Magazine

The MASS Insight Magazine

Issue 7 | Winter 2016

Also in this issue

Psychiatric / Psychological Claims – The Hidden Injury.

Whiplash and the Small Claims Limit. Effectively challenging the proposals.

Insurance Fraud Taskforce. A reflection on the outcome of their review.
Personal Injury

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Feature Article

CLAIMS FOR PSYCHIATRIC INJURIES

Psychiatric and psychological injuries can often be overlooked and hidden. Chris Bright QC considers the importance of identifying and recognising the symptoms and how to classify these claims.

PRIMARY AND SECONDARY VICTIMS

The complexity of psychiatric injuries are outlined by Susan Brown, especially when defining primary and secondary victims and the Courts approach.

A DEFENDANTS VIEW

Whilst recognising the complexity of these claims, Nigel Teasdale explains the defendant’s responsibilities, what they need to look for and how some clinical diagnosis and medical reports are insufficient.

DIAGNOSING INJURIES

Colin McGuinness explains the challenges that experts have in diagnosing these injuries through the use of diagnostic lists and tests and what the claimant is actually experiencing.

TREATING INJURIES

Once diagnosed the treatment of these injuries is vital and Peter Clarke explains the various options that are now available to help the injured victim recover.

MASS MATTERS

A big ‘Thank you’ to all MASS Members who supported our charity BIRT. Plus keep up to date with just some of the benefits of being a member and what forthcoming courses MASS Training has to offer.

CASE WATCH

Keeping up to date with case law is a constant battle. Iain Curtis provides a summary of just a few important judgments that have been published.

WHIPLASH AND THE SMALL CLAIMS LIMIT GOVERNMENT REFORMS

Following the Governments announcement to end damages for minor whiplash injuries and raise the small claims limit, Gordon Exall expresses how claimant lawyers may have to campaign differently this time round.

INSURANCE FRAUD TASKFORCE

With their report and recommendations now published, Susan Brown and Steve Jackson reflect on the Taskforce formation, work and end result.

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Welcome to our first edition for 2016 and we hope you will find our future editions continue to provide interesting views and information on topical issues within the personal injury and claims industry.

Roger Henderson
Editor, The MASS Insight Magazine

It has certainly been a “winter of discontent” for claimant lawyers (and more importantly the claimants themselves) following the proposals announced in the Autumn Statement to remove whiplash as a head of claim and to increase the small claims track limit for personal injury claims to £5,000. The consultation process is due to be announced late March/early April.

The pretence for this latest attack on access to justice is on the basis that these moves will achieve a further reduction in fraudulent claims and hence reduce the cost of premiums. It does seem ironic that both the Government and the insurance industry by their own admission seem unable to provide any figures or proof that savings from previous Jackson, LASPO and other Rule changes have been indeed passed on to consumers, at a time when most insurers balance sheets and dividends remain extremely healthy.

At pages six and seven Gordon Exall, well known personal injury barrister and commentator, shares his own thoughts on the whiplash proposals.

We will obviously have to await developments over the next few months.

In other news, the long awaited Insurance Fraud Taskforce released its report in January. Sue Brown, MASS Chairman and Steve Jackson from Covea Insurance provide their views on the taskforce report and recommendations.

Finally, we take a look at the psychological and psychiatric impact of road traffic crashes, which is often overlooked but is just as important as the physical injuries sustained. We hope you enjoy the collection of views from numerous experts on the mental trauma and consequences from road crashes.

So 2016 has all the makings of being another rollercoaster year for those involved in the claims industry. Let us hope that all the previous talk of collaboration and openness between respective sectors of the industry indeed takes place rather than just being mere rhetoric.
Why the honest lawyers are losing the “propoganda” war: the small claims limit and beyond.

Barrister Gordon Exall argues that the usual tools of advocacy are not sufficient in the campaign against the abolition of general damages and the increase in the small claims limit.

Sometimes in the near future a public relations company is going to print an article (possibly a whole book) on the brilliant job they did for the insurance industry when they got general damages abolished and the small claims limit raised.

