Welcome

Welcome to this week’s edition of BC Disease News.

In the last week, it has been reported that a recent ruling in Jones v Spire Healthcare, on the assignment of conditional fee agreements (CFAs), will not be going to the Court of Appeal. Elsewhere, the Swiss venture capitalists that invested in the collapsed PI law firm, GT Law, have reported a £3.5m loss. Today also marks the deadline for claimant organisations to submit NIHL costs data to the CJC who are looking at a fixed fee matrix for NIHL claims.

This week we present a feature in which we return to the topic of defendants obtaining their own medical evidence in NIHL claims. We do so in light of the judgment in Walton, handed down this week in which BC Legal, acting for the 2nd and 3rd defendants, successfully overturned an initial case management decision refusing the defendant permission to obtain its own medical evidence.

We are also pleased to announce the opening of our Cardiff Office next week and our EC3 Office and Client Knowledge Hub in July. Further details on this and the BC Legal Summer Drinks Party can be found in the ‘What’s New?’ section at the end of this edition.

Any comments or feedback can be sent to Boris Cetnik or Charlotte Owen.

As always, warmest regards to all.

SUBJECTS

BC Legal In The Press

BC Legal has been featured in the Legal Futures website this week, following the news of the opening of our office and ‘client knowledge hub’ in EC3 next month.1

Our Chris McCrudden was interviewed about the new venture and the full article can be accessed here.

UK Deafness Working Party Update On NIHL Claims

In edition 142 of BC Disease News we briefly reported that the Institute and Faculty of Actuaries UK Deafness Working Party has published updated data on the NIHL claims market in 2015.

The data is based on between 10-12 participating insurers but said to represent the ‘majority of the insurance market’.

The Working Party looked at:
(i) Claims volumes
(ii) Repudiation rates
(iii) Average Cost Per Claim for all concluded and paid claims

The data provided by the Working Party (© Institute and Faculty of Actuaries) has not been grossed up or adjusted in any way to provide direct comparisons with historic data (please also see footnote for the Working Party’s disclaimer1).

CLAIMS VOLUMES

The data provides new claims volumes from January 2013-end of December 2015 based on 12 participating insurers.

<table>
<thead>
<tr>
<th>Notification Year</th>
<th>Total No of Claims Notified</th>
<th>Number of entities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-2013</td>
<td>4,953</td>
<td>12</td>
</tr>
<tr>
<td>Feb-2013</td>
<td>5,501</td>
<td>12</td>
</tr>
<tr>
<td>Mar-2013</td>
<td>7,144</td>
<td>12</td>
</tr>
<tr>
<td>Apr-2013</td>
<td>8,589</td>
<td>12</td>
</tr>
<tr>
<td>May-2013</td>
<td>7,248</td>
<td>12</td>
</tr>
<tr>
<td>Jun-2013</td>
<td>6,919</td>
<td>12</td>
</tr>
<tr>
<td>Jul-2013</td>
<td>9,232</td>
<td>12</td>
</tr>
<tr>
<td>Aug-2013</td>
<td>9,684</td>
<td>12</td>
</tr>
<tr>
<td>Sep-2013</td>
<td>5,648</td>
<td>12</td>
</tr>
<tr>
<td>Oct-2013</td>
<td>6,812</td>
<td>12</td>
</tr>
<tr>
<td>Nov-2013</td>
<td>6,385</td>
<td>12</td>
</tr>
<tr>
<td>Dec-2013</td>
<td>5,706</td>
<td>12</td>
</tr>
<tr>
<td>Jan-2014</td>
<td>6,155</td>
<td>12</td>
</tr>
<tr>
<td>Feb-2014</td>
<td>5,794</td>
<td>12</td>
</tr>
<tr>
<td>Mar-2014</td>
<td>6,496</td>
<td>12</td>
</tr>
<tr>
<td>Apr-2014</td>
<td>6,382</td>
<td>12</td>
</tr>
<tr>
<td>May-2014</td>
<td>5,983</td>
<td>12</td>
</tr>
<tr>
<td>Jun-2014</td>
<td>5,508</td>
<td>12</td>
</tr>
<tr>
<td>Jul-2014</td>
<td>6,557</td>
<td>12</td>
</tr>
<tr>
<td>Aug-2014</td>
<td>5,165</td>
<td>12</td>
</tr>
<tr>
<td>Sep-2014</td>
<td>5,794</td>
<td>12</td>
</tr>
<tr>
<td>Oct-2014</td>
<td>5,863</td>
<td>12</td>
</tr>
<tr>
<td>Nov-2014</td>
<td>4,731</td>
<td>12</td>
</tr>
<tr>
<td>Dec-2014</td>
<td>4,789</td>
<td>12</td>
</tr>
<tr>
<td>Jan-2015</td>
<td>5,583</td>
<td>12</td>
</tr>
<tr>
<td>Feb-2015</td>
<td>8,015</td>
<td>12</td>
</tr>
<tr>
<td>Mar-2015</td>
<td>8,481</td>
<td>12</td>
</tr>
<tr>
<td>Apr-2015</td>
<td>7,748</td>
<td>12</td>
</tr>
<tr>
<td>May-2015</td>
<td>6,694</td>
<td>12</td>
</tr>
<tr>
<td>Jun-2015</td>
<td>7,145</td>
<td>12</td>
</tr>
<tr>
<td>Jul-2015</td>
<td>6,991</td>
<td>12</td>
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<tr>
<td>Aug-2015</td>
<td>5,386</td>
<td>12</td>
</tr>
<tr>
<td>Sep-2015</td>
<td>5,658</td>
<td>12</td>
</tr>
<tr>
<td>Oct-2015</td>
<td>5,562</td>
<td>12</td>
</tr>
<tr>
<td>Nov-2015</td>
<td>4,984</td>
<td>12</td>
</tr>
<tr>
<td>Dec-2015</td>
<td>3,728</td>
<td>12</td>
</tr>
</tbody>
</table>

