



FARRAR'S BUILDING.

Personal Injury Newsletter

June 2017

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Farrar's Building News

Huw P. Davies, Editor



Happy Summer!

I would like to invite all our readers to attend the upcoming chronic pain seminar hosted by Farrar's Building on 15th June at the London Transport Museum in London.

Two medical experts, Dr Dinshaw Master and Dr Rajesh Munglani will be joining Nigel Spencer Ley in a discussion about chronic pain and the current issues surrounding what is becoming an increasing feature of personal injury litigation. Further details can be found at <http://www.farrarsbuilding.co.uk/experts-forum-chronic-pain/> or alternatively contact Steve Gurnett in Chambers if you would like to attend.

In this edition of the newsletter consideration is given to some of the practical consequences of the recent seismic change to the discount rate. Nigel Spencer Ley considers what is to happen to Roberts v Johnstone calculation, Andrew Wille looks at Periodical Payment Orders whilst Hannah Saxena ruminates upon the effect upon pension claims.

Case Law Update

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Perhaps on a slightly more esoteric point, I've provided an article on the question that keeps many practitioners awake at night, namely whether discrimination claims brought under the Equality Act benefit from QOCS protection.

Our two pupils, Laura Fitzgibbon and Tom Emslie-Smith provide a case law update of the more recent cases of interest in the last few months.

Roberts v. Johnstone: a new accommodation

by [Nigel Spencer Ley](#)



Amid apocalyptic warnings from insurers as to the impact of the change in the discount rate, there is one small piece of good news for defendants: if the method for calculating damages for the additional capital cost of new accommodation set out in ***Roberts v. Johnstone*** [1989] 1 QB 878 is applied strictly, a claimant purchasing more expensive accommodation as a result of his disability will have to pay damages to the defendant.

Can that really be the law? The purpose of this article is to see where the rule in **RvJ** now stands with a negative discount rate, and to suggest some possible solutions.

The problem

The logic underlying lump sum awards of damages for future loss is that the award should gradually be used over the claimant's lifetime so that by the time he dies it has reduced to zero. In practice of course this will never be achieved. A claimant's individual life expectancy is always likely to differ from the statistical average, and investments will almost always do better or worse than initially predicted.

Badly-injured claimants may often need a larger house in which to live: for example to make space for wheelchairs, physiotherapy equipment and accommodation for carers. Let us assume that in a particular case the additional purchase cost is agreed at £250,000. Why

shouldn't the claimant simply receive damages of £250,000 to cover this head of loss? The answer is that this would offend against the logic underlying awards set out above. When the claimant died, the value of the damages invested in the property would not have reduced to zero, but would likely be worth at least the additional purchase price, and possibly a great deal more. The claimant would therefore have been over-compensated, and his estate would receive a windfall.

The solution in RvJ

RvJ was an unusual cerebral palsy claim. The claimant had suffered severe brain injuries at birth as a result of a haemolytic disorder due to the failure to provide appropriate treatment to her mother during pregnancy. She was very disabled (both physically and mentally) and would require constant care throughout her life. The demands of caring for her proved too much both for her parents and a first set of foster parents. She was eventually adopted by a second set of foster parents who already had a disabled son.

At first instance total damages of £334,769 were awarded¹. The claimant sought total damages of £96,784 in respect of accommodation: £68,500 for the additional cost of purchasing a bungalow, £38,284 for the cost of converting it, less £10,000 for betterment following conversion. The trial judge, applying the earlier Court of Appeal decision in **George v. Pinnock** [1973] 1 WLR 118, awarded only £28,800 (quite how he reached this figure is far from clear, but it included a further deduction to reflect the fact the new bungalow had a nicer garden and was in a more desirable residential area than the foster parents' previous home). The claimant appealed. In **George v. Pinnock** the court suggested that the solution to the problem was to award the notional mortgage interest costs on the additional sum needed for the purchase. On appeal the claimant pointed out that as mortgage interest

¹ Adjusted for inflation (RPI) the award would now be worth £921,369. A claimant today (even before the change in the discount rate) would expect to receive damages of many millions of pounds.

rates were then 9.1% per annum, using this approach would actually result in greater damages than awarding the full additional capital cost. It was argued that in these circumstances the full additional capital cost should be awarded.

The Court of Appeal disagreed. The loss to the claimant was being forced to tie up her capital in property rather than being free to invest it how she pleased. Had she been free to invest the capital elsewhere, a safe investment would have produced an income of 2% per annum above the rate of inflation. The court therefore awarded 2% per annum of additional cost of the bungalow, on the lifetime multiplier. The conversion costs were awarded in full, less the conceded £10,000 for betterment. The new total award was £50,204. No deduction should be made for the fact that the new property was more pleasant than the old one, where the purchase was reasonable.

This decision was hailed in Kemp & Kemp as “*a satisfactory and elegant solution*” and it has remained the basis on which accommodation claims have been pursued ever since. The reasoning of the decision was specifically endorsed by the House of Lords in ***Thomas v. Brighton Health Authority*** [1999] 1 AC 345. It has however been subject to regular criticism as it leaves claimants with a short life expectancy badly undercompensated. In **Thomas** the House of Lords increased the annual rate to 3%, however stated that in future the rate should be determined by reference to the rate set by the Lord Chancellor under the Damages Act 1996.

A new approach: arguments for claimants

It is clear that a new approach is required. Say a claimant aged 30 with normal life expectancy needs an additional £250,000 to buy a suitable property. Applying **RvJ** means that the award should be minus £133,931 ($£250,000 \times -0.75\% \times$ lifetime multiplier of 71.43).

It cannot be right that a claimant who has a real financial need as a result of the defendant's negligence has to pay damages to the defendant. In the circumstances it should be contended that **RvJ** should not be followed at a time when there is a negative discount rate set under the Damages Act.

Thus far the argument is strong. However how should the court now assess claims for additional capital cost? The following are possible solutions:

(1) Full capital cost, with or without a charge in favour of the Defendant

The boldest submission would be that the court should simply award the full additional capital cost. This argument is unlikely to succeed (and indeed has already been rejected - see below). The courts will remain instinctively uncomfortable in making an award which will inevitably result in a substantial windfall to the claimant's estate. In any event as **RvJ** was a decision of the Court of Appeal and has been endorsed in the House of Lords, a fundamental change of this sort would require a visit at least to the Court of Appeal, and probably to the Supreme Court.

Another solution would be to seek the full additional capital cost, but make the property subject to trust in favour of the defendant, so that when the claimant dies the property would be sold and the defendant would receive that proportion of its value to which it initially contributed. This also creates difficulties. It forces insurers to become long-term investors in property against their will. If the claimant has dependants when he dies, they would be forced to sell their home.

(2) Notional (or actual) mortgage interest

A better argument may be to go back to **George v. Pinnock**. Although the Court of Appeal took a different approach in **RvJ**, the decision in **George** was not specifically overruled. There is therefore a strong argument that it remains good law and can be followed by the lower courts. In **George** Orr LJ said this (my emphasis):

“For the plaintiff it has been contended, in the first place, that she should receive as additional damages either the whole or some part of the capital cost of acquiring the bungalow, since it was acquired to meet the particular needs arising from the accident. But this argument, in my judgment, has no foundation. The plaintiff still has the capital in question in the form of the bungalow.