Anyone involved in litigation at the moment has to realise the skill and expertise that is being applied. Large corporations that make millions are portraying themselves as the “victims” of injured people. They are doing this very well. There is a constant stream of stories, television features and briefings which bang home a message that personal injury claimants are all fraudsters.

The phrase “compensation culture”, which has been found definitively not to exist, is considered a “fact”, even being found in court judgments.

WHY HONEST LAWYERS ARE FAILING TO PERSUADE

There is no doubt at all that there is a well-financed, and sustained, campaign aimed at the victims of road traffic accidents. Waged, it has to be said, by insurers and those who represent them. I note that at least one defendant company now retains a former high ranking civil servant from the Ministry of Justice. The insurers are hiring people who understand the system and know how to influence.

We lawyers, on the other hand, are disadvantaged by our training. Consider the central points that effective advocacy relies upon.

EVIDENCE

Lawyers work with evidence. It is evidence that proves the case. It is evidence that judges look to. However, in lobbying politicians for change, evidence is one (seemingly small) element. Insurers are succeeding in creating and promoting a climate of prejudice by using the activities of a small group of dishonest criminals to tar each and every personal injury victim with the same brush. Put simply evidence does not seem to matter. The inventing of a simple phrase “compensation culture” and shoehorning every issue into that phrase is far more effective in dealing with the media and with politicians.

LOGIC

Lawyers are used to working with logic. Logic however plays little part in the political debate on these matters. The issues of whether premiums will
Why the honest lawyers are losing the “propaganda” war

The phrase “compensation culture”, which has been found definitively not to exist, is considered a “fact”, even being found in court judgments.

... go down or whether insurers will be monitored on their “promises” of decreased premiums is just ignored.

LITIGATION AND THE DARK ART OF LOBBYING
The only way of litigating is to be open and honest. Cunning has no place in the courtroom. Lobbying, on the other hand, is a much more subtle art. It involves a gradual campaign in the media and at the heart of government.

HOW DO WE RESPOND?
Firstly, and most importantly, we have to retain honesty. Secondly we have to recognise that there is a deliberate, sustained, well-planned and well-resourced strategy in place by the insurance industry. The people involved in this are good at what they do.

(1) A unified approach is essential. Claimant groups will never have the resources that insurers have.

(2) An immediate “response” team would help. The media cannot be allowed to get away with general and lazy assertions of a “compensation culture”.

(3) Questions should be asked about former civil servants who leave government and take up posts advising the insurance industry. There is always a suspicion that has undue influence upon past and future policy decisions.

(4) In addition to responding to the negative campaign that is being waged a positive message must be given. The honest claimant does not plan to get injured and having a received a cheque just wants to get back on with their lives.

The proposed reforms will effectively rob injured people of their right to damages and right to legal representation. This will have real and profound consequences for thousands of injured people. The surprising thing about the whole debate is that it is insurers that are succeeding in being portrayed as “victims”.

Finally, and as part of the process of retaining honesty, we have to recognise that there are a number of individuals who are dishonest. Fraudulent claims do exist.

However the fact that a minority of people are dishonest cannot be used as an excuse to deprive honest claimants of their rights.
Both the Insurance Fraud Taskforce (IFT) and the Personal Injury Working Group, whose recommendations were published alongside the Taskforce’s Final Report, held very interesting discussions and exchanges of ideas on issues relevant to insurance fraud and the perceptions and beliefs that can lead, as the Minister says in the Introduction to the Report, to “opportunistic fraud often undertaken by otherwise honest individuals.”

Much of this alleged opportunistic fraud is alleged to be in low value personal injury claims for whiplash, and as we now know, while the IFT and those of us on the Personal Injury group were having serious discussions about how to deal with fraud, the Government decided to legislate to put a stop to all low value whiplash claims, be they fraudulent, opportunistic or, as the vast majority are, the claims of people who have suffered a real injury which has had a real effect on their lives.

