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BC LEGAL

BRINGING CLARITY

BC DISEASE NEWS

A WEEKLY DISEASE UPDATE

CONTENTS

Welcome

Welcome to this week's edition of BC Disease News. In the last week it has been confirmed that the budgeting regime will be extended further and new amendments to the Civil Procedure Rules have been announced.

This week we present two features. The first is the next in our series on sensoineural hearing loss, this time focusing on the link between high cholesterol and hearing loss. For our second feature, we are pleased to include a contribution from John Williams of Crown Office Chambers. In the first of two articles, he examines mesothelioma claims brought against occupiers of premises.

Finally, we draw your attention to the back page of this week's edition, which makes a special announcement.

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

As always, warmest regards to all.

Budgeting to be extended even further

The Civil Procedure Rules Committee has signalled its support for costs budgeting by announcing that it will be extended to all cases in all courts unless the value of the claim exceeds £10 million.[1]

The extension of the costs budgeting regime had the support of the Master of the Rolls, Lord Dyson, and the deputy head of civil justice, Lord Justice Richards. However, Lord Justice Jackson himself supported having budgeting apply in all cases irrespective of their value.

The judges said they would have 'no hesitation in supporting [budgeting in all cases irrespective of their value], were it not for the concerns expressed so strongly by so many consultees that a requirement for costs budgeting would risk deflecting high-value cases away from London and the UK…We share the doubts that members of the committee have voiced about these concerns, but we do not feel in a position to dismiss them out of hand'.

The new rules will not directly affect disease practitioners since all multi-track disease claims are already captured by the costs budgeting regime. Nevertheless they indicate the senior judiciary's enthusiasm for costs budgeting and suggest that budgeting will remain a permanent feature of the litigation landscape. With that in mind, it is absolutely vital that practitioners engage with it meaningfully and competently. The better the regime is engaged with, the better it will work for practitioners.

The new rules are likely to be added to the Civil Procedure Rules this year.

Referral fee ban enforcement slows

Enforcement action against claims management companies (CMCs) by the Ministry of Justice for breaches of the referral fee ban is slowing.[2]

In response to a freedom of information request, the Ministry of Justice confirmed that 277 CMCs are subject to 'ongoing further reviews' in relation to non-compliance with the ban.

The ban on referral fees has now been in force nearly a year, having come into effect on 1 April 2013.

862 CMCs have being visited since the implementation of the ban. Warnings have been issued to 50 businesses for conduct rule breaches and 28 have surrendered their authorisation to practice.

The Ministry of Justice stated that 200 licences were removed in 2013. Justice Minister Shailesh Vara said that 'rigorous new measures' were being implemented to 'rein in rogue firms operating in this sector'. Notwithstanding this apparently strong action, the freedom of information response shows that enforcement has slowed, with the number of licence revocations the smallest since 2009. At the peak in 2011, 298 CMCs were stripped of their authorisation. By 2013, this has fallen by almost a third. However, more CMCs have voluntarily ceased trading.

It is welcome that the Ministry of Justice is taking action to enforce the referral fee ban.

Civil Procedure Rules changes

The latest batch of reforms to the Civil Procedure Rules has now been announced.

The rules are set out in the Civil Procedure (Amendment) Rules 2014. As to their effect on disease claims, they are chiefly reforms of form rather than substance. They make changes to reflect the introduction of a single County Court, replacing individual county courts. This will have no direct impact on the litigation of disease claims.

However, one reform of particular relevance to disease practitioners is the amendment of the statement of truth that appears on the Precedent H costs budgeting form. Currently, the statement of truth in Practice Direction 22, paragraph 2.2A, provides: 'The costs stated to have been incurred do not exceed the costs which my client is liable to pay in respect of such work. The future costs stated in this budget are a proper estimate of the reasonable and proportionate costs which my client will incur in this litigation'. The new wording, inserted by the 69th update practice direction amendments says: 'This budget is a fair and accurate statement of incurred and estimated costs which it would be reasonable and proportionate for my client to incur in this litigation.' The insertion of the word 'fair' is curious. The Rules deal only with what is just, reasonable and proportionate. Inserting this new word may be the source of new arguments on whether a budget is 'fair' or not and result in satellite litigation.

