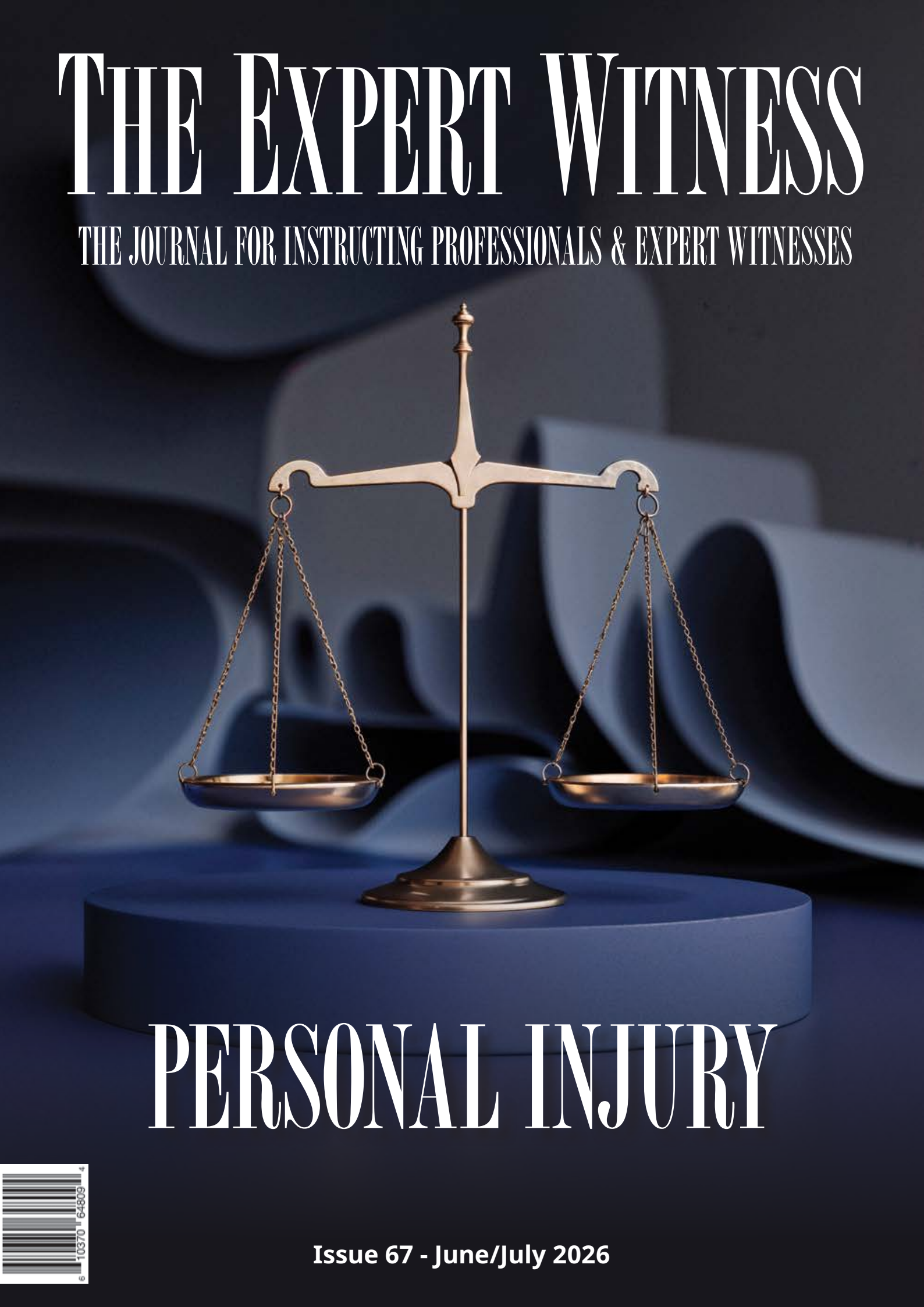
The Expert Witness

THE JOURNAL FOR INSTRUCTING PROFESSIONALS & EXPERT WITNESSES



PERSONAL INJURY

Issue 67 - June/July 2026

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Welcome to the Expert Witness Journal

Personal injury is a legal term used to describe harm caused to a person's body, mind, or emotions, as opposed to damage to property. It encompasses a wide range of injuries, including physical injuries like broken bones or internal trauma, and non-physical injuries such as emotional distress, psychological trauma, or reputational harm.

In this issue we feature articles covering a range of personal injury areas including: Psychiatric Disorders following Physical Trauma – A guide for the non-specialist by Dr Stephen Davies.

Personal Injury Guidelines – the recent High Court decision in Higgins v Coleman (2025), Emma Meagher at Eversheds Sutherland tells us about the current state of the Personal Injuries Guidelines, and how the judgment reflects a growing recognition that the guidelines are now of out date and how this may be relevant when assessing damages in individual cases.

Philippa Luscombe at Penningtons Manches Cooper discusses how local authorities must treat damages held in personal injury trust when determining eligibility for social care funding.

Why "User Error" is rarely the root cause for workplace injury – Adam King at RIMKUS looks at why courts, regulators, and insurers increasingly expect an engineering-led analysis of causation, and why reliance on "user error" alone presents both litigation and indemnity risk.

In part one of this two-part article, Divorce and Family partner Jenny Bowden and Personal Injury associate James Philpott at Stewarts Law LLP, consider personal injury awards in the context of divorce.

Tom McNeill (BCL Solicitors) and Colin Todd (C.S.Todd & Associates Ltd) have previously written of costs being awarded against a fire and rescue authority (FRA) for a prosecution case that "should not have been started" (February 2025 issue), they now update on costs awarded to the defendant.

We also have great articles from Dr Samah Boulis, Forensic Access and Expert Evidence.

Our next issue will be published in August 2026, it will have a non-medical focus, if you have a submission, please email us.

Nigel Hector

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Courtroom Skills
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11th June 2026

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If you missed our Annual Medico-legal Conference on 7th May 2026 in London then you can now book an on-demand pass for access to the recording and earn CPD.

Dr Stephen Peter Castell (3rd August 1946 – 1st April 2025)

by the family of Dr. Stephen Peter Castell.

Dr Stephen Castell, mathematician, entrepreneur, and ICT expert witness, passed away on 1st April 2025, surrounded by family, after a battle with cancer. For more than forty years, as Chairman of CASTELL Consulting, he stood at the forefront of software and systems forensics, dispute resolution, and digital innovation. He leaves a professional and personal legacy that will resonate for years to come.

Born in Cairo in 1946, Stephen's early life reflected his father's RAF postings. He attended eight primary schools and three secondary schools, including a period in Malta. He later graduated from the University of London with a First Class Honours BSc in Mathematics, Physics and Psychology. He went on to achieve an MSc and a prize-winning PhD in Mathematics at the University of Nottingham, where his doctoral thesis was published in full.

Stephen began his career applying advanced mathematical modelling in industry, before moving into management consultancy and information systems during their formative stage. In 1978 he founded CASTELL Consulting, which became his lifelong professional platform. He specialised in the strategising, planning and management of ICT systems and businesses, and in analysing the financial, contractual and legal issues associated with them.

A pioneer of Forensic Systems Analysis, Stephen created methodologies that allowed complex IT disputes to be understood and resolved in court. His expertise was engaged in some of the largest and longest-running ICT contract actions in the English High Court and in international cases across Europe, the USA and Australia. Notable instructions included the Airtours v EDS litigation, the Sydney TCard dispute, and multiple high-value arbitration and patent proceedings. His reports were frequently used in settlement discussions and were noted for their clarity, objectivity, and commercial grounding.

Stephen's work as an expert witness was complemented by his thought leadership, and contributions to professional publications. He authored Computer Bluff (1983) and The APPEAL Report (1990), a landmark study on admissibility of computer evidence commissioned by HM Treasury. His widely cited Cutter Consortium report (2006) set out his forensic methodology, while later writings explored blockchain forensics, AI, and the legal challenges of distributed ledgers. He was a Correspondent of the Computer Law and Security Report and contributed frequently to conferences, and professional journals such as this one.

He remained active in technology disputes throughout his career. In recent years he was appointed in US class actions relating to Voyager and FTX, advising on cases involving significant alleged cryptocurrency losses. He wrote extensively on blockchain and stablecoins, arguing for stronger standards of digital evidence and proposing national stablecoin models to UK government.

Stephen's professional recognition included the British Computer Society's IT Consultant of the Year medal, and awards as Independent ICT Project Manager and Expert Witness of the Year. He served as an ICC arbitrator, a CEDR-trained mediator, and was listed as an expert with the World Intellectual Property Organization in Geneva. He advised government departments, regulators, major corporations and law firms, but also offered pro bono assistance in cases of public importance, such as software failures affecting professional exams.

Stephen was both a frequent contributor to the Expert Witness Journal and a lively correspondent on topics from AI ethics to government algorithms. He was described by the editorial team as "a man of letters" who was "brim full of ideas," and he took real pleasure in sharing insights with fellow experts and readers. He will be remembered for his integrity, imagination, and enthusiasm to use his knowledge for good purpose. As our Profiles Manager recalls: "He was one of my favourites, and will always be one of my most memorable experts. Every time AI comes up, I think of him."

Stephen's colleagues described him as a highly active and generous contributor to knowledge, combining intellectual rigour with curiosity. He was regarded as a respected mentor and collaborator, valued not only for his technical expertise but also for his clarity of thought, pragmatic approach and breadth of perspective. Within professional groups, including the BCS Law Specialist Group, he was recognised as a significant and influential presence, noted for his authority and effectiveness in the courtroom.

In 1968 Stephen married Anne, settling in Wickham Bishops, Essex, where they raised their four children. After Anne's death in 2008, Stephen divided his time between Essex and the South of France, where he and Anne had long intended to spend later life. He then formed a partnership with Margie, with whom he shared a number of years. He was a proud grandfather and deeply devoted father.

He also maintained a longstanding interest in music, composing under the pen name Leo King across a range of styles, including popular and classical works. Sailing was a lifelong passion, and he was a patron of the London Cantamus Bach Choir and Orchestra.

Stephen's professional legacy includes a significant contribution to the development of forensic analysis of IT systems and the standards for expert evidence in this field. He left a body of published work that continues to guide practitioners.

From Expert Witness; About Dr Castell.

Dr Castell was published by Expert Witness as a specialist in all aspects of IT/IP, computer, software, systems, telecommunications, broadcasting and internet disputes, mediator, arbitrator and expert determiner.

His expertise covered complex software and systems inspection, expert reports, Forensic Systems Analysis, contract review, expert evidence in court (oral testimony, cross-examination), project management; cybercrime, evidence and data forensics; IP disputes: patents, copyright, trade secrets; internet, e-commerce and mobile platform technology; software verification and valuation for tax mitigation schemes; IT outsourcing and other supply agreements. Special experience in voice telephony, satellite communications and databroadcasting services and businesses.

Working with legal counsel, he achieved highly effective outcomes for clients, including involvement in the largest and longest software implementation contract actions heard in the English High Court.

He contributed articles, of note being one authored on the Horizon/ fujitsu debacle. He led a campaign to democratise ownership of A.I and drove for transparency from governments on the particular economic algorithms they were employing, encouraging all to ask the questions on the whys and wherefores of the applications and future of technology. He enjoyed referencing Asimov and our editorial team enjoyed playfully illustrating his 'I Robot ' articles, which he loved. A consumate expert witness and mathematician,with a highly creative mind, it is no surprise he enjoyed music, and was dedicated to life long learning and advancement for the good of society.

Instructing experts, and how long does the leash have to be for the acid test to be satisfied?

by Alex Ruck Keene KC (Hon), Barrister, Writer & Educator.

Bristol City Council v CC & Ors [2026] EWCOP 19 (T3) is an important decision in which Theis J set out a clear set of expectations about instructing experts. It also includes what is now an increasingly standard reminder that dividing care and residence decisions can frequently be artificial.

The guidance provided by Theis J requires reproduction in full:

10. At the invitation of the court the parties have liaised and produced an extremely helpful agreed note on the instruction of experts in the Court of Protection. This issue arose due to my concerns in this case as to (i) the length of the letter of instruction sent to the expert in this case (27 pages, 12 of which were under the heading 'Legal Framework'), and (ii) the incoherent management of the way documents were sent to the expert prior to this hearing by the local authority (he was sent large pdf bundles with no agreed guide as to what he should read/focus on). As a result, I hope what follows will be a useful reminder of the framework in which experts are instructed in the Court of Protection and how such instructions should be managed. Those willing to give expert evidence in cases in the Court of Protection are an invaluable resource to assist the parties and the court reach decisions in these difficult cases. The parties and the court need to ensure that all necessary steps are taken to enable them to undertake that important role.

11. The procedural rules on the instruction of experts in the Court of Protection are contained in rule 15 of the Court of Protection Rules 2017 ('COPR 2017'), as supplemented by Practice Direction 15A. The test is 'necessary' (rule 15.3(1) COPR 2017) and permission may only be given if it is necessary to assist the court to resolve the issues in the proceedings and could not otherwise be provided by a rule 1.2 representative or in a report pursuant to s49 MCA 2005 (rule 15.3(2) COPR 2017).

12. When making an application for the instruction of an expert on form COP9 the application must include a draft letter of instruction to the expert (rule 15.5 (2)(f) COPR 2017). The expectation is that the draft letter of instruction should be approved by the court or, if not (due to urgency or some other reason), clear directions in the order for the letter to be finalised with the questions for the expert being approved or overseen by the court.

13. The letter of instruction must be focussed and adapted to the facts of the particular case. Previous cases provide helpful guidance (such as Poole J in AMDC v AG and CI [2020] EWCOP 58 [28 (b)] "28... (b) [t]he letter of instruction should, as it did in this case, identify the decisions under consideration, the relevant information for each decision, the need to consider the diagnostic and functional elements of capacity, and the causal relationship between any impairment and the inability to decide. It will assist the court if the expert structures their report accordingly. If an expert witness is unsure what decisions they are being asked to consider, what the relevant information is in respect to those decisions, or any other matter relevant to the making of their report, they should ask for clarification." [emphasis added]). Lengthy and unwieldy recitations of the background facts and procedural history are to be avoided, as well as detailed descriptions of previous case law.

14. It may be helpful to keep in mind the following as the key components of a letter of instruction to an expert:

> *(1) A brief neutral statement of the essential facts of the case.*
>
> *(2) A list of materials with which they are being provided for the purpose of the assessment the expert is undertaking.*
>
> *(3) A core legal framework setting out the central principles of the MCA 2005, a summary of the relevant sections of the MCA 2005 should suffice and, if appropriate, to reflect, for example, the order in which a capacity assessment should be approached, as set out by the Supreme Court in A Local authority v JB [2021] UKSC 52. Any such references should be kept succinct and must be relevant.*
>
> *(4) If assessing capacity, identification of the relevant decisions to be assessed, with the relevant information for each decision as agreed between the parties. If required there can be a brief explanation as to where the*

information derives, providing confirmation that what the relevant information consists of should ultimately be a matter for the relevant expert to determine when undertaking the assessment, and a reminder of the importance that the expert is not an arbiter of fact.

(5) Confirmation as to whether the proceedings are in public or private and details of any Transparency Order in place.

(6) Details of any person(s) the parties consider the expert should or may meet with, and remind the expert of the importance of there not being any unrecorded/ informal discussions.

(7) The letter should clearly identify timescales for the report, dates of hearings/oral evidence, confirmation of who the report will be disclosed to, and a reminder about the ability to pose questions of clarification (rule 15.7. COPR 2017). It should also contain information about the expert's fees.

15. Questions to the expert after the filing of their report should only be done in accordance with rule 15.7(2) COPR 2017 or by order of the court (rule15.7(3) COPR 2017). In accordance with rule 15.7(2)(c) COPR 2017, any such questions must be for the purposes of clarification only.

16. In addition to ensuring experts have all the relevant documents at the point of their instruction, the parties should keep under active review what further evidence or documents should be sent to the expert with a suitable covering message identifying the relevant documents. If agreement is not possible, a COP9 application will need to be issued setting out the issue and the parties' competing positions with a draft order attached. This will enable the court, if appropriate, to determine the issue on the papers.

17. If an expert is going to give oral evidence at a hearing, they should be provided with the following in advance of the hearing by the lead instructing party:

(i) An updated court bundle at the same time as the bundle is lodged with the court.

(ii) A list of updating documents that have been filed since their instruction, which should highlight the specific documents that the parties consider that they should review in advance of the expert giving oral evidence.

(iii) Any further 'loose leaf' documents filed immediately prior to the hearing, that the parties will likely refer to in the course of their questioning of the expert.

The precedent letter of instruction on the Court of Protection Handbook website has been (lightly) amended to respond to the observations of Theis J, and also to add a 'red flag' around the use of artificial intelligence, an issue which is raising increasing concern, in particular in the context of assessing capacity.

Visit:
courtofprotectionhandbook.com/precedents/

Proving psychiatric injury in personal injury claims: What evidence do you need?

by Katie Charlton, Associate at Anthony Gold Solicitors LLP.

Psychiatric injury can arise after a traumatic or stressful event, and may include conditions such as post-traumatic stress disorder, anxiety, or depression. Psychiatric injuries often occur alongside physical injuries, though it can be possible in limited circumstances to make a claim where only psychiatric injuries have been sustained, which I discuss in more detail in my previous article which provides an overview of personal injury claims for psychiatric injury.

Psychiatric conditions are treated seriously in personal injury claims, but they must be supported by clear and reliable evidence. Unlike physical injuries, psychiatric harm is not always visible. This means the success of a claim often depends on how well the evidence shows both the existence of the condition and its impact on daily life. In this article, I explain the key types of evidence used in psychiatric injury claims and why they matter.

Medical Records

The claimant's medical records are obtained at an early stage of the claim. These often include GP notes, records of any therapy or counselling and hospital records (where applicable). It is important to obtain medical records from both before and after the event.

Medical records from before the event assist with assessing the impact of any pre-existing conditions. Where there is a history of mental health difficulties, this does not prevent a claim. However, it must be properly considered and supported by evidence. I discuss this in more detail in my previous article on pre-existing conditions in psychiatric personal injury claims.

Medical records created at or around the time of the event are contemporaneous evidence of symptoms caused by the event. These documents are often some of the most important pieces of evidence in a claim. They provide an objective account of when symptoms began and how they developed over time. This helps to support the claimant's account and adds credibility.

If there is a delay in seeking medical attention, or gaps in the records, this can raise doubts about the claim. This is particularly the case for psychiatric conditions as you cannot prove the presence of the injury with a scan or an x-ray (as you often can with physical injuries). For this reason, it is important for individuals to seek appropriate medical advice as soon as possible and to follow any recommended treatment.

Medical Expert Evidence

The role of independent experts

Medical expert evidence is central to any psychiatric injury claim. Courts rely on independent specialist expert witnesses, usually a Consultant Psychiatrist, to assess the claimant, review the medical records and provide an objective opinion.

The claimant and the defendant usually each obtain their own expert medical evidence. However, these experts are instructed to assist the court, not to act for either party. Their role is to provide a fair and balanced assessment based on their professional expertise.

What expert evidence covers

An expert report will usually include a diagnosis of the claimant's psychiatric injuries based on recognised medical criteria. It will also address whether the condition was caused by the event in question and provide treatment recommendations as well as a prognosis for recovery.

In addition, the report will usually consider how the condition affects the claimant's ability to work, maintain relationships, and carry out daily activities. This information is important when assessing the value of the claim.

Witness Evidence

Who can provide evidence

Witness evidence can play an important supporting role in psychiatric injury claims. Statements are often provided by people who know the claimant well, such as family members, friends, or colleagues.

What this evidence shows

Witnesses can describe how the claimant was before the incident and how they have changed since. This may include:

- Changes in mood or behaviour
- Symptoms they observe the claimant suffering (such as panic attacks or nightmares)
- Withdrawal from social activities
- Difficulties at work
- Impact on relationships
- Additional care and support provided to the claimant

This type of evidence helps to illustrate the day-to-day impact of the condition. It compliments medical evidence by providing a fuller picture of how the injury affects the claimant's life. It is also important in supporting a care claim where the witness has provided additional gratuitous care and assistance to the claimant due to their psychiatric injuries.

The Importance of Strong Evidence

There are several common issues relating to evidence for psychiatric injuries that can affect the strength of the claim, including:

- Delay in seeking medical treatment
- Inconsistent reporting of symptoms
- Failure to follow medical advice

The quality and consistency of evidence can have a direct impact on the outcome of a claim. Strong evidence supports the credibility of the claimant's account and helps demonstrate not only that a psychiatric injury exists, but also how serious it is and how long it is likely to last.

Conclusion

A specialist solicitor, such as the expert team at Anthony Gold, can guide you through the process, gather the right evidence, and put forward the strongest possible claim.

Early legal advice can make a significant difference to how well a claim is prepared and presented.

Understanding the risks and avoiding common pitfalls can also help protect the credibility of a claim. With the right evidence and legal support, claimants are better placed to achieve a fair outcome.

Jointly instructed expert witnesses remain subject to judicial scrutiny

by Bond Solon.

A recent High Court case confirms that the report of a jointly instructed expert is not necessarily conclusive. The trial judge will take the report into account, but it is the judge's findings of fact that are determinative, and this may not always align with the evidence of the jointly instructed expert.

It is tempting to assume that the evidence of a jointly instructed expert witness will be accepted by the courts. Afterall, both sides of the dispute will have agreed that the chosen expert has the requisite credentials to provide a reliable opinion.

However, as with all evidence in litigation, there are times when the court will be privy to facts beyond the expert's remit or see the facts of the case in a context that the expert did not perceive. In that case, it may be that the judge draws an alternative conclusion to the jointly instructed expert witness, dismissing their evidence altogether.

UAB Business Enterprise & Anor v Oneta Ltd & Ors [2026] EWHC 543 was one such case. After a hearing in January, IIC Judge Agenello KC's 11 March judgment dismissed the evidence of a jointly instructed expert on the basis that she had not been given access to all the relevant facts before drawing her conclusion.

Lacked all the facts

The claim related to ownership of shares in Oneta Ltd and whether the settlement agreement the case hinged on was genuine. The agreement, which was drawn up on scrap paper, ostensibly included the signatures of all parties but the claimant contended that it was not valid and that it had not been signed legitimately.

The expert witness in the case concluded that, while she agreed that the disputed signature of claimant Mr Jakstys had been handwritten by him, she could not verify the document as genuine and believed there was a high chance that it had been created around the signature.

Her report stated: "In my experience, the anomalies observed with respect to the Settlement Agreement are typical of a document manipulation process having been undertaken."

In assessing the case, the judge made it clear that the expert witness had not been in possession of all the facts. The judge said the expert had evaluated the authenticity of the agreement "in a complete vacuum of the facts and evidence as to how the document was created and signed". This was important because it was those very facts that were in dispute.

The judge said: "Additionally, she had been provided with no information relating to what happened to the document since it had been created, for example whether it had been folded, where it was stored and also whether it had been stapled previously."

The history of the document in fact explained the apparent anomalies that had led the expert to her opinion.

The judge explained: "It is clear that the third page had been separated from the other two pages. There was no evidence provided to [the expert] as to when the third page had been separated. In fact, there is evidence that it had been stapled to another letter earlier on."

Disregarded the joint expert's evidence

Moreover, the judge accepted that the document had been produced on scrap paper and that the parties were aware that had been the case.

The judge said: "There is no evidence relating to the condition of the scrap paper itself prior to it being used ... to print the document."

This means the anomalies were likely already present and not material evidence of any tampering during the drawing up of the contested agreement. As such, the judge found in favour of the defendants that the document was "authentic and binding". This was contrary to the conclusion of the jointly instructed expert.

Summary

This case highlights that the evidence of a jointly instructed expert will be scrutinised in the same manner as all evidence and never blindly trusted in court. The report will be considered alongside the full facts of the case. Where a judge feels there are gaps in the evidentiary basis for an expert's conclusions, they will point them out and may draw the opposite conclusion.

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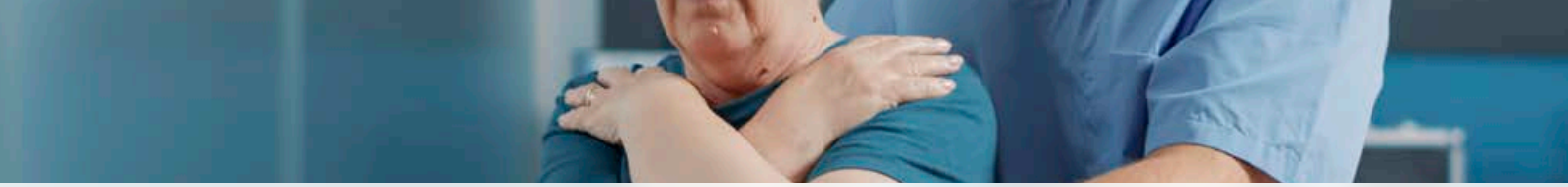

Funding rehabilitation for major trauma injury with Rehabilitation Code and interim payments

by Claire Roantree, Partner at Boyes Turner LLP.

It takes more than emergency or acute hospital treatment to recover from a major trauma injury. Severely injured people need ongoing support from a range of therapies, such as physiotherapy, OT, speech and language therapy and psychological treatment, long after their discharge from emergency, trauma and acute hospital care. This ongoing form of treatment is known as rehabilitation.

The timing and effectiveness of a severely injured person's rehabilitation after a major trauma injury can have a life-changing impact on their long-term physical and psychological recovery, their mobility and independence and their quality of life. That's why we believe that our injured clients shouldn't have to wait for their rehabilitation until their claim has concluded. We prioritise securing funding for timely, personalised, coordinated specialist rehabilitation for our injured client in every major trauma and serious personal injury claim.

In most cases, we are able to secure funding for rehabilitation from the insurer of the person (such as a driver) or organisation (such as an employer) that was responsible for the injury, via Rehabilitation Code funding or an interim payment.

What is the Rehabilitation Code and how is it used to fund rehabilitation?

The Rehabilitation Code sets out an approved framework for the injured persons' solicitor and the defendant's insurers (the paying compensator) to work together to prioritise the injured person's rehabilitation. The aim of the Rehabilitation Code is to promote the use of rehabilitation at an early stage in the claims process, to help the injured person make the best and quickest possible medical, social, vocational and psychological recovery.