Despite many predictions of claims falling in 2015 the annual total of 75,974 claims was in fact 6,757 more than the total of 69,217 claims seen in 2014 (a 9% increase).
Figure: Trend in monthly notifications 2013-2015

MONTHLY NOTIFICATIONS

Anecdotally many insurers report continued reduced claims volumes in 2016. Whether this decline is the start of a long term trend or a pause in the market is difficult to predict. It may reflect:

1. Difficulties of claimant firms making NIHL claims profitable and removing themselves from the market;

See below regarding increasing repudiation rates.

2. Reduced Slater & Gordon activity?

Slater and Gordon (S & G) acquired Quindell’s professional services division in April 2015 which was said to include some 53,000 NIHL cases. S&G immediately announced that initially there would be a moratorium on new NIHL client intake, and the existing NIHL file portfolio will be expedited to try and maximise cash generation. Pre-and post-acquisition activity by both Quindell and S & G may explain the high claim volumes in Q1 of 2015.

Shortly after the acquisition, Quindell released a statement revealing that PwC had identified that some of the policies adopted in Quindell’s accounting in relation to the worth of its NIHL claims ‘were not appropriate’. Its 2013 accounts transformed from a £107m profit to a £64m loss and then extended to a £375m loss in 2014. In August 2015, the Financial Conduct Authority (FCA) announced there was to be a Serious Fraud Office criminal investigation into Quindell and the statements it had made about its accounts in 2013 and 2014.

As a result, serious concerns were raised over the quality of the NIHL claims purchased by S&G and by October 2015, S&G share price plummeted from A$8 in January 2015 to A$2.94 and which today stand at A$0.43. In January 2016, S&G began consulting on redundancies in two different offices and the closure of two offices which dealt with personal injury claims. This was followed by the announcement in February 2016 that S&G suspended their shares on the stock exchange ahead of the announcement of its financial results for the second half of 2015 which showed a reported net loss after tax of £492.5million across Australia and the UK of which around £435m resulted from writedowns of goodwill relating to business assets, including the large volume of NIHL claims, acquired from Quindell.

Finally, in April 2016 S&G announced that NIHL work would cease completely at the Aldershot, Blackpool and Liverpool branches from May 2016.

3. Difficulties in farming sufficient numbers of new NIHL claims of any genuine quality;

We see more NIHL claims involving very modest / spurious noise exposures and by our estimation well over 50% of claimants have no demonstrable evidence of NIHL and show no more than typical hearing of an aged population not exposed to noise.