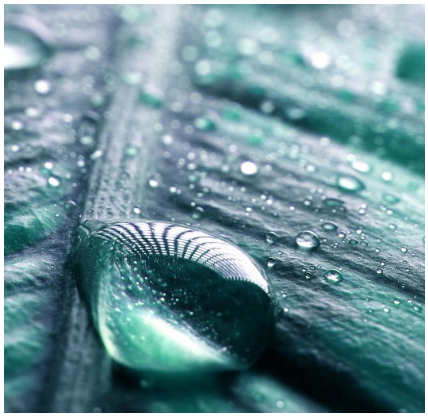
According to the Ministry of Justice's website, the new amended precedent H comes into force on 6 April. This is not entirely clear from the practice direction making document; the

commencement provisions in the document suggest the amendments to PD 22 come into force when sections 17(1) and (2) of the Crime and Courts Act 2013 enter force. However, this is not scheduled until 22 April 2014, which would supplant the apparent 6 April commencement date for the new Precedent H. Practitioners should aware of the need to use the correct Precedent H form.

Other reforms being introduced have no significant impact on disease claims. The rules do not contain the recently announced changes to the costs budgeting regime (discussed earlier in this edition). These can be expected in later legislation.

The new rules can be read here and the practice direction making document can be read here.

Finally it is also noteworthy that the High Court has confirmed the new Jackson approach universally applies to all rules in the CPR, not merely those specifically mentioned in the reforms. In *Samara v MBI and Partners UK Ltd*, Mr Justice Silber declared 'the new regime has universal application to all rules in the CPR…Indeed, it is based on and underpinned by the changes to the overriding objectives which apply to all parts of the CPR.'[3]



Mesothelioma Act to come into force

The Mesothelioma Act 2014 is to largely come into force at the end of March.

The Mesothelioma Act 2014 (Commencement No.1) Order 2014 provides, in article 3, that the majority of the provisions will come into force on 31 March 2014.

Article 2 provides that section 7 of the 2014 Act came into force on 4 March. Section 7 allows the Secretary of State to make arrangements with a body to administer the Diffuse Mesothelioma Payments Scheme.

Article 4 provides that section 13 of the Act will come into force on 1 September 2013. Section 13 contains the power for the Secretary of State to require payment by active insurers of the levy that will fund the payment scheme.

As to terms of the payment scheme itself, we continue to await the publication of the regulations. These can be expected to follow in the coming months.

The commencement order can be read here.

Meanwhile, the Government has released the final impact assessment for the payment scheme. It assumes that 14% of those with occupationally linked mesothelioma do not make a claim and that 15% of those who claim Industrial Injuries Disablement Benefit (IIDB) but do not make a civil claim do so because of insufficient evidence to succeed in a civil claim in the courts. Over 10 years it estimates the scheme will cost £380.3 million. The levy on insurers will raise £364.7 million and there will be £17 million in government funding. This will cover payments to individuals (totalling 283.6 million), benefit recovery (£72.2 million), claimant legal fees (£24.6 million) and administrative costs (£1.3 million).

The impact assessment can be read here.

Feature: sensoineural hearing loss – high cholesterol

Introduction

This week we continue our series on the link between various conditions and sensoineural hearing loss. The focus this week will be on the link between high cholesterol and hearing loss.

Cholesterol

Cholesterol is a fatty substance – known as a lipid – and is vital for the normal functioning of the body. It is predominately manufactured by the liver but is also found in some foods. It is carried in the bloodstream by proteins.[4]

High Cholesterol can be caused by a variety of factors. As to lifestyle related causes, an unhealthy diet, particularly one that is high in saturated fat, often results in high cholesterol.