Under the Rehabilitation Code, funding is provided by the defendant's insurance company to support the injured person's rehabilitation and treatment costs whilst a compensation claim is underway. Rehabilitation Code funding should be provided regardless of whether the defendant or their insurers have accepted responsibility (fault or liability) for the collision, accident or other events that caused the claimant's injuries.

Where the injured claimant has suffered serious injury, major trauma, complex or multiple injuries, a case manager will usually be instructed to prepare an immediate needs assessment (INA). The INA sets out the injured person and their family's needs, and makes recommendations for rehabilitation and support which, if agreed, will be funded by the defendant's insurer. Rehabilitation Code funding is usually paid directly by the insurer to the injured person's rehabilitation provider.

Rehabilitation Code payments are not counted as advance payments from the claimant's compensation, and are not affected by any proportional reductions in their compensation, such as discounts for litigation risk or contributory negligence. This enables the injured person and their family to rest in the knowledge that the costs of their rehabilitation are paid over and above their financial compensation and will not be deducted from their settlement or compensation award. Given this advantage for the claimant, where contributory negligence or the claimant's need for rehabilitation is disputed, the defendant's insurer may decline to make a Rehabilitation Code payment but, instead, agree to make an interim payment.

The Rehabilitation Code does not apply to medical negligence claims.

What is an interim payment?

An interim payment is a part payment of the claimant's compensation that is paid in advance by the defendant's insurer or compensator during their personal injury or medical negligence claim. The amount of the interim payment can vary significantly. Interim payments are often used to pay

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Mr Khatwa is a Consultant Otolaryngologist (ENT surgeon) at the Royal Devon and Exeter Hospital.

He has been an expert witness since 2014 and is Bond-Solon certified (excellence in report writing) and attends on regular basis the annual Bond-Solon expert witness conference.

Specialised in:

- Noise induced Hearing loss
- MOD noise induced hearing loss
- General ENT personal injury
- Rhinology-Rhinoplasty
- Otology
- Snoring and Sleep apnea
- Diving and ENT related injuries
- Vertigo
- Tinnitus

He has been actively involved in the area of research with national and international peer-reviewed publications

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Dr. Ayyaz Sultan

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Mr Burge has been a Consultant Plastic Surgeon since 1996 and has a broad experience having worked in the Army, the NHS and the Private Sector. He has over 20 years of experience writing reports and receives about 400 instructions per year. He has been instructed by Claimants, Defendants, and as a Joint Expert. He is aware of the Part 35 requirements of an Expert Witness and has obtained Part 1 of the Certificate of Medical Reporting (Bond Solon). He has experience appearing in court as an expert witness. Appointments are available in Bristol, London, Cardiff, Birmingham and Salisbury. All reports are produced within agreed timescales, usually six weeks, which can be expedited.

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Consultant Trauma and Orthopaedic Surgeon

MBChB (Hons) BSc (Hons) FRCS (Tr & Orth)

Mr Hussain Kazi is a Consultant Trauma & Orthopaedic Surgeon at Mid Cheshire Hospitals NHS FT. Mr Kazis' scope of practice includes the generality of trauma, hip fracture surgery along with an elective interest in primary hip and knee arthroplasty and revision hip arthroplasty.

Mr Kazi completed his FRCS (Tr&Orth) in February 2011 and specialist training in April 2013. His first fellowship was at Sunnybrook Health Sciences Centre, Toronto, Canada. He returned to the UK in June 2013 and completed 18 months as the hip fellow in the Exeter Hip Unit. He is currently a consultant orthopaedic surgeon responsible for both acute and elective admissions.

Mr Kazi commenced personal injury work in April 2015 and negligence work in 2017. He completes 200 personal injury and around 30 negligence reports per year.

Mr Kazi has undertaken Expert Witness training with Cardiff University Medico Legal Foundation Certificate in 2015.

Mr Kazi is involved in clinical research, is a Journal Reviewer and is also widely published.

Mr Kazi is happy to undertake the generality of personal injury along with a subspecialist interest in injuries of the hip.
His negligence practice focuses on Primary Hip and knee arthroplasty and revision hip arthroplasty (joint replacement).

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Consultant Plastic, Aesthetic and Hand Surgeon | MB MSc FRCS(Plast)

Mr Ragoowansi accepts instructions for personal injury claims and provides clear, balanced medico-legal reports for solicitors acting on behalf of both claimants and defendants.

Medicolegal and clinical background

- Renowned expert in Plastic, Reconstructive and Hand/Wrist Surgery, Senior Consultant at Barts Health NHS Trust.
- Over 20 years of experience in Medico-Legal reports and acting as an expert in Clinical Negligence cases.
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- Personal Injury cases: Hand & Wrist surgery, skin lacerations and scars, burns and scalds, aesthetic surgery (breast and body contouring).
- Clinical Negligence cases: causation, prognosis, or both; 3-7 carefully vetted cases per year.

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for medical or therapeutic treatment, care, specialist equipment, home adaptations or a move to a more suitable home, or to ease financial hardship that has been caused by the injury.

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An interim payment is often requested once primary liability (responsibility for causing the accident or injury) has been admitted or proven against the defendant. This may take place early in the claim, sometimes even before court proceedings have been issued, or following a successful trial in which the injured person has proven the defendant's liability.

The court can order the defendant to make an interim payment but, before applying to the court, the claimant's solicitors usually ask the defendant to make a voluntary interim payment, explaining how much is required and what it is intended for. If the defendant refuses to make an interim payment or is unwilling to pay an amount which will meet the injured person's immediate needs, then the claimant's solicitor can apply to the court, justifying the sum requested in the context of the overall value of the claim, and providing medical reports and other evidence to support the application. The claimant does not need to attend court for the interim payment hearing.

The court's permission must always be obtained before an interim payment can be made to a claimant who is a child or a protected party (with mental incapacity). This applies even where the defendant has agreed to make the interim payment voluntarily. A Court of Protection deputy may be appointed to oversee the management of the claimant's money. At Boyes Turner, our personal injury and medical negligence solicitors work closely with our own Court of Protection specialists to ensure that our client's money is managed and protected in accordance with the court's requirements but is easily accessible to meet their needs.

What are the advantages of an interim payment?

An interim payment allows our severely injured clients to make the changes that are necessary to manage their disability and see what works for them before final settlement. This helps clarify their long-term needs and demonstrate the benefit that their compensation will provide, helping us claim and recover the most suitable provision for their future.

Each individual's and family's circumstances are unique but our severely injured clients use interim payments:

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- to pay for a rental property whilst their existing property is adapted or a new property is found;
- to purchase specialist treatment, aids or equipment which are not readily available on the NHS;
- to purchase a wheelchair with regular seating assessments and adapted vehicles;
- to put a care plan in place;
- to put in place therapies, such as physiotherapy, OT, speech and language therapy, pain management and psychological support;
- to assist with the additional costs of caring and providing for a family member with a disability.

At Boyes Turner we have helped hundreds of disabled clients and their families rebuild their lives after serious personal injury, major trauma or medical negligence. The support we give our clients through funded rehabilitation and interim payments ensures that they can focus on rebuilding and participating fully in family life, whilst we work to achieve the best possible settlement of their claim.

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We are instructed by claimant and defendant solicitors, as well as directly by various insurers and reinsurers seeking to mitigate long term, high value, neurological related claims.

Psychiatric Disorders Following Physical Trauma - A guide for the Non-Specialist

by Dr Stephen Davies, Consultant Psychiatrist (General Adult & Liaison).

Dr Davies is a General Adult and Liaison Psychiatrist from Wales with an interest in the interface of Physical and Psychiatric disorders.

Summary

There is a strong association between physical injury and Psychiatric disorders, and this goes beyond Post-Traumatic Stress Disorder to include mood disorders, substance misuse, Somatoform/ Dissociative Disorder and anxiety disorders. If an expert witness practising outside of the field of mental health is asked to make recommendations about need for a psychiatric evaluation they might consider asking some key questions or make use of rating scales. As ever, experts should not stray outside of their own field of expertise.

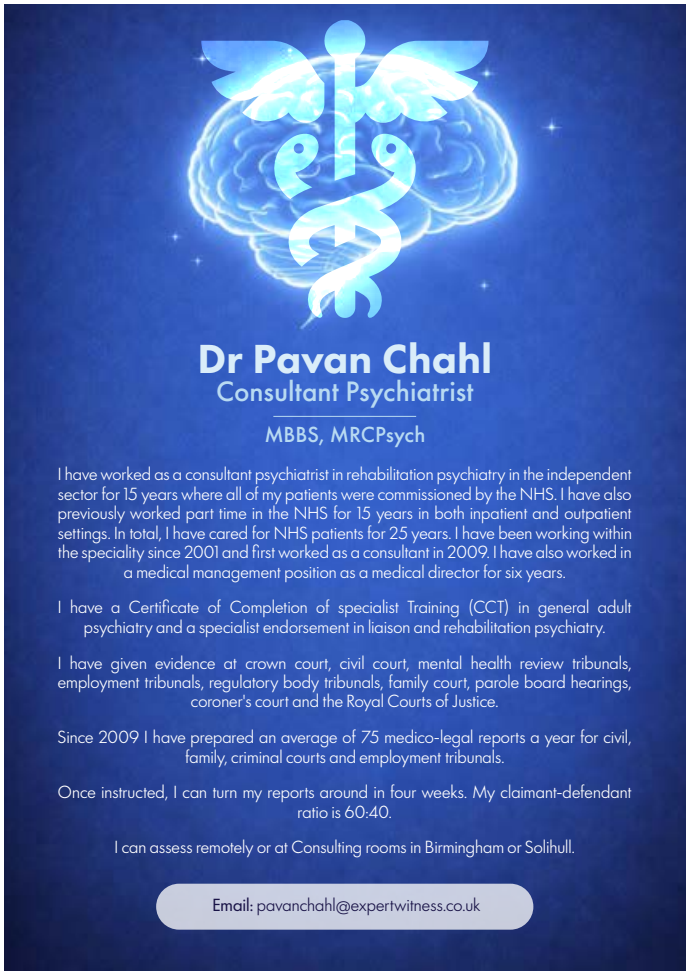
The expert witness who sees a claimant about their physical injuries often does so many months before an appointment with a mental health expert takes place. It can be helpful at this stage if the presence or absence of a few key Psychiatric symptoms is recorded. Experts in medical and surgical specialities are not expected to have detailed knowledge of mental health conditions, nor should they give opinions outside their expertise. But an understanding that is more than basic may be needed to say why a Psychiatry or Psychology report is required. Psychiatric symptoms can alter the course and manner of presentation of physical injuries or disease in a number of ways. Clinical Depression, Anxiety Disorders or Post Traumatic Stress Disorder may manifest as physical symptoms such as tiredness, pain, palpitations or weakness. Patients with depression or anxiety disorders may be reluctant to participate in rehabilitation (including physiotherapy) or resume work or exercise because of reduced motivation or fear of further injury. Patients with substance misuse may be more vulnerable to developing dependence on prescribed painkillers after an injury, and this in turn can contribute expression of pain or to impaired function for longer than expected. Unexplained physical symptoms or prolonged recoveries may be due to a variety of psychiatric disorders including somatoform disorders.

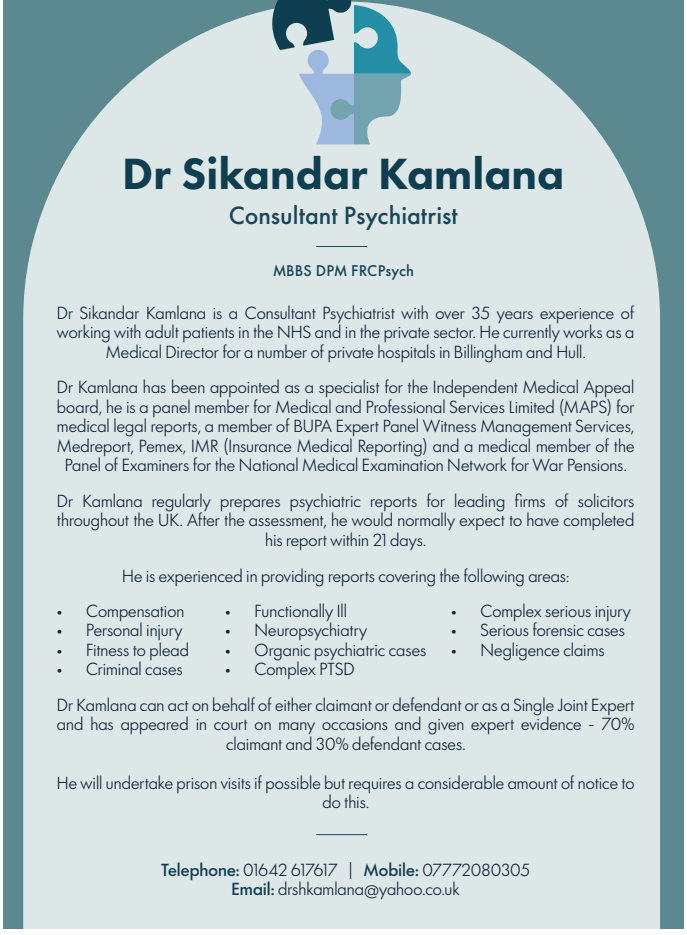
An association between injury and Psychological symptoms does not demonstrate causation, of course. There can be good reasons why individuals with existing psychiatric disorders are more prone to physical injury, aside from attempted suicide or self-injury. For example, cognitive impairment, sedative medication or excessive alcohol may all predispose to falls, road traffic accidents (RTAs), or burns. People with ADHD (with or without associated Neurodevelopmental Incoordination Disorder) are more prone to sustaining accidental injuries and road traffic accidents.

Psychiatric diagnoses are standardised in ICD-11 (World Health Organisation) introduced in 2022) and DSM5 (American Psychiatric Association, Text Revision, 2022). The former is more widely used in UK and is freely available online. Table 1 lists some disorders that a reporting Orthopaedic, Neurology or Pain Medicine Expert may want know a little about. It is worth these experts checking they understand some of the more commonly used terminology.

Table 1 – Psychiatric Disorders Relevant to Physical Injury

- Post Traumatic Stress Disorder
- Depression
- Anxiety Disorders
- Somatoform Disorders
- Functional Neurological Symptom Disorder
- Alcohol and Opiate Use Disorders
- Factitious Disorder and Malingering





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Dr Aftab Laher

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Accredited Cognitive-Behavioural Psychotherapist (BABCP)

Expertise: PTSD | Adjustment Disorders | Anxiety | Phobia | Depression | Sexual Abuse | Chronic Pain | Physical Disability Acquired Brain Injury | Body Dysmorphia | Workplace Well-Being | Rehabilitation | CBT

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Post-Traumatic Stress Disorder (PTSD) is perhaps the condition which clinicians will first think of as a psychiatric complication of physical trauma. Possibly it is unique among psychiatric disorders due to a specified requirement for a distressing event in order for the diagnosis to be made. The threshold is set fairly high, and a minor trip injury or low impact RTA would not be expected to lead to PTSD. ICD-11 requires "event(s) of an extremely threatening or horrific nature" eg natural or human-made disasters, serious accidents, torture, sexual violence, terrorism, assault or acute life-threatening illness, witnessing the threatened or actual injury or death of others in a sudden, unexpected, or violent manner; and learning about the sudden, unexpected or violent death of a loved one. Among the requirements in DSM5 is "Exposure to actual or threatened death, serious injury". What is "serious" in terms of injury or accident is not defined. Clearly, how threatening a particular injury is to a person will depend on its context and their psychiatric vulnerability or robustness. But only a minority of people experiencing an incident meeting the required threshold will go on to develop PTSD. A further requirement is that Psychological symptoms have a significant impact in terms of distress or altered activities. Of the two classifications of PTSD, ICD-11 is probably the more straightforward in terms of symptom profile. It requires all three of the following:

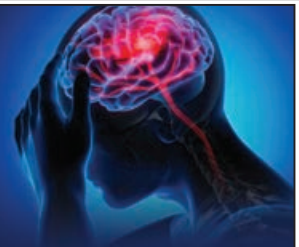
1. Re-experiencing. This could be in the form of frequent distressing dreams, intrusive distressing thoughts, or flashbacks. In psychiatric jargon, the term flashbacks has a specific meaning, denoting that the traumatic event is being experienced again, in the here and now. It entails a dissociative element and is different in that sense to a memory. In this context, a "flashback"is different to the way the term is used about a film or movie, denoting simply an insertion of past events into the narrative, and it is worth obtaining a description of what a claimant experiences if this term is used.
2. Hypervigilance/hyperarousal. Hypervigilance is not simply being careful. Anyone who has had a significant injury will be more careful next time, and all drivers are expected to remain vigilant. ICD-11 says that people who are hypervigilant "constantly guard themselves against danger and feel themselves or others close to them to be under immediate threat either in specific situations or more generally. They may adopt new behaviours designed to ensure safety (e.g., not sitting with ones' back to the door, repeated checking in vehicles' rear-view mirrors)".
3. Avoidance. In DSM-5, for PTSD, avoidance has to be persistent. It can be avoidance of internal reminders (thoughts, memories, feelings) or external reminders (people, places, activities, discussion). However, in ICD-11, the requirement is for avoidance not merely of reminders, but of situations or activity likely to lead to re-experiencing (eg flashbacks).

To screen for PTSD, a rating scale such as the PCL-5 (based on the DSM-5 criteria) could be used. Alternatively, consider a few questions about key symptoms such as: Do you get dreams or nightmares about the incident? Is there anything that you will not do because it reminds you of the incident in a way that is too upsetting? In what ways are you more on your guard than before the incident? Was there a time where you would not go to the place where the incident happened or do what you were doing at the time, e.g. driving, sport?

Depression

Depression is used as an everyday synonym for feeling sad, miserable or fed up. For example, "This weather makes me feel so depressed". It is worth reminding ourselves that the definition of clinical depression is different. Symptoms are more persistent and are present for most or all of the time over at least two weeks (usually longer). ICD-11 requires that during this period, depressed mood or diminished interest must be present most of the day, nearly every day, accompanied by other symptoms, such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. Importantly therefore, an episode consisting of low mood that has been present less than most of the time, with maintained interest in activities rules out a depressive episode. Likewise, DSM 5 specifies similar core symptoms (with the addition of loss of capacity for enjoyment) and the additional and core symptoms must make up a minimum of 5. There is also a requirement that symptoms are not better explained by another physiological process or substance.

Various rating or screening scales are sometimes used. The Beck Depression Inventory and Hospital Anxiety and Depression Rating Scale (HADS) have their merits but do not correspond well to the definition of Depression given above. NHS Psychological Services which operates in England has adopted the PHQ-9 which is also commonly used in primary care. The PHQ9 corresponds well to the DSM5 criteria for Major Depression and unlike HADS, is copywright free. If the medicolegal expert is going to use one of these scales, they might choose the PHQ9 in order that scores may be directly compared with those used by others. However, as with all such scales, they should not be regarded by the Courts as substitutes for a clinical assessment and nor should scores be interpreted very literally like blood test results or thermometer readings.



Dr Kailash Krishnan

Consultant in Stroke Medicine and Hon Asst Professor

MBBS, FRCP, FESO, PhD (Stroke Medicine)

Dr Krishnan is triple accredited in General Internal Medicine, Geriatrics and Stroke Medicine with expertise in Geriatrics and Stroke Medicine. He completed by PhD in Stroke at the University of Nottingham and has been a full-time Consultant since 2016.

He is involved in the management of patients in stroke and transient ischaemic attack (TIA) across the whole patient pathway including diagnosis, investigation, acute treatment, rehabilitation, secondary prevention and long-term complications.

Dr Krishnan is co-lead of the Mechanical Thrombectomy service at Queen's Medical Centre Nottingham University Hospitals NHS Trust and now involved in roll-out and implementation of AI regionally. Dr Krishnan is also co-lead the PFO closure for cryptogenic stroke at Nottingham which is now a regional service.

Dr Krishnan is a group chair for developing national guidelines for stroke and part of an international consortium which developed guidelines for HRT in stroke, thrombolysis and mechanical thrombectomy for pregnancy and peuperium for the European Stroke Organisation.

Dr Krishnan is now a chief investigator of a multicentre, randomised controlled trial in acute intracerebral haemorrhage (awarded by the NIHR RfPB) and principal/site investigator for eight other clinical trials. He has published widely in national and international journals (including the Lancet) and regularly peer-review publications submitted to various journals. He is an invited and elected member of various national and international committees.

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Dr Pete Fleming

Consultant Clinical Neuropsychologist

Dr Pete Fleming

Consultant Clinical Neuropsychologist

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Dr Fleming is a Consultant Clinical Neuropsychologist with over 16 years' of post-qualification experience. A Chartered member of the British Psychological Society (C.Psychol), and a Health and Care Professions Council (HCPC) Registered Practitioner Psychologist.

Dr Fleming's current NHS post is Consultant Clinical Neuropsychologist for Lincolnshire Partnership NHS Foundation Trust (LPFT), a community neuropsychology service involving clinical work with acquired brain injury and a wide range of other neurological conditions, leadership, considerations of service strategy and the management and supervision of junior colleagues. Previously, Dr Fleming has worked across a range of inpatient specialist neuro-rehabilitation facilities.

Within the independent sector, Dr Fleming provides neuropsychological assessment and rehabilitation to adults with a range of complex physical and neurological disabilities, including within the context of medico-legal matters. Dr Fleming is regularly instructed in Civil cases, including both personal injury and clinical negligence cases, and in Criminal court cases, he also regularly completes mental capacity assessments related to a wide range of decisions. Dr Fleming also supervises candidates undertaking the BPS Qualification in Clinical Neuropsychology (QICN). He has undertaken specialist expert witness training obtaining the Cardiff University Bond Solon Civil Expert Certificate.

Dr Fleming has authored articles on acquired brain injuries

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Specialising in the assessment and treatment of neurocognitive, behavioural and emotional changes resulting from traumatic brain injury, neurological disease, learning disability and psychiatric illness.

I hold a doctorate in Neuropsychology and a doctorate in Clinical Psychology. I am on the British Psychological Society's Specialist Register of Clinical Neuropsychologists. I have extensive experience in neuropsychological assessment and treatment.

I have been preparing expert witness reports since 1999. On average I prepare 65 medico-legal reports a year which includes people who have suffered a brain injury arising from a road traffic accident, medical negligence, or an industrial accident. Additionally, I have provided reports for employment tribunals and in high profile cases. I am regularly instructed by major firms of solicitors representing Claimants and Defendants.

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Anxiety Disorders

These might include Generalised Anxiety Disorder, Panic Disorder and specific phobia. It is helpful to think of both physical symptoms (eg palpitations, dry mouth) and psychological symptoms (worry, feelings of impending doom, wish to escape) when considering anxiety. Identical symptoms can occur as appropriate responses to fear, but also during drug or alcohol withdrawal, or as side effects of stimulants. Generalised Anxiety Disorder denotes free floating anxiety as well as problems with concentration, sleep, worries and restlessness. A panic attack is a severe paroxysm of anxiety unrelated to specific triggers or situations. It does not simply denote "panic" as used in an everyday sense, "I am in a panic because I am late for my appointment". The term "specific phobia" may conjure images of spiders or needles, and may seem irrelevant to physical injury. But this diagnosis might apply to someone unable to resume travel by car due to severe anxiety following a RTA (assuming the other features of PTSD are not present). Also, in the elderly, after injuries to the lower limbs, fear of falling is fairly common and can itself impair mobility. This can also occur following other fall injuries and in younger adults. Psychiatrists and Psychologists rarely see patients with phobic presentations in the clinical settings, and often they will be managed by pragmatic way eg by Physiotherapists. Specific phobia presentations often resolve with simple measures or with time, but are amenable to formal psychological treatment if symptoms persist. Sometimes care is needed to differentiate this situation from one in which somebody has taken a rational decision to not longer participate in a particular activity, e.g. motorcycling, hang-gliding, following an injury. It is helpful to ask whether the person misses the activity again, or if they are glad not to have to do so.

TABLE 2 - Psychologist or Psychiatrist? Which to recommend?

There is a lot of overlap. Both usually use a bio-Psycho-social approach. A Psychiatrist will usually have more expertise in Bio-medical matters and will be able to make recommendation about medication as well as Psychological therapy. Psychologists will often have more expertise in Psychological therapy and Psychometric testing. But expertise varries between individuals and solicitors will have particular experts they work with. So suggest a report by a "Psychiatrist or Psychologist with relevant expertise"

Alcohol Use Disorder

Features can include physical tolerance, craving, wanting to reduce or stop drinking but being unable to, continuing consumption despite physical harm or impact on work/relationships, and repeatedly consuming more than intended. For mild Alcohol Use Disorder (AUD) just 2 or 3 symptoms are required, and the threshold is lower than concepts confined to physical dependence and withdrawal. Criteria for other substances eg opiates are similar. AUD can develop anew following a physical injury. Sometimes claimants will say that following an incapacitating accident or injury, they found they had more time on their hands and their drinking crept up. Or that they began drinking to help with impaired sleep, due to pain or anxiety. Sometimes there is a pre-existing or previous pattern of heavy or dependent drinking which becomes worse following a physical injury. For the non-specialist, often it is sufficient to obtain an account of the current pattern of drinking and comparing it to the pre-injury account or recommended limits. Rating scales such as the Audit-10 can be useful.

Somatoform Disorders

The psychiatric classification of these conditions has changed in recent years, with new terminology of Somatic Symptom Disorder (DSM5) or Bodily Distress Disorder (ICD-11). They are no longer thought of as psychological or social factors "causing" pain, nor is it required to invoke unconscious mechanisms. It is best to think of these as conditions defined by disproportionate levels of concern, behaviour or thinking about a physical symptom eg pain. There is not a requirement that there be a total absence of any physical disease process, but rather that thinking, actions or worries are disproportionate or excessive. It is helpful if the physical health specialist can say whether, based on their experience the person's level of concern or behaviour is within the range of what is typically expected following an injury of this type, at this stage. If it is outside the expected range, then this is very helpful to the Psychiatrist or Psychologist considering a diagnosis of a somatoform disorder. In many cases, there will have been a similar patterns of thinking, behaving or worrying in relation to health concerns (not

necessarily the same health concerns) prior to the injury. The aetiology of the condition mainly involves factors present in early life, including family/genetics, personality traits, early experience of illness, abusive experiences. Scales such as the PHQ15 and SSD12 (Somatic Symptom Disorder-B Criteria Scale) are sometimes used to screen for or quantify symptoms. Three published meta-analysis indicate the treatment is amenable to Cognitive Behavioural Therapy.