Although the final version of the Final Report suggests that the recommendations “reflect and support” the whiplash reforms, in fact the work of the IFT was largely completed long before the Autumn Statement, and it is reasonable to infer that a considerable amount of quick re-writing was done between 25th November 2015 and 18th January 2016 in an attempt to reflect Mr Osborne’s bombshell as though it had some relationship with the work of the IFT. Whilst the possibility of driving the cash incentives out of whiplash claims by removing general damages was discussed, it was specifically expressed to be seen by the insurer members of the PI Working Group as an ultimate long-term solution, and certainly was not one of the unanimous recommendations of the Group.

The membership of the IFT itself had a heavy insurer bias, but the stakeholder meetings extended to a more diverse group, and there were frank discussions at these meetings about the contribution insurer behaviour makes to a public perception that making an exaggerated or dishonest insurance claim is acceptable. The discussions covered the behaviour of insurers in selling wholly unsuitable products, in burying important policy terms and conditions in lengthy documents consumers are unlikely to read, in increasing premiums for existing customers on annual renewals on the basis that most policyholders will pay rather than query the premium or switch insurer, and in putting impossible evidential hurdles in the way when claims are made with a view to delaying payment and minimising outlay. I am not sure that it is particularly easy to draw clear moral distinctions between (a) making a claim for whiplash injury when you did not suffer injury (b) making a claim stating that you suffered for 6 months when in fact you had fully recovered after 6 weeks (c) accepting a pre-medical offer made by an insurer when you had not suffered injury at all or (d) taking money from a consumer for an insurance policy under which you as an insurer know you will never have to make a payment as it does not cover the risk the policyholder thinks he is insuring against.

It was to be expected that this report would focus on the insurer as a victim rather than perpetrator of fraud, but I would have liked to see a little more insight by insurers into the genuine contribution their behaviour makes to the way they are perceived by the public. The report uses very careful language about “poor understanding” by consumers, rather than, for example, misleading terminology in sales literature.

MASS said at the start that the IFT should be made up of a balanced group of claimant and insurer representatives. Reading the report, I think we were right.

The Government decided to legislate to put a stop to all low value whiplash claims, be they fraudulent, opportunistic or, as the vast majority are, the claims of people who have suffered a real injury which has had a real effect on their lives.
There was almost unanimous agreement that pre-med offers encourage the ‘have-a-go’ culture associated with fraud and we need an approach to settlement that encourages a fair outcome.
Claims for Psychiatric Injury

The moving testimonies at the Hillsborough Inquest, now in its final stages, provide a stark reminder of the devastating effect of psychiatric/psychological injuries on both primary and secondary victims.

How can we ensure that such injuries are properly pursued and evidenced in RTA claims?
Psychiatric injuries are more common than appreciated and can often be overlooked. Continuing social stigma means that claimants, particularly men, often put on a ‘brave face’, will not admit the extent of their symptoms and resist a diagnosis or treatment. We need to be alive to the possibility of psychiatric/psychological injury and the tell-tale features of it, from medical notes, personnel/occupational records and comments from friends/family members as to significant symptoms and personality change. Handled sensitively, even the most ‘macho’/resistant man may be persuaded that such injuries are normal/to be expected, no reflection on them and require diagnosis and treatment for their own sake and that of their family.

We should familiarise ourselves with the classifications/consequences of psychiatric injury in ICD-10 and DSM-5 and of treatments, whether by medication and/or ‘talking therapies’ such as cognitive behavioural therapy (CBT), usually involving a course of at least 12/up to 20 treatments on an out-patient basis.

Defendants historically relied on failures in effort testing (more accurately ‘symptom validity testing’ - ‘SVT’), to suggest that a claimant is exaggerating his/her symptoms or even malingering. However, individual experts and the British Psychological Society have long questioned the practice and interpretation of SVT, in that factors other than malingering and/or exaggeration may come into play; see the BPS survey in ‘The Clinical Neuropsychologist’, Volume 23, Issue 6, August 2009, 1050-1660.