In addition, certain foods, such as eggs, contain cholesterol, although they have little effect on overall blood cholesterol level. In addition, a lack of physical activity and exercise can be responsible for high cholesterol. Linked with that is obesity, another leading cause of high cholesterol. Similarly, regularly consuming high quantities of alcohol and smoking can also result in higher levels of cholesterol. Certain underlying conditions are also associated with high cholesterol. This includes kidney disease, liver disease and an underactive thyroid gland.[5]

High cholesterol is strongly linked with an increased risk of heart attacks, atherosclerosis – that is, narrowing of the arteries - , strokes and mini-strokes[6].

It does not, however, cause any symptoms.

In addition, high cholesterol is a prevalent condition. In 2008, the percentage of people with high cholesterol levels ranged between 54-64% for men across different regions of England, and between 56 and 68% for women.

To what extent is high cholesterol linked to sensoineural hearing loss? Given the high prevalence of the condition, if there is a strong link between the two then high cholesterol may in fact be the cause of, or a contributor to, hearing loss in many NIHL claims where it is alleged that prolonged exposure to excessive noise is the cause of the hearing loss. High cholesterol may provide a full or partial defence in many claims.

High cholesterol and sensoineural hearing loss

According to Consultant Audiological Physician John Irwin, in 1983, 'considerable evidence' had accumulated over the last quarter of a century that sensoineural hearing loss was associated with hyperlipidaemia – high cholesterol.[7]

Early studies certainly support the apparent link between high cholesterol and sensoineural hearing loss. In the 1960s Rosen studied the Mabaan people of Sudan. They had no noise exposure, were vegetarian and had a diet containing no saturated fats. High cholesterol was entirely unknown amongst the people. Rosen found that at the age of 70-79 years, subjects had normal hearing thresholds from 125 Hz to 2 kHz and at 6 kHz the maximum hearing loss was just 25 dB, the suggestion being that their low cholesterol levels insulated them from hearing degradation.[8]

In 1970, Rosen et al considered the effects of diet on hearing loss in two institutions for long-stay patients in Finland.[9] One group had their diet altered to reduce polyunsaturated fat intake while the other carried on with the 'normal' high fat Finnish diet. After 5 years the study group had significantly lower serum cholesterol levels and significantly better hearing. At 5 years, the diets were reversed and the populations restudied for a further 3.5 years. The cholesterol levels were again lower in the group on the low fat diet and there was now no difference in mean hearing levels between the groups. The pattern of loss was then typical of age associated hearing loss. The conclusion was that high cholesterol was clearly associated with the induction of hearing loss – high cholesterol appeared to induce hearing loss while low cholesterol did not affect the ordinary course of age associated hearing loss.

Evidence of an association between high cholesterol has also come from studies of the hearing impaired. In 1977, Booth investigated 44 subjects aged between 25 and 55 with symmetrical hearing loss of unknown origin.[10] 38% of the subjects were found to have abnormally high cholesterol levels. Spencer found an even stronger association. In 1983 he studied 300 patients, including himself, who had symptoms of unspecified inner ear disease.[11] He found 51% of patients had elevated cholesterol levels. In a comparative group of patients attending an otolaryngology clinic for unrelated reasons, only 19.3% had elevated levels, despite that group containing only those who were overweight or had a family history of diabetes or heart disease.

In 1985, Axelsson and Lindgren posited a relationship between high cholesterol and noise induced hearing loss.[12] They recognised that previous studies had found a link between high cholesterol and hearing loss, and that noise also affects hearing, especially at higher frequencies, noting that noise appears to increase cholesterol levels during short-term experiments. They sought to address whether a combination of high cholesterol levels and noise exposure had an increased adverse impact on hearing. They considered 78 50-year-old men with high cholesterol levels from a WHO study and compared them with 75 50-year-old men who were randomly selected from the same WHO material. Audiograms showed that hearing was similar in both groups, with a moderate high frequency hearing loss having a configuration suggestive of noise induced hearing loss. Analysis of histories and audiograms showed that noise was the predominant factor affecting hearing loss. However, there was a statistically significant tendency for the high-cholesterol group that had suffered the most noise exposure to have high frequency hearing loss. But there was also a tendency for the low-cholesterol group to have high frequency hearing loss if they had been excessively exposed to occupational noise. Nevertheless, they concluded that there was a slightly increased risk of acquiring high frequency hearing loss in those who work in noisy environments and have high cholesterol. This finding plainly supports an argument of contributory negligence in those cases where the claimant has high cholesterol even if the hearing loss can also be attributed to exposure to excessive occupational noise.