Table 3 Somatic Symptom Disorder in DSM 5 - requires A,B and C

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.

B. Excessive thoughts, feelings, or behaviours related to the somatic symptoms or associated health concerns as manifested by at least one of the following:

   1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
   2. Persistently high level of anxiety about health or symptoms.
   3. Excessive time and energy devoted to these symptoms or health concerns.

C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

Functional Neurological Symptom Disorder

This requires one or more alterations in voluntary motor or sensory function,but that clinical findings are incompatible with neurological or physical disease. Presentations include seizure-like activity, tremor, dystonia, visual symptoms etc. In DSM-5, the term Functional Neurological Symptom Disorder (FNSD) has replaced the term Conversion Disorder. There is no assumption of Psychological causation and no requirement for underlieing stress. There have been several publications by an Edinburgh group using a slightly different term, Functional Neurological Disorder (FND not FNSD). This term emphasises that this is not a diagnosis of exclusion, but rather that there are specific "rule in" signs and symptoms. The ICD-11 uses a different term again - "Dissociative neurological symptom disorder" and does not require rule-in signs or symptoms to be present. It should be added that the Psychiatric classifications make a make a distinction between FNSD/DNSD on the one hand and Factitious Disorder / Malingering on the other. The concept used by neurologists of "FND" does not make this distinction explicitly and many of the published "rule in" signs for FND and symptoms can also be features of malingering / factitious disorder. It will be appreciated that with this rather confusing terminology, there is scope for cross-examiners to have a field day. Some experts, sensibly perhaps, stick to the descriptive term "Functional", but should define what they mean. Finally, while DSM5 recognises that Functional Neurological Symptom Disorder may arise anew after even minor physical trauma, the aetiology of the condition involves mainly factors present from early life.

According to ICD-11, "Factitious disorders are characterised by intentionally feigning, falsifying, inducing, or aggravating medical, psychological, or behavioural signs and symptoms or injury in oneself or in another person associated with identified deception". Sometimes a person deliberately induces additional symptoms or signs with an established illness, injury or wound. A distinction is made between Factitious disorder and deliberate feigning of symptoms for material gain (ie Malingering, which is not considered a Psychiatric disorder). But in a medicolegal context, a person's motives will often be difficult to determine and as always, reliability of a person's account is a matter for the court. Tread carefully here!

What is the personal injury discount rate (PIDR)?

by Susan Brown, Partner at Boyes Turner LLP.

The personal injury discount rate (PIDR) is an actuarial tool that helps lawyers calculate the amount of compensation that should be paid to an injured claimant in a medical negligence or personal injury claim.

The PIDR is used to adjust the amount of compensation that an injured claimant will receive for future expenses or financial losses that they will suffer over the course of their lifetime, to reflect the fact that they are receiving their full lifetime's compensation early in one lump sum. When correctly pitched and applied, the PIDR is designed to ensure that the injured person is neither over-compensated nor under-compensated for their injury and its financial consequences, when factors such as their expected lifespan and the interest that they will receive from investing their compensation are taken into account.

Why is a discount rate applied to future losses in medical negligence and personal injury claims?

The personal injury discount rate (PIDR) is one of the ways in which the law ensures that injured claimants receive sufficient compensation to cover the losses that they will suffer over their lifetime as a result of a wrongfully caused injury, in full, but not more or less.

The defendant must compensate the claimant fully for the injury that they have caused as a result of their negligence, but compensation is not intended to punish the defendant, as a fine would under criminal law. Applying the same principle, neither should compensation create a windfall situation for the claimant if their lump sum, when reasonably prudently invested, would actually put them (financially speaking) in a better position than they would have been without the injury.

The PIDR adjusts the multiplier (the number of years by which an annual cost or loss is multiplied) to avoid the windfall scenario by factoring into the calculation the claimant's early receipt and potential investment interest from their compensation.

What impact does the personal injury discount rate (PIDR) have on compensation for serious injury?

The PIDR has an enormous impact on the value of a medical negligence or personal injury compensation claim, particularly where the injured person's claim includes a large element of future loss. In claims involving permanent severe disability, such as from injury to the brain or spinal cord or the loss of a limb, the claimant often has a substantial claim for future loss related to long-term loss of income, lifelong dependence on care, therapies, specialist vehicles and equipment, assistive technology and other support, resulting in significant annual costs. A lower or higher discount rate makes a huge difference to the amount of compensation that the injured person receives for those future losses, because it determines the 'multiplier' that is applied to the claimant's annual loss.

During the calculation of an injured claimant's compensation claim, all recurring, annual losses and expenses that the claimant is expected to suffer in future, such as loss of earnings or costs of care, are multiplied by a multiplier. The multiplier is a figure which represents the number of years that the cost or financial loss will be suffered, for the purposes of arriving at a lump sum for the claim. Choosing the multiplier is rarely as simple as just identifying the number of years that the specific type of loss will be incurred, although that is an important starting point. The multiplier that is applied to the various types of annual loss has been adjusted by the

Mr David Miller

Consultant Orthopaedic Surgeon

MBChB, MRCS, FRCS (Orth)

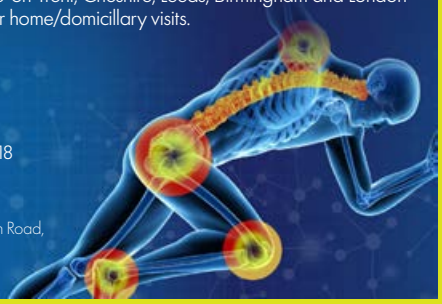
I am Clinical Lead in Trauma & Orthopaedics at MidCheshire NHS Foundation Trust.

As a Consultant Orthopaedic and Trauma Surgeon with a specialist interest in; shoulder, trauma, complex fractures, whiplash claims, soft tissue injuries, elbow and upper limb injuries, I specialise in high value and complex medicolegal claims both for the Defence and Claimants.

I have experience in shoulder arthroscopy, shoulder replacement, rotator cuff surgery, frozen shoulder, shoulder stabilisation surgery, shoulder surgery, shoulder pain, arthroscopy. Rotator cuff repair, shoulder replacement surgery, upper limb surgery, elbow surgery, carpal tunnel decompression, trigger finger release surgery, Dupuytren's surgery, ganglions, thumb base arthritis, carpometacarpal CMC joint osteoarthritis and trapeziectomy.

I undertake approximately 100-150 personal injury reports per year, with a defence, claimant and single joint expert ratio of 35:55:10. I also undertake medical negligence cases.

I cover the Crewe, Stoke-on-Trent, Cheshire, Leeds, Birmingham and London areas. Also available for home/domicillary visits.



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Mr Nikhil Shah

Consultant Trauma and Orthopaedic Surgeon

FRCS(Tr & Orth), FRCS(Glasg), Mch(Orth), MS(Orth), DNB(Orth).

I provide medico legal reports in personal injury in various conditions – trips, slips, whiplash injury, hip surgery, complex pelvic acetabular fractures, long bone and articular fractures, ankle, lower limb injuries, hip/knee joint replacements, periprosthetic fractures, soft tissue injuries and LVI cases.

I also provide clinical negligence related reports in my specialist area pf practice concerning hip and knee replacements, revision surgery, and trauma including pelvic-acetabular fractures.

Instructions from claimant/defendant solicitors or single joint expert approximately (ratio 45:45:10). I provide the regional tertiary service in pelvic-acetabular fractures.

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Mr Nigel Kiely

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I am a Consultant Adult and Children's Orthopaedic Surgeon and have been in post since 2004. My clinical practice encompasses a breadth of standard and complex paediatric conditions and effects into adulthood.

I undertake personal injury reports for children, including severe injuries and complex diagnoses.

My negligence work is mainly for paediatric cases such as cerebral palsy, DDH, SUFE and trauma. I also write reports for young adult hip cases such as pelvic osteotomy .

I regularly attend medico-legal courses.

I am based in Shropshire, but see clients from a wide geographical area.

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Mr Nicholas Parkhouse

Plastic, Reconstructive & Aesthetic Surgeon

DM, MCh, FRCS

Private Practice at McIndoe Centre, East Grinstead, 1994 - current.

Plastic, Reconstructive and Aesthetic Surgeon at the Queen Victoria Hospital, East Grinstead and the McIndoe Burn Centre, East Grinstead 1994-2006.

Plastic Surgeon and Director of the Burns Unit, Mount Vernon Hospital 1991 to 1994 and Director of the McIndoe Unit at the Queen Victoria, East Grinstead 1994 to 1997.

Mr Nicholas Parkhouse has over thirty years' experience of plastic and reconstructive surgery, nineteen years of which have been at Consultant level. He has a busy clinical practice in mainstream plastic surgery including the repair and reconstruction of scar disfigurement relating to trauma and burn injury and in all forms of aesthetic and cosmetic plastic surgery. He was the Editor of the British Journal of Plastic Surgery between 1997 and 2002 and has twice sat on the Council of the British Association of Plastic Reconstructive and Aesthetic Surgeons.

Mr Parkhouse has developed a serious interest in medico-legal issues throughout his career and maintains a high volume medico-legal practice. He has produced over 4000 reports for claims relating to personal injury and medical negligence.

Mr Parkhouse is available for face to face, remote or home consultation (please see available clinic locations.)

Consultations also available at:
Cadogan Clinic, 120 Sloane Street, Chelsea, London SW1X 9BW
King Edward VII's Medical Centre, 54 Beaumont St, London W1G 6DW
McIndoe Surgical Centre, Holtye Road, East Grinstead, West Sussex RH19 3EB

Telephone: 01825 741100
Email: admin@parkhousesurgical.co.uk
Area of work: Nationwide

Address: McIndoe Centre
Holtye Road, East Grinstead
RH19 3EB

PIDR to reflect the claimant's early receipt of their compensation for their lifetime's future loss, and the fact that they will invest it and earn interest on it.

Given the very substantial costs of care and other future losses that follow severe disability, such as cerebral palsy, brain injury, amputation or spinal cord injury, even small differences in multipliers make a big difference to the value of a claim. For that reason, the factors that are considered in setting the multiplier take on great significance in a serious injury case and are often closely examined and disputed by the experts and lawyers on each side. Altering the multiplier is the most effective way to significantly increase or reduce the value of the claimant's claim. When the discount rate is higher, claimants' compensation awards are lower (owing to the multiplier being discounted by more), and when the discount rate is lower, compensation awards go up.

How is the personal injury discount rate (PIDR) set?

A discount rate could, in theory, be calculated for every individual case, but this would mean carrying out a detailed investigation of how the individual claimant is likely to invest their compensation throughout their life, their attitude to risk and any other economic factors which will affect their compensation fund in future. To do so in every case would unjustifiably increase the costs of the case, waste court time and reduce the likelihood of early settlements. To avoid these problems, the Damages Act 1996 provides for the Lord Chancellor to set a standard personal injury discount rate (PIDR) which is used by the court and the parties in most cases.

The standard PIDR is set by the Lord Chancellor after consideration of the types of investments that are available, claimants' investment behaviour, taxation, inflation and investment management costs. The PIDR is currently reviewed at intervals of not more than three years. The Lord Chancellor must take advice at each review from an independent panel of experts with experience in actuarial, investment management, economic and consumer investment practice, and chaired by the Government Actuary.

Currently, the PIDR is set on the assumption that claimants are low risk (but not very low risk) investors. This is because, unlike other investors, who might accept a greater element of risk in the hope of higher returns on their savings and investments, most disabled claimants are totally dependent on their compensation fund to meet their nursing, housing and other essential needs for the rest of their lives. Given this dependency, it is generally accepted that claimants are risk averse and much more likely to adopt a cautious approach to their money and invest predominantly in low risk but low return investments. On the basis of this assumption, the PIDR now reflects the rate of return that a properly advised recipient of a lump sum of compensation for future financial loss could be expected to receive from a low risk, diversified investment portfolio.

In cases where the claimant's circumstances are unusual, such as where they expect to live and invest their compensation abroad, either party can challenge the general assumption that the standard PIDR should be applied, and make their case for a higher or lower discount rate to be applied to that individual case.

Discount rate changes in current claims

When the discount rate changes, any active compensation claims which include a future loss element must be recalculated to ensure that the claim takes into account the new discount rate and its impact on the multiplier. PIDR changes may have a significant impact on the value of a claim, but our specialist medical negligence and personal injury claims solicitors are skilled in anticipating discount rate changes and responding to discount rate challenges from defendants, such as NHS Resolution.

Examples of recent claims in which we protected our severely disabled clients from personal injury discount rate challenges include:

- In a £31.5 million settlement in a birth injury claim for a young teenager with cerebral palsy, we successfully resisted NHS Resolution's attempt to delay settlement negotiations pending PIDR changes which would have risked a significant reduction in our client's compensation.
- We successfully defended NHS Resolution's last-minute application for the court's permission to rely on expert evidence to support an increase in the PIDR, which would have significantly reduced the value of our client's future loss claim, in the reported case of CNZ -v- Royal United Hospitals Bath NHS Foundation Trust.

CARDIFF SPORTS ORTHOPAEDICS

Mr Stuart Roy
Consultant Orthopaedic Surgeon

MBChB, MPhil(Cantab), FRCS Ed (Tr & Orth)

Mr Stuart Roy is a Consultant Orthopaedic Surgeon at The Royal Glamorgan Hospital. He has a broad experience in general elective orthopaedic and trauma workload with specialist expertise in lower limb surgery, especially that of the knee.

He has over 20 years' experience in Trauma and Orthopaedics and has gained extensive experience in the more common injuries seen in Personal Injury Claims, such as whiplash.

Mr Roy has been preparing medico-legal reports for over 18 years. He prepares in the region of 200 – 250 reports per annum, for claimants and defendants with a ratio of 80:20. In addition to personal injury work Mr Roy also undertakes medical negligence. He has appeared in court several times.

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Professor Bijayendra Singh
Consultant Orthopaedic Surgeon

FRCS (Tr & Ortho), FRCS, PG Diploma (Tr & Ortho), MS (Ortho), DNB (Ortho)

Professor Bijayendra Singh is an experienced consultant orthopaedic surgeon with over 25 years of clinical practice, specialising in the management of upper limb conditions, trauma surgery and joint replacements. He has strong analytical and communication skills, with an emerging interest in medico-legal practice. He is adept at producing clear, concise reports and providing expert opinions based on extensive clinical expertise. He is currently developing expertise in medico-legal reporting, with a strong foundation in clinical documentation and case analysis.

He has a comprehensive knowledge of orthopaedic conditions, trauma, and management of both non-surgical and surgical interventions.

Expertise includes:
Special interest in the management of shoulder, elbow, wrist, and hand disorders, including but not limited to:

- **Shoulder Problems:**
  Rotator cuff tears, Impingement, Arthritis, Dislocations, Frozen shoulder, Fractures
- **Elbow Problems:**
  Tennis elbow, Golfer's elbow, Trapped nerve, Arthritis, Fractures
- **Wrist Problems:**
  Arthritis, Ganglion cysts, Ligament injuries, Fractures
- **Hand Problems:**
  Carpal tunnel syndrome, Trigger finger, Arthritis, Dupuytren's contracture

He is highly skilled in keyhole (arthroscopic) surgeries, performing minimally invasive procedures for the shoulder, elbow, and wrist. He is proficient in complex trauma cases, performing surgeries for fractures and injuries regularly. As a recognised leader in shoulder joint replacement surgery, Professor Singh is amongst the highest-volume practitioners in the country, achieving outstanding patient outcomes.

Contact: Kim White 07361 895875
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Atul Khanna FRCS (PLAST)

CONSULTANT PLASTIC, RECONSTRUCTIVE & HAND SURGEON

MBA, MBBS, FRCS, DIP EUR B(PLAST), FRCS(PLAST)

Mr Atul Khanna is a Consultant Plastic, Reconstructive and Hand Surgeon and has been involved in medical legal work since 1998.

In this period he has provided over 4,300 medical reports. These have been predominantly in the following areas of expertise:

- Hand surgery: Sequelae of hand injuries and surgery
- Soft tissue injury: Sequelae of post traumatic scarring
- Burns management: Sequelae of disability following burns injury, scarring and surgery.
- Medical negligence in Cosmetic Surgery

His work involves the treatment of patients with hand injuries, burns, soft tissue and facial injuries, breast surgery, scars and deformities, skin cancer and cosmetic surgery. He is on the GMC's specialist register in Plastic Surgery.

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Raising the Barre: Clinical Standards in Dance and Performance

by Nina Slawson, Chartered Physiotherapist at Somek & Associates Ltd.

Career Stages

I would like to introduce you to my work and clinical specialty as a physiotherapist in dance and sport performance, and expert witness who joined Somek and Associates in 2024.

My career began in 1999 and, in this time, I have treated over 600 dancers and worked with some of the world's best athletes, including world champions and Olympic medal winners across multiple sports. Due to recognition of my work in this field, I have also been requested to work with professional performers on stage, film and television, including Strictly Come Dancing.

The complexity of my role has developed, as has the growing research and evidence base body of work in dance medicine, notably demonstrated by the development of the International Association for Dance Medicine and Science. Over the past 15 years a career in dance has become ever more competitive and diverse. The opportunities, structure, and intensity of training and skill set have intensified too. The industry includes touring, being part of dance companies and academies, theatre, cruising, ariel performance and independent artists. These industries have committed and talented individuals pushing peak performance and precision that requires years of dedication and skilled management.

Requirements of Injury Recovery in Dance

During the working week I am responsible for the physiotherapy care of 120 dancers in a Performing Arts Institute. This role is highly advisory, as I get asked questions about improving technique and overcoming technical difficulties for dancers. I am expected to advise on protecting against injury and whether a dancer can train or perform due to an injury, plus the expected recovery times and limitations. Of note, in ariel training, the dancers are suspended in the air, wrapped and twisted around silk ropes or hoops. This requires immense strength and endurance to make movements look graceful and effortless but with significant control. An understanding of whether a dancer is fit to train or fully recovered and allowed to participate comes with a high level of adherence to health and safety standards and competence for decision making.

To view Nina Slawson's expert profile visit:
www.somek.com/expert-witness/nina-slawson/

Following detailed assessment, an injury will be diagnosed, and rehabilitation plans put in place with evidenced-based treatment and recommendations. Onward referrals are sometimes required to GPs and Orthopaedic Specialists.

Examples of injuries I may encounter include traumatic ligament injuries of the hip and knee, stress fractures of the spine and feet, disc injury and muscle tears. Due to the strength, flexibility, capacity, and control necessary, I am accountable for deciding if it is safe for a dancer to return to

training and performance. I give feedback to the team on changes, considerations, and adjustments for each dancer. To make these decisions, I assess the site and stage of injury, healing time, and analyse the requirements to restore the structure and function to the highest and safest standard.

In response to the needs of the dancers as athletes, I decided to develop a screening system to identify risk factors for each dancer, with a strong focus on injury prevention. This led to me being asked to create and teach a course module on injury prevention and management. This now sits as an integrated component of a dance degree course. I realised my knowledge could be of value in different and developing forms. As a physiotherapist, I must recommend restrictions to safeguard at every stage of injury.

The Devastating Impact of Injury, and the Importance of Reporting

My ethos is always to rehabilitate a patient to better condition than pre injury, which has maintained my reputation and enabled me to work with the world's elite. But what if a dancer has sustained an injury, and long-term effects of injury? In these circumstances I may be asked by case managers and solicitors to what extent the individual is likely to be physically affected and to provide detailed reasoning as to the extent of the physical limitations, likely recovery times and intensity of rehabilitation needed. I review evidence and consider accountability. Thorough codes of conduct and professional standards are in place for health professionals to adhere to. In circumstances where this is called into question in this field, an experienced practitioner with a detailed understanding of the work is essential. As an expert witness, I use my knowledge to take the complex and guide with reason and clarity.

The expert's role in breach of duty reports is to provide an independent, objective, and evidence-based opinion to the court on whether a professional's actions fell below a reasonable standard of care. As an expert witness, I have written impartial reports on both claimant and defendant cases and given evidence under cross examination for a criminal case in Crown Court.

Physiotherapy in Dance is a specialised niche role, but a growing specialty within the sport and musculoskeletal field. There is a high expectation for injury prevention, effective rehabilitation, and return to high performance.

To navigate patient care, there are comprehensive standards of practice, rehabilitation protocols, and a duty of care that must be adhered to by health care professionals in this field. Where the clinician's and professionals' actions fall below the set standards expected, the implications can be serious. When a professional's actions do not meet the required standards, there is a high risk of misdiagnosis, delayed diagnosis, inappropriate return to play, and negligent practice leading to harm.

Specialist Physiotherapy Expert Witness Services in Sports and Dance Injury Claims

by Jessica Thurston, Care/Occupational Therapist at Somek & Associates Ltd.

Sports injuries require specialist knowledge. At **Somek & Associates** we provide expert witness services from physiotherapists with **specific experience in sports/dance injury management**, ensuring clarity and credibility in complex cases. Our physiotherapists practice clinically in the NHS and/or in independent practice. Our sports/dance injury physiotherapists can provide reports for breach of duty and/or quantum purposes, and for professional regulation purposes.

Physiotherapy Evidence in Quantum Valuation

Physiotherapists provide **objective assessment and analysis of injury, that includes detailed measurement and consideration of the following**:

- Strength, power, endurance, and neuromuscular control
- Movement quality, biomechanics, and compensatory patterns
- Alignment

- Injury risk
- Capacity to train/compete
- Load tolerance and fatigue thresholds
- Time scales for return to-sport specific training and competing
- Time scales for return to dance training and performing
- Condition and prognosis following surgery
- Short- and long-term rehabilitation requirements

Sports and dance require precision, agility, and high level physical conditioning and endurance. Our expert physiotherapists evaluate:

- Technical movement requirements (e.g. jumps, turns, explosive acceleration, pointe work)
- Training volume, intensity, and progression
- Performance expectations at amateur, semi professional, or elite level
- Safe return to compete/perform

Our sports/dance physiotherapy reports will **reflect the true physical demands of the claimant's discipline.** For example, aerial performers, stunt performers and those undertaking impact sports are more likely to sustain high-level trauma.

Our physiotherapy experts will provide realistic, clinically-grounded projections regarding:

- Condition and prognosis
- Expected recovery timelines
- Likelihood of re injury or long term functional limitation
- Permanent impairment and its implications for performance
- Future treatment, rehabilitation, and conditioning needs

These insights directly inform future care costs, loss of earnings, and loss of opportunity valuations.

- For athletes and dancers, injury can alter:
- Career longevity
- Ability to progress to higher levels
- Access to scholarships, contracts, or touring opportunities
- Capacity to maintain training loads

Physiotherapy Evidence in Breach of Duty & Professional Regulation

- **Delayed diagnosis**
  Failure to conduct necessary tests, delayed onward referral, communication errors.
- **Misdiagnosis**
  Often leading to inappropriate treatment causing delay or harm and failing to refer.
- **Incorrect Rehabilitation for Sports/Dance Injuries**
  Unsafe exercise plans or premature return-to-play advice leading to re-injury.
- **Failure to Identify Serious Injury**
  Missing red flags, ligament tears, fractures, or concussion symptoms and failing to refer appropriately.
- **Inadequate Supervision During High-Risk Exercises**
  Leaving athletes unsupervised during advanced drills or equipment use.
- **Equipment Safety Issues**
  Using faulty or poorly maintained rehab tools or gym apparatus.
- **Lack of Informed Consent**
  Not explaining risks of aggressive rehabilitation or sports-specific interventions.
- **Poor Documentation**
  Missing treatment notes or progression records that compromise continuity of care.
- **Advice Beyond Scope**
  Giving clearance for competitive return without proper medical authority.
- **Infection Control Breaches**
  Poor hygiene practices in shared sports facilities or therapy environments.

Why Choose Somek & Associates?

- Specialist Sports/Dance Injury Expertise – Our physiotherapy experts have hands-on experience with elite athletes and sports rehabilitation protocols.
- Independent, Evidence-Based Opinions – Clear, impartial reports for claimant and defendant cases.
- Trusted by Leading Law Firms – Decades of experience supporting solicitors in personal injury and clinical negligence claims.

Typical Cases We Support

- Mismanaged rehabilitation after ACL reconstruction or tendon repair.
- Incorrect physiotherapy advice causing delayed recovery or further harm.
- Sports/dance injury claims involving physiotherapy treatment errors.
- Breach of duty causing preventable injury.
- Safety protocols falling below acceptable standards leading to injury or delayed return to sport/performance.

- Dangerous training techniques causing athletes to train beyond physical capacity.
- Inappropriate management of training load causing stress fractures or severe career-limiting soft tissue issues.
- Evidence-based opinion on if care fell below a reasonably skilful and competent practitioner involved with sports teams/athletes/dancers and performers.
- If you're a solicitor handling a sports/dance injury case, or need expert insight into physiotherapy standards, Somek & Associates can help.

Contact us today to discuss your requirements:

Phone: 01494 792 711
Email: enquiries@somek.com
Website: www.somek.com

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Claimant Solicitor

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- Our experts are fully trained, supported and aware of their responsibilities under the relevant procedure rules
- We have the flexibility to support proceedings in different jurisdictions across England, Wales, Scotland & Ireland as well as internationally

Telephone: 01494 792711 | **Email:** enquiries@somek.com
Website: www.somek.com/expert-witness/

What are periodical payment orders (PPO) in medical negligence claims?

by Susan Brown, Partner at Boyes Turner LLP.

A periodical payment order or PPO is a structured method of paying compensation, commonly used to provide for the lifelong care needs of a severely disabled child in a cerebral palsy, birth injury, or neonatal brain injury claim.

A PPO requires the defendant to pay the injured claimant a regular income, at a pre-determined, agreed rate, for the remainder of the claimant's life. PPO payments are based on medical and care experts' assessments of the claimant's current and future needs and are usually protected from the long-term impact of inflation by linking them, for example, to the Annual Survey of Hours and Earnings (ASHE).

PPOs are not new. At Boyes Turner we have been using them in appropriate cases to meet our clients' lifelong needs for almost 20 years.

When should a PPO be considered in the settlement of a medical negligence compensation claim?

Periodical payment orders (PPOs) are most commonly recommended for claimants who have suffered severe permanent disability, such as children with cerebral palsy birth injury or other types of neurodevelopmental disability caused by brain injury around the time of their birth or in their early years.