The Working Party data shows increasing industry repudiation rates which is probably in part-indicative of the poorer quality of claims we see today.

4. Fears of future fixed fees in the NIHL market having a deterrent effect;

In October 2015, the Ministry of Justice asked the Civil Justice Council (CJC) to investigate how a fixed-costs regime might work in NIHL claims. On 23rd May 2016 Lord Justice Jackson stated in a lecture that the CJC is ‘currently seeking to develop a grid of fixed recoverable costs for noise induced hearing loss claims on the fast track’.

APIL and legal consultancy outfit ZebraLCTM have been collating data on behalf of the CJC from the claimant market to benchmark the typical costs of running NIHL cases. The deadline for submitting the data is today.

It is inevitable that fears of a fixed fee regime will make claimant organisations more cautious in the market— at least until the level of fixed fees is known and organisations have assessed whether they can adapt to make work profitable under a new costs and handling regime.
**REPUDIATION RATE**

In the table and figures below we reproduce some of the Working Party data on repudiation rates and Average Cost Per Claim between 2010-2015 (please note between 2010-2012 the data is based on 12 participating insurers and between 2013-2015 on 11 participating insurers—hence why the total number of claims in column 2 differs from the previous totals).

*Table: Concluded % outstanding claims by notification years 2010-2015 and outcomes*

<table>
<thead>
<tr>
<th>Notification year</th>
<th>Total claims</th>
<th>Concluded claims</th>
<th>Outstanding claims</th>
<th>Paid claims</th>
<th>Nr claims</th>
<th>ACPC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>2010</td>
<td>24,076</td>
<td>22,419</td>
<td>93%</td>
<td>1,657</td>
<td>7%</td>
<td>10,725</td>
</tr>
<tr>
<td>2011</td>
<td>32,766</td>
<td>28,402</td>
<td>87%</td>
<td>4,364</td>
<td>13%</td>
<td>12,582</td>
</tr>
<tr>
<td>2012</td>
<td>49,730</td>
<td>37,574</td>
<td>76%</td>
<td>12,155</td>
<td>24%</td>
<td>13,509</td>
</tr>
<tr>
<td>2013</td>
<td>76,787</td>
<td>50,765</td>
<td>66%</td>
<td>26,021</td>
<td>34%</td>
<td>9,088</td>
</tr>
<tr>
<td>2014</td>
<td>62,316</td>
<td>28,136</td>
<td>45%</td>
<td>34,180</td>
<td>55%</td>
<td>3,513</td>
</tr>
<tr>
<td>2015</td>
<td>65,274</td>
<td>8,907</td>
<td>14%</td>
<td>56,367</td>
<td>86%</td>
<td>397</td>
</tr>
</tbody>
</table>

The figure below shows the repudiation rate of claims by notification year-increasing from 52% in 2010 to 86% in 2014.

*Figure: Industry repudiation rate by notification year*

However, as can be seen from the number / % of concluded claims by notification year in the above table, much of the recent data is still relatively immature. So for notification year 2014, where the repudiation rate is 86%, 55% of the claims still remain outstanding. More mature data from between 2010-2012, where at least ¾ of claims are concluded, suggest a repudiation rate of between 52-64%. It can be seen from the figure below that claims data that repudiation rates only reach their true levels about 3 years post notification.
That said repudiation rates for 2013-2015 do appear to be running at higher than historic patterns and it might be anticipated that mature repudiation rates for these notification years will be at c. 75%. This higher repudiation rate is further evidence that the quality of claims being brought is getting worse.

**AVERAGE COST PER CLAIM (ACPC)**

The repudiation rate obviously also impacts on the ACPC-see figure below. If we take data from 2013 as representing a reasonable level of maturity / accuracy, then the ACPC (all concluded claims including nils) is just under £2,400 and shows a fall of c. £500 (c. 17%) from the peak ACPC of c. £2,900 in 2008 (the caveat of this comparison being that there are still a 1/3rd of claims from 2013 outstanding).
However, when nil claims are removed, paid levels are consistently high and running at c. £6,000 over 2009-2013 over double the ACPC when including nils over the same period. The trend for both average paid costs including and excluding nils from 2010-2015 can be seen in greater detail below:

These figures highlight how crucial the repudiation rate is to lowering industry indemnity spend.