In 2007, Sutbas et al suggested that lowering cholesterol levels can in fact improve hearing.[13]Their aim was to outline the prevalence of high cholesterol in patients who had high frequency hearing loss and tinnitus due to noise exposure. They investigated the role of a low cholesterol diet and statins (cholesterol lowering medicines) to alleviate the severity of tinnitus and possibly promote hearing improvement. 42 patients with high cholesterol and tinnitus and noise induced hearing loss were placed on a low cholesterol diet and statins for 24 months. They were then designated either as responsive or unresponsive according to whether their

cholesterol levels had lowered in response to the diet and medication. In those patients that responded their changes in tinnitus scores were significant: 35% of them reported decreased tinnitus and 20% reported no tinnitus at all. Similarly, significant improvement was found at high frequency hearing thresholds (4 kHz to 8 kHz) in the responsive group. Before treatment the average hearing threshold in the responsive group was 43.1 dB for the right ear and 45.2 dB in the left ear. However, after treatment the thresholds had improved to 37.4 dB in the right ear and 40.9 dB in the left ear. The researchers concluded that the incidence of high cholesterol is high amongst those with noise induced hearing loss and that *significant* improvement in hearing and tinnitus can be achieved by lowering cholesterol level. This is an important finding. It raises the prospect of defendants raising arguments about claimants mitigating their loss when they are responsive to cholesterol lowering treatments (diet and medication). Since all claimants are under a duty to mitigate their loss, if they have high cholesterol and respond to treatment it would be incumbent on them to take steps to lower their cholesterol and therefore mitigate the severity of their hearing loss. Failure to do so would lead to a reduction in damages equivalent to the difference between their current hearing loss and what it might have been had the claimant lowered their cholesterol.

Similar findings were reported by Gopinath et al in 2011.[14] They examined the link between cholesterol with the prevalence, incidence and progression of age-related hearing loss, and the link between statins and hearing loss. Hearing loss was measured in 2956 patients. The likelihood of hearing loss increased in those with the highest cholesterol intake. Among those reporting statin use, a 48% reduced odds of prevalent hearing loss was observed. Participants with higher monounsaturated fat intakes had a significantly reduced risk of hearing loss progression 5 years later. They concluded that a diet high in cholesterol could have adverse influences on hearing, whereas treatment with statins and the consumption of monounsaturated fats may have a beneficial influence.

More recent studies confirm the link between high cholesterol and hearing loss. In 2014, Chang et al considered the association between high cholesterol and sensoineural hearing loss, testing the hypothesis that high cholesterol is a risk factor for developing hearing loss.[15] 73,957 individuals with high cholesterol diagnosed from 2001 to 2006 were compared with the same number of control patients. Each patient was followed until the end of 2009. It was found that sensoineural hearing loss was 1.6 times more likely to occur in those with high cholesterol.

Conclusion

There is strong evidence of a link between high cholesterol and hearing loss. Given the wide prevalence of high cholesterol in the nation it could be a relevant factor in many noise induced hearing loss claims. The nature of the research suggests arguments on contribution, or even full causation, and the duty to mitigate loss may be tenable. Where high cholesterol is present questions should be put to the medical expert to consider its impact: could it have been a sole or contributing cause of the senseoineural hearing loss? Could the claimant have improved their condition with an altered diet and/or medication? Experts should be pointed to the above research for comment.

Feature: mesothelioma claims against occupiers of premises

In the first of two articles, John Williams of Crown Office Chambers examines mesothelioma claims against occupiers of premises.