Claimants with severe, permanent disability caused by birth injury and other types of medical negligence remain dependent on others for their care throughout their life. Boyes Turner's specialist high value claims lawyers carefully consider with our experts and our client's family the best way to provide for the injured person's long-term needs, and whether their settlement should be paid as a lump sum, a PPO or a combination of both.

The difference between a PPO and a traditional lump sum settlement is in the way the compensation is structured, which is why settlements involving PPOs are sometimes called 'structured settlements'.

Not all claims are suitable for settlement with a periodical payment order, but PPOs should always be considered in cases where a large proportion of a severely injured claimant's compensation must provide for their lifelong care or other essential long-term needs.

Does a lump sum or PPO settlement make better provision for a severely disabled child's future care?

A totally dependent, severely disabled claimant's compensation must provide a lifetime's worth of nursing care, specialist therapies and equipment, assistive technology and adapted housing in order to put them (in so far as money can) back in the position that they would have been but for the negligence which caused their injury.

The law requires an injured claimant's lump sum compensation to be calculated according to agreed principles which assume that it should run out on the day the claimant dies, having met all their additional needs that were caused by the defendant's negligence at the time that those needs arise. This principle of 100% compensation, which governs the way lump sum compensation for future loss is valued, is designed to ensure that the injured person is neither under-compensated nor over-compensated for the negligently-caused injury. In practice, even with careful professional management of the claimant's compensation, it is impossible to ensure that the claimant's compensation will last until the date of their death but not a day more.

Our specialist birth injury solicitors are experts at ensuring that every foreseeable element of an injured child's future loss is identified and correctly

Mr Ross Fawdington

Consultant Trauma & Orthopaedic Surgeon

MBChB, FRCS Ed (Tr&Orth), MFST Ed, MSc Hand Surg

I am a Consultant Trauma and Orthopaedic Surgeon working in a Major Trauma Centre that receives tertiary referrals for civilian and military patients. My clinical practice involves both upper and lower limb surgery managing complex trauma, malunions, nonunions, infection and metastatic bone disease.

My elective practice focusses on hand and wrist pathology and upper limb conditions. I have two fellowships in Hand Surgery, and Lower Limb Complex Trauma Reconstruction.

I have a Masters Degree with merit in Hand Surgery and have passed the Cardiff University Bond Solon (CUBS) Expert Witness Certificate.

I have been the QE hospital T&O department Clinical Service Lead and am a core member of the Metalwork Review Group discussing complex cases that potentially need corrective revision surgery. I am currently the Clinical Lead for Metastatic Bone Disease.

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Dr Sohail Salam

Rehabilitation Medicine Consultant

MBBS, M.Sc (Hons) Anatomy & Anthropology (Dublin), MRCS (RCSI), CCT Rehabilitation Medicine

Dr Sohail Salam is a Neuro-Rehabilitation Consultant at The James Cook University Hospital. He provides Neuro-Rehabilitation input to inpatients, outpatients and also patients in the community. He covers private neuro-rehab units in the North East and also supports medico-legal clients as a private treating clinician. Dr Salam has been actively involved in service development, teaching, training and research activities. He is an elected executive member of British Society of Physical Rehabilitation Medicine (BSPRM) and chair of Vocational Rehabilitation Specialist Interest Group (VRSIG) of BSPRM. He has worked with DWP and has trialled new PIP assessment forms and has also been involved in teaching/training PIP assessors. Dr Salam has been a committee member of Northern Acquired Brain Injury Forum (NABIF) for the last few years and has also been involved in meetings/discussion with the local ICB team.

Dr Salam has developed a special interest in Medico-legal work for Neuro-Rehabilitation clients and works closely with legal firms to provide thorough assessments and reports in the specified time period. He provides input as a Treating Rehabilitation Medicine Consultant to Medico-legal clients in the North East and surrounding areas.

Special area of interest includes:

- Rehabilitation of Brain Injury patients (including mild brain injury and concussion).
- Stroke
- Cerebral Infection, including Meningitis and Encephalitis
- Cerebral palsy.
- Spinal Cord Injury.
- Amputee/Prosthetic rehabilitation.
- Complex Major/Poly Trauma patients.
- Spasticity management (including Botulinum toxin interventions).
- Pain management.

Practice Locations

- Home visits
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Professor D M Taylor

Psychopharmacologist, Pharmacist

BSc, MSc, PhD, FRPharmS, FFRPS, FRCPEdin, FRCPsych (HON)

Recognised international expert in psychopharmacology – the effect of medicines and drugs on perception, mood, behaviour, arousal and cognitive function. World-renowned expert on the use of clozapine and other antipsychotics. Internationally recognised expert on drug withdrawal reactions.

Director of Pharmacy and Pathology at the Maudsley Hospital and Professor of Psychopharmacology, Kings College, London. International profile in research (author of over 500 publications) and editor of several textbooks of psychopharmacology, including the Maudsley Prescribing Guidelines. Former member of UK Government panel on Drug Driving and of the Advisory Council on Misuse of Drugs.

Has provided expert witness testimony for more than 400 cases and made over 50 court appearances. Extensive experience of cases involving suspected adverse effects of psychotropic medicines and of claims resulting from prescribing errors (including those resulting in addiction/dependence and withdrawal). Expertise in the behavioural effects of antidepressants and many other drugs.

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calculated when valuing their claim. However, when looking to the future, the valuation of any child's future loss is based on experts' estimates of their longevity, future needs and care costs. Following settlement, and throughout their life, the injured person's health, care needs or circumstances may change or the costs of professional care may increase unexpectedly. Multiple uncertainties at the point where traditional lump sum compensation for future loss is calculated mean that some claimants live longer than expected, with a risk that they run out of money for care whilst still alive. Sadly, others leave money unspent after their death, either because their life was shorter than predicted, or because they or their families held back from spending money on an appropriate level of care out of fear that their compensation fund might run out.

We use periodical payment orders (PPOs) to overcome these problems by guaranteeing that money to pay for care will be available throughout the claimant's life. In addition to the regular annual income that a PPO provides, 'stepped PPOs' can schedule increases in the payments at pre-set future dates to cater for predicted increases in the need for care.

Additional PPOs can also be set to start or finish at specified times in the claimant's life, such as to pay for special needs educational school placements during the child's teenage years. The claimant is guaranteed to receive the income provided by a PPO to pay for their care throughout their life, even if they far outlive their predicted lifespan. PPO payments cease on the day the claimant dies.

What are the advantages of periodical payment orders (PPO) in compensation claims?

PPOs provide several advantages for a claimant with severe lifelong disability, if included as part of their compensation settlement:

- PPO payments are guaranteed to continue for the remainder of the claimant's life, even if they outlive their predicted lifespan. The claimant can use the money from their PPO to pay for their care, knowing that it will not run out.
- PPO payments are calculated based on the injured claimant's individual needs, ensuring that they get the level of care that is right for their disability.
- PPO payments can be scheduled to increase or boost the claimant's income at specified times in their life, such as when their need for care and support is expected to increase owing to changes in life-stage, circumstances or level of disability.
- PPO payments are index-linked to protect them from the impact of inflation over time, so the payments increase along with costs of professional care.
- Compensation which is paid as income via a PPO is treated as capital by HMRC, which means that the annual income payments are tax free.

What are the disadvantages of periodical payment orders (PPO) in compensation claims?

Despite the long-term benefits of PPOs there are reasons why a PPO might not be appropriate in every case.

- The major disadvantage of having compensation paid via a PPO is that it limits the claimant's flexibility as to how their money is spent. In order to fully compensate someone who has suffered severe, lifelong disability, such as cerebral palsy or neurodevelopmental disability, caused by medical negligence, a lump sum may be needed to pay for larger essential purchases, such as a more suitable or adapted house which can accommodate professional carers or a specialist vehicle.

  In practice, we help most of our clients overcome this problem by structuring the final settlement to combine PPOs for care with a lump sum to cover one-off purchases and provide flexibility for unexpected contingencies.
- Where the case is settled on a discounted (proportionately reduced) basis to protect the claimant from a significant risk of losing their case, depending on the level of the compensation that the claimant receives, a PPO might not make the best use of the claimant's final compensation in meeting their priority needs.
- If the injured claimant's life expectancy is significantly shortened, they may get better value from having their compensation paid fully as a lump sum which they can use immediately for priority needs, such as an adapted home, rather than as annual income from a PPO which will end on the date of their death.

We work closely with our experts and independent financial advisors to ensure that each of our clients receives expert advice on the most favourable format for their compensation settlement, based on their individual circumstances.

Who decides if a compensation settlement is paid as a lump sum or a PPO?

The courts can order PPOs but in practice in medical negligence claims it is more common for them to

approve PPOs in settlements that have been agreed between the claimant's legal representatives and NHS Resolution, rather than to impose them.

Severely injured claimants are, therefore, dependent upon their own solicitor's knowledge, experience and expertise to advise them about the possibility, availability and advisability of a periodical payments order. For over 30 years, Boyes Turner's specialist solicitors have helped the families of brain-injured children to obtain the highest and most appropriate form of settlement for their child. Our medical negligence team regularly achieve top level compensation settlements for our clients, building in inflation-proofed, guaranteed long-term provision for their needs with index-linked periodical payments.

Our medical negligence settlements involving PPOs

Examples of settlements in which PPOs have been used to provide for our clients' future care and other needs include:

- £31.5 million settlement for a teenager with severe cerebral palsy disability from HIE birth injury, combining a £7.1 million lump sum with PPOs rising to £400,000pa for care;
- £18.7 million settlement for a teenager with HIE birth injury and cerebral palsy, including annual PPO payments for care rising to £300,000pa;
- Settlement combining a £5 million lump sum, lifelong PPO care payments rising to £232,750pa plus an additional PPO covering the annual costs of the injured child's educational placement at Treloar's to the age of 19;
- $23 million settlement in a kernicterus neonatal brain injury claim combining a $10.3 million lump sum and US inflation-linked PPOs rising to $457,000pa for care;
- £12 million settlement in a severe dyskinetic cerebral palsy birth injury claim combining a £5.35million lump sum with care PPO payments rising to £447,000pa.

Boyes Turner

Digital dementia and the insurance implications of social media addiction

by Joanna Wallens, Associate & Tim Johnson, Partner at UK and Ireland law firm Browne Jacobson

The term 'digital dementia' describes the deterioration of cognitive function attributed to overuse of digital technology. Alongside it, a growing body of clinical evidence now characterises compulsive social media use as a behavioural addiction with measurable neurological consequences.

Digital dementia and social media addiction

For insurance professionals, these developments carry real and practical implications across a range of product lines. As with any emerging risk, those who engage early will be better placed to price, underwrite and manage their exposures.

Digital dementia is not a formally recognised clinical diagnosis, but it is attracting serious scientific attention. It refers to a pattern of cognitive decline, particularly in memory, attention, and concentration, which is linked to prolonged and excessive use of digital devices.

Research has demonstrated structural and functional changes in the brains of heavy social media users. Critically, the evidence suggests these effects disproportionately affect younger people whose brains are still developing, raising particular concerns about the long-term cognitive trajectories.

Social media addiction is increasingly understood through the same neurological framework as substance addiction. Platforms are deliberately engineered to trigger dopaminergic reward cycles (the 'like', the notification, the scroll) each reinforcing compulsive use.

Clinically, it presents with features familiar from other behavioural addictions: preoccupation,

heavy use to elevated rates of anxiety, depression, poor sleep, and increased rates of self-harm.

The UK's Online Safety Act 2023 imposes duties on platforms to mitigate harms arising from addictive design, signalling growing regulatory acceptance of the addiction framing.

What does this mean for insurers?

Life and critical illness

If cognitive decline attributable to technology use presents earlier in life than traditional risk models anticipate, current actuarial tables may underestimate future exposure. Underwriters should consider whether application processes adequately capture relevant risk factors in younger applicants. The established link between social media addiction and mental ill-health including depression, anxiety, self-harm may also carry pricing implications.

Health, income protection and PMI

The mental health consequences of social media addiction are already driving increased claims across these lines. Disrupted sleep linked to screen use has also been associated with elevated cardiovascular and metabolic risk. As more studies occur, the physical health implications may prove broader than currently appreciated.

Employers' liability

As awareness of digital addiction grows, there is a realistic prospect of employers' liability claims from employees who argue their employer failed to manage workplace technology use in a way that protected their mental and cognitive health. Underwriters should be alert to this as an emerging occupational health risk, particularly in sectors where intensive screen use is inherent to the role.

Professional indemnity

If digital dementia represents a genuine degradation of cognitive function in working-age professionals (including impaired memory, reduced concentration, and poorer decision-making) of which the downstream risk is professional error. There is potential for a broad pattern of increasing human error claims in high-cognition professions.

D&O and product liability

Thousands of personal injury claims have been consolidated against large technology companies in United States of America litigation. Similar trends could emerge in the United Kingdom and the European Union. Directors and Officers of technology companies face growing exposure as platforms are increasingly characterised as having knowingly deployed harmful design features. D&O underwriters should be examining the adequacy of their cover in light of this trend.

Practical steps for underwriters

1. Horizon scan actively: Assign responsibility for monitoring clinical, academic and legal developments in this space.
2. Review policy wordings: Consider whether existing mental health, cognitive impairment and addiction exclusions are adequate.
3. Engage actuarial teams: Examine whether current pricing captures emerging mental health and cognitive decline risk in younger cohorts.
4. Monitor litigation: Keep a close watch on social media personal injury litigation in the United Kingdom and internationally. Early coverage analysis of D&O and product liability policies is advisable.
5. Engage with commercial clients: Encourage insureds in high-screen-use industries to develop digital wellbeing and occupational health frameworks.

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The Gynaecology Chambers

Mr Nicholas Morris

Consultant Obstetrician and Gynaecologist

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Clinics in Harley St. London and Manchester.

With over 15 years' experience of Medico-Legal work I am trained in report writing, giving evidence in the Crown Court and the Coroner's Court. I also lecture on these topics.

I undertake 100 cases annually, 10% Single Joint Expert, 70% Claimant, 20% Defendant. I am an AVMA and MPS Panellist.

I am now in full time private practice, and run both a Clinical and Legal Practice.

I see patients for Medico-Legal Consultations in London, Birmingham and Manchester.

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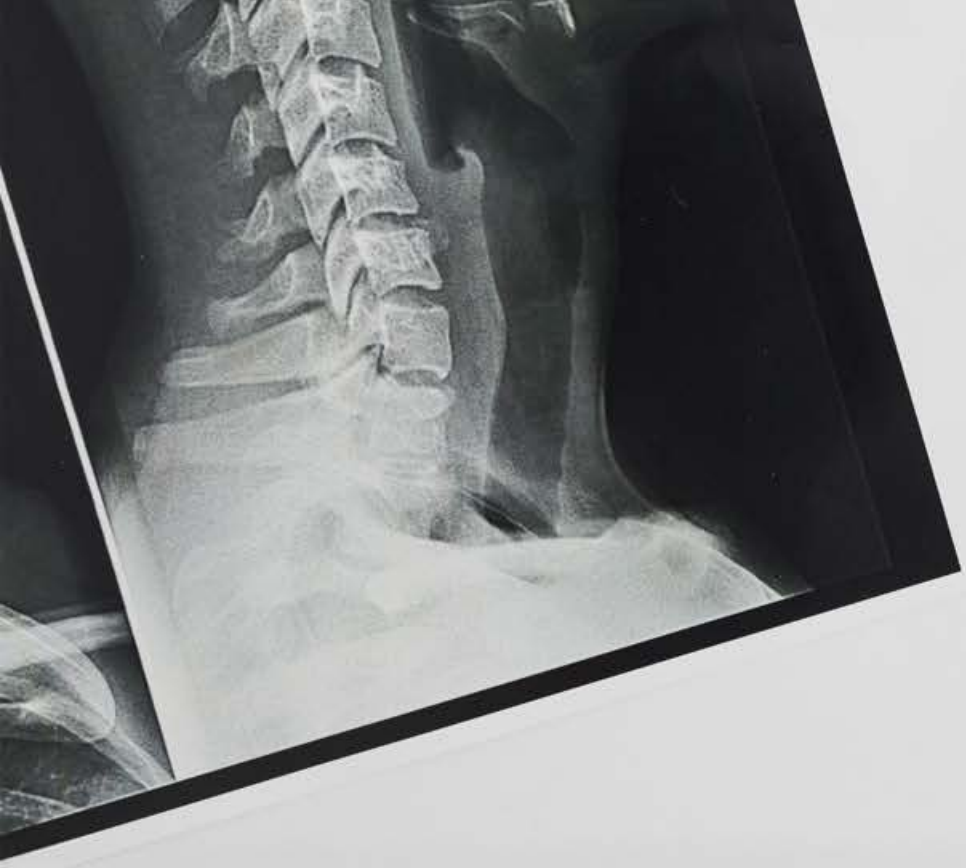

Evidential Gaps in Primary Care Communication: When "Usual Practice" Is Not Enough — Expert GP Analysis of Shaheen and Ahmed v Daish

by Dr Samah Boulis, GP Expert Witness.

Clinical negligence cases in primary care rarely turn on dramatic errors. More often, they hinge on small, easily overlooked moments within routine consultations. The High Court decision in *Shaheen and Ahmed (Executors of the Estate of Mr Ajaz Ahmed) v Dr Joanna Daish* is a clear illustration of this reality.

At its core, this case is not about diagnostic failure in the traditional sense. It is about communication—what was said, what was not said, and, crucially, what cannot be proven to have been said. For those of us practising as GP expert witnesses, it represents a clear and instructive example of how workflow, documentation, and patient-led systems intersect to create medicolegal risk.

Factual Background and Chronology

Mr Ahmed, aged 49, consulted his GP, Dr Daish, on 11 February 2019 with worsening breathlessness following a respiratory infection. At consultation, he was assessed as having an asthma exacerbation, treated with inhalers and oral steroids, and a chest X-ray was requested via the ICE system. This operated as a walk-in service requiring the patient to attend radiology independently.

The key chronology is as follows:

- 11 February 2019: Consultation recorded examination, diagnosis, treatment, and the X-ray request. However, there was no documentation of any discussion with the patient about the investigation or how to access it. Audit data indicated that parts of the management plan, including prescribing, were completed after the patient had left, and the record was then closed.
- 11 February 2019 (later): A text message was sent regarding medication changes only; no communication was sent about the X-ray.
- 27 February 2019: A nurse follow-up appointment was scheduled but not attended, with no clear link to imaging.

Dr. Jordan Burgess

Consultant Haematologist | Expert Witness

MBChB (Hons), FRCPath, MRCP, M.Phil (Cantab), M.Math, M.Phys

I am a Consultant Haematologist providing independent medico-legal opinion in civil claims, including personal injury and clinical negligence.

I provide clear, structured, and objective reports grounded in specialist haematology expertise and a strong analytical background in mathematics and physics (double first class honours). This supports a logical, probability-based approach to complex issues of causation, particularly in cases involving multiple contributing factors or diagnostic uncertainty.

My reports are concise, transparent, and written for a non-medical audience, with clear separation of fact, assumption, and opinion. All conclusions are expressed on the balance of probabilities and supported by explicit reasoning, enabling the Court to understand and rely upon the evidence.

I have extensive experience in clinical governance, including Serious Adverse Event review, Root Cause Analysis, and complaints investigation. This provides practical insight into clinical decision-making, system failures, and the assessment of standards of care.

My expertise can be applied to cases requiring expertise pertaining to the following conditions:

1. Haemostasis & Thrombosis (H&T)
2. Malignant Haematology
3. Transfusion Medicine
4. Haemoglobinopathies & General Haematology

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Mr Savvas Papagrigoriadis

Consultant Colorectal Surgeon

MD MSc FRCS

Mr Savvas Papagrigoriadis holds a Degree in Medicine from the University of Athens, a Fellowship of the Royal College of Surgeons of England, a Masters of Research Methods in Health Sciences of the University of Northumbria at Newcastle. He is in the Specialist Register of the General Medical Council since 1995.

He has been a UK Consultant General and Colorectal Surgeon since 1998, The Lead of Colorectal Surgery at King's College Hospital, London, and Honorary Senior Lecturer in Surgery at King's College London, between 2001 and 2018. Between 2004 and 2018 he was the Chairman of the Colorectal Cancer MDT and also Chairman of the Pelvic Floor MDT, Chair of the regional South East Early Rectal Cancer MDT, and Head of Clinical Governance for surgery. He has been on call general surgeon consultant in a centre of major trauma for 25 years and has extensive experience in emergency general surgery. Also served as a trainer of the national training program in laparoscopic colorectal surgery (LapCo) 2008-2012.

His clinical and research interests have been colorectal cancer, emergency general surgery, diverticular disease and pelvic floor disorders, An academic supervisor of several postgraduate MD(Res) and PhD thesis degrees, as well as an examiner at the University of London. Mr Papagrigoriadis retired from the NHS in 2018 and since then has been working in private practice and medicolegal work.

Mr Papagrigoriadis is an Expert Witness for the courts with 25 years' experience, including as appointed Joint Expert by the courts. He is an accredited Mediator. His medicolegal expertise includes diverticular disease, pelvic mesh complications, bowel impact of cauda equina syndrome and all aspects of colorectal surgery and emergency surgery. Mr. Papagrigoriadis has worked extensively as expert in pelvic mesh cases, including as joint single expert.

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Professor Ganesh Subramanian

Consultant Stroke Physician

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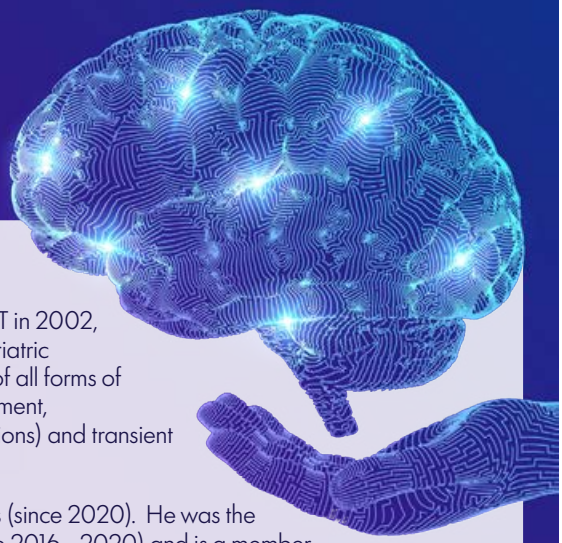

Professor Ganesh Subramanian is a Consultant Stroke Physician based in Nottinghamshire (currently working in Chesterfield, having previously worked in Nottingham [for over 15 years] and Central Manchester. Since attaining his CCST in 2002, Prof Subramanian has been employed as a Consultant in general, stroke and geriatric medicine, including cerebrovascular disease. He is involved in the management of all forms of stroke across the whole patient pathway (i.e. diagnosis, investigation, acute treatment, rehabilitation and re-integration, secondary prevention and long-term complications) and transient ischaemic attack (TIA).

Prof Subramanian is the Regional Clinical Director for Stroke in the East Midlands (since 2020). He was the Chair of the Clinical Advisory Group for Stroke in the East Midlands region (since 2016 - 2020) and is a member of CVD steering group. He led the development of Mechanical Thrombectomy pathway for East Midlands as well as led the deployment of artificial intelligence (AI) software for stroke imaging and CT perfusion regionally.

Prof Subramanian writes reports for both claimants and defendants (roughly 70/30 split); he also produces reports for CPS/Police. He produces around 150 - 200 reports a year.

Prof. Subramanian is available for teleconferences, will happily visit patients in their homes, conduct virtual assessments (if appropriate), and attend Court, etc.

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- 2019–2022: No chest X-ray was undertaken. There is no evidence that Mr Ahmed was aware of an outstanding investigation.
- January 2022: Mr Ahmed stated in a witness statement that he had not been told to attend for an X-ray.
- February 2023: Mr Ahmed died from lung cancer.

The Claimants alleged failure to communicate the X-ray request and its process. The Defendant relied on usual practice but had no specific recollection. The court was asked to determine breach, causation, and contributory negligence.

The court was asked to determine three preliminary issues:

1. Whether the Defendant failed to inform Mr Ahmed of the X-ray request;
2. If so, whether Mr Ahmed would have attended had he been informed;
3. Whether Mr Ahmed was contributorily negligent in failing to attend subsequent follow-up appointments.

The Judge's Conclusion and Reasoning

Christopher Kennedy KC, sitting as a Deputy High Court Judge, found for the Claimants on all preliminary issues. The court held, on the balance of probabilities, that Dr Daish did not inform Mr Ahmed of the need to attend for a chest X-ray, despite being described as a "caring and competent" clinician.

1. Communication of the X-ray

The court relied primarily on the contemporaneous record:

- No documentation of discussion: The record confirmed the X-ray request but contained no evidence that it was explained to the patient, unlike other investigations in the same notes.
- Clinical context: Given Mr Ahmed's anxiety about his symptoms and recent urgent attendance, the court found it unlikely he would have ignored a cancer-excluding test if informed.
- Audit trail evidence: Post-consultation prescribing and record closure supported an inference that key actions may have occurred after the patient left, without communication.

2. Causation

The court found Mr Ahmed would have attended the X-ray if informed, relying on:

- prior compliance with walk-in investigations;
- clear concern about his health;
- expected engagement with serious pathology exclusion.

There was no evidence of informed non-attendance.

3. Contributory Negligence

The defence failed.

The court found no evidence that Mr Ahmed knew about the X-ray or understood any risk in not attending follow-up. Non-attendance could not therefore be characterised as negligent, and the burden of proof was not met.

GP Expert Witness Perspective

The facts will be immediately recognisable to any practising GP. Speaking as a GP who also works in medico-legal cases, what stands out in this case is how ordinary it all is. There's nothing exotic here clinically. No diagnostic outlier. No missed red flags in the traditional sense. The dispute turns on something far more familiar in general practice: communication, timing, and what the record does—or doesn't—show.

The key issue isn't diagnosis, it's communication

What the court was really trying to establish wasn't whether the GP acted competently in clinical terms. It was much narrower and, in some ways, more unforgiving: was the patient told about the chest X-ray, and did he know how to act on it?

That's a question every GP recognises. It's the "I'm sure I told them" problem, which in day-to-day practice is usually true—but legally, it has to be demonstrable.

The record tells the story, not memory

When you step back and look at the audit trail from 11 February 2019, it essentially reconstructs the consultation more reliably than any recollection could. This chronology allowed the court to reconstruct events with a high degree of precision. It also reinforces an important medicolegal principle: primary care records are best understood as time-stamped datasets rather than narrative recollections.