*“An alternative argument advanced was, however, that as a result of the particular needs arising from her injuries, the plaintiff has been involved in greater annual expenses of accommodation than she would have incurred if the accident had not happened. In my judgment, this argument is well founded, and I do not think it makes any difference for this purpose whether the matter is considered in terms of a loss of income from the capital expended on the bungalow or in terms of annual mortgage interest which would have been payable if capital to buy the bungalow had not been available. **The plaintiff is, in my judgment, entitled to be compensated to the extent that this loss of income or notional outlay by way of mortgage interest exceeds what the cost of her accommodation would have been but for the accident.**”*

The argument should therefore be that the claimant is entitled to the annual notional cost of mortgage interest payments on the additional cost of the property (or better still actual interest if a mortgage could be arranged).

The immediate problem with this approach is that it may produce an award in excess of the capital cost. Using the example above (£250,000 capital cost, claimant aged 30) if the typical

variable mortgage interest rate is currently 3% per annum, the award (using the new lifetime multiplier) would be £535,725 – i.e. more than double what the claimant actually needs to purchase the property.

A possible solution to this problem is to make the award on a periodical payment basis, namely £7,500 per annum for life.

(3) Rental costs

A claimant could seek to rent suitable property and claim the additional rental cost. While this approach has always been open to claimants, in reality it will be very hard to find either properties which have already been adapted for the claimant's precise disability, or landlords willing to allow their tenants to make such adaptations.

While a claim could in theory be based on the notional additional rental costs of the house purchased by the Claimant, compared with the rental value of his previous accommodation, this approach feels very artificial.

A new approach: arguments for defendants

The simple argument for the defendant is that **RvJ** remains the law and should be followed. Therefore if the claimant pursues an accommodation claim he should give credit against the recoverable items (e.g. conversion costs, moving costs, additional running costs etc.) for the benefit he will receive in having in property an asset which is likely to go up in value rather than down. So using the example above, the damages should be reduced by £133,931.

This is unlikely to succeed: the claimant has a real financial need at the time of trial, and any possible benefit at the end of his life will not be enjoyed by the claimant but by his estate. The claimant cannot cash in the benefit as he will always need somewhere to live.

A better argument for defendants is that in a time when safe financial investments produce a negative return, a claimant who is forced to invest in property has suffered no loss. Therefore no award should be made for any additional capital cost. This approach applies the reasoning of **RvJ** to the particular economic circumstances in which the country now finds itself. My suspicion is that until we have guidance from the appellate courts, this is the approach most likely to find favour with judges (see below).

JR v. Sheffield Teaching Hospital [2017] EWHC 1245

This is the first High Court decision to address the issue of accommodation in the light of the new discount rate.

The Claimant contended for the full additional capital cost of the accommodation required.

The Defendant argued that in the present economic situation (which is reflected in the new discount rate) a Claimant had no ability to obtain any positive return on a capital fund based on risk-free investment. This meant that there was no need to compensate the Claimant for the loss of that return. It therefore followed that no award should be made.

Davis J held that he was bound by the decision in **Roberts v. Johnstone** and made no award for the additional capital cost.

In his judgment he did however refer to the possibility of an award based on based on mortgage interest, or an award of the capital cost with a charge in favour of the Defendant.

However in the absence of evidence as to mortgage costs (which the Claimant did not adduce), or any proposal from the Claimant for a charge or reversionary interest in favour of the Defendant, he could not consider such alternatives.

The Judge gave permission to appeal and suggested that a hearing on the accommodation point should be expedited.

Periodical Payment Orders

by [Andrew Wille](#), Barrister



With such turmoil in the world of lump sum compensation, how will the parallel PPO regime be affected? Will claimants abandon PPOs in favour of handsome lump sums? Will insurers become more enthusiastic about them for the same reason? If so, is there a prospect of the courts being persuaded to impose PPOs on unwilling claimants? If not, will the government intervene to prop up PPOs by statutory or regulatory reform?

PPOs under the old discount rate

PPOs got off to a slow start, but their popularity with claimants increased once the indexation arguments were resolved in their favour.² PPOs have had particularly good uptake by the NHSLA, which budgets annually and prefers to avoid the short-term impact of large lump sum settlements. By 2013 the NHSLA had submitted to 643 PPOs.³ It is currently responsible for more than 50% of all PPOs issued.⁴ The MIB has also been enthusiastic, for similar reasons.

Amongst motor insurers there has been less enthusiasm. Uptake has been greater in the largest cases. Most (60%) motor claims over £5m settle by PPO. This is probably because claimants have insisted upon PPOs in these cases in order to fund high future care costs. In

² *Flora v Wakom (Heathrow) Ltd*[2007] 1 W.L.R. 482 and *Thompstone v Tameside and Glossop Acute Services NHS Trust*[2008] 1 W.L.R. 2207.

³ *RH v University Hospitals Bristol NHS Foundation Trust* [2013] EWHC 229 (QB)

⁴ *The Discount Rate*, Consultation Paper 2017, para 98

smaller motor claims the uptake has been markedly lower (only 20% in the £1m-£2m bracket).⁵

The evidence suggests that motor PPOs as a whole have been in decline since a peak in 2010-12 (from 80+pa in 2010-12 to nearer 50pa in 2014-15).⁶ This probably reflects insurers' determination to settle cases on a lump sum basis, as the high discount rate has meant that lump sum compensation has been cheaper for most insurers in recent years than the financial reserve required to offset PPO liabilities.

PPOs under the new discount rate

The changed incentives for claimants are obvious, and have been acknowledged by the government:

*"...there must be an expectation that the decrease in the rate will make lump sums larger and more attractive to claimants. Whether they will be sufficiently attractive to claimants as to overpower their present reasons for choosing PPOs, particularly in cases of life long injuries to a person without any independent mental capacity, will only become clear with time."*⁷

In the short-term there has been a downturn in large claims settling whilst both sides take stock of what the changed discount rate means for them. It is likely that a stronger claimant preference for lump sums over PPOs will emerge in the context of such a low discount rate, compounded by:

⁵ *The Discount Rate*, Consultation Paper 2017, para 102

⁶ *Update from the PPO Working Party*, Institute and Faculty of Actuaries, 21st June 2016

⁷ *The Discount Rate*, Consultation Paper 2017 para 108

- (i) The potential disappearance of *Roberts v Johnstone* awards, meaning that any capital expenditure on accommodation will have to come from other parts of the lump sum compensation;
- (ii) An ASHE 6115 index that has been trailing rather than outstripping RPI since 2010.