Introduction

This article examines the legal liability of an occupier of premises ("O") to mesothelioma victims who were exposed to asbestos whilst visiting the premises. Such claims can arise in a variety of different ways – the common feature being that, for whatever reason, there is no employer against whom proceedings can be brought. Typically, claims of this nature allege exposure due to the static nature of the premises (e.g poorly maintained asbestos containing materials - "acms") or exposure due to activities by O's contractors when construction or maintainence works involving "acms" were undertaken. Of course, the facts of any given case may allow the claimant to successfully sue an occupier of premises on other grounds (e.g under general principles governing duty situations in tort) and this must always be borne in mind when considering such claims.

This article focuses on: (a) the Occupiers Liability Act 1957 ("the 1957 Act") and (b) common law principles that are sometimes invoked to try to impose liability on occupiers of premises in respect of work undertaken by contractors. A second article will examine other statutory provisions that can be relied on in claims based on breach of statutory duty.

Where insurance exists, such claims fall to be dealt with under O's Public Liability policy. Difficulties in tracing historic PL insurers and the operation

of asbestos exclusion clauses mean that these claims are often possible only where O is a public authority or a company with the means to pay.

Claims of this nature do not fall within the Diffuse Mesothelioma Payment Scheme established under the Mesothelioma Act 2014.

The 1957 Act

The starting point is the 1957 Act. Section 2(2) sets out the common duty of care that O owes to his visitors in respect of dangers due to the state of the premises or the things done or omitted to be done on them. This duty is a duty to take such care as, in all the circumstances of the case, is reasonable to see that the visitor will be reasonably safe in using the premises for the purposes for which he is invited or permitted by the occupier to be there. Section 2(3)(b) provides that an occupier "*may expect that a person, in the exercise of his calling, will appreciate and guard against any special risks ordinarily incident to it*." Section 2(4)(b) addresses the situation where damage is caused to a visitor by a danger due to the faulty execution of any work of construction, maintenance or repair by an independent contractor employed by the occupier. In such a case, the occupier is not to be treated without more as answerable for the danger if in all the circumstances he had acted reasonably in entrusting the work to an independent contractor and had taken such steps (if any) as he reasonably ought in order to satisfy himself that the contractor was competent and that the work had been properly done.

In *Fairchild v Glenhaven Funeral Services Limited* [2002] 1 WLR 1052, the Court of Appeal held that, as was the case at common law, the 1957 Act was concerned with the duty owed by an occupier in respect of the dangerous condition of his premises (the so-called "*occupancy liability*")

and not with any lack of safety due to the manner in which activities were carried on at the premises (the so-called "*activity liability*"). Mr. Fairchild was a joiner who worked for G H Dovenor & Son. In the course of his job, he was exposed to asbestos from the work of other contractors whilst undertaking joinery work at premises owned by Leeds City Council and Waddingtons plc. He was unable to sue his employers and instead, sued Leeds City Council and Waddingtons plc in their capacity as the occupiers of the premises where he did his work and where he was exposed to asbestos. In dismissing Mr. Fairchild's claim, the Court of Appeal stated [at para 149]: "*the statutory duty of care created by* [the 1957] *Act imposed a duty on those occupiers to see that Mr. Fairchild was reasonably safe in using the premises for the purposes for which he entered them, and he encountered no dangers in his use of the premises, as he would have done if he had fallen through an unguarded hole in the floor. It was what was going on in those premises which caused him harm*". The same principle was applied to the other 2 cases where the Defendants had been sued in their capacity as occupiers of premises (*Dyson v Leeds City Council* and *Babcock International Ltd v National Grid Co plc*).

It follows that a mesothelioma victim cannot rely on the 1957 Act where the alleged exposure arose from activities conducted on the premises. Where, however, exposure arose from poorly maintained acms, then it is clearly arguable that the occupier's failure to maintain the acms in good condition is an "occupancy liability" under the 1957 Act.