You can see the consultation itself: assessment, examination, clinical reasoning, and a decision to request imaging. Then you can see the subtle but crucial timing issue—the X-ray request appears to have been generated after the patient had left the room. The same applies to later prescribing and administrative updates.

None of this is clinically unusual. It's how general practice actually runs: decisions made in real time, paperwork completed immediately afterwards.

But legally, that gap between "decision" and "documentation" becomes very important.

What is missing, though, is the one thing that matters most in this scenario: any clear, contemporaneous evidence that the patient was told about the X-ray and what to do next.

Communication vs "Usual Practice"

The GP defendant, described as a competent and conscientious clinician, had no independent recollection and relied on her usual practice of explaining investigations and access arrangements.

This is a familiar evidential position in primary care litigation. However, the court preferred contemporaneous documentation.

From an expert witness perspective, this reflects a consistent judicial approach: contemporaneous clinical records are given greater weight than reconstructed accounts based on habitual practice.

Usual Practice: Evidential Weight and Its Limits in Clinical Negligence Claims

Where records are silent, and particularly where other entries demonstrate that similar discussions are routinely documented, courts are entitled to infer that the communication did not occur. This is not a criticism of clinical care; it reflects evidential hierarchy.

The Consultation Extends Beyond the Consultation Room

One of the most important practical points this case highlights is something GPs know but often underestimate in its legal significance: a consultation doesn't finish at the end of the face-to-face encounter.

Ordering the test, coding it, sending the text, finishing the notes—all of that often happens after the patient has gone. This is operationally efficient but legally significant.

If an investigation is generated post-consultation, or not explicitly communicated before the patient leaves, a critical step remains incomplete: patient understanding.

The court, in essence, separated two things we often blur together in practice:

- initiating care (ordering the X-ray), and
- delivering care (ensuring the patient understands and can act on it).

Patient-Led Systems Increase Risk

The ICE walk-in model is widely used and efficient, but it quietly shifts responsibility onto the patient.

That only works safely if one condition is met: the patient knows what has been requested and what they are supposed to do next.

When that step fails, the system doesn't visibly break. It just quietly fails downstream.

From a GP perspective, that makes communication not a "soft skill", but a safety-critical step. The greater the reliance on patient initiation, the greater the importance of explicit explanation and documentation.

Documentation isn't defensive - it's functional

There's a tendency in primary care to think of documentation as something we do for medico-legal protection. That's not really the right way to think about it.

The more accurate framing is this: if it isn't documented, it's very difficult to prove it happened.

In this case, a single line such as:"CXR requested, patient advised to attend walk-in radiology" would likely have changed the evidential picture entirely.

That's not about defensive medicine. It's about closing the loop.

Behaviour matters more than we sometimes admit

One of the more subtle aspects of the judgment is how much weight is placed on what the patient was likely to do, not just what was recorded.

This wasn't a disengaged or chaotic patient. He was health-aware, proactive, and had already sought assessment. In that context, the court found it unlikely he would have ignored a potentially serious investigation if he had been told about it properly.

Whether one agrees or not, this reflects a broader trend: courts increasingly test clinical narratives against realistic human behaviour, not just paperwork.

Contributory negligence remains a high bar

Attempts to argue contributory negligence in cases like this usually struggle, and this one was no exception.

Missing an appointment or not following up isn't enough on its own. There has to be evidence the patient understood:

- that further action was needed, and

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With a clinical practice centered on the latest evidence based surgical techniques, he offers authoritative independent assessments on surgical complications, delayed diagnosis and substandard operative care.

Areas of Legal Expertise:

- **Clinical Negligence:** Specialised analysis of surgical complications, substandard operative care, and delayed diagnosis.
- **Complex Nerve Injuries:** Expert evaluation of carpal tunnel and cubital tunnel releases, including nerve damage and entrapment.
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Chris Dawson BSc MBBS FRCS MS LLDip

Consultant Urologist

Mr Dawson is a Consultant Urologist with over 29 years' experience. He has formal training in personal injury and medical negligence reporting and completed the Bond Solon Expert Witness Course in 2006. In 2008 he completed a Diploma in Law at the College of Law in Birmingham.

Mr Dawson has over 22 years of medico legal report writing and expert witness work and has completed over 2000 reports, He has completed numerous Fitness to Practise reports for the General Medical Council.

He is the author of the ABC of Urology, now in its 3rd edition, and also co-edited the Evidence for Urology which won first prize in the urology section of the BMA Medical Book Competition in 2005.

Mr Dawson is happy to accept instructions for personal injury, clinical negligence and condition and prognosis reports.

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- what the consequences of inaction might be.

In routine GP consultations, that level of explicit understanding is often assumed rather than confirmed—and that assumption rarely holds up well in court.

The reality of a routine GP consultation

What's striking is how unremarkable this all is from a clinical point of view.

This is standard general practice:

- a busy clinic with limited time,
- a reasonable clinical decision to investigate,
- the usual flurry of admin after the patient has left,
- and a system that depends on the patient taking the next step

There's nothing unusual in any of that. It's how most of us work every day.

The risk sits in a very small space—the gap between deciding to act and making sure the patient knows what to do.

In a system where investigations are often patient-led, that gap matters more than we sometimes think. If the patient leaves without a clear understanding of what's been arranged and what they need to do, the pathway is already vulnerable.

So the practical lesson is simple, if slightly uncomfortable:

If an investigation depends on the patient doing something afterwards, then the communication needs to be explicit, and the record needs to reflect it.

Not because GPs are failing to do their job—but because in a digitised, fragmented system, the record is often the only thing that survives the passage of time intact.

Why This Case Matters for Instructing Solicitors?

For practitioners in clinical negligence, the case highlights recurring evidential themes:

- Chronology is decisive: audit trails often determine factual findings;
- Internal consistency matters: variation within records can undermine "usual practice" evidence;
- Communication failures are highly litigable: particularly in patient-led pathways;
- Expert evidence must reflect real practice: not retrospective idealisation.

Expert Witness Role

Acting as a GP expert isn't just about reading the notes and commenting on clinical decisions. It's about understanding how general practice really works:

the pace of consultations,
the habit of completing tasks after the patient has gone,
the way electronic systems shape workflow,
and the points at which communication can realistically break down

That context is essential when forming an opinion on what is, and isn't, reasonable.

Final Reflection

From a GP standpoint, this isn't a case about getting the medicine wrong.

It's about something much more familiar—communication in a system that assumes patients will understand and act, but doesn't always make that understanding explicit.

The reality is simple, but not always easy in a busy clinic:

If the next step depends on the patient, the job isn't finished when the test is ordered. It's finished when the patient knows about it, understands it, and there is a clear record of that.

That's why this case feels so close to home.

There's nothing unusual here:
a routine consultation,
a sensible decision to investigate,
and just a small gap in communication.

And that small gap is exactly where the risk sits – a small omission which proved pivotal.

From an expert witness point of view, this isn't really about knowledge or clinical judgment. It's about what happens at the join between the GP, the patient, and the system we're all working in.

Modern general practice is busy, digital, and increasingly reliant on patients to take the next step themselves. Most of the time that works fine—but when communication isn't clear, or isn't documented, that's where the risk sits.

None of this is new. It's the sort of thing we've all been told before.

But cases like this show how little room there is now for things to be left assumed rather than said—and written down.

Dr S. Boulis, GP Expert Witness

As a GP expert witness, I prepare independent reports in clinical negligence cases, with a focus on informed consent, standards of care and decision-making in primary care.

My overriding duty is to the Court. All reports are prepared in accordance with CPR Part 35, Practice Direction 35, and the Guidance for the Instruction of Experts in Civil Claims (2014).

I welcome instructions from clinical negligence solicitors and counsel in England, Scotland and Northern Ireland.

If you would like to discuss a potential instruction or expert witness query, please feel free to get in touch: spboulis@doctors.org.uk

Successful application for summary judgment in exaggerated claim - saving 1 million pounds

by Jennifer Brown, Consultant & Georgia Court, Partner at DAC Beachcroft.

Overview

In the matter of *Muhammad Ayaz v Royal Sun Alliance Insurance Limited* 2026, the defendant (D) made a successful application for summary judgment in a personal injury claim following disclosure of surveillance evidence that conclusively demonstrates that the claimant (C) has been fundamentally dishonest, saving £1m.

Facts

The claim arose out of a road traffic accident in February 2020. In 2022, C, in a wheelchair, saw one medical expert and stated he was barely able to stand or walk for a few minutes, relied on family for care provision, had not worked since the accident, was unable to dress himself and required assistance with bathing, washing and personal hygiene. In 2023, again, using a wheelchair, he saw another expert and claimed he was unable to stand unaided, was unable to use both hands and was in constant pain. C also signed a schedule of loss totalling £661,000 and claimed he had been unable to work since the accident and required care.

C subsequently saw a third expert, Dr Edwards, again in a wheelchair, stating he was unable to walk for more than just one or two steps. He required support in all aspects of activities of daily living. C's wife reported that she hadn't worked since the accident because she is his full-time carer.

Evidence

Days 1, 2 and 3 surveillance:

C was seen walking outside his house without his wheelchair driving a Range Rover to go shopping. He carried a shopping basket and bent and crouched whilst putting air into his tyres. He manoeuvred various cars outside his house and drove to B&Q, where he was seen carrying a large piece of MDF. C was seen driving away from his house and returning on foot.

Days 4 and 5 surveillance:

C was seen walking outside his house and carrying boxes. He was seen driving to his medical appointment. He exited the car and immediately entered the wheelchair. After the appointment, he was helped to transfer into the car. Some distance away from the consulting rooms, C was seen exiting the vehicle and walking and shopping.

When attending the medical appointment, C stated that he could not get out of his wheelchair and that he spent all his time in bed. The expert noted there was evidence of exaggeration or malingering.

Day 6 surveillance:

C was seen walking around his house without his wheelchair. He loaded the wheelchair into the car. He drove to another expert's appointment and on arrival, was helped into the wheelchair and after the appointment was helped into the car. When he returned home, he was seen walking unaided.

Day 7 surveillance:

C was seen walking around his house, bending and loading the wheelchair into the car. He drove away from the house, but was no longer driving when he arrived at Dr Edwards' consulting rooms.

C stated to the medical expert that he could not hold anything in his right hand and that the use of his left hand caused pain. He stated that he could not walk for more than one or two steps, was unable to drive, and could not stand or bend over.

Application for summary judgment

The surveillance evidence was disclosed, which prompted C's solicitors to remove themselves from the court record. D was given permission to rely on an amended defence to plead fundamental dishonesty, the surveillance evidence and expert evidence commenting on the footage.

Appropriate references to case law pertaining to s.57 were contained within the skeleton arguments along with a recital of the principles to be applied to applications for summary judgment in *EasyAir v Opal Telecom [2009] EWHC (Ch)* at para 15.

For all the reasons mentioned above, the court was asked to enter summary judgment given that the evidence was so compelling that there was no real prospect of C resisting such a finding even if the matter had proceeded to trial.

The judge commented that this is an unusual application, though unsurprisingly, there are authorities stating that there is no bar to granting such an application. He went on to say that very considerable caution is required and that subject to being satisfied that CPR 24.2 is met, there is no impediment to the court granting the application where dishonesty is alleged. In the judge's view, C had according to the usual meaning of the term, acted dishonestly and had substantially affected the presentation of the case.

The court granted the application, made a finding of fundamental dishonesty and made an interim costs order against C in the sum of £150,000.

Discussion

There are a number of ways to secure a finding of fundamental dishonesty and summary judgment is one means of securing an early finding where the evidence is sufficiently clear-cut. With court backlogs and adjourned trials ongoing with no signs of it abating, this is a cost and time-efficient way of securing the right outcome.

Claire Laver, Head of Fraud, CSG, said,

> *"Collaboration between complex injury and fraud lawyers to develop an appropriate strategy to successfully defend this claim has borne out in an early successful decision saving Intact Insurance (formerly Royal Sun Alliance Insurance Limited) £1m. The lengths that this claimant, his wife and adult children went to in their attempt to defraud Intact Insurance were audacious and well thought out but Intact Insurance's willingness to secure surveillance evidence thwarted those attempts with significant financial consequences for the claimant."*

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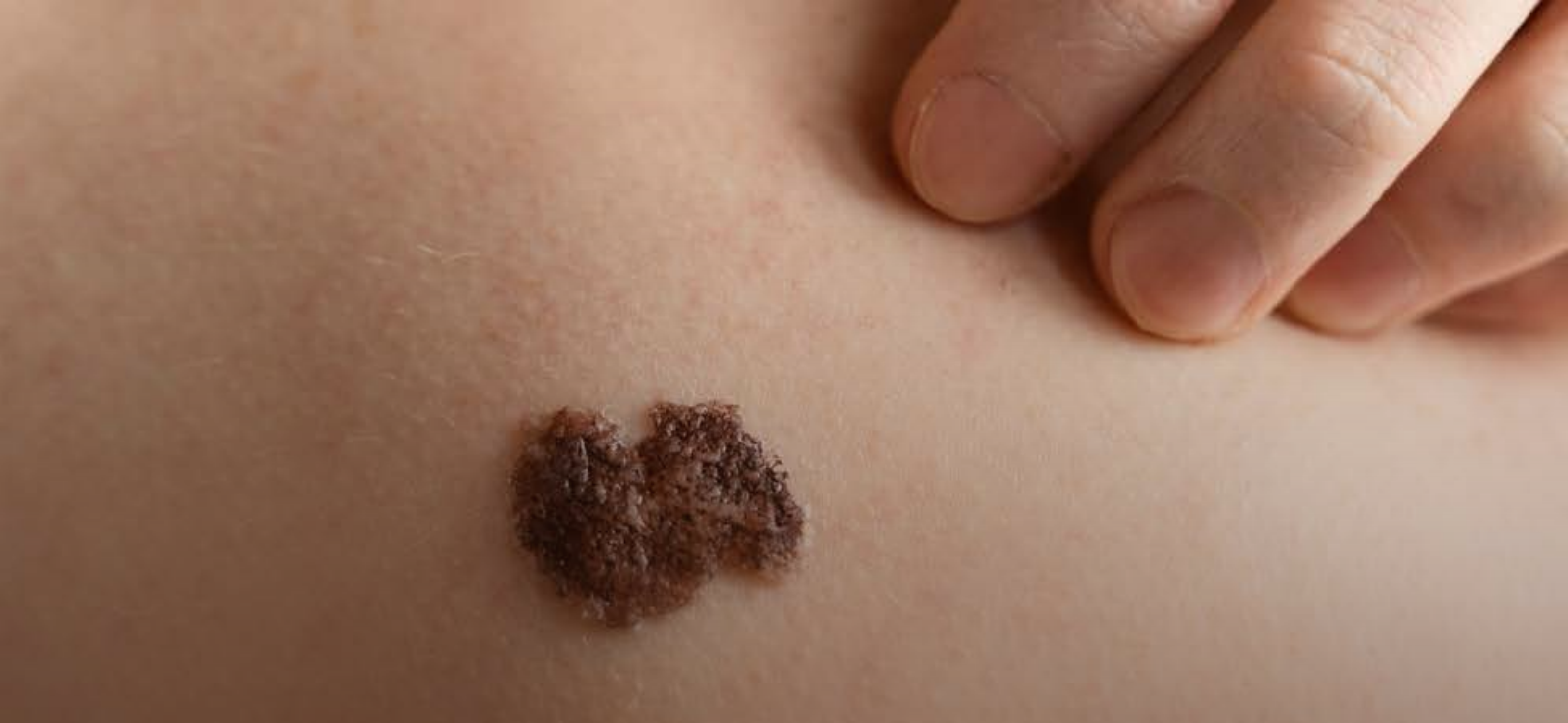

Missed malignant melanoma diagnoses can lead to severe outcomes and litigation. Dr Ernest Allan explains why early excision is critical - and why relying solely on visual assessment can be dangerously misleading.

by Dr Ernest Allan, Honorary Consultant Clinical Oncologist.

Litigation as a result of delay in the diagnosis of malignant melanoma occurs frequently. It may arise from the failure of the GP, the dermatologist or the pathologist.

Malignant melanoma may arise de novo as a small black speck which gradually progresses to a substantial tumour. Alternatively, and more usually, it arises from a naevus which may have been present for many years.

NICE and the BAD have issued guidelines to enable GPs and dermatologists to identify malignant melanomas and to differentiate them from benign skin lesions. Members of the legal profession tend to rely on these guidelines. As a result clinicians either discharge patients who do not have the characteristic features of malignant melanomas or keep them on follow up until the characteristic features develop.

Patients frequently present as the horizontal growth phase is changing to a vertical growth phase. At this time no features of malignancy may be apparent.

The Breslow thickness and the presence of lymph node involvement are the two most important prognostic features. As the tumour enters the vertical growth phase the lesion may have a Breslow thickness of 0.5 mm with a 10 year survival of 95%. When the Breslow thickness is allowed to progress to more than 4mm the 10 year survival falls below 50%.

For each mm increase in Breslow thickness there is a 13% increase in the risk of metastatic disease. The growth rates of Breslow thicknesses are variable but may be as rapid as 0.5 mm per month during the vertical growth phase.

The only safe procedure is to excise all pigmented lesions when the patient gives a history of change.

As a result of this many benign lesions would be excised but there would be a substantial reduction in mortality from malignant melanomas and litigation from missed melanomas would become a feature of the past.

For a broader look at delayed diagnoses in oncology and their legal implications, see Litigating Delayed Diagnosis of Lung Cancer.

Relying on the naked eye or dermascope appearance of a pigmented lesion may delay the diagnosis and reduce the chances of cure. A long-standing pigmented lesion that is exhibiting features of change or a new pigmented lesion that is increasing in size should be assumed to be malignant melanoma until proved otherwise.

Diagnostic delays aren't exclusive to skin cancer. Our post on Legal Insights into Sarcoma explores similar medico-legal challenges in soft tissue cancers.

Backwards Extrapolation of Breslow Thickness

The courts accept backwards extrapolation of the Breslow thickness in an attempt to assess the Breslow thickness when there was a failure to identify the lesion as a malignant melanoma.

However the rate of progression of the Breslow thickness, as published in peer review journals, is based on one measurement after excision and an estimate by the patient as to when the lesion first appeared and when it changed in character. In addition the Breslow thickness increases at a faster rate during the vertical growth phase than during the radial growth phase.

Therefore it must be accepted that estimates of the Breslow thickness by backwards extrapolation are basically unsound. A description of the lesion and its change in appearance over time as described by the claimant or relatives remains the optimum way of assessing the Breslow thickness at the time of the breach of duty of care.

About the Author:

Dr Ernest Allan is an Honorary Consultant Clinical Oncologist at The Christie Hospital one of the largest and most prestigious cancer treating institutes in Europe. He retired from clinical work in 2019, however has an honorary appointment to enable him to continue his research.

Dr Allan spent over 40 years at the Christie's and is therefore experienced in the management of all forms of cancer and able to comment on these claims. He has been undertaking medico-legal work for 20 years.

Personal Injuries Guidelines: inflation, judicial discretion and Higgins v Coleman

by Emma Meagher, Consultant at Eversheds Sutherland.

The recent High Court decision in Higgins v Coleman [2025] IEHC 757, is less significant for its facts than for what it tells us about the current state of the Personal Injuries Guidelines.

While the 2021 Guidelines remain in force, the judgment reflects a growing recognition that they are now out of date and that this may be relevant when assessing damages in individual cases.

The current position

The Personal Injuries Guidelines were introduced under the Judicial Council Act 2019 and continue to provide the framework for assessing damages in personal injury cases.

Courts are required to 'have regard' to the Guidelines. However, they are not strictly binding and judges retain discretion to depart from them where appropriate, provided reasons are given.

The 2019 Act provides that the Guidelines should be reviewed every three years . That review was completed in 2024 and draft amendments were submitted to the Minister for Justice, Jim O'Callaghan, in early 2025. The proposed revisions recommended an overall increase of approximately 16.7% to reflect inflation and wider social developments.

However, those revised Guidelines have not been introduced. The Minister did not bring them before the Oireachtas, which is a necessary step before they can take legal effect. As a result, the 2021 Guidelines remain the applicable framework.

Judicial discretion

The courts have consistently confirmed that the Guidelines are intended to guide, rather than strictly control, awards. In Meehan v Shawcove Ltd [2022] IECA 208, the Court of Appeal made clear that proportionality remains at the forefront and that judges may depart from the Guidelines where justified.

What has been less clear is how far judges can go in taking account of factors such as inflation, particularly where updated Guidelines have been proposed but not brought into force.

The decision in Higgins v Coleman

In Higgins v Coleman, Mr Justice O'Higgins confirmed that the 2021 Guidelines remain the applicable legal framework and awarded the Plaintiff a total of €170,564, including €75,000 for serious psychiatric injury (top of bracket) and a €33,000 for back injury, discounted to €22,000 for overlap.

He did not apply the proposed 16.7% increase, nor did he treat the draft revised Guidelines as being in force. However, he went on to state that it is not unreasonable for a court to take account, "in a very general sense", of inflation since 2021. He also noted that the court should not ignore the fact that the Judicial Council has itself concluded that the Guidelines are now out of date.

In practice, this resulted in the court placing the award towards the upper end of the relevant brackets.

Why this matters

This decision does not change the Guidelines, but it is a useful indication of how the Guidelines may now be applied:

- The 2021 Guidelines remain in force, but may be applied more flexibly in practice;
- Courts may be more inclined to assess damages towards the higher end of the ranges;
- Inflation, while not expressly referred to in the Guidelines, may still influence awards; and

- The level of certainty originally intended by the Guidelines may be reduced.

Conclusion

Until revised Guidelines are formally introduced, courts are likely to continue applying the 2021 brackets, while taking a broader view of factors such as inflation when deciding where an award should fall within those ranges.

In practical terms, when reserving claims, it would be prudent to assess quantum on the basis that a court may place injuries towards that higher end of a bracket

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Pedal cycle investigation: Using GPS and activity data to reconstruct road collisions

by Siobhan O'Connell, Forensic Collision Investigator & Steven Mairs, Chartered Engineer at Hawkins.

Introduction

The increasing use of GPS-enabled devices, particularly cycle computers and smartphone applications, has created a valuable new source of information for collision reconstruction. GPS data can provide insights into rider behaviour in the lead up to a collision. This type of data can provide speed and positional information, whilst also illustrating an individual's typical activity patterns, such as regular routes, usual times of day, and overall duration or distance. When seeking to understand liability and causation, this type of data can be crucial.

Moreover, it can support comparative analysis, for example by showing how other users have travelled along the same path or stretch of road, or by evidencing changes in a person's activity profile before and after a collision, including frequency, duration, distance and speed. For a court, this kind of insight can be highly valuable as it may assist in assessing how an "ordinary" person behaves in a similar environment.

In its simplest form, GPS data obtained from cycle computers and wearables consists of a series of location points, commonly recorded at one sample per second (1 Hz) in sports activity applications. Platforms such as Strava are extremely popular in the health and fitness space. The availability of this kind of data is therefore becoming more prevalent. Wearable devices, such as smart watches and activity

trackers are now commonly owned, contributing further to the volume of available data. However, not all GPS-derived data is equal.

Many people subscribe to the familiar phrase, *"If it's not on Strava, it didn't happen."*. In practice, however, even Strava does not always show exactly what occurred. Differences between platform outputs are not uncommon. Often, the investigator's initial task is to understand the distinction between what is displayed on the platform, what the exported data indicates, and what actually happened, an important consideration when assessing evidential reliability.

As with other forms of digital data, on the surface the data appears straightforward and simple to interpret. In reality, uncertainties arising from the way GPS data is captured, and how those uncertainties are addressed, introduce significant complexity. This article sets out three tiers of data and their implications for forensic analysis.

The Activity View: Interpreted and Processed Data

The activity page on websites such as Strava presents a user-friendly visualisation of an activity, including route mapping, speed, elevation, and segment efforts. However, this view represents processed rather than raw data. When an activity is uploaded, Strava parses the incoming file and independently recalculates metrics such as distance and speed (Strava, 2026a). As a result:

- Displayed speed and distance may differ from the recording device
- Data may be resampled, averaged, or normalised
- Graphs often reflect smoothed or reconstructed values

From a collision reconstruction perspective, this creates an important limitation: website interfaces are an interpretation layer rather than a primary data source. This layer is designed with consumers in mind, and is often processed to be both visually appealing and to allow users to easily interpret it. While minor uncertainty or processing errors may be acceptable for recreational used, they may be critical in litigation. It is therefore generally unsuitable as the sole evidential basis, particularly where second-by-second dynamics, such as braking, sudden deceleration or sudden acceleration, are under scrutiny.

Getting the Most Accurate Data

Many of these websites allow users to export activities as GPX (Global Positioning XML) files. These are widely used because of their compatibility and readability. However, GPX files exported from some platforms, including Strava, represent a reduced dataset (Strava, 2026b). These exports typically contain time-stamped location data and limited sensor information but do not retain the full-range, original sensor streams. Moreover, their distance calculations between sequential points may require recalculation. Over greater distances, the data tends to be fairly accurate, but over shorter distances – which are often most relevant in collision reconstruction – errors may become more pronounced and must be accounted for. In evidential terms, these types of exported files are often used as **secondary data**: useful for mapping and general movement analysis, but limited in precision.

GPS measurements are inherently subject to error, often varying by several metres even under good conditions. To improve usability for consumers, platforms and devices often apply filtering and smoothing algorithms. While these processes improve visual clarity, they can obscure short-duration events that may be critical in a collision scenario. In simplified data sets (GPX files for example), speed is reconstructed from positional change and can amplify noise potentially resulting in sporadic speed values being displayed.

The most complete and forensically valuable dataset is the original activity file, typically in FIT (Flexible and Interoperable Data Transfer) format. Garmin's documentation confirms that the format is designed to store rich, multi-parameter activity data at high fidelity (Garmin, n.d.). Strava, for example, recommends exporting the original activity file where possible (Strava, 2026b). FIT files are designed specifically for performance and sensor recording and may contain:

- High-resolution timestamped GPS data
- Recorded speed (not just derived speed)
- Distance streams (e.g. wheel-based measurements)
- Sensor inputs (power, cadence, heart rate)
- Device metadata and recording intervals
- Event markers (pauses, laps, etc.)

