appeal, the Court of Appeal again doubted the correctness of the *dicta* of Laws LJ in ***Molloy v Shell UK Ltd***[48]. C had a legitimate claim and, in beating the Part 36 payment, was the successful party. However, exaggeration was a relevant conduct under CPR rule 44.3(5)(d). D could have made a better Part 36 offer. C's dishonesty was to be penalised as was her refusal to negotiate. The proper order was no order as to costs.

There is one recent case where insurers took the initiative to pursue a fraudulent claimant in the civil courts after the litigation was over. In ***Walton v Kirk***[49] C sustained injuries in an accident. Liability was not disputed. Her claim for damages was in the region of £800,000. During the claim C made a number of statements verified by statements of truth which depicted her as having suffered significant injury and long-term disability as a result of the accident; she said she could only walk 10 steps without help and required crutches or a wheelchair and was "bed-bound".

D's insurers thought that she was exaggerating her injury and claim for damages. They paid £25,000 into court than would have been appropriate if her injuries were genuine and then placed her under surveillance. This showed that there was a huge gulf between the level of disability spoken to in the statements and the reality of her presentation. She was seen out walking, driving and shopping.

C then accepted the payment in without seeking to negotiate a higher figure and agreed to pay all D's costs from 21 days after the payment in was made. Once the costs liability was taken into account she had derived no financial benefit from the litigation at all.

D's insurers applied with permission to commit C for contempt of court relying on the statement of truth which affirmed her "Incapacity for Work" questionnaire and her application for a disabled parking blue badge and on the contend of the DVDs. C gave evidence herself, and called members of her family and friends and her doctor to give evidence.

D submitted that the content of the videos alone automatically showed that she had been untruthful and dishonest and that this was supported by the way in which the litigation had come to an end. C contended that she had become exhausted by the litigation and that the DVDs had had no impact on her decision at all.

Coulson J held that D had to prove three matters beyond reasonable doubt: [1] that C had made a false statement, [2] that this was in a document verified by a statement of truth and

[48] [2001] EWCA 1272

[49] [2009] EWHC 703 (QB)

[3] that she had no honest belief in its truth. There was no question of a contempt of court arising automatically. What mattered was the degree of exaggeration or the circumstances in which it arose. Gross exaggeration or dishonesty would not be tolerated. It was in the public interest that claimants pursued honest claims and did not significantly exaggerate these. In this case, C was an unreliable witness and her account of why she brought the litigation to an end stretched credibility well beyond breaking point. She had had a genuine claim and probably had fibromyalgia and, in the circumstances, most of D's insurers' allegations against C were not made out. However, C had not honestly believed in many of her "Incapacity for Work" questionnaire answers and her blue badge application was contradicted by the DVDs and her own witnesses' evidence. That application, once verified by a statement of truth, would have interfered with the course of justice in a claim, as C would have known and intended to demonstrate a high degree of disability. The content of court was made out as regards the claim for state benefits and the blue parking badge.

Ultimately, C had to pay a fine of £1,500 and 2/3rds of D's costs, the reduction applying because D had failed to prove all of the allegations for which they contended.

This case may provide the blueprint for holding fraudsters to account within the civil jurisdiction in a relatively short timescale after the completion of the civil action. Properly publicized through the media, such cases may act as at least an effective deterrent as criminal proceedings which may well take much longer to come to fruition.

WHAT ORDER AS TO COSTS IS APPROPRIATE WHERE A PARTY'S EXPERT WITNESSES ARE SEVERELY CRITICISED?

The judgment in ***Williams v Jervis***[50] is one which every expert witness would be well advised to read as an object lesson as to what can happen if his/her Part 35 obligations are not complied with

In ***Williams***[51] C obtained a finding of 100% liability against D on a liability trial. The judge rejected D's case, based on expert evidence, that C was not a reliable witness, had exaggerated her symptoms as part of an orchestrated deception to gain substantial compensation. The judge found that, stripping away the eccentricities of her personality, she was in essence a truthful witness and her account was reliable. He made the order described above. In doing so he rejected the evidence of two experts called by D in highly critical and explicit terms.

- The judge described one orthopaedic expert as a "very unsatisfactory witness" whose report contained inaccuracies which were the product of not reading source material and not reading witness statements and whose opinions on what he

[50] [2009] EWHC 1837 (QB)
[51] Ibid

considered would have been C's foreshortened working life in the uninjured scenario were "nonsense" because he had not read her osteopath's treatment records and had not appreciated that despite her pre-existing back pain she had only taken 3 days off work in 30 years because of neck pain.

- The judge described another neurological expert as displaying "very poor judgment" when he had solicited from another neurological expert, formerly instructed by C but no longer relied, on a copy of his privileged report and then told untruths to D's solicitors and through them to the judge, asserting that he had received it unsolicited and anonymously and had not become aware of the report until recently; that this was untrue became apparent largely because the expert no longer relied on provided a statement setting out the real position. This expert had also misrepresented and economised on information obtained from C in interview, a matter which only became apparent when C's own recording of the interview was transcribed. The judge found that there were clear indications of a lack of thoroughness and a failure to spend adequate time in properly analysing the case. He felt that the expert approached thr case with a set view of C and her claimed symptomatology through the prism of his own disbelief.

CAN AN APPROVED SETTLEMENT BE SET ASIDE WHERE UNFORESEEN EVENTS HAVE OCCURRED POST-APPROVAL?

In ***Roult v NW Strategic HA***[52] the court had approved the settlement of a claim for damages for cerebral palsy caused by clinical negligence on the basis that C would reside in a specialist group home. Some of the costs were uncertain and so the order provided for these to be quantified later. Some 4 months later C served a revised schedule purporting to deal with the outstanding claim which sought damages for future claim on the footing that C would reside in privately adapted accommodation with privately recruited carers. C said that he had move into and out of the group home which was and would always be unsuitable. D referred the matter to the judge as to whether he had power to vary or revoke the order.

Christopher Clarke J. held that he did not have power to vary or revoke the order under CPR rule 3.1(7) even where an unforeseen subsequent event had destroyed the assumption on which it was made.

The Court of Appeal agreed, holding that C's suggestion came perilously close to allowing a judge in effect to hear an appeal from himself or to review his own order where it was not being suggested he had not made any error. CPR rule 3.1(7) only applied to case

[52] [2009] EWCA Civ 444

management decisions and did not apply where an order was founded on a settlement agreed between the parties after detailed and skilled advice. It was not a case management order and even though there remained issue which needed managing towards future disposal that did not alter the position.

AND FINALLY - EMPLOYER'S COMPULSORY PENSION CONTRIBUTIONS

We all know that the effect in outline of the Pension Act 2008 will be, when it is brought into force, to impose compulsory pension contributions on both employers and employees. The projected date in 2008 was 2012 notwithstanding the current economic crisis. Employers have to enrol their employees unless they are ready in a decent pension scheme. Minimum contributions will be employees 4%, employers 3% and tax relief 1%. Contributions will be payable between the threshold of the primary threshold and the upper earnings limit for ERNIC calculations [currently £5,736 pa and £44,009 pa]. The only recent information is that in the Personal Accounts Delivery Authority Key Facts document in August 2009 the dates for implementation are vaguer than they once were. It was originally proposed that implementation would be over a 3 year period from 2012 with 1% in the first year, 2 % in the second and 3% in the third. However, the precision is not currently repeated and it is not known whether there might be some reduction in NIC for small employers.

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