Common Law Liability for the Activities of Contractors

The long established rule at common law is that, if an occupier or employer has engaged an independent contractor to do work on his behalf,

the occupier/employer is not vicariously liable for any tort committed by the contractor in the course of the execution of the work: see e.g *Salisbury v. Woodland* [1970] 1 QB 324 at 336H to 337A.

However, the question remains whether an occupier has any primary duty at common law and, if so, what the content of that duty is?

Engaging Competent Contractors

At least where dangerous activities are being undertaken, the primary duty on an occupier is a duty to take reasonable care to engage competent contractors: see *Ferguson v Walsh* [1987] 1 WLR 1553 and *Bottomley v Todmorden Cricket Club* [200] EWCA Civ 1575.

The difficulties confronting a claimant who wishes to rely on this principle are formidable and are amply illustrated by the recent decision of Nichol J in *Yates v National Trust* [2014] EWHC 222 (QB). This was an accident case in which the claimant suffered serious spinal injuries whilst working as a sub-contractor to contractors undertaking tree surgery on land managed by the National Trust. Having reviewed the authorities, Nichol J concluded that, on the facts as found by him, the National Trust did not owe a duty of care to the claimant in its choice of the contractors who were to undertake the work. Whilst the work of a tree surgeon is hazardous, it was in a different league to the kind of dangerous activities in respect of which the Courts have previously imposed such a duty. Further, the National Trust had no means or measure of control over the work of the contractors.

Of course, different conclusions might be reached in other cases (e.g where an employer employed an unlicensed contractor to undertake asbestos removal works after the implementation of the Asbestos (Licensing) Regulations 1983)

but such cases are likely to be rare.

Assuming such a duty exists, claimants may well encounter problems in proving the duty has been breached. In each of the 3 *Fairchild* appeals for example, the claimants sought to argue that the occupier had breached this duty but, in each case, the trial judge rejected the argument on the facts[16]. In 2 of the cases, there was also a finding that the occupier was unaware of the risks.

Extra Hazardous Activities

The question remains however, whether there is scope for imposing a primary duty on an occupier notwithstanding the fact that the contractors appeared to be competent?

One way in which this might conceivably be achieved is by seeking to apply the principle in *Honeywill & Stein Limited v Larkin Brothers Limited* [1934] 1KB 491 regarding "ultra hazardous" operations. In short, a person (O) who employs an independent contractor will be liable for the negligence of that contractor where the contractor is engaged to carry out "extra hazardous" operations. The argument here would be that a contractor engaged in work to instal or remove acms is engaged in "extra hazardous" operations[17] and that, given the hazardous nature of the work, the occupier is personally responsible for having the work done in a competent manner.

The principle in *Honeywill* has been much criticised both academically[18] and judicially[19] - both as to its provenance and the uncertain ambit of its application. In *Biffa Limited v Machinenfabrik GmbH* [2009] QB 725, the Court of Appeal reviewed both the origins of the principle and how it has fared in subsequent case law. Stanley Burnton LJ (giving the judgment of the Court) concluded that the authorities relied on by the Court of Appeal in *Honeywell* did not support the principle [paras 69-72]. The principle has been rejected by the High Court of Australia[20] and is difficult to reconcile with the decision of the House of Lords in *Read v J Lyons & Co Limited* [1947] AC 156. In the Court of Appeal's words "*...the principle in the Honeywill case is anomalous*" and that "*It is important that it is understood that its application is truly exceptional.*"

In *Biffa Limited* itself, the Court of Appeal emphasised that the principle should be confined to activities which are exceptionally dangerous whatever the precautions taken. This limitation largely emasculates the rule and it is difficult to see how it could be relied on in the type of case under consideration.