Sadly, psychiatric/psychological injuries can have a negative effect on socialisation, daily functioning and employment capacity and also complicate the diagnosis, rehabilitation and treatment of physical injuries. It can be difficult to tease out the relative contributions of organic brain injury and continuing depression, being common after TBI (25-50% of cases), Loss of memory, concentration and motivation, sleep disturbance and irritability can either result from TBI (particularly frontal lobe dysexecutive syndrome), or a psychiatric/psychological illness, or both. By definition, the latter may be amenable to treatment, whereas the former is not. In Amy Verlander v Mohammad Rahman [2012] EWHC1026 (QB) an assessment of the relative contributions of frontal lobe brain damage, depression and psychological factors informed findings upon prognosis, residual earning capacity, support worker/case management assistance and mental capacity.

Section 4/pages 11-15 of the Judicial College Guidelines, 13th Edition sets out damages for PSLA, determined by impact upon socialisation, work and relationships and the prospects of successful treatment and prognosis. Heads of claim include treatment costs, earnings/pension loss, support worker/case management input and, in the event of a loss of capacity, Court of Protection/professional Deputyship costs, a sometimes neglected but usually substantial head. Witness evidence from friends and family, former colleagues and neuropsychological/neuropsychiatric experts’ reports will be crucial.

Note however that capacity is presumed until proven otherwise and that the test is ‘issue specific’; a familiarity with Sections 2 and 3 and the five key principles of the Mental Capacity Act 2005, the Act’s Code of Practice and the position of a Mental Capacity Advocate is desirable. See also the case of Folks v Faizey [2006] EWCA Civ 381 as to the non-adversarial nature of and limited threshold test in an application to appoint a litigation friend.

For a definitive decision on the Court’s approach to assessing retrospectively a Claimant’s capacity to settle, see the Supreme Court case of Joanne Dunhill v. Shaun Burgin [2014] UKSC 18. A brain-injured Claimant settled her case (worth £800,000) for £12,500 but nobody considered the issue of capacity. The settlement was of no effect.

Can a PPO for Court of Protection/Deputyship Costs be varied under Article 2 of theDamages (Variation of Periodical Payments) Order 2005 if a Claimant regains capacity? No, but see the case of AA (by his Mother and Litigation Friend, BB) v. (1) CC (2) MIB [2013] EWHC 3679 and the imaginative use of a Tomlin Order to remedy that difficulty.

Finally funding: what happens when a claimant’s psychiatric condition deteriorates during the course of litigation such that they lose capacity? Fortunately, some consolation is found in the Court of Appeal decision of Diann Blankley v. Central Manchester & Manchester Children’s University Hospitals NHS Trust [2015] EWCA Civ 18. The loss of the Claimant’s capacity did not terminate her CFA; the fact that a solicitor’s retainer was a personal contract did not mean that instructions had to be received from the claimant personally.

Chris Bright QC of No5 Chambers is a leading personal injury Silk with a national practice and a recent catastrophic injury lump sum/PPO award capitalised at £12m+. 

Chris Bright QC No5 Chambers
The law in relation to psychiatric injury has undergone considerable development over the past 25 years or so. The courts have always been mindful of the risk of opening the floodgates to claims from the large numbers of people who may be psychologically affected by, for example a major disaster to which they were witnesses as bystanders without being themselves at risk of injury, but following the Hillsborough Football Stadium disaster in 1989 the House of Lords was persuaded that the control mechanisms governing the basis on which those who suffer psychiatric injury without being exposed to risk of physical injury should be extended.

**Primary Victims**

Since Dulieu v White [1901] 2 KB 669 it has been recognised that a person who suffers psychiatric injury as a result of the reasonable fear of immediate physical injury can recover damages. They would be defined as a primary victim because they are put at risk of physical injury although not actually physically injured.

**Secondary Victims**

The secondary victim is someone who was never at risk of injury himself, but developed a psychiatric disorder as a result of the injury or death of someone else, generally a close relative.

**The Proximity Test**

The secondary victim must show (Alcock v Chief Constable of South Yorkshire Police [1992] 1 A.C. 310) that

- he had a close tie of love and affection with the victim
- he was present at the accident or its immediate aftermath
- the psychiatric injury was caused by the direct perception of the accident or its immediate aftermath and not by hearing about it from somebody else

which must ultimately lead to virtually limitless liability.