Next week we consider what a fixed fee NIHL market might look like in the future and what might happen to industry volumes, repudiation rates and ACPC.

ATE Insurer Criticises Proportionality Ruling

Following the decision of *BNM V MGN Limited* [2016] EWHC B13 (Costs), which we reported on in edition 143 of BC disease news, an after-the-event (ATE) insurer, Temple Legal Protection, has voiced concerns over the outcome of the case stating that it should not apply to those areas of litigation where additional liabilities are still recoverable.²

As a reminder, the decision was one in which a ‘reasonable’ bill of costs was cut in half on grounds of proportionality and as a result, the ATE insurer saw its premium halved. Temple Legal Protection stated that it was supporting the claimant’s bid to appeal in this decision on the grounds that it risked reducing claimants’ access to justice. A representative from Temple stated: ‘The implications for this judgment are that the rule of law will only be open to those who can afford it’.

He noted that even though the judge found the ATE insurance premium was set at a reasonable level, and that it was necessary for the claimant to purchase ATE, ‘the judge has slashed this figure in half with no apparent justification’. He went on to say:

‘My deepest concern is that this judgment will be used by well-resourced defendants, who can afford not to recover all of their costs, to run up their legal spend knowing full well that a claimant would not be able to match this and, therefore, could only recover a level of costs in line with their damages. This flies in the face of the recent judgment in Miller v Associated Newspapers Limited where the Judge found that ‘ATE provides a legitimate social purpose’ and that the ‘burden imposed by the ATE premium scheme is not so large and not so lacking in appropriate controls as to amount to a disproportionate inference in their right to freedom of expression’.

It has been argued that ATE insurance should be considered in the context of the risk assumed by ATE insurers rather than against the level of damages being claimed. Further to this, Master Gordon-Saker has been accused of not applying the principles laid out in the 2007 Court of Appeal case of *Rogers v Merthyr Tydfil BC*, that any necessarily incurred premium would be proportionate but also that any challenge to or reduction of the ATE premium should be based on evidence which, it has been said, was absent in this case.

The success of any appeal is yet to be seen but we will continue to report on any developments.

Civil Justice Statistics Q1 2016

The Ministry of Justice has released the civil justice statistics (incorporating the Royal Courts of Justice) for the first quarter of 2016.. The statistics show that in this period, a total of 437,430 claims were issued, the highest quarterly total since 2009, and a 10% increase on the same quarter last year. Annually, there had been a general downward trend in the total number of claims issued between 2006 and 2012 from 2.1 million to a low of 1.4 million – since then, the trend has reversed, showing increases in 2013 and 2014. Revised figures for 2015 show this trend has once again reversed, with a slight decrease of 2% compared to 2014.

In January to March 2016, there were 301,345 PI claims which made up 95% of money claims compared to 94% in the same period in 2015. This trend has been consistent since the second quarter of 2012, when the County Court Money Claims Centre (CCMCC) took over the processing of the money claims and more accurately recorded personal injury claims.
The full report can be accessed [here](#).

**Government Response to Insurance Fraud Taskforce**

The Insurance Fraud Taskforce was established as an independent body by HM Treasury and the Ministry of Justice in January 2015 in order ‘to investigate the causes of fraudulent behaviour and recommend solutions to reduce the level of insurance fraud in order to ultimately lower costs and protect the interests of honest consumers’. The final report of the Insurance Fraud Taskforce published on 18 January 2016 made 26 recommendations to tackle fraudulent activity ranging from organised or premeditated crime to opportunistic fraud.

The recommendations included:
- Improving consumer trust in the insurance sector
- Improving the data available in fraud databases and data sharing schemes
- Ensuring data is share appropriately
- Coordinating and sharing best practice
- Taking a more robust approach to defending claims
- Considering legal changes to reduce exaggerated or fraudulent late claims
- Be alive to new fraud risks
- Improving cross industry coordination
- Toughening action against dishonest solicitors
- Improving communication between insurers and the regulators of professionals that enable fraud
- Strengthening regulation of CMCs
- Clamping down on nuisance callers that encourage fraudulent claims
- Tackling fraudulent claims for NIHL (a growth area for insurance fraud)
- Improving the ability of aggregators to detect fraud at the point of quote