Conclusion

Claimants seeking to sue occupiers of premises for asbestos exposure caused by the activities of contractors who were installing or removing acms face formidable difficulties. There is no right to claim under the 1957 Act (this being an "*activity liability*"). Where competent contractors have been appointed, no liability arises at common law. The rule in *Honeywill* relating to "extra hazardous" activities is barely alive but has, in any event, been so emasculated as to be of little value. As such, liability at common law is likely to be established only where the claimant can prove that the occupier failed to take reasonable care in its choice of contractors and that the occupier knew or should have known of the risks that existed if the work was not undertaken competently.

References

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[3] [2014] EWHC 563 (QB).

[4] 'High Cholesterol' (NHS Choices) <http://www.nhs.uk/conditions/cholesterol/Pages/Introduction.aspx> accessed 5 March 2014/

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[6] (n 8).

[7] Irwin, 'Causes of Hearing Loss in Adults' in Dafydd Stephens (ed), *Scott-Brown's Otolaryngology: Adult Audiology* (Fifth Edition, Butterworths 1987)

[8] ibid 140.

[9] Rosen et al, 'Dietary Prevention of Hearing Loss' (1970) 70 Acta Oto-Laryngologica 242.

[10] Booth, 'Hyperlipidaemia and Deafness: A Preliminary Survey' (1977) 70 Proceedings of the Royal Society of Medicine 642.

[11] Spencer, 'Hperlipioproteinaemias in the Aetiology of Inner Ear Disease' (1983) 93 The Laryngoscope 639

[12] Axelsson et al, 'Is There a Relationship Between Hypercholesterolaemia and Noise-Induced Hearing Loss?' (1985) 100 Acta Otolaryngol 379.

[13] Sutbas et al, 'Low Cholesterol Diet and Antillipid Therapy in Managing Tinnitus and Hearing Loss in Patients with Noise Induced Loss and Hyperlipidemia' (2007) 13 The International Tinnitus Journal 143.

[14] Gopinath et al, 'Dietary Intake of Cholesterol is Positively Associated and use of Cholesterol-Lowering Medication is Negatively Associated with Prevalent Age-Related Hearing Loss' (2011) 141 J Nutr 1355.

[15] Chang et al, 'Hypercholesterolemia is Correlated with an Increased Risk of Idiopathic Sudden Sensoineural Hearing Loss: a History Prospective Cohort Study' (2014) 35 Ear Hear 256.

[16] In claims by workmen working on O's premises, the scope of any such duty is also relevant given that the primary duty to protect the workman rests with the workman's employer.

[17] At least post 1965/6 and, depending on the facts, before then.

[18] See Atiyah: "Vicarious Liability in the Law of Torts".

[19] See e.g Lord Macmillan in Read v J Lyons & Co Limited [1947] AC 156.

[20] Stevens v Brodribb Sawmilling Co Pty Limited (1986) 160 CLR 16.

What's new?

BC Legal Leeds

BC Legal are proud to announce the opening of our second office in the centre of Leeds.

We have been joined by Gary Brankin, Darren Goldthorpe and Harjinder Gill from the Leeds office of DAC Beachcroft. Gary and Darren were both Associates with DAC Beachcroft and together managed the Occupational Disease team in that location, acting for major insurers and corporate clients. Gary and Darren will manage our Leeds office and look to continue the rapid growth that we have seen in our Southend on Sea office.

Harjinder is a Legal Executive with over 8 years occupational disease litigation experience and acted for the insurers of Hobourn Eaton in the recent Court of Appeal decision of Johnson v Ministry of Defence.

We have taken premises at 40 Park Square North, right at the heart of Leeds's legal district. This location will allow us to service our existing national clients, but also allow us to reach more easily those potential clients in the Midlands and the North of England.

On joining Gary said *"We are pleased to join a firm that we feel meets the existing needs of clients in this market place. The key to ensuring a lower indemnity spend for our insurer clients is maintaining a high repudiation rate across a range of Occupational Disease claims and Darren and I have a proven track record of delivering results through litigation strategy and use of market information. Insurance clients also want that service at lower cost and we believe that Boris and Charlotte's model will allow us to be very competitive on price, while maintaining the highest possible standards and we look forward to working with them and growing our offering in the North of England."*

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