Nevertheless, it is expected that some claimants with extensive care needs will continue to be advised to use PPOs, given the uncertainties of investment returns (minimal interest rates, Trump, Brexit etc), and given the unique linkage of PPOs (via ASHE) to the real cost of claimants' real future care needs.⁸

Defendant attitudes might be expected to change in the reverse direction. This change may not, however, be universal. Some insurers value their PPO liabilities differently from others. Insurers are required to set reserves for their PPO liabilities. They quantify such reserves by reference to their own discount rate, i.e. the net return that they project to achieve on a low risk investment over and above inflation. This requires an assumption to be made in respect of (a) investment return (typically 4%, but ranges from 2% to 5%) and (b) inflation (for ASHE 6115 this is typically 3.5%, but ranges from 2.5% to 4.5%).⁹ The net (real) discount rate across the industry therefore varies widely (from -1.5% to 1.0%) but is typically in the region of **0%**.

What does this mean? Insurers' actuaries may now advise PPOs over lump sums in the catastrophic cases. A lump sum valued by reference to a 2.5% discount rate was almost always preferable for an insurer to a PPO liability (valued by reference to a 0% discount rate). By contrast, a lump sum valued by reference to a -0.75% discount rate may be regarded as marginally less desirable for insurers than a PPO.

⁸ *The Potential Premature Demise of PPOs for Care in a Negative Discount Rate World*, Richard Cropper, 21st April 2017: "In respect of the single most important need for a claimant, future care, even if this discount rate sustains, there remains a place for periodical payments."

⁹ *Update from the PPO Working Party*, Institute and Faculty of Actuaries, 21st June 2016

The actuaries' advice may prove difficult for insurers to swallow, however, given a habitual dislike of the open-ended nature of PPO liability (echoed by reinsurers) coupled with the administrative burden of running them.

In practice, the short-term strategy will surely be to defer quantum hearings and settlements where possible until the long-term future of the discount rate is known. Preliminary trials of liability and contributory negligence are likely to be canvassed, with quantum issues being deferred.

Court's approach where parties disagree as to suitability of a PPO

Given the prospect that some insurers (and certainly the NHSLA and the MIB) will now be pushing for PPOs, whereas more claimants will be pushing for lump sums, how will this conflict be resolved by the courts?

The relevant statutory provisions which give the court a discretion to award periodical payments are contained in Sections 2 and 2A of the Damages Act 1996. In summary:

- s.2(1)(a): a court awarding damages for future pecuniary loss in respect of personal injury may order that the damages are wholly or partly to take the form of periodical payments
- s.2(1)(b): a court must consider whether to make such an order when awarding damages for future pecuniary loss in respect of personal injury
- s.2A(1): the CPR may require a court to take specified matters into account in considering whether to order periodical payments.

The relevant provisions in the CPR are set out in Part 41 . In Rule 41.7(b) it is provided that:

"When considering ...

(b) whether to make an order under section 2(1)(a) of the 1996 Act, the court shall have regard to all the circumstances of the case and in particular the form of the award which

best meets the claimant's needs, having regard to the factors set out in the practice direction.”

The Practice Direction to CPR Part 41B provides at para. 1 :

“The factors which the court shall have regard to under rule 41.7 include—

(1) the scale of the annual payments taking into account any deduction for contributory negligence;

(2) the form of award preferred by the claimant including—

(a) the reasons for the claimant's preference; and

(b) the nature of any financial advice received by the claimant when considering the form of award; and

(3) the form of award preferred by the defendant including the reasons for the defendant's preference.

Attempts by defendant insurers to persuade the courts to impose PPOs upon unwilling claimants have not fared well thus far. In **Thompstone** the Court of Appeal indicated that it would only be in a rare case that the defendant should argue that its proposals will meet the claimant's needs better than the proposals being advanced by the claimant; or be given permission to call its own independent financial adviser.¹⁰

Nonetheless it is clear from PD 41B, and was acknowledged by the Court of Appeal in **Thompstone**¹¹, that when the court is itself choosing what order to make and the parties are not in agreement, then the defendant's preferences must be considered. The

¹⁰ [\[2008\] 1 W.L.R. 2207](#) at [110] to [112]

¹¹ [122]

defendant's preferences are relevant so far as they go to relevant matters, in particular which form of order will best meet the claimant's needs.

If claimant IFA reports come out against PPOs, defendants may wish to reconsider commissioning their own, notwithstanding the discouraging comments of the Court of Appeal. After all, there is substance in the submission that the settlement which 'best meets a claimant's needs' is one which is coterminous with his life span. As per Swift J:

*"the 'once and for all' approach frequently results in over- or under-compensation. The multiplier is calculated by reference to average life expectancy which may have little bearing on the actual life expectancy of the individual claimant concerned. ...a claimant may survive longer than expected, in which case his damages may be insufficient to meet his needs during the last years of his life. Investment returns will vary according to an individual's investment strategy and the economic conditions prevailing at the time. The returns may alter from those anticipated at the time of trial or settlement, and costs which were estimated at rates current at the trial date may increase significantly thereafter."*¹²

Taylor v Chesworth & MIB [2007] EWHC 1001 (QB) is an example of a case where the court did impose a PPO upon an ultimately unwilling claimant. Interestingly this was done notwithstanding:

- 25% reduction for contributory negligence
- C's care needs were variable or 'lumpy'
- C's financial adviser (Richard Cropper) cautioned against a PPO (at that time the indexation arguments had not been resolved)

One (non-determinative) factor that was taken into account was the MIB's preference:

¹² *Thompstone* [2006] EWHC 2904 (QB) at para 15

“...the fact that the MIB is acting under agreements with the Government to fulfil an important part of the Government's obligations in relation to motor insurance under European law, gives the MIB's preference added weight. The reason for the preference relates to the manner in which the MIB is funded on an annual basis by a levy on insurers who underwrite motor insurance. I accept that by spreading payments over a longer period, there will be a more equitable impact in any one year on the insurer members and those members of the public who pay premiums. This, again, I consider is a valid reason based on policy and not affordability and it has weight.”¹³

Ramsey J's solution was a PPO which catered for the baseline care needs, whilst spikes in need were to be provided for by way of a lump sum. This hybrid approach to future care may become more common.

One strategy that clearly is within the control of defendants is the way in which their Part 36 offers are put forward. In recent years insurers have dangled tempting lump sum offers in order to encourage lump sum settlements. Now that insurers' attitudes are expected to be more ambivalent, it is likely that more defendants will resort to offering PPOs by way of Part 36, therefore putting more pressure on claimants to give serious consideration to such settlements.