A key distinction is that FIT files often contain **several independent measurements of movement**, whereas a GPX file is typically limited to positional data. Having the most accurate and reliable data allows collision investigators to cross validate between data sources, identify anomalies or signal loss, and obtain more accurate speed and positional data. Whilst this data is also subject to the general uncertainty of any GPS device, having access to a wider range of inputs allows for independent processing and a more accurate assessment of uncertainty. In litigation, this is preferable, as it provides experts with the ability to be completely transparent in explaining how the data was processed to achieve the conclusions cited in reports.

Case Study

A cyclist was participating in a road race when a collision involving several riders occurred, causing them to be thrown from their bicycle. He recorded the ride using a Wahoo ELEMNT ROAM V2 cycle computer. The FIT file was downloaded from his mobile phone using the Wahoo app, and the ride had also been uploaded to his Strava profile.

The FIT file contained data including timestamps, latitude and longitude, heart rate, distance and speed. The timestamps showed that around the time of the collision there was a gap of seven seconds in the recording, followed by a further period of 13 seconds during which no data was recorded. The rider logged into their Strava account and downloaded the GPX file from the website. This file contained less information than the FIT file and, for example, did not include recorded distance or speed data. A third party also viewed the rider's Strava profile and downloaded the GPX file from the website. However, the file available to the third party contained even less information, likely because of privacy settings. It did not include timestamps, which meant speed could not be calculated. Only positional information (latitude, longitude and elevation) was available.

The Strava website displays information about the ride in the Analysis section through a series of graphs and a map. The graphs can be viewed by elapsed time or distance, and the values are shown on the right-hand side as the cursor moves along the graph. Figure 1 shows the data recorded across the entire ride, with the collision occurring within the annotated red box.

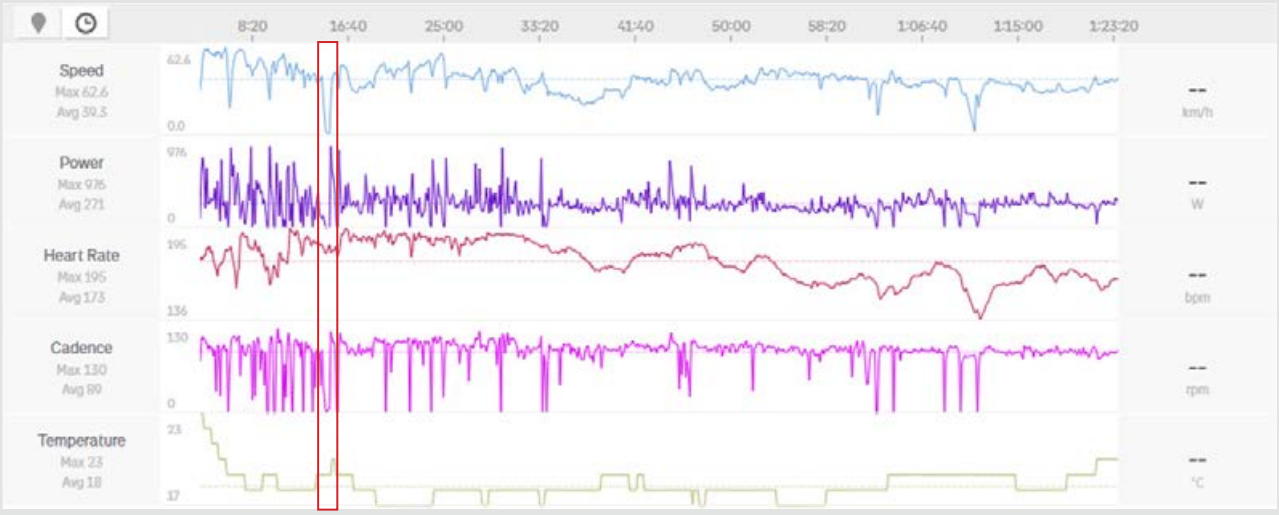

Figure 1 – Extract of the analysis section graphs on the Strava website (taken with permission from the rider)

It is possible to select part of the activity by highlighting an area on the graph and zooming in to an area of interest. Figure 2 shows the speed trace against elapsed time around the time of the collision, as displayed on the Strava website in blue. The speed and time data taken from the FIT file has been overlaid in red. This illustrates the difference between the FIT file data and the smoothed data displayed on the Strava website. The FIT file contains no information during the seven and 13-second periods when the cycle computer was not recording, as shown by the gaps in the red line. By contrast, the Strava graph fills these gaps and displays a continuous line.

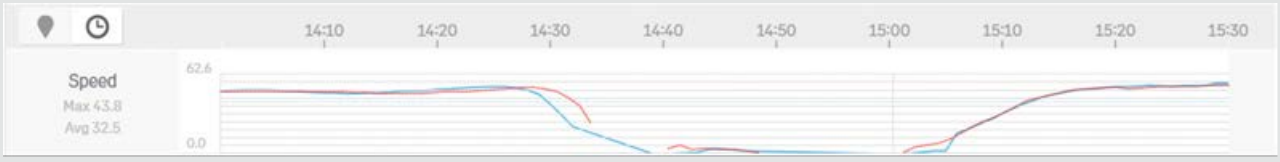

Figure 2 – Extract of the speed/time graph on the Strava website, with Strava data shown in blue and FIT file data shown in red.

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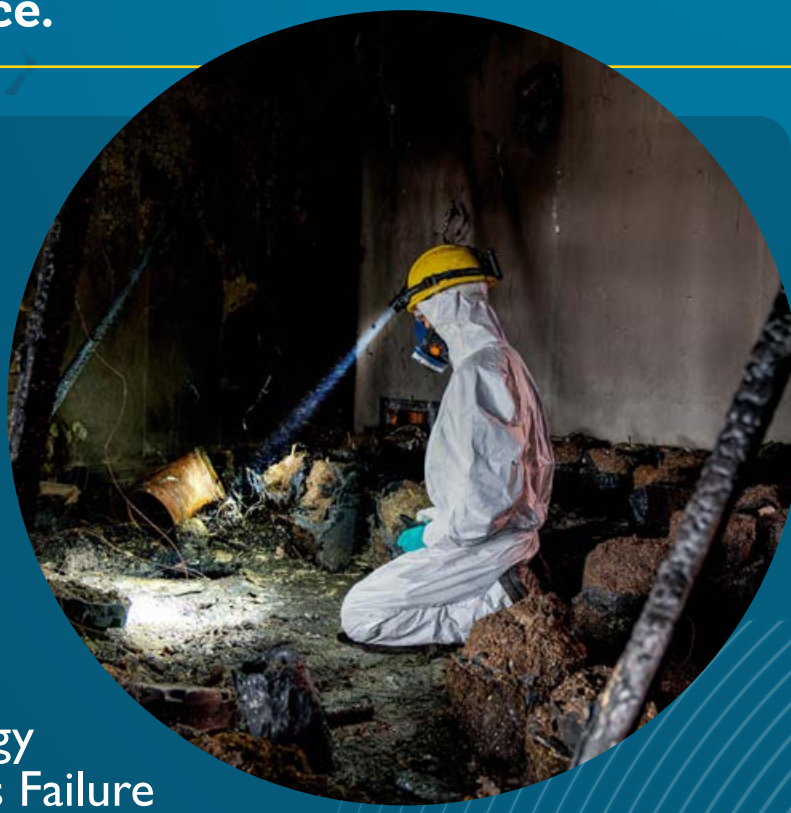

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Table 1 provides an overview of the data contained in each of the downloaded files and on the Strava website.

	FIT	GPX (user downloaded)	GPX (3rd party downloaded)	Strava website
Timestamp	✓	✓	✗	Read from graph
Latitude/Longitude	✓	✓	✓	Location shown on map
Heart rate	✓	✓	✗	✓
Cadence	✓	✓	✗	✓
Distance	✓	✗	✗	Read from graph
Power	✓	✓	✗	✓
Grade	✓	✗	✗	✗
Temperature	✓	✓	✗	✓
GPS accuracy	✓	✗	✗	✗
Enhanced speed	✓	✗	✗	✓
Elevation	✓	✓	✓	Read from graph

***Table 1** - Overview of the data contained in each of the downloaded files and on the Strava website.*

The case study highlights the importance of providing experts with the most accurate data. Whilst the provision of any data from the parties involved in litigation is helpful, it is incumbent upon experts to assess the best evidence obtainable.

It must be recognised that GPS devices are not designed as collision sensors. While they can provide substantial information about the circumstances leading up to a collision, they cannot identify the precise point or mechanics of impact in the way a dedicated crash telematics device can. They often record at a rate of 1 Hz (1 data point per second) whereas devices designed for recording collision data would record at much higher rates, potentially as high as 100 hertz (100 data points per second) or more. The positional accuracy of GPS data is device-dependent and may be affected by factors such as dense tree cover, tall buildings, bridges, tunnels or electrical interference. When used alongside wider evidence relating to the collision, such as photographs, scene marks, and post-impact positions of the vehicles or persons involved, GPS data can be interpreted in a balanced and reliable way.

Evidential Hierarchy in Practice

From a forensic standpoint, GPS-related evidence can be ranked as follows:

1. **FIT (Original File)**
   Highest evidential value; a complete, unprocessed dataset suitable for detailed reconstruction. If the cycle computer or mobile phone is available, data may be downloaded directly rather than through an app.

2. **GPX Export**
   Moderate evidential value; useful for route analysis, but limited in precision. A user may also have access to more data when downloading a GPX file from their own Strava account than a third party can access.

3. **Website based Activity Display**
   Lowest evidential value; interpretative and not always suitable for quantitative reconstruction, although it may provide a more representative indication of cyclist or runner speed than reliance on published average-speed data alone.

Conclusion

The widespread use of Strava and similar platforms has made GPS data increasingly accessible in collision investigations. However, accessibility should not be mistaken for evidential reliability.

The key distinction lies in data fidelity:

- The Strava interface presents an interpreted narrative
- GPX exports provide a simplified dataset
- FIT files preserve the original recorded data

For robust collision reconstruction, reliance on the original FIT file is essential. Anything less introduces uncertainty through smoothing, recalculation or data loss, each of which may materially affect conclusions in both civil and criminal contexts. When considered alongside the physical evidence from the collision, the data can be used more robustly.

For insurers and lawyers dealing with such cases it is advisable to request the involved parties obtain both the FIT and GPX files from their online account. Depending on the platform, export options may not be clear, and if that is the case it is worth seeking early advice from experts with specific experience in processing and analysing this data. It is always helpful to seek this advice as soon as possible as the device itself may also contain useful data.

References

Garmin (n.d.) FIT SDK Overview. Available at: https://developer.garmin.com/fit/overview/

Strava (2026a) How Distance is Calculated. Available at: https://support.strava.com/hc/en-us/articles/216919487-How-Distance-is-Calculated

Strava (2026b) Exporting your Data and Bulk Export. Available at: https://support.strava.com/hc/en-us/articles/216918437 Exporting-your-Data-and-Bulk-Export

About the authors

Siobhan O'Connell is a forensic collision investigator specialising in the reconstruction of serious and fatal road traffic collisions. She holds a First-Class Master's (Hons) degree in Medical Engineering from the University of Surrey and has practical investigative experience from her time with Hampshire and the Isle of Wight Constabulary, complemented by road safety research undertaken whilst working at the Transport Research Laboratory. Her expertise includes collision reconstruction, CCTV analysis, Advanced Driver Assistance Systems (ADAS), and injury biomechanics. She has prepared evidential reports and provided expert evidence in Coroner's Court and the Crown Court.

Steven Mairs is a Chartered Engineer and Member of the Institution of Mechanical Engineers with a First-Class Master's (Hons) degree in Mechanical Engineering from Queen's University Belfast. He has extensive experience as a collision investigator, specialising in the forensic reconstruction of road traffic collisions. His expertise includes scene examination, vehicle and component analysis, and interpretation of digital evidence such as CCTV, tachograph data, and event data recorders. Steven is a registered Bosch Crash Data Retrieval analyst and has acted as an expert witness in Magistrates' and Crown Courts and at Coroners' Inquests.

Part 36 offers when the prognosis is unclear

by Colm Nugent, Barrister & Vanessa McKinlay, Full-time Area Coroner at Gatehouse Chambers.

This article considers the impact of IEH v Powell [2023] which remains unchallenged in the higher courts.

As we know, for QOCS cases issued before **6 April 2023**, rule 44.14 allows a Defendant to enforce a costs order made in its favour case against an **order** for damages and interest made in favour of a Claimant.

Cases issued after 6th April 2023 (and for those who have a PI claim that arose on or before 5th April 2023, time is running out!) have been subject to the new rule. This allows a Defendant in a QOCS case to enforce a costs order in its favour against a Claimant's order **or settlement** for damages, interest **and costs**.

Where a Defendant makes a Part 36 offer and it is accepted after the 21 day 'relevant period', rule 36.13(5) provides that the Claimant will recover costs to the end of the relevant period and the Defendant will recover its costs from the end of the relevant period to the date of acceptance. However, if the court considers that it would be unjust to apply this rule, it will not do so.

Following the rule change, Claimants receiving a Part 36 offer will have in mind the risk that late acceptance of that offer might now go beyond not recovering their costs from the end of the relevant period. They might also face a Defendant being able to enforce its costs order against the Claimant's damages, interest and costs obtained in that settlement.

What happens in a clinical negligence or personal injury case where a Defendant makes a Part 36 offer at a stage when the Claimant's prognosis is still uncertain? If a Claimant waits until the picture becomes clear and then accepts the offer late, will the Defendant be able to recover its costs or will the court consider that to be unjust in the circumstances?

This issue arose in the High Court decision in *IEH v Powell* [2023] EWHC (KB).

The Claimant was 8 years old when he was injured in a road traffic collision in 2016. He sustained a traumatic injury to the brain, along with other injuries. Judgment was entered for the Claimant in August 2018.

The Defendant made an offer to settle in November 2020, with the end of the relevant period being in December. The offer was accepted (subject to the court's approval) in July 2022. This was a claim issued before the rule change, so the issue was not whether the Defendant could enforce a costs order against the Claimant's settlement amount or costs. The issue was whether the Claimant could have his costs of the action up to the date of approval. In other words, the court had to decide whether it would be unjust to follow the provision in rule 36.13(5) which would otherwise result in a costs order in the Defendant's favour from December 2020 to the date of approval of the settlement. The Claimant had the burden of establishing that it would be unjust.

Medical reports were served with the Particulars of Claim addressing the Claimant's brain injury. These were from a Consultant Paediatric Neurologist and a Consultant Neuropsychiatrist. Following a stay, the Claimant was ordered in December 2019 to serve updated medical reports by March 2022. The Defendant's Part 36 offer therefore came long before the date for the Claimant to serve his updated evidence.

The position of the Claimant's experts when proceedings were served was that it was too soon to provide a reliable prognosis, given the possibility of latent disability which might not become evident until the Claimant got older. The neurologist recommended reassessment in three to four years'

time and the neuropsychologist at the ages of 13, 16 or 18, depending on the Claimant's progress.

Following the Part 36 offer, the Claimant's legal team took a number of steps. They obtained updated evidence from the original experts and additional reports from a Child and Adolescent Psychiatrist and a Speech and Language Therapist. They obtained evidence from the Claimant's teacher and family (complicated by the fact that the Claimant lived abroad). They then obtained advice from Leading Counsel. Having taken these steps which showed a significant improvement in the Claimant's condition, they were able to advise acceptance of the Part 36 offer.

The court held that it would be unjust to follow the usual rule and make a costs order in the Defendant's favour. The court considered the particular facts of this case and the matters contained in rule 36.17(5). The following points were central to the judgment:

1. Following *SG (A Child) v Hewitt (Costs)* [2012] EWCA Civ 1053 and *Briggs v CEF Holdings Ltd* [2017] EWCA Civ 2363, the court avoided where possible analysis of the facts in other costs authorities, instead concentrating on the principles and the facts of this particular case.
2. The fact that the Claimant is a child may not always be relevant to an issue under rule 36.13(5) but in this case it was because the long term effects of a traumatic brain injury cannot usually be known until later in a child's development.
3. Having to wait to determine the effects of the Claimant's injury was not 'a normal contingency of litigation'.
4. It was reasonable for the Claimant not to accept the offer within 21 days on the evidence then available. At the time of the offer, the Claimant's solicitors were working towards obtaining updated evidence in line with the court's timetable and their conduct in doing so was reasonable.
5. There were added complications in that the Claimant lived abroad and both his ability to travel for expert assessments and his ability to attend school were affected by the pandemic. The need to appoint the Official Solicitor as litigation friend owing to the Claimant's mother's illness added a further delay (although it did not delay the updating of the medical evidence).
6. It was *"extremely doubtful"* that the court would have been able to approve the Claimant's acceptance of the offer in late 2020 on the basis of the evidence as it was. It was more likely that the court would have adjourned the approval hearing and given directions for updated evidence.

There was an issue about how much information had been given to the Defendant about the steps that the Claimant had taken. Whether this would affect the amount of costs recovered by the Claimant would be a matter for detailed assessment.

The approach taken by the court in this case should provide some reassurance to Claimants facing Part 36 offers where the prognosis is unclear, particularly given the importance of the rule changes regarding recoverability of Defendant's costs. However, it was important in this case that the Claimant was able to show that active steps had been taken to move the medical evidence forward and not simply wait for time to pass. In doing so, the Claimant's improvement was confirmed, and the offer was deemed acceptable.

The practice point for Claimant lawyers seems to be to take active steps to review the Claimant's progress in the face of an offer, and keep the Defendant informed that you are doing so. Be aware that the correspondence sent during this period may well by the subject of judicial scrutiny at a later date.

Bristol student-led initiative aims to transform psychological support in rugby injury rehabilitation

by University of Bristol.

A new concept designed by Bristol students to address the psychological wellbeing of injured athletes was unveiled at the recent University of Bristol's Centre for Innovation and Enterprise's Innovation Showcase.

The initiative, named Headstrong, seeks to redefine how professional rugby clubs and organisations approach injury rehabilitation by placing equal emphasis on a player's mental, emotional, and physical recovery.

Co-developed by University of Bristol students Anna Leppard, Jenna de Vera, and Sam Chevin as part of their dissertation project, Headstrong explores a critical research question: *How do current injury rehabilitation practices in professional rugby address the psychological wellbeing of players, and how might these practices be improved to support holistic recovery?*

Jenna, who is balancing her studies in Film and Television with Innovation alongside playing elite rugby for Bristol Bears and the Wales Women's rugby team – for whom she made her senior debut this February – is no stranger to overcoming serious setbacks having suffered an ACL injury which forced her out of the game for 14 months.

While still at the early stage, the trio behind Headstrong are actively exploring its real-world potential with plans to present the concept to Bristol Bears to assess its feasibility within a professional rugby environment.

The hope is that this initial step could pave the way for broader implementation across not just rugby clubs and organisations worldwide, but other team sports such as football, and eventually individual disciplines like golf.

Anna said:

> *"The vision is for Headstrong to become a flexible protocol or consultancy-style initiative that can be embedded directly into existing rugby club structures.*

> *"While traditional rehabilitation focuses heavily on physical recovery, our research looks more broadly at how injury impacts areas such as identity, routine, sense of purpose, and overall outlook on life. These effects can be especially significant for elite athletes, whose lives are often highly structured around performance.*

> *"By working closely with coaching and medical staff, the initiative aims to equip organisations with the tools and knowledge needed to better support athletes during injury and recovery."*

> *"Our focus is on creating meaningful, lasting change," added Anna. "Success isn't just about implementation - it's about improving awareness, strengthening support systems, and ensuring athletes feel genuinely supported throughout their recovery journey."*

> *"There is also a huge benefit to the clubs in having this embedded within their approach towards player welfare because it demonstrates genuine 'athlete-first' thinking."*

One concept the team is exploring is the introduction of an additional assessment during a player's onboarding at their club. This would capture more holistic insights about the individual, such as how they manage stress, their support networks, and personal circumstances. The goal would be to give coaches and support staff better context to support players more effectively if and when injuries occur, with regular check-ins and person-to-person interaction incorporated into the assessment.

The team has already conducted research featuring focus groups, workshops, and expert interviews with a wide range of professionals across club and international rugby including players, coaches, and physiotherapists.

The student team presented Headstrong at the recent University of Bristol's Centre for Innovation and Entrepreneurship's annual Innovation Showcase to raise awareness of the project, gather feedback, and validate the concept. In parallel, the team is exploring potential long-term funding models, including the possibility of a sustainable non-profit structure supported by grants and public sector funding.

Members of the Headstrong student team at the University's annual Innovation Showcase © Headstrong

Dr Eugene McNally

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Consultant Musculoskeletal Radiologist

Dr Eugene McNally is a Consultant Musculoskeletal Radiologist with over 25 years' experience working at the highest level in MSK imaging in the UK.

His experience is in all forms of imaging and image guided treatment of trauma, tumour, inflammatory, sports injury and generalised disorders of the musculoskeletal system including joints and spine.

Dr McNally acts as an expert witness, including the preparation of medico legal reports and giving evidence in court, in personal injury and clinical negligence cases relating to:

• Musculoskeletal imaging • Neck injury
• Ultrasound • Trauma
• Joint, muscle and tendon MRI scans
• Arthritis and rheumatology imaging
• Spinal injury • CT scans
• Sports imaging

Dr McNally can take instructions on behalf of either claimant or defendant or as a Single Joint Expert.

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Miss Sheweidin Aziz

Consultant Spinal Surgeon

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Sheweidin Aziz is a full-time consultant spinal surgeon at University Hospitals of Leicester, with specialist interests in metastatic spinal disease, cauda equina syndrome, and degenerative spinal pathologies. She has presented her work nationally and internationally, received awards for her research, and contributed to multiple peer-reviewed publications. Her research portfolio is extensive, with particular interests in metastatic spinal disease and cauda equina syndrome.

Miss Aziz currently serves as Audit Lead for the Trauma and Orthopaedics Department and remains actively involved in service development and clinical governance. She is also committed to undergraduate and postgraduate education, regularly contributing to teaching programmes, interview panels, and revision courses. Her dedication to medical education was recognised with the Outstanding Clinical Teacher Award from the University of Leicester Medical School.

Miss Aziz was privileged to be among the first cohort of Spinal Training Interface Group (TIG) Fellows in the UK. During her TIG fellowship, she gained broad experience in paediatric deformity, spinal trauma, primary spinal tumours, and degenerative spinal conditions. She subsequently completed a prestigious spinal fellowship at the Leeds Centre for Neurosciences, further consolidating her subspecialist expertise before commencing her consultant career at the University Hospitals of Leicester.

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Mr. Mike Hart

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Mr. Mike Hart performs work as an expert witness with Eopinex. His aim is to provide specialist information in a clear and timely manner, producing the highest standard of court-compliant reports. He actively participates in regular formal training delivered by certified providers to remain up to date, in line with guidance from the Academy of Medical Royal Colleges (2019).

His specialist interests encompass the full spectrum of functional neurosurgery, including movement disorders, pain, and epilepsy. He also undertakes general neurosurgery—such as the management of hydrocephalus, infection, and traumatic brain injury—as well as spinal surgery, including decompression, discectomy, and cauda equina syndrome.

Areas of Expertise

- General neurosurgery including traumatic brain injury, infection, hydrocephalus).
- Spinal neurosurgery including back pain, sciatica, lumbar disc disease, lumbar stenosis, whiplash, neck pain, cervical disc disease, cervical myelopathy.
- Functional neurosurgery; movement disorders; Parkinson's disease; tremor; dystonia; pain; spinal cord stimulation; epilepsy; vagal nerve stimulation; spasticity; intrathecal drug delivery; peripheral nerve stimulation.

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Dr Ioannis Mavroudis

Consultant Neurologist

Dip.Cr, CFM, MD, PhD, FRCP

Dr Ioannis Mavroudis is a Consultant Neurologist at Leeds Teaching Hospitals Trust. He also runs private clinics at The Good Health Centre and 10 Harley Street, London. He is also an Honorary Senior Lecturer at Leeds University and a Medical Director at Sigma-Pi Healthcare Ltd, and Sigma-Pi MedicoLegal Ltd.

He completed his basic training in Greece in 2004, where he obtained his MD. Worked as a research fellow with the Laboratory of Neuropathology and Electron microscopy of the Aristotle University of Thessaloniki from 2005 to 2013, when he presented his Thesis and obtained his PhD.

He joined the Neurology department at Leeds General Infirmary in October 2017 as a Consultant Neurologist, and joined the Motor Neurone Disease team on January 2021.

He has experience with the entire spectrum of Neurology from Traumatic brain injuries and post-concussion syndrome, Multiple Sclerosis, Parkinson's disease, Motor Neurone Disease, Dementia, Headache treatments, Functional Neurological Disorders, cognitive disorders, medically unexplained symptoms and Epilepsy.

He runs Traumatic Brain Injury (Concussions/post-concussion syndrome), general neurology and Functional Neurological disorders clinics.

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Illegality as a Defence in Personal Injury Claims

by Kelvin Farmaner, Partner, Insurance & Regulatory at Trethowans LLP.

This article is one of a series of articles about defending personal injury claims. It focuses on the illegality defence (ex turpi causa) – a powerful but often overlooked argument that can completely defeat a claim.

In a recent case handled by our team, the claimant's solicitor had never encountered this defence before and subsequently dropped the claim he was advancing on behalf of his client.

What is the illegality defence?

The illegality defence in personal injury claims prevents a claimant from recovering damages where their injury arises from their own criminal conduct.

Often referred to as *"ex turpi causa"*, the principle is grounded in the wider public policy notion that it would bring the whole legal system into disrepute if people were allowed to benefit from their own criminal conduct.

This defence can be particularly relevant in claims involving dangerous driving, criminal behaviour and joint illegal enterprises.

How the courts apply the illegality defence

The leading case on illegality is *Patel v Mirza 2016*. The Supreme Court confirmed that courts should adopt a flexible, public-policy based approach when considering the application of the defence.

In doing so, the court emphasised the need to have regard to the purpose of the law that has been breached, any competing public policy considerations, and whether denial of the claim would be a proportionate response. This approach replaced the previous rigid reliance test and means that outcomes may vary depending on the facts of each case.

Illegality in practice: *Pitts v Hunt 1991*

In the case of *Pitts v Hunt 1991* the claim of a pillion passenger who encouraged a motorcyclist to ride recklessly, and who he knew to be intoxicated, was dismissed. When the claimant sued for injuries sustained in a collision between the motorcycle and a car, the court found that there was an ex turpi causa defence, as the claimant and first defendant were engaged in a joint illegal enterprise.