The Government published its response to these proposals late last month, in which they accepted all of the recommendations from the Taskforce final report, stating:

‘The report highlighted the particular problem of fraud in relation to low value personal injury claims and the Government has established a programme of reforms in this area, particularly in respect of whiplash claims. We are pleased that the report’s recommendations reflect and support that reform programme. The Government accepts each of the recommendations addressed to it and we will set out in due course how we propose to implement them. However, there needs to be a concerted effort by all those involved in the insurance process to tackle this serious problem, which is estimated to cost policyholders up to £50 each per year, and the country more than £3 billion. We therefore expect organisations tasked with taking forward recommendations to do so with urgency. The Government will do what it can to assist and, in order to make sure that all of the recommendations are actively pursued, we will seek an update on progress later in the year’.

Ben Fletcher, Director of the Insurance Fraud Bureau said:

‘We are glad to see that the statement clearly recognises that insurance fraud has a real impact on honest members of the public and that it is not a victimless crime. Tackling this problem requires a collaborative approach and we are fully supportive of this. The IFB have welcomed all of the recommendations made by the Taskforce and we are committed to working with Government and industry organisations to ensure we are tackling this serious problem of insurance fraud’.

The full government response can be accessed [here](#).
PI Lawyers Call For Independent Investigation Into Fraud Figures

Following the acceptance by the government of the Insurance Fraud Taskforce’s recommendations, personal injury lawyers are now urging the government to commission independent research into insurance fraud.3

Following the comments of Lord Faulks, above, the figures in relation to the cost of fraud on the insurance market have been challenged by the Association of Personal Injury Lawyers (APIL) with the president, Neil Sugarman, saying there was ‘no independent evidence available, as far as we are aware, which paints a clear picture of the situation, and we know figures for personal injury fraud are routinely distorted by the insurance industry’.

He went on to say that the association’s own figures obtained from the Association of British Insurers found that motor insurance fraud was a fraction of the level often quoted by insurers.

In addition to this, the Law Society chief executive Catherine Dixon, last week called for claimant and defendant representatives to work together to clarify the extent of the problem.

She stated: ‘A starting point would be to have a clear definition of what constitutes a fraudulent claim so that the levels can be measured and targets set to reduce the cost of fraud. In particular, the scale of fraudulent behaviour in obtaining a quote and securing a new motor insurance policy is unclear. Likewise, we do not know the cost of fraud to the consumer through higher motor insurance premiums.’

The commercial secretary Lord O’Neill of Gatley, responded to these statements by stating that the government would seek an update later this year on progress by all organisations tasked with taking forward recommendations.

CFA Judgment in Jones v Spire Healthcare Not Headed to Court of Appeal

The recent ruling on the assignment of condition fee agreements (CFAs) will not be going to the Court of Appeal after all, it has emerged.4

We reported on the judgment in Jones v Spire Healthcare, in edition 140 of BC disease news. The case was one of a successful appeal at Liverpool County Court, from a decision that a conditional fee agreement transferred from defunct north-west firm Barnetts to SGI Legal had not been validly assigned. His Honour Judge Graham Wood QC, held that ‘both the benefit and the burden’ of the CFA were successfully assigned, and ‘there was a valid retainer allowing recovery of both pre- and post-assignment costs’.

The decision has been welcomed by claimant representatives, as tens of thousands of pre-Jackson CFAs have been bought up by larger practices on the basis that the recoverable success fees and after-the-event (ATE) premiums would be preserved.

It was reported in BC disease news that permission was granted for both an appeal and cross-appeal in Jones to be heard by the Court of Appeal. However, we report this week that the defendants no longer intend to appeal this decision.

Despite the fact that HHJ Graham Wood QC speculated within his judgment, that SGI could lose out substantially, the claimant representative stated that virtually all of the cases it had acquired had now concluded which meant that there was no further fallout for the firm.

Though Jones will not be going to the Court of Appeal, it is widely expected that the issue will be considered there sooner or later. The underlying debate is whether the High Court ruling of Mrs Justice Rafferty (as she then was) in Jenkins v Young Brothers Transport Ltd [2006]

EWHC 151, by which HHJ Wood considered he was bound, was correct.