The Government's Response

The government is concerned that the new discount rate will see PPOs fall off a cliff edge. Given that the government stands behind the single largest payer of PPOs (the NHSLA) it has a direct interest in preventing this from happening. Hence PPOs form an important part of the current consultation. The options put forwards are:

¹³ Ramsey J at [160]

- (i) Wait and see: the government is clearly reluctant to do so for fear of allowing *“problems to develop that could be avoided by prompter action.”*
- (ii) Change the rules of court or guidance (i.e. the CPR and PDs) so as to ‘clarify’ when the discretion should be exercised (for which read encourage increased exercise of the discretion in favour of PPOs). A concern expressed here is whether such changes would be effective given that most cases settle. *“A means may need to be found to influence the decisions made at an earlier state of the process”*. It is not clear what is contemplated here, given that the Courts are already required by CPR r.41.6 to express a view on the suitability of a PPO *“as soon as practicable”*;
- (iii) Alter the legislation (i.e. amend the 1996 Act) so as to Create a rebuttable presumption in favour of PPOs for long-term financial loss (e.g. losses extending for 15 yrs or more; perhaps restricted to future care needs);
- (iv) Require the Court to order a PPO wherever a secure PPO is available (perhaps restricted to future care needs; perhaps subject to the defendant wishing to provide compensation in this way). This last is the most radical proposal and clearly runs contrary to the current CPR and the case law. It may find opposition within the insurance industry as well as amongst claimants.

What will happen? Nobody knows. Options (i) and (iv) seem distinctly unlikely. Option (iii) is a possibility. Option (ii) – rule change – is perhaps the most likely, given that it does not require primary legislation and as it would leave the discretion in the hands of the judiciary, albeit subject to more directed guidance.

Pension Claims: The Impact of the New Discount Rate



By [Hannah Saxena](#)

Final salary pension schemes

Background to calculation of final salary pension loss claims

Pension loss claims are intended to compensate the claimant for the prospective loss that is forecast to occur at the date of retirement but capitalised at trial/settlement following the injury.

In ***Auty & Others v National Coal Board*** [1985] 1 W.L.R 784 the Court of Appeal set down a process for calculating pension loss where the claimant had a final salary pension scheme:

1. Gross value of the pension loss is calculated ignoring inflation.
2. The capital sum is discounted for accelerated payment – this is the number of years between settlement/trial and the intended retirement age by a rate of between 4% and 5%.
3. There is then a further discount to cover the contingencies during the claimant's working life (i.e. risk of death, accident, disablement, illness, redundancy or dismissal between the date of trial/settlement and retirement). This was 27% in ***Auty***.

Since ***Wells v Wells*** [1998] 3 WLR 329 the approach set out in ***Auty*** has moved on and judges are now very familiar with using the Ogden tables to calculate future loss, although ***Auty*** has never been overruled. The discount rate set at 2.5% alongside Tables A to D

which provide discount factors for contingencies other than mortality has since provided a much more precise mechanism of calculating pension loss.

The standard method for calculating pension loss in a final salary scheme has been as follows:

- Work out the annual loss of pension from the intended retirement date at present day values
- Find a multiplier from Tables 15 to 26 of the Ogden tables depending on the claimant's intended retirement date
- Apply a reduction factor from Tables A to D of the Ogden tables to the multiplier to account for contingencies other than mortality
- Apply the adjusted multiplier to the annual pension loss

New discount rate

The new discount rate has a stark effect on multipliers from Tables 15 to 26. A quick glance at the Ogden tables shows that for a 40 year old woman who was due to retire at age 60 (Table 20) at a 2.5% discount rate there would have been a multiplier of 12.19. Using -0.75% as a discount rate gives a multiplier of 39.27, over three times the previous multiplier.

In the circumstances there is scope for defendants to argue that the method for calculating pension loss claims should be revisited. It is likely that there will be a stronger argument for the use of pension loss experts to calculate pension loss claims.

In **Auty** the actuarial evidence was rejected as being inadmissible being 'based on hearsay' and 'speculative in its nature'. The Court of Appeal agreed with this with Lord Justice Waller commented that even if such evidence were admissible he would "*strongly discourage it*" – p9D. Lord Justice Oliver went further and noted that "*as a method of providing a reliable guide to individual behaviour patterns, or to future economic and political events, the*

predictions of an actuary can only a little more likely be accurate (and will almost certainly be less entertaining) than those of an astrologer” – p17B.

Notwithstanding these comments the dramatic change in discount rate might well open up the arguments for use of pension loss experts to assist in calculating pension loss claims.

Money purchase or defined contribution

Background to calculation of money purchase pension loss claims:

Conventionally it has been argued by claimants that the loss is not simply the value of lost annual contributions by the employer to the fund as that would undercompensate the claimant because there are tax advantages to contributing to a pension fund and claimants argue that they would have invested the contributions.

The guidance in Kemp at §11-036 suggests that the current method of calculating money purchase pension loss claims should be:

- Calculate the annual contributions that the employer would have made to the pension scheme but for the accident
- A multiplier is found based on Tables 3 to 14 of the Ogden tables depending on the claimant's expected retirement age
- Apply a reduction factor from Tables A to D of the Ogden tables to the multiplier to account for contingencies other than mortality
- Apply the adjusted multiplier to the annual loss of contributions

In practice evidence is often produced on behalf of claimants from pension loss experts who calculate the net annual loss of pension based on a cumulative fund value that has grown with investment each year and then apply that annual loss to a multiplier from Tables 15 to 26 of the Ogden tables.

When the discount rate was 2.5% the detailed calculation done by a pension loss expert often did not deviate much from working out the loss in the conventional way set out in Kemp.

New discount rate:

The new discount rate dramatically changes things and claimants who still seek to rely on evidence from pension loss experts who on one hand support the contention that the claimant will recover a good rate of interest on their long term investment but on the other hand are using a multiplier from Tables 15 to 26 that uses a -0.75% discount rate.

As an example of the extreme effect this could have. In a case where the pension loss expert has calculated the new annual loss of pension as £10,000 based on a fund that is accruing net interest of 3% pa.

Using the old multipliers for a man aged 35 who is intending to retire at 65 the old multiplier would have been 7.55 based on a 2.5% discount rate from Table 21, adjusted by a reduction factor of 0.90 from Table A gives an adjusted multiplier of 6.80. The loss would therefore have been £68,000.

Using the new discount rate of -0.75% gives a basic multiplier of 30.87 and an adjusted multiplier of 27.78. The total pension loss would be £277,800 which is over 4 times the previous calculation!

Given the substantial increase in pension loss multipliers it is likely that defendants will challenge the use of pension loss experts even more.

If a claimant is just recovering the amount of the lost contributions that will in itself be higher because of the -0.75% discount rate being applied to Tables 3 to 14. This will support the argument that nothing further should be allowed as the claimant will have a larger lump sum.

Summary

The new discount rate will have a considerable impact on all pension loss claims and is likely to open up arguments about the use of expert evidence. It is another head of loss where defendants may seek to argue that PPOs are more appropriate. Increased pension loss claims are also likely to lead to more arguments about life expectancy in an attempt to move away from the multipliers in Tables 15 to 26.

Discrimination Claims in the Civil Courts: Is an Injury to Feeling sufficient to trigger QOCS protection?



By Huw P. Davies

Whilst discrimination claims are usually heard in the Employment Tribunals, section 114 of the Equality Act 2010 provides jurisdiction to the County Courts to hear discrimination claims against, inter-alia, Services Providers (under Part 3 of the Act), Landlords (under Part 4), Education Establishments (Part 6) and Associations (Part 7).