In Galli-Anderson v Seghal [2003] EWCA Civ 1792, where the victim’s mother attended the accident location but was not allowed to cross the police cordon and saw her daughter’s badly disfigured body only at the mortuary, it was held that the immediate aftermath “extended from the moment of the accident until the moment the appellant left the mortuary”.

Proximity is required at the time of initial accident and not simply at consequential events; see the case of Taylor v. A Novo UK Limited [2013] EWCA Civ 194. The recent case of Liverpool Women’s Hospital NHS Foundation Trust v. Ronayne [2015] EWCA Civ 888 reasserted the four qualifying control mechanisms, namely a close tie of love and affection, proximity to the incident in time and space, direct rather than indirect perception, and the illness induced by a sudden, shocking event. Sadly in that case, the relevant period of 36 hours did not involve “a seamless tale”, constituting one event, as in the case of Walters v. North Glamorgan NHS Trust [2002] EWCA Civ 1792, arguably the high point of recovery for secondary victims, and identified in Ronayne as an ‘exceptional’ case. See also the unfortunate rolling back of recovery in these cases in Owers v. Medway NHS Foundation Trust [2015] EWHC 2363 and Wells v. University Hospitals Southampton NHS Foundation Trust [2015] EWHC 2376.

These cases show how difficult it can be in practice to apply the test, but suggest that an important factor is the claimant’s physical proximity in both time and place to the accident.
generally speaking, a Claimant has to show a recognised psychiatric disorder in order to recover damages for psychiatric injury. The main classifications for a recognised disorder are set out in two diagnostic manuals for mental disorders: DSM-5 (published by the American Psychiatric Association) and ICD-10 (published by the World Health Organisation). However, both the DSM and ICD warn of using the classifications without considering the wider context. As a lawyer it is important to note the DSM introduction:-

‘In most situations, the clinical diagnosis of a DSM mental disorder is not sufficient to establish the existence for legal purposes of a mental disorder, disability, disease or defect... assignment of a particular diagnosis does not imply a specific level of impairment or disability’

The diagnosis itself needs to be forensically reviewed. Take as an example PTSD, which can be a debilitating condition. DSM-5 states that the trigger to the PTSD must be 'exposure to actual or threatened death, or serious injury’. Does the Claimant involved in a minor RTA meet that test? Many less serious psychological conditions or stressors are often misdiagnosed as PTSD.

It is also important to differentiate between a working diagnosis of PTSD by the therapist for treatment purposes and a formal, medico-legal diagnosis of PTSD.

For significant claims it should be born in mind that the DSM-5 definition of PTSD specifically requires the expert to rule out malingering in a medico-legal context. The expert should be invited to comment on:-

- Any failing to provide the expert with key information.
- Any exaggerated information to the expert by comparison with other evidence.
- Inconsistency in accounts between that given to the expert, treating doctors and in witness evidence

In putting questions to the expert reference should be made to the entries/lack of entries in the medical records, personnel records, occupational health records and DWP records.

When assessing or valuing the claim, the diagnosis needs to be considered in context and it is crucial to look at the symptoms in respect of:-

- Severity and duration.
- Attendances at GP/treatment sought.
- Ability to cope with work and life.
- Any past history and future vulnerability.
- Effect on relationships.

It is also important to consider all aspects of the claim, not just the medical evidence. It is not uncommon to see a medical report being produced, where the expert diagnoses PTSD/travel anxiety and to then find the Claimant has hired a car post accident and travelled 1,000 miles in two weeks.

An area of concern is the number of infant claims being presented, where there is no injury and no recognised psychiatric condition. Though these claims do not qualify for compensation, they are pursued nevertheless.

Secondary victims are subject to policy 'control mechanisms' and must prove:-

- A close tie of love and affection with the victim.
- Proximity to the incident in time and space.
- Perception by sight or hearing of the incident.
- The psychiatric injury must be induced by a 'shocking event'.
- Unlike primary victims, secondary victims need to prove that psychiatric injury itself was reasonably foreseeable.