It was against public policy to allow the claimant to succeed. The nature of the joint enterprise was such that it precluded the court from finding that the defendant owed any duty of care to the claimant.

It is apparent that each case will turn on its own specific facts but that there are some general principles to be gleaned from the case law. The courts will look at the illegality involved, consider whether there are any competing public policy considerations engaged if a claim is turned down and the court will also look at matters proportionately and consider whether a claimant's illegal act is closely connected to their claim or whether it is unrelated.

Kelvin Farmaner is a Partner and Head of the Insurance and Regulatory team at Trethowans. Contact Kelvin by:

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Our defendant insurance expertise is independently recognised by leading legal directories. Kelvin Farmaner is ranked UK-wide by Chambers for Personal Injury: Mainly Defendant, while Trethowans is ranked in the Legal 500 for Personal Injury: Defendant (South East – Insurance), with both Kelvin Farmaner and Bethany Blamire named as Leading Partners, highlighting the strength and track record of our insurance disputes team.

Dr. Philippa Corson

Consultant Obstetrician & Gynaecologist

BA MA MBBS MRCOG
PGDip Healthcare Leadership

I am a Substantive NHS Consultant Obstetrician & Gynaecologist and Clinical Lead for Obstetrics (2021–present) with extensive experience in high-risk and complex maternity care. I am also an experienced labour ward consultant with strong decision-making in acute and high-pressure environments, delivering safe and efficient patient flow. I am responsible for the Clinical leadership of obstetric services and patient safety, I am the Senior decision-maker on the labour ward and provide oversight of high-risk antenatal and intrapartum care

Areas of Specialism

Ventouse delivery: As an Accredited Trainer and Course Facilitator for the internationally recognised gold standard Vacca Academy Masterclasses in Vacuum Birth

Breech Birth and ECV: Optibreech trainer and course facilitator.

Accredited Patient Safety Specialist (PSS) University of Loughborough.

Labour Ward: Consultant-level labour ward cover . Management of high-risk and complex intrapartum cases· Instrumental delivery and complex caesarean sections· Escalation, risk management, and clinical leadership· Supervision of junior staff and multidisciplinary teams.

Antenatal Care: Routine and high-risk antenatal clinics· Maternal medicine and complex pregnancy management· Triage and referral assessment· Virtual and in-person clinic delivery.

Obstetric Expertise: High-risk obstetrics and complex comorbidities· Intrapartum fetal monitoring and decision-making· Birth planning and complex counselling. · Bereavement and post-loss care.

Medico-legal

I have drafted medico legal reports for Clyde and Co and Kennedy's Law LLP who represent Barts.

Defendant: Approximately 30-40 reports. I have authored over 60 internal concise/serious incident reports and represented the Trust at Coroner's inquests.

Statement: ' I understand as an Expert Witness, my duties are to the Court under the Civil Procedure Rules, part 35.'

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Mr Stephen Keoghane

Consultant Urological Surgeon MBBS MS FRCS (Urol)

• I am an NHS consultant with over 22 years experience in urology.

• Having qualified from the Middlesex Hospital Medical School in 1989, my first job as a junior doctor was in the urology department at the Middlesex Hospital - at the time one of the premier units in the world. My training in surgery was broad, with 2 years spent in clinical research in Oxford and 2 years in radiology. The latter allows me to offer what I believe to be a unique insight into the radiological aspects of medico-legal cases.

• I completed a formal endo-urology fellowship, which included time in the US training in complex surgery and have published widely in the international scientific literature, and continue to write feature articles for the urology press.

• I served as a medical officer in the Army Reserve (AR) for 22 years. I was promoted to lieutenant colonel at a young age and have experience as an adviser to the MOD on urological conditions. Having been selected for higher training at the Army Staff College, I passed out in the top third of all AR officers. My clinical experience includes the treatment of blast injury and ballistic trauma in Afghanistan. Assessing the impact of illness on occupation was an inherent part of my time in the British Army Reserve.

• My surgical and medico-legal practice covers both core and sub-specialist endo-urology, acting for both claimant and defendant in the UK and Ireland.

• As an education lead, I have won many awards for teaching undergraduates and surgical trainees.

• I am also a very experienced public speaker and have a parallel career as a military historian, published author and feature writer for well-known, high-circulation, international magazines.

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Eur Ing Dr Robert Brown
Chartered Electrical Engineer

BEng (Hons), PhD, CEng, MIET, IntPE (UK), Chartered Electrical Engineer

Dr Robert E Brown is an expert witness in the fields of electrical, electronic and control engineering.

Achieving a first class honours degree (BEng), in Electronic Systems and Control Engineering, a Doctor of Philosophy degree (PhD) in Electrical Engineering, and attaining Chartered Electrical Engineer status, Dr Brown has worked extensively within the manufacturing, utility and construction sectors, as a consultant engineer with many large blue chip organisations and well as small OME and start-up companies.

Robert, as he likes to called, is an acclaimed expert in the operation and design of electrical fault protection systems. He also has extensive experience in the operation, design, manufacture and testing of electrical and electronic control systems for domestic and industrial environments.

Robert continues to work as a consultant engineer and researcher whilst in the main, undertakes to help in litigation and insurance claims where an understanding of electrical circumstances and phenomena are sought for settlement.

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Case Note: Spicer v Greene King Brewing and Retailing Limited [2026] EWCC 18

by Kitty Kirton, Probationary Tenant at Hailsham Chambers.

Introduction

1. The judgment in Spicer v Greene King Brewing and Retailing Limited [2026] EWCC 18 contains guidance for practitioners on the correct tests to apply when determining the deduction of Conditional Fee Agreement ("CFA") success fees and After the Event insurance ("ATE") premiums, in personal injury claims brought on behalf of children.

2. All paragraph references in this note are to those in the judgment unless otherwise stated.

Facts

3. The Claimant, a child then aged 4, had visited a pub owned by the Defendant. While playing in the pub garden, the child tripped on uneven paving slabs and suffered a nasty gash to his forehead. His wound fully healed within two months, and he was left with a faint scar below his hairline which was visible on close inspection.

4. The Claimant's mother acted as the Litigation Friend. The pub manager admitted liability for the accident straight away and offered the child's mother some vouchers to spend on a meal at the pub on a future occasion. The child's mother thought that vouchers were insufficient compensation for the injury and had emailed the Defendant who passed her email on to their Claims Handling Agents. They advised that they would deal with the claim but any award of damages would have to be approved by the Court as they were sought for a child. They asked her to instruct solicitors to get a medical report to forward to them so that they could settle the claim.

5. The solicitors advised the Claimant's mother to sign up to a CFA and to take out an ATE insurance policy. They instructed a medical expert through their wholly owned subsidiary medical reporting agency. District Judge Lumb described the claim as a "very straightforward Occupiers Liability personal injury claim" (§10) and that "[a]ll the solicitors had to do was to advise on funding, obtain a medical report with copies of the notes and records, complete the online minor injury portal Claim Notification Form and then provide a copy of the medical report to the Defendant and negotiate settlement and a formal written advice on settlement for the benefit of the Court" (§11).

6. A settlement of £10,000 was agreed between the parties and approved at the infant approval hearing. The fixed costs had been agreed prior to the hearing. The only further issue for the Court to consider was the request for a deduction of the success fee under the CFA and of the ATE premium set at 10% of the recovered damages plus insurance premium tax ("IPT").

7. A schedule of solicitor and own client costs claimed £13,316 worth of profit costs with recorded time of 73.1 hours incurred between 18 fee earners. The CFA and Risk Assessment assessed the percentage success fee at the maximum 100%. As 100% of £13,316 would be greater than 25% of the damages (ie £2,500), a success fee of £2,500 was sought to be deducted together with the ATE premium including IPT of £1,120. This meant total sought deductions of £3,620 (ie 36.2% of the damages). District Judge Lumb was "sceptical that even on a solicitor and own client indemnity basis that £13,316 worth of costs could have been reasonably incurred and be reasonable in amount and the success fee percentage of 100% was obviously too high" (§16). The Court directed that the solicitors file a complete copy of their file of papers for inspection and assessment.

8. A finding was made that the Litigation Friend did not give fully informed consent to the charging model (§18), as explained further below at §22 below. The Court carried out a summary assessment on the indemnity basis of the reasonably incurred and reasonable in amount solicitor and own client costs.

9. The Court concluded that the case could and should have been run by the Grade D fee earner with supervision from a Grade B fee earner and the reasonably incurred time would have been 15 hours at Grade D and 2 hours at Grade B (§27). The base costs should have been no more than £3,000.

10. The deduction of the ATE premium was disallowed (§29) and the appropriate deduction of additional liabilities from the Claimant's damages was limited to a success fee of 11% (totalling £330 plus VAT) (§28).

Analysis

11. District Judge Lumb stated that "[i]t would appear that from time to time, and perhaps with surprising regularity, both practitioners and members of the judiciary have not applied the correct tests in dealing with these issues" (§2). The remainder of this note provides a summary of the practical points that should be borne in mind in personal injury claims brought on behalf of children when dealing with: (a) ATE premiums; and (b) success fees, as highlighted in the judgment.

ATE premiums

12. So far as ATE premiums are concerned, these are either to be allowed in full or disallowed unless judges have before them evidence from actuaries or insurance underwriters as to appropriate levels of premiums (§3). Such expert evidence is rarely, if ever, produced.

13. When determining whether or not to allow the deduction of an ATE premium from a child's damages, the Court will consider whether it was an expense which was reasonably incurred.

14. The Court asked what risk there was to insure against where the solicitors' own client profit costs are covered by the CFA. The Defendant's Claim Handling Agents had told the Litigation Friend that a Court hearing was necessary, so there was said to be no risk of failing to recover that. The Claims Handlings Agents had also explained that a medical report was required and that the Litigation Friend should instruct solicitors to obtain one, which she did. All disbursements were paid by the Defendant as part of the proposed settlement and the Court found that there was no real risk that they would not do so. The only possible risk of an adverse costs order was in the event of failing to beat a Part 36 offer but given that approval by the Court was always going to be required, that risk was "practically non-existent and certainly didn't justify the expense of a premium to be calculated as 10% of the recovered damages + IPT of £1,100" (§29).

15. Practitioners should consider the risks to the claimant that the ATE premium is seeking to reduce and what costs the opponent has told the claimant to incur and/or has agreed to pay in the context of the facts of each case. There will of course be claims where ATE premiums are justifiable, but they may be difficult to justify in the more straightforward and lower risk cases with a CFA in place.

CFA success fees

16. When calculating the appropriate CFA success fee, the Court will consider the appropriate level of profit costs charged by the solicitors and whether these have been reasonably incurred and whether they are reasonable in amount. That figure is then multiplied by the appropriate percentage success fee based on the risk of losing the case (§4). When assessing the appropriate percentage, the Court has to consider any risk assessment undertaken by the solicitors and whether that was reasonable given the state of knowledge about the case at the time the assessment was carried out. The figure is then compared with 25% of the recovered damages for pain and suffering and loss of amenity and any past special damage loss. If it exceeds 25% of the damages, the success fee is then capped at that figure. If the calculated figure is less than 25% of the damages to be awarded, then that lower figure represents the success fee. It is strongly recommended that practitioners carry out a risk assessment when calculating the success fee and that clients see the assessment, are advised on it and that they approve the success fee with that in mind. If a risk assessment is not carried out, practitioners should be able to demonstrate how they calculated the success fee and how the client's approval was obtained. Per Herbert v H H Law Ltd [2019] EWCA Civ 527, if a risk assessment was not undertaken, the solicitor needs to obtain informed consent from the client to satisfy CPR 46.9(3) (per §38 of that judgment). Such informed consent was informed approval given following a full and fair explanation to the client (per §37 of that judgment).

17. The Court found that a success fee of 100% could not be justified in this case given the minimal risks involved in the case being unsuccessful (§28). Allowing for the minimal risks involved

and taking into account the deferment of not being able to charge until the conclusion of the case, a more realistic assessment of the prospects of success was found to be 90% which applying the ready reckoner equated to a success fee of 11%. The Court concluded that the appropriate success fee would be 11% of £3,300 (ie the base costs that were decided at §27 and referred to at §9 above), which totals £330 plus VAT (§28).

18. The Court noted that where practitioners often appear to have fallen into error is to assume that the success fee will always amount to 25% of the relevant damages. If that was the correct approach, it would risk being a contingency fee which is unlawful and irrecoverable (§5). The cap of 25% should not be regarded as the default success fee and it may well be difficult to justify in low-risk claims.

19. Another common error by practitioners that was noted is where details of the solicitor and own client base costs are not produced (§5). This prevents the Court from being able to calculate an appropriate success fee and would lead to no success fee being deducted from the damages. To avoid this, sufficient details of the profit costs should be provided to the Court to justify the reasonableness of those costs.

20. The judgment also refers to a reported common error made by judges when assessing the appropriate success fee, namely expressing the appropriate success fee as a percentage of the damages, rather than assessing the risk of losing the case (§6). It is important for practitioners to ensure that the success fee in the CFA is recorded as a percentage uplift of the amount that would be payable if there was no CFA, as opposed to a percentage of the damages.

21. District Judge Lumb refers to a "disturbing trend amongst some solicitors to sign clients up to hourly rates which are significantly higher than the guideline hourly rates provided by the SCCO and claim to have recorded time far in excess of what could be objectively considered to be reasonably incurred and reasonable in amount" (§7). This results in the base profit costs being significantly higher than reasonable and "inevitably draws suspicion that this practise is deliberately designed to ensure that no matter what percentage success fee the court may assess as being reasonable (often significantly less than the permissible maximum of 100%) the 25% cap on deduction from the damages will always be reached". This judgment is a useful reminder of the need to ensure that fees are reasonably incurred and reasonable in amount to the claim that is being pursued. Further, hourly rates should reflect the complexity of the case.

22. Reference is made to a witness statement included in the bundle for the original approval hearing of the Litigation Friend "which was clearly a template statement prepared by the solicitors and not in her own words and therefore to be viewed with some degree of caution as its contents were obviously designed to be self-serving for the solicitors about the choice of funding model and ATE insurance" (§18). It is further noted that it was clear to District Judge Lumb that the Litigation Friend "didn't really understand what was in the statement or its meaning and effect and that she had been conditioned to expect that 25% of [the child's] damages would be deducted for the success fee as the norm" (§18). This is a helpful reminder of the need to comply with the requirements of CPR 21 in proceedings involving children and protected parties, and to ensure that clients receive information in a way that they can understand and that they are in a position to make informed decisions about the services they need. Specific reference is made to the Warning Notice published by the Solicitors Regulation Authority on 28 January 2026 regarding "no-win, no-fee" and other fee arrangements in high-volume consumer claims, available here, at §§22-24 and 31-32. Costs and fee arrangements can be complex and confusing for many clients. Practitioners should ensure that information on the success fee is provided in a clear and comprehensive way before a client signs the terms of agreement, and such documentation is available to be relied upon in Court if needed. If oral advice is given, practitioners should keep a written record of this to demonstrate that informed consent was given. Success fees must also be justifiable, fair and reasonable.

Conclusion

23. The postscript to the judgment notes that "[s]olicitors who are acting in this way [ie where costs are artificially inflated to ensure that the 25% cap was always reached] through their business models have been warned that the Courts will remain vigilant and the next step may well be investigation by the SRA given the Warning Notice of January 2026" (§32). This judgment serves as a useful reminder of ensuring that practitioners are acting in their clients' best interests.

hailshamchambers

Material contribution: where catastrophic injury cases become fatal

by Kirsty O'Donnell, Partner at Digby Brown LLP.

Transport Scotland statistics for 2024 were recently published and out of 869 road traffic collisions involving pedestrians, 373 people suffered serious injuries and 37 people sadly died. However, are these statistics truly representative of reality?

In the serious injury team at Digby Brown LLP, we often see cases where an individual suffers catastrophic injuries and then sadly dies weeks, months or even more than a year later. In situations like this, one must ask the question, what really caused this person's death? It is an important question to pose because it could be that as well as the claim to the estate for the individual's initial injuries, there are also valid family claims to be pursued under the Damages (Scotland) Act 2011.

Material contribution is considered in a large body of case law in Scotland, usually, in industrial disease cases. The House of Lords case of Bonnington Castings Ltd v Wardlaw [1956] A.C 613 was the first case to depart from the usual "but for" test. It held that alongside proving negligence or breach of duty on the part of the defender, the pursuer must prove that the negligence caused or materially contributed to their injury. It also held that any contribution that was not de minimis would be material.

We often see cases where the pursuer suffered life changing spinal cord, brain injuries or polytrauma injuries at the time of the accident and thereafter, they develop further medical complications and die some time later. The situation is not complicated where this happens a short time after the accident and the person had no real pre-existing conditions of note. However, this sort of case is few and far between.

More often than not, people have pre-existing conditions and the argument is made that notwithstanding the accident, they would have died in any event. This is often the case when a person survives for many months after the accident. It is trite law however that one must take the victim as one finds them. The true test is whether the injuries sustained at the time of the accident caused or materially contributed to their death.

This point was considered in the case of Young v AIG Europe Ltd [2015[EWHC 2160 (QB). In this case, the question before the court was that of causation only. The pursuer was injured in a road traffic accident and suffered a heart attack 2 days later. He then suffered a spinal haematoma 4 days later rendering him paraplegic. It was admitted by the defenders that the accident caused these injuries. Around 3 weeks later, he suffered a non-haemorrhagic stroke. Causation for this element of the claim was the question before the court. The court held that although he had pre-existing risk factors that increased the likelihood of him suffering a stroke in the future, after considering medical evidence, the accident materially contributed to the stroke occurring and probably caused it. The court referred to the case of Alphacell v Woodward [1972] UKHL 4:

> *"The nature of causation has been discussed by many eminent philosophers and also by a number of learned judges in the past. I consider however that what or who caused a certain event to occur is essentially a practical question of fact which can be best answered by ordinary common sense rather than abstract metaphysical theory"*

The judge's comments are worth bearing in mind when considering cases where death takes place sometime later. If one steps back and considers the position factually, then often the fatal element of these civil cases becomes clear. This is an important avenue of investigation for practitioners to ensure that advice is sound in relation to all aspects of potential damages in the case. There is no definitive answer as to the cut off point for when a fatal case cannot be pursued if the death occurs some time later. It can become harder to prove as time goes on but it is not necessarily the case that a fatal claim cannot be pursued in these circumstances.

Evidentially, the first port of call is the death certificate. Often one will see the road traffic accident or injuries sustained at the time of the accident being noted as a primary or, more likely, secondary cause of death. Often this is sufficient to establish that the accident materially contributed to the individual's death. Much will depend on the insurer's view of this as to whether further evidence is required pre litigation or whether a claim can be resolved without the need for this. If the case requires to be litigated, it would always be prudent to obtain expert evidence in respect of causation unless there is a clear admission by the defenders on record.

If the accident or injuries sustained at the time are not noted on the death certificate, then this does not necessarily preclude the fatal family claims. Medical evidence is then required from an appropriate expert to comment on whether the injuries sustained at the time of the accident caused or materially contributed to the accident. It may be that there are competing expert reports in this regard between parties and it then will be a question of the court to determine at proof.

A practical side note to pursuing these claims is to ensure that the individual has a will or if he or she does not, that a timeous application is made to the court to allow an executor dative to be appointed. This will be required to pursue the heads of claim due to the estate after death. This is a point that can often be overlooked.

A further consideration is life expectancy of the deceased. It should not be ignored as likely, this will be factored into any settlement in these cases. Expert evidence will be required to comment on this point if there is to be a departure from the usual approach of using the Ogden Tables. Of course, it is preferred that medics comment on this rather than statisticians, but this often is a live issue that requires due consideration when pursuing these cases.

These cases can be difficult to pursue, and it is important that practitioners have the relevant experience to navigate the terrain of cases where death comes sometime later after the accident. At Digby Brown LLP, 3 of our partners, David Wilson, Mark Gibson and Kirsty O'Donnell are the only solicitors in Scotland to have the Fatal Accident Accreditation from the Association of Personal Injury Lawyers (APIL). Expertise in this area of law is crucial in being able to pursue these cases properly and sensitively. In any fatal case, the family is the priority because pursuing these cases, often in the pursuit of truth about what happened at the time of an accident or justice, comes at a personal cost to them. It is important that they are dealt with efficiently to ensure the process is as least distressing as possible.

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New High Court decision confirms claimants can seek means tested social care while holding damages in a personal injury trust

by Philippa Luscombe, Partner at Penningtons Manches Cooper.

The High Court's decision in R (CGT) v West Sussex County Council [2026] EWHC 293 (Admin) provides welcome clarification on how local authorities must treat damages held in a personal injury trust when determining eligibility for social care funding under the Care Act 2014 (which is means tested).

This judgment is of significant reassurance to claimants as it confirms the principles of PI trusts, ie, that compensation held in such trusts is protected and preserved for the claimant's needs, is not to be treated as 'savings' for the purposes of statutory financial assessments, and that there is no obligation to utilise such funds before seeking statutory funding.

Personal injury trusts

Following an injury claim, a person may receive substantial sums of money by way of damages. These damages are assessed to meet specific current and long term needs – such as suitable accommodation, therapy, and equipment.

A personal injury trust is a legally binding arrangement for holding and managing funds received as a consequence of an injury. The trust must be managed according to specific rules and with money held separately from any other funds owned by the claimant.

Sometimes, damages received may not be sufficient to cover all outgoings that a claimant has – particularly if they are not working or if the damages award was a negotiated settlement at less than the full value of the claim.

This can mean that even with a substantial award of damages, a claimant will still need to access means-tested benefits and funding for care services. It is

important that the person is able to claim all of the state benefits and care funding that they may be entitled to, both now and in the future, and that the person has a suitable structure in place to manage their funds.

Funds held in the trust are disregarded when assessing eligibility for some means tested state benefits and services (such as residential care). As a result, a claimant can continue to receive these benefits and/or services in the future. A personal injury trust helps to define and 'ring fence' the funds that have arisen from a personal injury, keeping them separate from other assets.

However, despite previous case law and guidance on this issue, from time to time local authorities who are aware of the existence of a personal injury trust do seek to argue that the funds should be considered when carrying out means testing.

Background to the case

CGT, a severely disabled adult with lifelong care needs resulting from a catastrophic brain injury sustained in infancy, received a Criminal Injuries Compensation Authority (CICA) award exceeding £3.5 million in 2012. These funds were placed in a discretionary personal injury trust and were being managed with a view to trying to ensure the funds would last to meet CGT's long term needs.

CGT's father later sought for his local authority (West Sussex County Council – WSCC) to provide care to CGT. The council resisted on the basis that the damages in the trust should fund all care, and later demanded repayment of previous care provided (a sum of over £200,000).

CGT's father brought a judicial review, arguing that the council's refusal was unlawful because PI trust capital should be fully disregarded in financial assessments and that to both pay for care and reimburse WSCC would threaten the ability of the funds in the trust to meet CGT's long term needs.

The court's decision

The High Court agreed unequivocally with CGT's father, ruling that:

1. **PI trust funds must be completely disregarded in Care Act assessments** – if funds originate from an award in an injury claim and are held in a qualifying trust, the local authority must ignore them in full. WSCC could not lawfully treat the trust as capital available for care costs;
2. **the council's refusal to fund care and its demand for reimbursement were unlawful;**
3. **the 'double recovery' doctrine has no place in Care Act assessments** – the court rejected the council's argument that public funding would lead to 'double recovery' since CGT had already been compensated for care, on the basis that the double-recovery principle applies only to damages in tort and assessment of the same, and has no relevance to statutory duties under the Care Act.

Conclusion

The ruling in CGT v West Sussex County Council is not necessarily a change in the position regarding personal injury trusts and statutory funding but it does provide clarity and certainty – which is welcome.

It reinforces the protective purpose of PI trusts, reaffirms statutory obligations under the Care Act 2014, and brings much-needed clarity to an area fraught with tension between compensation principles and public funding duties. Above all, it ensures that vulnerable individuals like CGT who have compensation designed to meet their long term needs in all respects do not end up being forced to use it on care provision that they would otherwise be entitled to receive from statutory services, and that potentially exceeds the value of any damages recovered for care.

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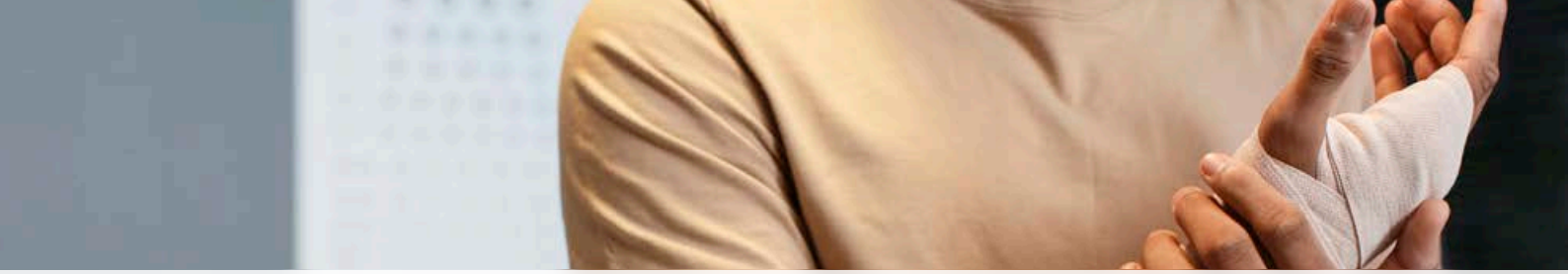

Why "User Error" Is Rarely the Root Cause of Workplace Injury

by Adam King, EUR ING, MSc, CEng, TechIOSH, MIAAI, Associate Director, Forensic Investigation and Personal Injury at RIMKUS.

In workplace personal injury claims involving work equipment, an employer frequently cites "user error" as the cause of an incident. While user actions often feature in the final moments of an incident, forensic engineering investigations consistently demonstrate that user error is rarely the root cause. This article looks at why courts, regulators, and insurers increasingly expect an engineering-led analysis of causation, and why reliance on "user error" alone presents both litigation and indemnity risk.

Introduction: The persistence of "user error"

From initial notification through to early expert instruction, claims documentation frequently characterises workplace incidents using phrases such as:

- The operator misused the equipment
- The injured party failed to follow the training
- The employee failed to follow the employer's instructions.

Although such descriptions may appear straightforward, they are increasingly vulnerable to challenge under forensic and legal scrutiny. In litigation, courts now move beyond these surface explanations and ask a more fundamental question: why was the system capable of producing harm at all?