The usual remedies sought in discrimination claims in the Employment Tribunal are the special damages flowing from such discriminatory conduct (usually in relation to loss of employment), and the general damages arising from injury to feelings. On occasion the discriminatory conduct can lead to a recognised psychiatric injury and general damages can be awarded for such injury.

For actions brought in the County Court, the remedy provisions of the Equality Act are contained in section 119, which provides that all remedies available to the High Court can be awarded by the County Court. This expressly provides for damages for “injury to feelings”.

Does a discrimination claim brought in the County Court for injury to feelings but which does not allege that a recognised psychiatric injury has been suffered benefit from the cost protection afforded by the QOCS regime under CPR 44.13? Can a potential claimant be confident that they will not have to pay the defendant’s costs following an unsuccessful claim?

CPR 44.13 provides

44.13—

- (1) This Section applies to proceedings which include a claim for damages—
(a) for personal injuries;**

There is no definition of personal injuries within Part 44. CPR 2.3 does provide a definition:

2.3—

“personal injuries” includes any disease and any impairment of a person’s physical or mental condition

This is obviously a very wide definition and it may be argued that an injury to feelings can be capable of constituting an impairment of a person’s mental condition, albeit one that may fall short of a recognised psychiatric illness.

However, the phrase “damages for personal injuries” for the purposes of CPR 26.6(1) (which considers small claim track allocation under the Court’s case management powers) is defined under CPR 26.6 (2) :

“damages for personal injuries” (for the purposes of 26.6(1)) means damages claimed as compensation for pain, suffering and loss of amenity and does not include any other damages which are claimed.”

It is more difficult to categorise ‘injury to feelings’ as constituting pain, suffering and loss of amenity. Chapter 4 of the Judicial College Board Guidelines for the Assessment of Damages in Personal Injury states that psychiatric and psychological injury covers only those claims where there is a recognisable psychiatric injury. In relation to minor injuries at Chapter 13, it is stated *“Claims solely in respect of shock or travel anxiety in the absence of physical or recognised psychiatric injury will not attract an award of compensation”*.

That there is a distinction in kind between a personal injury and an injury to feelings is evidenced by the fact that it is clearly recognised that claims for both types of injury can be brought in the same action. The distinction was made clear by Stuart Smith LJ in ***Sheriff v Klyne Tugs (Lowestoft) Ltd*** [1999] I.C.R. 1170 where he stated (in a case considering race discrimination)

“there is a well recognised difference between injury to health or personal injury, and injury to feelings.”

Such distinction has been maintained by Mummery LJ in ***Vento v Chief Constable of Yorkshire*** [2003] ICR 318 and Judge CJ in ***Simmons v Castle*** [2012] EWCA Civ 1288 [2013] 1 WLR 1239.

It is unfortunate that Lord Justice Jackson did not give express consideration to claims brought under the Equality Act in his Review of Civil Litigation Costs: Final Report (December 2010). However, even though there may not have been express consideration within his report, he clearly drew a distinction between damages for personal injury and damages for suffering arising from a breach of a statutory tort (*“nuisance, defamation and any other tort that causes suffering...”*). A breach of the Equality Act would of course be a statutory tort as made clear in *Sheriff v Klyne Tugs*.

Despite the ambiguity of definition provided by CPR 2.3, it is likely that applying a purposive interpretation of CPR 44.13 would preclude a claim for injury to feelings by itself as constituting a claim for injury to feelings. To do otherwise would have potential consequences for other types of claims not brought under the Equality Act. For example, the QOCS regime has not been extended to defamation claims, yet defamation is a tort where an award of damages can include a claim for injury to feelings. If QOCS were to apply to Equality Act claims by reason of only a claim for injury to feelings, why not if defamation claims?

This is a matter that has not been considered definitively at the appellate level. In the Court of Appeal case of *Black v Arriva North East Limited* 2014] EWCA Civ 115 Clarke LJ did not demur by the suggestion by counsel for the claimant (who was seeking a costs capping order in relation to a discrimination appeal) that one way cost shifting is not available for Equality Act complaints. However this was not a point upon which any detailed submissions had been made.

The matter has been argued successfully by the author at first instance in front of HHJ Mellissa Clarke in the County Court sitting in Oxford. In this case a claim was brought against an Oxford college for alleged acts of discrimination, with, inter-alia a claim for damages by way of injury to feelings. A successful declaration was obtained on behalf of the College that the claim did not benefit from QOCS protection, HHJ Clarke finding that damages for personal injury and damages for injury to feelings are distinct claims.

If QOCS protection does not apply to such claims, should they be?

It may be argued that it is arbitrary and unfair that if an act of discrimination takes place in an employment relationship then a claimant has the benefit of the costs protection of the Employment Tribunal regime (where, whilst adverse costs orders can be made against unsuccessful claimants, this is the exception rather than the norm), but not where such discrimination is made by a college or a university against a student.

Equally, there is very often a very fine line between where an injury to feelings end and a personal injury begins. It is possible to envisage a situation where two claimants are subject to the same act of discrimination by a defendant, one reacts worse to the act than the other, and thereby benefits from QOCS protection but not the other individual.

Further, claimants are not to recover After the Event insurance premiums following a successful claim. The level of damages recovered in all but the worst cases of discrimination for injury to feelings are generally relatively modest, and it is likely that the costs of ATE premiums will be significantly higher than the damages awarded following a successful claim. A claimant is likely to be financially out of pocket even if successful.

However, there is strong argument that applying QOCS to injury to feelings would create significant financial prejudice for defendants. Whilst employers may not be able to recover costs in a successful defence of an employment claim in an Employment Tribunal, they are not faced with the very significant costs that the claimant may incur in the civil courts. The effective no cost regime of the Employment Tribunal applies to both parties to a claim. QOCS broadly only protects claimants.

Most discrimination claims in the County Court are likely to be multi-track, not because of value, but because of either the complexity of issues or number of witnesses to be called. By comparison the majority of traditional personal injury claims brought fall within the Fast Track, and are governed by the fixed cost regime (i.e. RTA or EL claims). Discrimination claims are very expensive to bring and to defend. By comparison, the run of the mill personal injury claims are not.

Finally, unlike personal injury claims, many discrimination claims in the County Courts are not principally about the recovery of damages (as very often there is no special damage, such as loss of earnings suffered), but about obtaining declaratory relief about discriminatory practices. Defendants in a personal injury claim are able to limit their cost exposure by the use of Part 36 offers. It is less easy to do so if the principle remedy sought is not financial. Of course, there may be little sympathy for such an argument when a defendant is a discriminator. They should either admit their discriminatory practices, make changes and cough up, or face the costs of forcing a claimant to go to court.

However, not all acts of discrimination are intentional, nor are all acts of discrimination of equal severity. Should the very fact of an alleged act of discrimination (which will inevitably cause a degree of injury to feelings) give a claimant cost protection that other deliberate torts or contractual breaches do not?

It seems unlikely that there will be any rush to amend the CPR to extend QOCS protection to discrimination claims. However, should a fixed costs regime be implemented for multi-track personal injury claims there would be stronger argument to apply this to discrimination claims. The alternative may be instead to extend the jurisdiction of the Employment Tribunals.