Whether or not a secondary victim satisfies these criteria to recover damages is a question of fact in each individual case, taking all the factors above into account. However, the more shocking and tragic the event, the more sympathy the court is likely to have for the Claimant. One particular area that is often overlooked is that it must be the shocking nature of the event that causes the psychiatric injury. Grief alone is not compensable.

It is trite law that the normal human emotional response following an accident, falling short of recognisable psychological or psychiatric injury does not of itself give rise to damages.
The more we understand mental health, the more blurred the line between psychological and physical symptoms becomes.

Psychological diagnosis is based on lists of symptoms (criteria) set out in one of the two diagnostic manuals - DSM 5 and ICD-10. Psychologists generally prefer the former; UK psychiatrists the latter. Psychiatrists are doctors who specialise in mental illness; Clinical and Counselling Psychologists (generically entitled Practitioner Psychologists) are psychologists who specialise in mental health.

Despite these detailed criteria lists (DSM's has 947 pages; ICD-10 a mere 369), we can only advise the court on the basis of symptoms reported by the Claimant. Using psychological tests for diagnosis in the legal setting is questionable. They are mostly designed to measure longitudinal treatment response; they are not definitive diagnostic tools.

Furthermore, Claimants tend to report how they were immediately following the accident rather than how they are at the clinical interview (probably conducted several months later). Test results can present a confusing picture and, in my opinion, risk wasting the court's time. So, for the psychologist and psychiatrist, it really is down to good old clinical judgement, as is assessment of severity (Mild-Moderate-Severe-Extreme).

ANXIETY
Anxiety diagnoses in road traffic accidents commonly range from Travel Anxiety (an informal diagnosis) through to Specific Phobia (Car Type); Panic Disorder, and PTSD. Adjustment Disorder is often used where the full symptom criteria for PTSD is unmet. PTSD is diagnosed where the Claimant persistently re-experiences the accident through flashbacks and nightmares. This re-experiencing can present somatically (headaches or gastric upset being common). The onset can be delayed for months and occasionally years. In children, it often presents as repetitive play and/or enuresis. Secondary symptoms include sexual dysfunction (particularly in adult males); alcohol/drug use, and errant behaviour.

Anxiety conditions can restrict or preclude a Claimant from work; travelling; it can exacerbate pain; interrupt memory/concentration (when instructing Solicitors/Counsel) and prevent Claimant's accessing proper treatment. Prognosis varies, though generally responding well to psychotherapy.

DEPRESSION
The diagnosis of Major Depressive Episode (MDE) comes with descriptors-single episode (accident related); Recurrent (pre-existing but may have relapsed due to accident). The accident's disruption of normal functioning (sleep, work, family role, hobbies) is a common trigger. Again, Adjustment Disorder (With Depressed Mood) is used where the full criterion is unmet.

MDE restricts occupational, familial and leisure functioning, either fully or partially. Depression exacerbates pain and can restrict rehabilitation. It can be accompanied by suicidal ideation, psychosis and at its worst, requires urgent hospitalisation.

Prognosis can be poor, with Claimants' left highly vulnerable to relapse, particularly when accompanied by chronic pain and loss of role. The efficacy of antidepressants has recently received strong criticism.

THE PSYCHO-SOMATIC INTERCHANGE
The more we understand mental health, the more blurred the line between psychological and physical symptoms becomes. This can be an area that the Courts find difficult to understand, particularly in cases involving chronic pain, where the levels of pain and disability reported by the Claimant are not congruent with the medical evidence. People with depression and anxiety experience higher pain and more disability. Conversely, chronic pain causes depression and anxiety. The relevant diagnoses are;

- Somatic Symptom Disorder;
- Adjustment Disorder;
- Illness Anxiety Disorder
- Anxiety Disorder due to another medical condition.

Of course almost any pre-existing mental health condition, and many medical conditions, can be exacerbated by the shock of a road traffic accident or can trigger a relapse. It has been shown for example, that previous episodes of PTSD have a kindling effect, vastly increasing the likelihood of PTSD being triggered by subsequent traumatic events.