In addition to this the decision in Budana v Leeds Teaching Hospitals NHS Trust, as reported in edition 129 of BC disease news, is also likely to head to the Court of Appeal. Here District Judge Besford in Kingston Upon Hull County Court, held that the CFA was not validly assigned, as the agreement had been terminated prior to the assignment when the original firm closed its personal injury practice. The defendant has asked for the case to be leapfrogged to the Court of Appeal, and a decision is awaited.

Venture Capitalists Set to Lose £3.5m After Law Firm Collapse

The personal injury firm, First Stop Legal Service Ltd, trading as GT Law, which went into administration in October 2015, is now reported to have cost the Swiss venture capitalists who invested in the firm more than £3.5m.

The firm went into administration after a failed group litigation and the introduction of the Jackson reforms. The administrator, Quantuma, confirmed that the Switzerland-based HTG Ventures Limited was owed almost £4m on its appointment. Although the administrator’s report confirms that HTG Ventures is a secured creditor it shows that it stands to recover only 12% (£486,000) of the full £4m debt. The picture is slightly bleaker for those unsecured creditors who have collectively made claims worth around £580,000 but only stand to recover just 14.4p in the pound. The director of GT Law, Gordon Tucker, is indebted to the company in the amount of £264,000 in respect of his overdrawn directors’ loan account (DLA).

Around £126,000 has been received from three firms that acquired client files, with estimated realisations of £950,000 from those cases. The three are IC Law Solicitors, Pilkington Shaw Solicitors and Neumans LLP. All files relating to group claims for the Sonae and Mau Mau actions were assigned to IC Law Solicitors. GT Law will receive a pre-defined percentage
The firm was referred to the SRA in August by Mr Justice Jay following the High Court’s dismissal of 20 test cases involving people living near the Sonae chipboard-plant fire in Kirkby, Merseyside in 2011. This was known as the Sonae Industria Group Action and was also reported on in edition 106 of BC disease News. The claims of over 16,000 claimants alleged personal injuries and other losses from smoke exposure following a fire in 2011. The damages and costs if the claimants were successful had been estimated by their lawyers to be in the order of £100m. However, Mr Justice Jay found in favour of the defendant and described ‘serious weaknesses in the claimant’s overall case. He went on to criticise the GT Law for encouraging the claimants to take part in the group litigation and exaggerating their claims. As well as this, several documents submitted to the court were found by Mr Justice Jay to ‘bear forged signatures’.

This is another example of a claimant firm lacking the infrastructure and experience to effectively handle so many claims at the same time. We outlined in last week’s feature the woes of Isaac Abraham following the dismissal of 37 of their cases. This week they have again been refused permission to appeal the decision to strike out 37 of their NIHL cases.

Feature
Obtaining Medical Evidence in NIHL Claims: Further Guidance

Introduction

We have previously featured the obtaining of medical evidence in NIHL claims in editions 32, 118 and 126 of BC Disease News. We follow up with a County Court judgment of His Honour Judge Peter Hughes QC, handed down this week, in which BC Legal, acting for the 2nd and 3rd defendants, successfully overturned an initial case management decision refusing the defendant permission to obtain its own medical evidence.

Background

Firstly, let us look at the protocols and rules which govern expert evidence for both pre-litigation and litigated cases. Although we have already outlined the relevant protocols and rules that govern expert evidence it is worth doing so again as familiarity with them is vital for success.

Pre-Action Protocol on Disease and Illness Claims

Paragraph 1.2 of the Protocol provides that its aim is to, amongst other things, settle claims ‘fairly’. Paragraph 9.4 of the Protocol provides that where the claimant obtains a medical report prior to writing the letter of claim, the defendant will as a matter of course be entitled to obtain its own medical evidence. Paragraph 9.4 of the Protocol prescribes that a ‘flexible’ approach must be adopted to obtaining expert evidence. Further to this paragraph 9.13 provides that further guidance can be found in CPR 35, such that the principles applicable to litigated cases are also relevant to pre-litigation cases. Consequently, the following arguments are applicable to obtaining expert evidence whether at the pre-litigation stage and/or once proceedings have been issued.

The Civil Procedure Rules

The relevant rules are set out in Part 1 and Part 35 of the Civil Procedure Rules.