Case Law Update

By Laura Fitzgibbon and Tom Emslie-Smith

Webster (A Child & Protected party, by his Mother and Litigation friend, Heather Butler) v Burton Hospitals NHS Foundation Trust [2017] EWCA Civ 62

Jackson LJ, Simon LJ, Flaux LJ

Significance: This case is the first Court of Appeal decision following the Supreme Court's decision in *Montgomery v Lancashire Health Board* [2015] UKSC 11. It was held that the High Court had been wrong to apply the *Bolam* test and to find that the hospital had not been negligent.

Facts: C was born on 7 January 2003. He was born with a profound brain injury which occurred between 72 and 48 hours before his birth. It was not in dispute that, had C been born three days previously, he would not have suffered the injury. On 18 November 2002, C's mother had an ultrasound scan, during which anomalies that should have been identified were not. It was admitted that the doctor had been negligent in failing to arrange further scans. The date of the expected delivery of was 27 December 2006. On 26 December 2002, C's mother was unwell. It was found by the judge that, had she been advised to undergo an induction at this time, or of the increased risks of waiting, then she would have wanted to do so. The judge at first instance applied the *Bolam* test and found that a body of consultant obstetricians would not have advised C's mother to induce labour. It was submitted by C in the Court of Appeal that, following *Montgomery*, the issue was the advice that the mother should have been given and what would have happened in the light of it.

Held: The decision of the High Court was reversed. It was held that the hospital was liable for C's prenatal brain injury. Following *Montgomery*, it was not the correct approach to apply the *Bolam* test. The obligation of the doctor, other than in circumstances when it would damage the patient's welfare, was to present the material risks and uncertainties of the treatments and allow patients to make informed decisions that would affect their health and wellbeing. The judge found that the C's mother should have been given the information of the risks of continuing the pregnancy, even though they were based on a small statistical base and on an only recently emerging trend, and that she would have made the decision to

induce labour. C would not then have suffered the brain injury.

Caren Sharp v Leeds City Council [2017] EWCA Civ 33

Jackson LJ, Briggs LJ, Irwin LJ

Significance: The fixed costs regime applicable to the Pre-Action Protocol for Low Value Personal Injury (Employers' Liability and Public Liability) Claims applied to an application for pre-action disclosure made after the claim was no longer proceeding under the protocol. This case has important practical consequences on the cost/benefit of making pre-action disclosure applications in such cases.

Facts: In February 2014, the Appellant tripped and fell on an allegedly defective paving slab. Her claim was commenced under the ELPL protocol, but in October 2014 it proceeded under the Personal Injury Protocol. The Appellant applied for pre-action disclosure in February 2015, since the Respondent had failed to give it. The Appellant argued that costs should not be fixed and the Respondent argued that they should be.

Held: Appeal dismissed.

The fixed costs regime was subject only to a very small number of clearly stated exceptions and to recognise other implied exceptions would go against the regime's clear purpose. CPR r45.29E and Table 6C Part A made clear that the fixed costs regime applied to cases begun under the ELPL protocol even though such cases might never reach the stage of court proceedings being issued. Furthermore, the wording of CPR r45.29A(1) and CPR r45.29D supported that conclusion.

It was appropriate for a pre-action application to fall within the description of an 'interim application' within CPR r 45.29H since: there was close connection between the claim and the pre-action disclosure application; the application furthered the Claimant's claim and responded to the default of the Defendant; and it enabled the court to make good the procedural advantages intended to be conferred by the protocol and which contributed to early settlement.

The submission of the Appellant that allowing fixed costs to apply to such an application

would not properly deter Defendants from non-compliance with pre-action disclosure obligations had real force, so too did the submission that fixed costs compensate only for a small amount of the actual costs usually incurred. However, the appropriate course of action was to encourage applications under r45.29J, although the frequency with which the applications arise may prevent the circumstances from being considered 'exceptional'. It may be that, in a review of the scheme, a more generous, but still fixed, amount of costs recoverable for pre-action disclosure applications could be justified. To allow applications for pre-action disclosure to be subject to assessed costs would give rise to disproportionately expensive and undesirable satellite litigation.

X v Kuoni Travel Limited [2016] EWHC 3090

Judge McKenna

Significance: The case concerns the liability of a tour operator under the Package Travel, Package Holidays and Package Tour Regulations 1992 ('the Regulations') in circumstances where an electrician, employed by the hotel at which C was staying, sexually attacked C. The case is also an example of the application of the statutory defence under Regulation 15 (2)(c). Permission to appeal to the Court of Appeal has been sought.

Facts: C was on a package holiday with her husband and had been on her way to the hotel's reception when an employee indicated a shortcut that she could take. He led her to an engineering room where he assaulted and raped her. C reported the attack and identified her attacker. She initially claimed that she thought that he was a security guard, and subsequently accepted that he was an electrician. On returning home she discovered that she was pregnant and was diagnosed with a sexually transmitted disease. She subsequently was diagnosed with post-natal depression and resigned from her job before returning from maternity leave.

The claim was initially brought as including a claim of vicarious liability, which was not pursued at trial. The case concerned the contractual liability of the travel company under the Package Travel, Package Holidays and Package Tour Regulations 1992.

The issues were:

- 1 – What were the circumstances of the sexual assault?
- 2 – Did the sexual assault amount to an improper performance of the holiday contract for which D was liable? It was argued by C that, since the rape happened after the employee had offered to help C, it was within the scope of the contractual services which D had agreed to provide, which included that all employees connected with the hotel who had to discharge their duties with reasonable skill and care.
- 3 – Did D have a statutory defence under Regulation 15(2)(c)?
- 4 – Did C cease to continue her job as a direct result of the psychological injuries suffered following the attack?

Held:

- 1 – On the balance of probabilities, C was subject to a sexual assault by the employee.
- 2 – Under section 15 of the Regulations, C had to show that there was fault on the part of D or the supplier of the service, for whose fault D was responsible. It could not be said that the employee's actions formed any part of the contractual services that D agreed to provide with reasonable care and skill. This was due to a number of reasons, including:
 - The employee was not D's supplier, that was the hotel, and when he lured C to the engineering room, he was not discharging any of the duties he was employed to do.
 - The electrician's services were not services which D had a contractual obligation to provide to C.
 - There was no term in the contract between C and D that the hotel would employ the electrician.
 - It was not part of the contract between C and D that any electrician employed by the hotel for that particular purpose would also provide C with general assistance, such as showing her the shortcut to reception.

The court also held that the hotel was not vicariously liable: there was no close connection between the employee's duties and the attack so as to make it just for the hotel or D to be held liable for the attack. C had encountered the employee during the night and was offered a shortcut. That offer had no connection whatsoever with his duties. In any direct claim by C against the hotel, it would not be held vicariously liable.

3 - Obiter, if Regulation 15 had applied, the defence under Regulation 15(2)(c) would have applied: the attack could not have been foreseen or forestalled.