In summary, psychological and psychiatric diagnosis relies on the subjective opinion of the clinician working within the parameters of published criterion. It guides treatment and provides evidence based prognosis.
Repeated evidence has shown that involvement in a road traffic accident can have a significant psychological impact regardless of the level of physical injury. Matching the treatment to the individual is paramount, and that severity of symptoms is never the one issue.

Individuals can experience flashbacks, nightmares and significant alteration to normal behaviours.

Perceptions vary on psychotherapy and different treatment approaches will suit each individual’s situation and expectations. Psychological assessment should always consider the nuances of the individual in developing a bespoke treatment approach to treat the individual in the most successful, timely and cost effective way.

Even low impact collisions can have a significant psychological impact, leading to irritability, low mood, disturbed sleep and reduced interest in activities. Up to 20% of individuals experience post-accident stress symptoms. The higher the level of distress during and immediately after the accident produces more severe post-traumatic stress symptoms including anxiety and clinical depression. Individuals can experience flashbacks, nightmares and significant alteration to normal behaviours.

Some experience of these symptoms is considered normal and will resolve naturally, however, prolonged symptoms, experienced by around 10% of individuals, can be indicative of a post traumatic stress disorder (PTSD).

Counselling alone has been suggested to be ineffective when attempting to deal with the more serious symptoms of PTSD (National Institute of Health and Clinical Excellence – NICE) and more focused psychotherapeutic input is indicated. Treatment may take the form of Cognitive Behavioural Therapy (CBT), Eye Movement Desensitisation and Reprocessing (EMDR), Mindfulness Based Cognitive Therapy (MBCT) or a combination of these treatment approaches. CBT was initially developed as a treatment for depression but is now used more widely to treat many psychological symptoms. CBT practitioners use various techniques to modify negative thought processes to impact on both mood and behaviour. CBT is largely the treatment of choice within the NHS. It has been demonstrated to be effective and can often be delivered remotely, making use of telephonic support and video conferencing. CBT is routinely delivered in one to one sessions, however, some self-help techniques can be adapted to be delivered to groups.

It does need a high degree of engagement from the individual who needs to continue with exercises in their own time. Effectiveness can be hindered by a negative perception of EMDR is particularly well suited to the treatment of PTSD symptoms. It is often recommended in conjunction with more traditional CBT as a supplementary treatment. EMDR can be more effective for those less willing to engage with CBT.

EMDR practitioners suggest that the memory of traumatic or disturbing events can overwhelm the individual and impact on normal coping mechanisms, affecting their ability to cope in situations previously not difficult. EMDR calls for the individual to focus on these disturbing memories whilst receiving bilateral visual stimulation. It has been found that the resulting eye movement has a significant impact on the distress associated with these memories.

The biggest criticisms of EMDR is the lack of long term data related to its effectiveness and that researchers who have studied the treatment cannot be certain why it works, yet treatment has clearly been effective for many. MBCT is growing in popularity, particularly in the corporate world. Mindfulness is often marketed as a way of life rather than a psychotherapeutic tool and it has been effective in treating depression. In the case of repeated depressive relapse, it has been shown to be more effective than CBT.

Mindfulness focuses awareness on the present moment while acknowledging and accepting feelings and physical sensations, without attempting to change these. CBT therapists often interweave their treatment with the principles of mindfulness, however MBCT can be delivered as a separate treatment, offering the added benefit of being deliverable to groups of people as well as individuals.
MASS Matters

MASS Training – Upcoming Courses

Following the success of our Credit Hire Seminar last November we are running another one! This time focusing on witness statements and court perceptions whilst also looking at the cases of McBride, Clayton and Sobrany

We will be back in Manchester on Wednesday 13th April 2016.

The pace of change continues to gather momentum in the personal injury world with different costs regimes now running side by side, making costs recovery more complicated than ever. As a result there are many new pitfalls for the unwary. With this in mind we have decided to run a Costs Update Seminar in four different locations.

Leeds on Tuesday 19th April
Birmingham on Wednesday 20th April
Manchester on Wednesday 27th April
London on Thursday 28th April

For more information on our courses, please, check out our website www.mass.org.uk

BIRT – MASS Charity for 2016

Jane Loney

MASS is delighted to be supporting the Brain Injury Rehabilitation Trust (BIRT) and recently myself and committee member Roger Henderson, were delighted to present a cheque for £9,640, raised by MASS Members in 2015.