CPR PART 35

CPR 35.1 provides that expert evidence shall be restricted to ‘that which is reasonably required to resolve the proceedings’. The particular policy objective underlying this rule is that of reducing the incidence of inappropriate use of experts to bolster cases.5

Reference should also be made to Part 35.6. This provides that written questions must be proportionate, they may only be put once, unless the other party agrees or the court authorises it, and they ‘must be for the purpose only of clarification of the report’. The note in the White Book on this part of the rule reads:

‘The meaning of “clarification” is not explained in the rule or Practice Direction. However, it would seem that questions should not be used to require an expert to carry out new investigations or tests, to expand significantly on his/her report, or to conduct a form of cross-examination by post’.

CPR Part 35 should be read in conjunction with CPR Part 1 as follows:

CPR PART 1

The overriding objective is contained in Part 1 of the CPR and provides that the court must deal with all cases justly and at proportionate costs. CPR 1.1 states that this includes, so far as is practicable:

(a) Ensuring that the parties are on an equal footing:
(b) Saving expense:
(c) Dealing with cases in ways which are proportionate:
   a. To the amount of money involved
   b. To the importance of the case
   c. To the complexity of the issues
(d) Ensuring that the case is dealt with expeditiously and fairly.

In short, where medical evidence is reasonably required by the defendant, cases must be dealt with justly, fairly and ensuring that parties are on an equal footing by allowing such evidence to be obtained. At the same time there needs to be considerations of proportionality and saving expense.

Applying these rules, it becomes plain that, firstly, where there are legitimate concerns about the claimant’s medical evidence, further expert evidence is reasonably required to verify or fairly challenge the case and to ensure that the parties are on an equal footing. Further, expert evidence would also be necessary to fairly meet the case and ensure that it is dealt with justly.

This position is supported by recent NIHL case law and authority, which we have previously discussed and we will now review the most recent decision in Walton, in order to highlight how this also supports granting permission for repeat
audiograms/defendant’s own expert evidence.

Facts

Mr Walton, the claimant, was 72 years of age and brought claims against three of his former employers. He worked as a maintenance worker/pipe fitter for United Utilities from 1962 to 1972; for Ready Mix Concrete as a batch man/labourer and its successor, Cemex Investments in a similar role from 1972 to 1982. The value of the claim was limited to £15,000.

The claimant solicitors obtained a medical report from a consultant ENT surgeon, Mr Manjaly who carried out audigram testing on the 3rd November 2013 in a hotel room in Carlisle. The medical report stated that:

‘Mr Walton gave a reliable history of exposure to loud noise during his employment (R2). Audiometry carried out on the 3/11/2013 revealed bilateral high frequency sensorineural deafness (R1), with a bulge at high frequencies, characteristic of noise-induced damage (R3). Clinical examination carried out on 03/11/2013 revealed no middle ear disease responsible for this hearing loss. On balance of probability, Mr Walton’s hearing loss is a result of exposure to loud noise, combined with age-related hearing loss’.

Following this, the defendants wished to obtain their own medical opinion from Professor Lutman. However, their initial application was refused at the Case Management Conference on 4th August 2015 pending Part 35 questions put to Mr Manjaly. The defendants renewed this application once Part 35 replies had been obtained on 15th December 2015 which was refused by Deputy District Judge Robson. In doing so he gave permission for further Part 35 questions and allocated the claim for trial to the fast track. The reasons given for the refusal of permission were:

a) Permission was given for Part 35 questions and these were fairly detailed and searching
b) DDJ Robson was ‘impressed’ with the Part 35 replies which he felt showed a ‘very earnest effort to respond to the questions without dodging the issues’.

c) Any clarification needed could be dealt with by additional Part 35 questions honed more directly to the issues which had been raised.
d) It would be disproportionate to have two experts for such a modest case as this would force the case into the multi-track list.

The defendants appealed.

Submissions

The defendants made four main submissions:

a) The audiological evidence was not clear cut;
b) The defendants were disadvantaged by being required to pursue their case through Part 35 questions;
c) Cross-examination through Part 35 questions was not permissible and an inappropriate use of the CPR; and
d) The trial date was liable to be put at risk by delaying a decision as to whether the defendants should be allowed their own expert to see how the claimant’s expert answered the Part 35 questions.

Counsel for the claimant contended that the application for a separate medical expert was a ‘costs building exercise’ and suggested that counsel specialising in this area of litigation was capable of dealing with the medical issues on behalf of defendants without the need for a defence medical expert.