Merrix v Heart of England NHS Foundation Trust [2017] EWHC 346 (QB)

Mrs Justice Carr

Significance: The case considers the relationship between costs budgeting and detailed assessment. There have been numerous detailed assessments stayed pending this decision, which now provides High Court authority on the point. A case considering the same point, (*Harrison v Coventry NHS Trust*, unreported) is due to be heard by the Court of Appeal. The judge suggested that any appeal from this decision could be heard conjoined with that case.

Facts: The Appellant was the successful party in a claim against the Respondent for damages for clinical negligence. A costs management order under CPR 3.15(2) was made and the Appellant's cost budget was approved. The Appellant then accepted a Part 36 offer and so the costs bill was less than the total of the approved budget. The appeal to the High Court was not about the budget, but about a preliminary issue that was formulated by the Costs Judge: *'To what extent, if at all, does the costs budgeting regime under CPR Part 3 fetter the powers and discretion of the costs judge at a detailed assessment of costs under CPR Part 47?'*

The Appellant argued that, where a receiving party claims costs at or less than the budgeted figure, then his or her costs should be assessed as claimed, unless the paying party establishes a good reason to depart from the budgeted figure. The Respondent argued that the paying party is entitled to detailed assessment de novo, and the costs budget is to be only one factor in determining reasonable and proportionate costs on detailed assessment.

The Costs Judge decided that the strict answer to the preliminary issue was that the discretion of a costs judge is not fettered by the costs budgeting regime, save that the budgeted figures should not be exceeded unless good reason be shown. But the full answer is that the Respondent does not have *'complete discretion to attack a bill on detailed assessment'*.

The Appellant appealed.

Held: Appeal allowed.

The starting point is CRP 3.18. The words clearly say that the court will not depart from the budget, absent good reason. On a detailed assessment on a standard basis, the costs judge is bound by the agreed or approved costs budget, unless there is good reason to depart from it. This applies as much where the receiving party claims a sum equal to or less than the sums budgeted as where the receiving party seeks to recover more than the sums budgeted.

This conclusion reflects the fact that costs budgeting involves the determination of reasonableness and proportionality: the judge is not determining the maximum future costs, but what costs are reasonable and proportionate. The budget is not a cap.

Further, it is difficult to see why so much time and effort would be invested in the costs budgeting exercise if were to only be a guide, as contended by the Respondent.

1) RE (A minor by her mother and Litigation Friend) 2) LE 3) DE v Calderdale & Huddersfield NHS Foundation Trust [2017] EWHC 824 (QB)

Significance: Both the mother and the grandmother of a baby who suffered hypoxic brain injury during birth succeeded in claiming damages for 'nervous shock' from witnessing the event.

Facts: Baby RE had significant complications with her birth, suffering a hypoxic-ischemic insult minutes prior to and following her delivery. Immediately after delivery she was pale, floppy and without respiratory or heart rate and had to be resuscitated.

Because RE was a large baby, there was a risk of shoulder dystocia. During birth, RE had become stuck in the birth canal. When this became apparent, the attending midwife did not call for assistance immediately, but summoned another midwife several minutes later. An Obstetric Registrar was bleeped five minutes after this and attended the room, but was told by the attending midwife to remain outside, so there was a delay of about a minute before he could assist.

RE sustained hypoxic brain injury as a result of an insult that began during the birth and continued until she was resuscitated around 12 minutes after being born. On the agreed

expert evidence, had RE been delivered 8 – 9 minutes earlier, she would have avoided all damage.

RE's mother suffered PTSD which was "triggered by the birth of a flat, apnoeic baby." RE's grandmother also suffered PTSD from first-hand observation of the first 15 minutes of RE's life. Both claimed damages for nervous shock.

Held: There was a negligent delay in the summoning of help during RE's delivery. Had assistance been summoned at the right time, the delivery would have been earlier and hypoxic brain damage would have been avoided. Therefore, RE's claim was allowed.

The claims for nervous shock were also allowed. RE's mother was held to be a primary victim. The negligence occurred when RE's head crowned, but her body remained in the birth canal. At this stage, the baby was not a separate legal entity from her mother, and they were to be treated as one under the law. The insult that was responsible for hypoxic injury began when RE and her mother were a single legal entity.

Goss J considered what the position would be if he was wrong in his judgment that RE's mother was a primary victim. If she was a secondary victim, her claim would have to satisfy the controls established in *Mcloughlin v O'Brian* [1983] A.C. 410 and *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 A.C. 310:

- a) Sufficient closeness, both in terms of love and affection to the injured person and being in sight or sound of the injurious event;
- b) The induction of psychiatric illness by shock.

Goss J held that these preconditions were satisfied. RE's condition at birth was a sudden and unexpected event, for which she had no conditioning beforehand and no warning of the risk as it materialised. Goss J was satisfied that the event was exceptional and horrifying judged by objective standards, and not 'part and parcel' of the ordinary demands of childbirth.

ABC v (1) ST GEORGE'S HEALTHCARE NHS TRUST (2) SOUTH WEST LONDON & ST GEORGE'S MENTAL HEALTH NHS TRUST (3) SUSSEX PARTNERSHIP NHS FOUNDATION TRUST [2017] EWCA Civ 336

Gloster LJ, Underhill LJ, Irwin LJ

Significance: It was arguably fair, just and reasonable to impose on clinicians treating a patient with Huntington's disease a novel duty of care to disclose his diagnosis to his daughter, given that the condition was inherited. High court decision overturned.

Facts: The Claimant's father was diagnosed with Huntington's disease. If a parent has Huntington's Disease, there is a 50% chance that their child will also suffer from it. Therefore, the health professionals treating the Claimant's father sought to disclose the fact of his diagnosis to the Claimant. Furthermore, the Claimant was pregnant at this time.

The Claimant's father refused to allow the fact of his diagnosis to be given to her. The health professionals treating him complied with his request. In August 2010, the Claimant was accidentally told by one of her father's doctors that he had Huntington's Disease. She was later diagnosed with the condition too.

The Claimant brought a claim in negligence against the Defendant. She argued that their failure to inform her of her father's diagnosis had caused her psychiatric damage. In addition, she argued that, had she been informed of her father's condition, she would have been tested and diagnosed with the condition and would have then had an abortion. She argued that if her daughter does have the disease (it is not practice to test for Huntington's until adulthood) then she will incur additional expenses which would have been avoided.

The claim was struck out on the basis that there was no reasonable ground for bringing it, since it was not fair, just or reasonable within the third limb of the tripartite test in *Caparo v Dickman* [1990] 2 AC 605 to impose such a duty of care to third parties on medical professionals.

The Claimant appealed. She relied on clinical guidance entitled "Consent and Confidentiality in Genetic Practice, Guidance on Genetic Testing and Sharing Genetic Information". She submitted that the guidance made it clear that there were professional obligations towards those who, although not in an existing doctor/patient relationship with a clinician, had a vital interest in genetic information which the clinician had obtained. She argued that those obligations were a good foundation for an extension of the legal duty of care to individuals affected in that way.