After personally visiting the Woodmill Centre in Devon, I was amazed and humbled by the incredible work they do and the dedication and care provided to all who are resident with an acquired brain injury. Not only do they attend to the basic physical and care needs, they also provide learning activities like art and pottery classes, the results of which were amazing. As the service users improve the centres are equipped with facilities to help them reintegrate into a home and family environment through learning how to do the basics in life like making a cup of tea!

Ann Buckler (Director of BIRT) said; “We were delighted, surprised and humbled by the generosity of guests at the MASS Conference Charity Dinner and throughout the year. The donations will be used to support adults with acquired brain injury through our network of BIRT services across the UK.

We have big plans for 2016 – which will mark BIRT’s 25th Anniversary and would like to thank everyone who showed BIRT such generosity.”

I appreciate that firms often support specific charities that they may have an affinity to, but I would urge as many as possible and their staff to do whatever they can to raise still more for BIRT during 2016 – you can be assured that all money raised will go to an excellent charity.

Member Benefits

We have recently added a new ‘benefit’ to the portfolio of discounted schemes that are available to MASS Members.

All these schemes have been negotiated on your behalf and we encourage you to take advantage of them. Most of the schemes are business orientated to enable you to not only support accident victims but also assisting with operating a cost effective and viable business. All schemes can be found on the MASS website on:

http://mass.org.linux.rh-temp.co.uk/solicitors/membership-benefits/discounted-schemes/

Moving forward, we are looking towards developing an experts database which will be available via the members area of our website. We recognise that sourcing appropriate experts can be a minefield and we are looking to provide a ‘Gold’ standard information source of ‘trusted’ specialists.
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With fixed costs the topic of the moment, any decision around allowing costs on an hourly rate basis by way of an indemnity basis order is likely to be met with anticipation. With the conflicting county court decisions of *Smith v Taylor* (unreported, 9 November 2015) and *Dixon v Bennett* (unreported 23 December 2015), the court of appeal will be considering the issue later on this year.

The point centres on the interplay between the fixed costs rules under CPR 45 and CPR 36.21 with the point being taken that it was clearly Parliament’s intention not to limit a claimant who beats a Part 36 offer where fixed costs apply otherwise, an indemnity basis order would be rendered useless.

However, clearly this point has yet to be decided definitively although the future direction of this will inform tactics around dealing with fixed costs cases going forwards.

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**Case Watch**

**Paying the right court fee – Lewis and others v Ward Hadaway (a firm) [2015]**

With the increase in sums payable to the court on issuing a claim, fees have been a focus for claimants since the rise in April last year.

The High Court held that to try and avoid paying the correct court fee by deliberately understating the value of the claim is an abuse of process and the case becomes capable of being struck out.

The defendant in Lewis applied for orders to strike out 30 negligence claims where claimants had suggested in correspondence exchanged pre-action that their cases were worth hundreds of thousands of pounds yet upon issuing, the value of these cases were significantly lower.

11 of the claimants were dismissed by the court granting summary judgment due to limitation; the remaining cases were spared from being struck out with a clear message on paying the correct fee when issuing a case.

**Fixed costs and indemnity orders under Part 36**

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**Part 36 and the “near miss” rule - Sugar Hut Group v AJ Insurance Service [2016]**

Following a High Court decision on Part 36 offers, the Court of Appeal considered the “near miss” rule on whether a Claimant beating an offer by a margin of 10% was sufficient to deprive the claimant from costs following the offer (see *Carver v BAA* [2008]).

Consistent with changes to the Part 36 rules clarify the position, the Court of Appeal made it clear that a Claimant beating an offer by any margin would avoid costs sanctions and therefore the Claimant in this case should not be deprived of costs following the offer in question.

This is a useful reminder on what position the court should be taking on Part 36 offers. So long as a Part 36 offer has been beaten by any amount, the court should award costs following the event. Any decision to the contrary goes against recent cases like this and the intention of Jackson following his 2013 reforms.
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