Discussion and Outcome

At para 43 in Walton, HHJ Hughes, referred to several authorities in this area, including Langley v Caterham Marble (Stoke-on-Trent County Court, 21st March 2014), Aspinall & Offermans v BT (Sheffield County Court, 10 April 2015) and Maplesden v Sarek Joinery (Middlesborough County Court, April 2015). As we have discussed these judgments in great detail in editions 118 and 126, we will not reiterate their findings here. However, these were relied upon in Walton to show that County Court judges routinely allow defendants their own medical evidence and HHJ Hughes stated at para 55:

‘I am in broad agreement with the views expressed by my colleagues in the cases quoted above. There are, though, a couple of small points on which I differ slightly, from local experience in dealing with these cases at trial in both the multitrack and fast track lists.’

HHJ Hughes then went on to provide some useful guidance for judges dealing with NIHL claims and medical evidence at the case management stage. He said at para 56:

‘From my own experience and that of my colleagues as cited above, I think that it is possible to glean a number of guiding principles:-

a) Unless the audiology is accepted to be reliable and uncomplicated, the defendant should not be required to accept the expert selected by the claimant as the sole expert;
b) The claimant’s report should include details of when, where and in what conditions the examination and audiological assessment took place. The claimant’s expert should also provide details not only of his or her experience in medico-legal work but of the proportion of this which is for claimants and defendants.
c) Part 35 questions have only a limited role to play. They should be used only for clarification as the rule stipulates. An appropriate use, for example, is by defendants, at an early stage, after initial receipt of the report to clarify the conditions in which the audiograms were conducted and to establish whether there is likely to be any challenge to their accuracy and reliability;
d) Especially where the claimant’s audiological examination has taken place in less than ideal conditions, as for example at a ‘claim clinic’ held in a hotel or village hall, consideration ought to be given to refusing the claimant permission to rely on the report and directing that the claimant is examined by a single jointly instructed expert;
e) Where the audiology is not straightforward and significant issues as to interpretation are to be expected, the parties should be allowed to have their own experts;
f) The decision as to what order to make in respect of expert medical evidence is not necessarily determinative of the question as to the track in which to list the case for trial. Where there is a single jointly instructed expert the case is likely to remain in the fast track and the expert will only be called at trial to give oral evidence where this can be demonstrated to be necessary. Where both sides have their own experts, decisions as to whether to give permission for the experts to give oral evidence at trial are best made only after they have met and identified the points on which they disagree. It is at that stage that the court can best judge whether the case needs to go into the multitrack list. There will be cases where, with robust case management at trial, the case can still be completed in a day and hear in the fast track list.

It was subsequently found that in the first instance in Walton, DDJ Robson, in exercising his discretion available to him in case management decisions, was wrong. HHJ Hughes concluded that there were issues with the audiogram which could not be determined through Part 35 questions alone and in any event this was not a proper use of the CPR.

Similarly, he rejected the claimant’s submission that it is the place of counsel to act as an expert. With respect to this point he said at para 58:

‘I do not agree with the point made by Mr. Buckley that no defence expert was needed because experienced counsel, such as Mr. O’Leary, were well able to deal with the medical issues. It is not for counsel to act as the expert, and, neither, is it right to assume that trial counsel will necessarily have this depth of specialist knowledge and experience. The submission confuses the boundary between the role of advocate and expert’.

The defendants were granted permission to obtain their own medical evidence from Professor Lutman and the case remained in the fast track.

Conclusion

The judgment in Walton follows the trend of County Court judgments which support the granting of permission for repeat audiograms/the defendant’s own medical evidence. In edition 118 of BC Disease News, we provided a summary of some common reasons why repeat audiometry/defendant’s own medical evidence is reasonably required in NIHL claims and these should be utilised in any submissions made and be accessed here. Also, our template letter outlining the legal basis for defendants requiring their own medical evidence can be accessed here.

Further features on this topic in editions 32,118 and 126 can be accessed here.

Next week we consider further why diagnosis of NIHL cannot be made upon a single audiogram. As a number of recent studies have shown, a single audiogram can be described as no more than a ‘best guess’ of an individual’s hearing thresholds.
References


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