Held: Appeal allowed.

It was arguably fair, just and reasonable to impose on the Defendants a duty of care towards the Claimant on the facts alleged. The policy reasons relied on by the Defendants to argue

against any extension of the duty of care were not persuasive. The arguments, and the Court of Appeal's comments on them, were as follows. In each, the Court of Appeal confined its consideration to whether the outcome of the argument must be adverse to the Claimant, since the question being considered was whether the strike out was appropriate on the ground that the case is unarguable and cannot succeed.

- *No public interest to counterbalance obvious public interest in preserving doctor/patient confidentiality* – The professional guidance envisages a clinician breaking patient confidentiality if the circumstances demand it. It does not necessarily increase public confidence if the patient can sue the clinician but the third party who needs the relevant information could not. Therefore, the answer to the consideration of the public policy point was not necessarily adverse to the Claimant.
- *Subjecting doctors to conflicting duties* – This difficulty already arises, exemplified by the professional guidance already in existence. The Claimant's argument was that the balancing of risks was already an inherent part of clinical practice, and that the imposition of the legal duty advanced by her would serve to protect the interests of both parties and ensure that a proper balancing exercise was performed. The Court found that her position was a properly arguable one and a matter on which the Court might be assisted by expert evidence, preferably of the most senior and authoritative character.
- *Duty to disclose information to third parties would undermine trust and confidence* - It was possible that confidence in the doctor/patient relationship could be reduced if the patient was aware that confidentiality might be breached. However, the degree to which such a loss of confidence may be affected by the existence of a common law duty of care to the 'third party', as opposed to any already existing professional duty to disclose, was questioned by the court. The matter was clearly arguable.
- *"Floodgates" argument: the problem in the instant case could arise in a variety of medical scenarios aside from those involving genetic conditions* – Examples given by the Defendant included: a patient suffering from a sexually transmitted disease who refuses to tell his or her previous sexual partners; a patient whose vasectomy has failed but who refuses to tell his sexual partner; and a patient dying from a long, distressing illness and who does not wish his family to be told for fear of psychiatric harm. Here, the Court recognised the force in the Defendants' submissions. However, it noted that there was an important distinction between the situation of a geneticist and all the other examples given by the respondents. However problematic, and whatever the implications for third parties, the clinician usually

only had knowledge of medical facts about the existing patient. It was only in the field of genetics that the clinician acquired definite, reliable and critical medical information about a third party, often meaning that the third party should become a patient. While it might be that the distinction applying to genetic cases might, on close consideration, be insufficiently robust to sequester genetic cases from a broad range of other situations, it was not unarguably so. Therefore, the submission did not justify a strikeout of the action.

- *The extension of a doctor's duty of care was not consonant with the incremental development of the common law: it would be for Parliament to make such a change -* The ambit and content of the duty of care in such cases had long been a matter for common law. If it were cease to be so, the law could ossify in the area.

CAMERON V HUSSAIN & LIVERPOOL VICTORIA INSURANCE COMPANY [2017] EWCA Civ 366

Gloster LJ, Lloyd Jones LJ, Cranson J

Significance: The Court of Appeal expanded the scope of section 151 of the Road Traffic Act 1988: Claimants can now bring a claim under the Act against the vehicle's insurers even when the identity of the driver is unknown, instead of using the MIB's Untraced Drivers Agreement.

Facts: The Claimant, a motorist, had been injured in a hit and run collision. The registration number of the car and the registered keeper were identified, but the driver was not. There was a policy of insurance on the vehicle covering a named person, who was not the registered keeper, to drive the car.

The Claimant issued proceedings against the registered keeper, erroneously believing him to be the driver. It became clear that the registered keeper was not the driver and so the Claimant added the insurer as a defendant, seeking a declaration under section 151 of the Road Traffic Act 1988. The insurer denied liability and argued that the policy did not cover the registered keeper and that the driver had not been identified.

The insurer sought summary judgment on its defence. The Claimant applied for permission to amend her claim form and particulars of claim by removing the registered keeper as first defendant and substituting "The person unknown driving vehicle registration number Y598 SPS who collided with vehicle registration number KG03 ZIZ on 26th May 2013". At first instance, the Claimant's application was dismissed and the insurer was granted summary judgment. HHJ Parker dismissed the Claimant's appeal. The Claimant now appealed to the Court of Appeal.

The issues on appeal were:

1 - Whether it is possible to obtain a judgment in respect of a claim for damages against a defendant identified only by description ("an unnamed defendant"), in the context of a motor claim against an unidentified hit-and-run driver, where the vehicle was identified and an insurance policy had been effected in respect of such vehicle in the name of either a non-existent person or someone who was not traceable.

2 - Whether an insurer would be liable to satisfy any unsatisfied judgment against such an unnamed defendant under section 151 of the Road Traffic Act 1988 ("the 1988 Act").

3 - Whether the judges below were right to refuse to allow the Claimant permission to amend her claim form and particulars of claim so as to substitute, for the named first defendant, a defendant identified only by the following description: 'The person unknown driving vehicle registration number Y598 SPS who collided with vehicle registration number KG03 ZIZ on 26th May 2013.'

Held: Appeal allowed (Cranson J dissenting). As to each issue:

1 – The Court of Appeal held that an insurer should be liable under section 151 irrespective of whether the insurance policy covers the driver/tortfeasor and irrespective of whether the identity of the driver is known. The intention of Parliament in enacting section 151 was that a motor insurer should compensate any parties injured by a vehicle it insures, even if the insurer has no contractual liability to indemnify the driver of the insured vehicle under the policy. The insurer is given a remedy against the tortfeasor under section 151(8) but the risk as to whether that will be effective is clearly intended to be borne by the insurer. Permitting a Claimant to sue an unnamed party under section 151 is consistent with the policy of Part VI of the Act.

2 - It is permissible under the CPR in appropriate cases for a Claimant to bring proceedings against an unnamed driver, suitably identified with an appropriate description, for damages: there was no procedural bar to such a claim. Whether this should occur in any particular case should depend on whether the overriding objective would be furthered. The ability of the Claimant to sue the MIB instead did not preclude her from bringing a claim against the defendant insurer.

3 – The Claimant should be permitted to amend her claim form and particulars of claim as sought.

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Alan Jeffreys QC	Andrew Wille	Georgina Crawford
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Andrew Arentsen	Clive Thomas	Aidan O'Brien
Lee Evans	Tom Bourne-Arton	Robert Golin
Nick Blake	Emma Sole	Jake Rowley
Huw Davies	Grant Goodlad	Frederick Lyon
James Pretsell	Tim Found	Joel McMillan

Rajiv Bhatt

Telephone: 020 7583 9241 Fax: 020 7583 0090 E-mail:
chambers@farrarsbuilding.co.uk

Farrar's Building
Temple
London EC4Y 7BD
www.farrarsbuilding.co.uk

DX: 406 Chancery Lane, London
Tel: (020) 7583 9241
Fax: (020) 7583 0090
chambers@farrarsbuilding.co.uk