Forensic investigations across machinery operation, maintenance activities, and industrial environments have demonstrated that user action is typically the final link in a longer causal chain, rather than the initiating failure. These statements may describe what occurred, but they do not explain why injury was possible.

Courts increasingly require an analysis of whether:

- The equipment was inherently safe by design
- The incident was foreseeable
- Were engineering controls sufficient and correctly implemented
- Did the system rely excessively on procedural compliance rather than physical safeguards and supervision?

From a forensic perspective, reliance on user error alone risks oversimplification and can weaken a claim's defensibility.

The distinction: Immediate cause, underlying cause and root cause

A recurring issue in personal injury claims is the confusion among three distinct concepts: immediate, underlying and root cause. These terms are often used interchangeably in claims narratives, despite having materially different meanings within an engineering-led causation analysis.

- Immediate Cause: The immediate action preceding the injury
- Underlying Cause: The means by which the work equipment was able to cause harm
- Root cause: The reason the hazardous condition existed.

For example:

- Immediate Cause: The operator's hand entered the danger zone
- Underlying Cause: Exposure to unguarded moving parts
- Root cause: Inadequate guarding, ineffective interlocking, or unsafe by design

In practice, claims frequently focus on the immediate as though it were the cause. Whilst this initially looks convincing, this approach is increasingly vulnerable to forensic and legal scrutiny.

Consider the above scenario of a user reaching into a machine and sustaining injury. Labelling the cause as "user error may describe the final action, but it does not explain why the hazardous underlying cause remained accessible. The critical forensic question is not what the individual did, but why the system of use permitted injury to occur, the root cause.

Equipment does not fail randomly

From an engineering standpoint, for the use of equipment, workplace safe systems of work are designed on the premise that:

- People make mistakes
- People take shortcuts
- People deviate from training from time to time.

These assumptions are fundamental to established safety-engineering principles, including:

- Hierarchies of guarding and protection
- Fail-safe design philosophies
- Interlocks and system redundancy
- Ergonomic control layout and people–machine interface design

When an injury occurs, it is often because the system has tolerated foreseeable human behaviour without adequate engineering mitigation. In such cases, the presence of user action does not negate system failure, rather, it highlights a design or control deficiency that allowed predictable behaviour to result in harm.

Case study – electric saw injury during operations

Incident Summary

Unsafe use of saw machinery, specifically a failure to keep hands clear of the blade. The activity being undertaken formed part of normal, routine production operations. The physical guarding system in place was intended to provide primary protection against contact with the blade. However, damage and degradation of the guard reduced its effectiveness as a protective measure. As a result, the system relied on operator vigilance to compensate for diminished safeguarding performance.

Conclusion

The injured party's interaction with the saw was the immediate cause of the incident, rather than its root cause. The underlying cause was that the safeguarding system was not delivering its intended level of protection. The root cause of the injury was systematic failures to implement statutory equipment maintenance and inspection requirements. The failure to identify the defect allowed foreseeable user interaction to result in harm.

Case study– entanglement during ship birthing

Incident Summary

The injured party was attaching lines to a newly installed capstan alone when a tangle began to develop. While the capstan remained in operation, an attempt was made to adjust the lines. During this interaction, the fingers became caught in the line, resulting in a crushing injury.

Conclusion

The injury occurred because the system permitted foreseeable user interaction with moving lines. The actions of the injured party constituted the immediate cause. The underlying causes were the absence of supervision and the lack of engineered measures to prevent access during operation. The failure to recognise the training needs of newly installed equipment and implement an engineered safe system of work was the root cause.

Regulatory and legal context

The Health and Safety Executive has consistently emphasised that employers must anticipate foreseeable user interaction and misuse, and that training alone cannot compensate for unsafe design or systems of work. The risk should be eliminated through adequate engineering measures included in the safe system of work.

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Dental Expert

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Dr Raj Kumar has written over 400 reports in matters arising from patient and regulatory complaints, dental negligence and accidental injury.

Dr Kumar qualified from Guys Hospital in 1989 with a BDS. In 1990 he obtained his LDS RCS from the Royal College of Surgeons London.

He also has an expertise over 20 years in Invisalign orthodontics, having treated over 1400 patients. He worked as an NHS dentist from 1990 and set up a private practice in 1995 in the West End of London.

He has expertise on breach and causation. Dental regulatory guidelines and those of independent dental associations. He has worked closely with regulators, indemnifiers, lawyers, mentees and patients. He is fully compliant with Part 35 rules.

Experienced in assessing patient complaints, record card assessment, record keeping and assessing the patient consent process. Has worked closely with regulators, indemnifiers, lawyers, mentees and patients. He has acted as a mediator for patients as well.

Doctor Kumar as an ability to read into patient treatments and to decipher the important tracts that relate to consent and treatment provided.

Having a good understanding of dental guidelines and expert literature helps Dr Kumar to create informative and corresponding medical legal reports.

Areas of expertise include;

- Emergency dental care
- Patient consent
- Periodontal care
- Crowns
- Fixed bridge work
- Extractions
- Treatment planning and diagnosis
- Routine dental treatment including:
- Restorative dentistry
- Root canal treatment
- Removable prostheses
- Cosmetic dentistry

Complex dental treatment including:

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Dr Anke Hensiek

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Dr Hensiek is a Consultant Neurologist at Cambridge University Hospitals with excellent experience in clinical and academic neurology.

Dr Hensiek assesses and manages a range of neurological symptoms and conditions including:

- Headache (such as migraine, tension type headache etc.)
- Dizziness
- Sensory disturbance
- Disorders of gait and movement
- Parkinson's disease
- Multiple sclerosis (MS)
- Epilepsy
- Stroke
- Coordination problems and ataxia
- Memory disorders and Dementia
- Hereditary neurological disorders
- Peripheral nerve and muscle disorder

Dr Hensiek has medicolegal experience since 2009, including personal injury reports, medical negligence reports, reports for the GMC and NHS resolution. She currently receives an average of 80 instructions per year, which comprise of roughly 80% claimant, 10% joint reports and 10% defendant reports. Attendance at court as required. Draft reports are available on request.

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Dr Nader Khandanpour is a radiology consultant, subspecialising in neuroradiology, based in London.
Accredited Mediator: CEDR, Centre of Effective Dispute Resolution, London.

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Cardiff University Bond Solon Accreditation: CUBS Civil, Criminal & Family Expert Witness.
Winner of The Expert Witness Awards - London, UK, Lawyer Monthly Magazine (2019)

Expertise includes:

Neuroradiology (Brain and Spine CT & MRI)
Neonatal - Paediatrics - Adults

Brain related expertise includes:

Non Accidental Head Injury	Alzheimer's & other Dementias	Stroke/Cerebrovascular Disease
Vertigo/Dizziness	Brain injury	Brain tumour
Cerebral palsy	Concussion	Dementia
Physiotherapy Rehab	A&E Medicine	Mental Health
Seizures/Epilepsy	Numbness	Tremor
Memory loss	Seizures	Bell's palsy
Normal pressure hydrocephalus	Headache	Multiple sclerosis
Muscular dystrophy	Neuralgia	Neuropathy
Neuromuscular and related diseases,	Parkinson's disease	Scoliosis
Movement Disorders	Neurodegeneration	Infection Radiology imaging
Neuroradiology imaging, MRI & CT scan	Psychiatric conditions (severe depression, obsessive-compulsive disorder)	

Spinal expertise includes:

Trauma	Spinal trauma	Back pain
Birth defects of the brain & spinal cord	Disk disease of neck & lower back	Spinal cord injury
Spinal deformity/malformation	Spine tumour	Pain
Peripheral neuropathy, myasthenia gravis & neuromuscular disorders		

Instructions on behalf of:
Claimant , Defendant and Joint

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These principles are embedded within the statutory framework, including the Provision and Use of Work Equipment Regulations (PUWER) and the Health and Safety at Work etc. Act (HSWA). Under these duties, employers are expected to:

- Anticipate foreseeable misuse of equipment
- Design out risk wherever reasonably practicable
- Avoid excessive reliance on procedural controls alone.

In civil litigation, arguments founded solely on "user error" are increasingly vulnerable. Such positions are open to challenge based on contributory negligence analysis, strict statutory duties, and expert evidence demonstrating that the risk was foreseeable and should have been controlled through engineering measures.

Conversely, expert opinions that attribute causation solely to operator behaviour, without examination of the adequacy of engineering controls, are often exposed under cross-examination and carry reduced evidential weight.

When user error is the root cause

A safe system of work does not exclude findings of genuine user error. Where engineering controls are appropriate, effective, and properly maintained, forensic investigation can demonstrate that the injured party's actions were the proximate cause of injury. Crucially, this conclusion must be physically evidence-led rather than procedural or documentation-focused.

From a forensic engineering perspective, user error is defensible where the system is shown to be fundamentally safe, and the behaviour leading to injury was exceptional or unforeseeable.

Key considerations include:

- Engineering integrity: Confirmation that guarding, interlocks, and safety systems were present, compliant, and functioning as intended, with no defects or degradation.
- Foreseeability: Assessment of whether the action was a clear deviation from normal operation
- Training and instructions: Evidence that clear, reasonable, and task-appropriate training and instructions were in place and aligned with system design.
- Deviation from safe systems: Identification of unjustified change from established systems of work, such as bypassing isolation or removing safeguards.

Why this matters to stakeholders

Claims Strategy

Early acceptance of "user error" as the cause of an incident can have adverse consequences. It may:

- Obscure potential third-party liability, including that of equipment manufacturers, installers, or maintenance contractors
- Undermine subrogation prospects by prematurely narrowing the causation narrative
- Reduce leverage in liability apportionment and settlement discussions by conceding primary fault too early.

An engineering analysis at an early stage helps identify all contributing factors and preserves recovery and liability options.

Policy Response

Forensic engineering causation analysis frequently informs policy response by providing clarity on:

- Compliance with policy conditions relating to maintenance, inspection, and safe use
- The appropriate application of policy exclusions
- Allocation of liability between insured and uninsured parties, including third-party contributors.
- Early technical scrutiny therefore supports both defensible coverage decisions and effective claims management.

Conclusion

User behaviour is almost always present in workplace accidents. However, it is rarely the root cause. Across machinery, industrial, and marine environments, forensic engineering analysis repeatedly demonstrates that injuries occur when systems fail to adequately manage predictable user interaction.

For insurers, brokers, and legal advisers, moving beyond default reliance on "user error" is essential to achieving defensible liability positions, accurate apportionment, and informed commercial outcomes. User actions provide the immediate context for many incidents, but they are seldom the originating cause of injury. It is the 'system's tolerance of foreseeable behaviour, through design, safeguarding, or control deficiencies, that typically enables harm.

Where forensic investigation establishes that equipment was appropriately designed, safeguarded, and maintained, and that risks were controlled through effective engineering measures, injury may properly be attributed to user error. In such cases, the decisive factor is not the mere presence of user action, but evidence that the behaviour was exceptional, unforeseeable, or involved deliberate circumvention of safety systems.

References:

1. Health and Safety Executive (HSE). Safe use of work equipment (PUWER Approved Code of Practice L22).
2. ISO 12100:2010 – Safety of machinery – General principles for design – Risk assessment and risk reduction.
3. HSE. Reducing risk, protecting people – HSG65.

About the Author

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Adam is a Chartered Mechanical Engineer with over 20 years of multi-sector experience in engineering, mechanical maintenance, technical operations, and forensic investigation. He specialises in CPR 35 expert reporting, technical causation analysis, and evidence gathering for insurers, solicitors, and corporate clients.

He has led complex investigations across the UK and internationally, covering industrial facilities, biomass and CHP systems, marine fires, and large commercial and residential incidents. Adam also brings extensive expertise in PSSR and LOLER compliance, including developing and managing statutory inspection schemes to support operational safety, regulatory compliance, and equipment integrity.

He is recognised as a Chartered Engineer by the Engineering Council and as a European Engineer by Engineers Europe.

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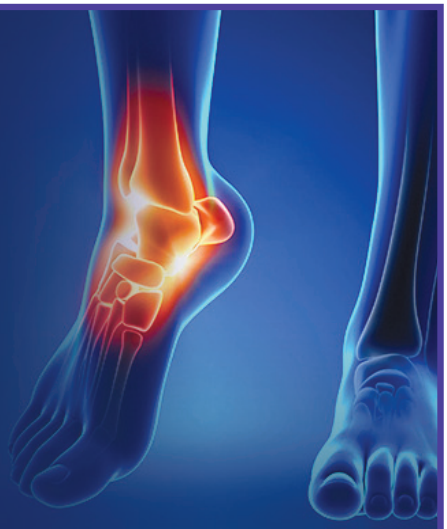

Mr Raj Kumar is a Consultant Orthopaedic Surgeon with a special interest in foot and ankle surgery, and general trauma. Mr Kumar is based at Lancashire Teaching Hospitals which is a major trauma centre dealing with serious injuries that are life changing and could result in serious disability, including head injuries, severe wounds and multiple fractures. He is part of the trauma service with a special interest in lower limb reconstruction surgery. Mr Kumar gained experience in lower limb reconstruction working at the trauma unit in Belfast.

Mr Kumar undertook his foot and ankle fellowship at Wrightington Hospital. He was granted a Fellowship of the British Orthopaedic Foot and Ankle Society, which he used to gain experience in ankle arthroscopic surgery under the internationally renowned Professor Van Dyke at Amsterdam.

Mr Kumar is involved in teaching and training nurses, physiotherapists, medical students and Orthopaedic Registrars. He has students from the University of Manchester who undertake various clinical attachments with him. He is an Honorary Senior Lecturer and examiner for the University of Manchester Medical School.

Mr Kumar provides a high quality, patient-centred foot and ankle service. His experience covers the entire spectrum of orthopaedic foot and ankle disorders. Besides the more common foot and ankle procedures, he performs ankle replacements, ankle arthroscopy, complex hind foot fusions, deformity corrections, and ligament and tendon reconstructions about the foot and ankle.

Mr Kumar has expertise in assessing personal injury, soft tissue and sports injury, complex polytrauma and low velocity injuries.

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Abbott v Ministry of Defence: The Highlights

by Kate Longson, Barrister at Ropewalk Chambers.

The long-anticipated judgment in *Abbott v Ministry of Defence* has now been handed down. Kate Longson, who was instructed as junior counsel to the Ministry of Defence, summarises the key aspects of the judgment.

In 2021, Hugh James solicitors issued a Claim Form in the name of David Abbott and approximately 3500 other Claimants for military noise-induced hearing loss. Since that time, thousands more have been added to that claim form and many more thousands of claims have been brought or intimated by other firms of solicitors.

Those who have been following the case will already know that, in the run up to the trial which took place from October to December 2025, the parties selected six test cases to be used as a vehicle for resolving various generic issues concerning causation and quantum which arose across the cohort, breach of duty, limitation and various other issues having been compromised by way of a settlement matrix.

Of the six test cases selected, two settled immediately prior to trial, and two discontinued during the course of the trial. The two remaining cases, *Jack Craggs* and *Christopher Lambie*, fortunately covered all of the generic issues, allowing for their resolution by Garnham J in this lengthy and comprehensive judgment which favours the Defendant in a number of notable and material respects, not least on the issues of latency, synaptopathy and the reliability of military audiometry.

I intend, in due course, to produce a mini-series of blogs addressing the main generic issues, some of which have wider implications, individually. For now, the following will hopefully provide a helpful summary of the Court's findings on the most pertinent issues, namely:

- The reliability of military audiometry;
- The appropriate method for the diagnosis and quantification of military noise-induced hearing loss;
- Latency;
- Cochlear synaptopathy;
- Tinnitus;
- *De Minimis*;
- Assessment of damages for future loss of earnings.

Reliability of Military Audiometry

It had been the Claimants' position that military audiograms are inherently less reliable than BSA compliant audiometry and that, whilst they may be suitable for screening purposes, they could not be used for the purposes of diagnosing or quantifying NIHL.

The Defendant had argued that the overwhelming majority of military audiograms were obtained in good faith and using appropriate equipment. There was accordingly a legitimate presumption of accuracy and where, as in the case of Mr Lambie, there was purposeful inaccuracy, such would likely be readily apparent.

The Claimant's position was derived from the generic evidence of Prof Moore who had suggested in his report that there is "*persuasive evidence to suggest that occupational audiograms obtained during military service are often unreliable*". However, as noted by the Court, that evidence was never identified and, by the end of the trial, the Claimants' experts had conceded that military audiometry cannot be disregarded on a generic basis.

The Court's conclusions ultimately favoured the Defendant:

> ***233.*** *It follows, that to a substantial extent, I accept the Defendant's submissions on this issue. My conclusion, against the evidential background set out above, are as follows:*

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Consultant Cardiologist

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Consultant Cardiologist, Associate Professor of Cardiovascular Medicine, and Clinical Lead for cardiac imaging in Oxford, with specific expertise in diagnostic testing, including all forms of cardiac imaging and functional cardiac assessment.

Professor Myerson is based in the internationally-renowned cardiac MRI department in Oxford and provides expert advice on all areas of cardiology including cardiomyopathy, coronary disease, heart valve disease and aortic disease.

He produces around 50 expert reports a year, for both claimant and defence teams, including many national solicitors, the Medical Protection Society and Medical Defence Union, and is also an expert witness for the GMC. His experience includes the High Court and employment tribunals, as well as criminal cases and for the Court of Protection. Professor Myerson also holds a Cardiff University Bond-Solon expert witness certificate in civil law.

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Mr. Vittal Rao

Consultant Surgeon

MBBS, MS, FRCS (Ed & Glasg), MD FRCS (Gen Surg)

Mr Vittal Rao is a Consultant Laparoscopic and Upper GI & Bariatric Surgeon based at the University Hospital of North Midlands NHS Trust. He completed his surgical training in Yorkshire and research degree in Hull

Vittal performs the whole range of advanced laparoscopic, upper GI and bariatric procedures. His main fields of work include weight loss surgery and laparoscopic (key hole) surgery for hernias and gall stones. With a special interest in endobariatric procedures and academia.

Expert witness service includes medical negligence and injury claims pertaining to abdominal wall injuries. He has undertaken extensive expert witness training and holds the Cardiff Bond Solon Expert witness certificate.

Areas of interest include:
Weight loss surgery
Laparoscopic surgery including ventral, incisional and groin hernias and gall bladder surgery
Gall stones
Abdominal pain
Reflux disease
Gastroscopy for diagnosis
Umbilical hernia
Paraumbilical hernia,
Inguinal hernia,
Femoral hernia,
Hiatus hernia,
Laparoscopic hernia repair,
Gastro oesophageal reflux disease

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Mr Philip Coleridge Smith DM MA BM FRCS

Medical Expert Witness - Vascular Surgeon - Medical Editor

Areas of expertise:

- Limb ischaemia
- Pulmonary embolism
- Surgical treatment of vein problems
- Deep vein thrombosis
- Post-thrombotic limbs
- Venous ulcers
- Laser treatment and radio frequency ablation of vein problems
- Peripheral vascular disease including diseases of arteries and veins
- Ultrasound examination of the peripheral vascular system

Types of report prepared:
Screening report - a preliminary assessment of the likelihood of successful litigation. (Non-CPR35 compliant).
Report addressing issues of Breach of Duty and Causation (CPR35 compliant)
Report addressing issues of Condition and Prognosis, usually following clinical and duplex ultrasound imaging examinations of arteries and veins. (CPR35 compliant).

Consulting rooms:
The London Vein Institute, 4 Upper Wimpole Street, London W1G 6LF
The Bridge Clinic, Bridge Road, Maidenhead, Berkshire, SL6 8DG
British Vein Institute, 24-28 The Broadway, Amersham, HP7 0HP
Waiting time for an appointment for examination: approx. 2 weeks.

Contact Details:
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(i) Pure Tone Audiometry (PTA) conducted in compliance with the protocol and standards set by the British Society of Audiology (BSA) is the gold standard of audiometric testing and should be used in medico-legal cases as the best evidence whenever it is available.

(ii) However, screening audiograms, including military screening audiograms, are ordinarily suitable for screening and triage. Furthermore, especially when they are part of a consistent pattern, they may also be used, as part of the exercise of clinical judgment by clinicians advising in medico-legal cases, for diagnostic and quantification purposes.

(iii) It may be possible to obtain from screening audiograms an understanding of the hearing profile and trends of an individual (in other words his auditory capabilities and the changes in those capabilities) where there is a consistent pattern in an audiometric series. That may not be possible where the screening audiograms show significant and unexplained variation.

(iv) Audiometry evidence (including BSA-compliant PTA) should, wherever possible, be considered in context and as a whole, rather than in isolation.

(v) The arrangements operated by the MoD are designed to give a good degree of oversight over the hearing capacity of members of the armed forces. The majority of such audiograms are conducted properly and in good faith. This is particularly so once a referral for medical assessment is made. However, there may, on occasions, be systemic or operational inadequacies, or even deliberate falsehood, and the Court should be alive to that possibility.

Method for Diagnosis of Military Noise-induced hearing loss

The Court had before it four methodologies for the diagnosis of noise-induced hearing loss in a military context, three of which were authored principally by Professor Brian Moore and put forward by the Claimants, namely:

- The M-NIHL 2020 method;
- The rM-NIHL 2022 method;
- The MLP(18) method.

The final methodology considered was the method proposed by Coles, Lutman and Buffin (CLB) which has been in conventional use in cases of industrial noise exposure since the Nottinghamshire and Derbyshire Deafness Litigation. This was the method relied upon by the Defendant.

Having carefully set out the competing methods, the Court concluded that the M-NIHL method and MLP(18) method could be rejected in short order.

Dealing first with the M-NIHL method, the Court noted that this method had been superseded, two years after publication, by the rM-NIHL method. The revised method was necessitated by issues which had been identified with the specificity of the original method. Although he had said in evidence that the rM-NIHL method should be preferred, Prof Moore also suggested that, if the revised method was not met, it would be appropriate to go back to the original method to see if it yielded a positive diagnosis. As to that, the Court, having set out in detail the identified shortcomings in the M-NIHL method, concluded:

> ***350.*** *I unhesitatingly reject the suggestion that, all that notwithstanding, it might in certain cases be reasonable, if a case did not receive a diagnosis under rM-NIHL, to go back to the original method on the basis that it has a positive predictive value or 'PPV' greater than 0.5 (which, Prof. Moore said, indicates the balance of probabilities was met.). It was deficiencies in the original method, notably its tendency to produce false positives, that prompted the revised method and it would be nonsensical, if not improper, to seek to advance a case on the basis of what has been shown to be a deficient test, merely because the better test did not produce the desired outcome.*

The MLP(18) method was addressed in similarly robust terms by the Court.

MLP(18) is a machine learning AI methodology which was trained by Prof Moore using a database of audiograms obtained by Claimants making claims for noise-induced hearing loss and a control database of Germans not known to have had significant noise exposure. It is fair to say that, during cross examination, Prof Moore conceded that it was not possible to tell why MLP(18) had given a diagnosis in a particular case:

> ***Q.*** *It gives a result, doesn't it, that you can't say why it has made a particular diagnosis in a given case? The output is still the black box?*
>
> ***A.*** *That is true. That is true.*
>
> ***Q.*** *So, for instance, an ENT surgeon who is using it couldn't – wouldn't be in a position to interrogate or challenge the result that comes out the other end?*
>
> ***A.*** *Well, no – they wouldn't – the result will come out positive or negative, they won't know why...*
>
> ***Q.*** *...with the individual case of Mr Craggs, for instance – his Lordship would not be in a position to understand why that number has come out the other end, would he?*
>
> ***A.*** *That's correct.*

Mr Zeitoun, the ENT surgeon instructed by Mr Craggs, accepted in his evidence that he did not use the MLP(18) method because he did not understand it.

Ultimately the Court concluded that:

> ***356.*** *In my judgment, that inability to understand how a result was obtained, to interrogate the method to reveal its workings, makes MLP(18) entirely unsuitable as a means of establishing a case in litigation. For a judge to accept a diagnosis on the basis of MLP (18) would be a complete dereliction of duty. Unless the Court could be satisfied, on evidence, that the method was entirely reliable in every case, then it has at least to be possible for a Court to understand how the method produces the result where the outcome is disputed. The alternative would, furthermore, make an appeal against the conclusion impossible on any ground other than the total absence of underlying analysis, because the appellate Court would be equally unable to test the reasoning on which the conclusion was based.*

The Court was accordingly left to choose between the CLB method and the rM-NIHL method.

In the course of the expert evidence it had been argued that the presence of noise damage at 8 kHz in cases of exposure to impulse noise might disguise a notch/bulge and lead to a false negative diagnosis using the CLB method. Conversely the rM-NIHL method accounted for the potential for loss at 8 kHz.

The Defendant pointed to the potential for rM-NIHL to reach a false positive diagnosis in cases of idiopathic hearing loss. However the Court, in reliance on its own findings about the reliability of military audiograms, was satisfied that cases of idiopathic hearing loss would be capable of identification.

The Learned Judge ultimately concluded as follows

> ***418.*** *I conclude, on the basis of all the evidence I have heard, that Mr Steinberg is right when he submits that military NIHL can present without a CLB notch/bulge and the absence of a notch does not exclude NIHL, that military noise commonly affects hearing at 8 kHz and this can erase or disguise a notch or bulge; and that military impulse noise tends to produce a different and more variable audiometric pattern than steady state noise.*
>
> ***419.*** *It follows, first, that the original M-NIHL method and the MLP(18) method should not be relied on in medico-legal work (see [346] above and following; second, that CLB is not generally suitable in military cases and third that the rM-NIHL method is the method to be preferred. A proper diagnosis of NIHL depends on the careful application of each element of the rM-NIHL test.*

In an earlier chapter, the Court had already concluded that there should be a baseline correction to the presbycusis data set out in the 2017/2024 ISO database and it is this data which should be used when determining both diagnosis and quantification.

The Court also concluded that it would not be necessary as a matter of course in every case to make the, now customary, 6 dB deduction at 6 kHz to account for the use of TDH-39 headphones.

Method for Quantification of Military Noise-induced hearing loss

The Court was presented with two competing methodologies for quantification: that proposed by Prof Moore and the "LCB" methodology which accompanies the CLB diagnostic paper.

In light of his findings as to diagnostic methodology, the Learned Judge favoured the quantification method proposed by Prof Moore with some important caveats:

Firstly, as to referent percentile, Prof Moore had suggested, both the MLC paper and in oral evidence, that the 50th percentile should be used as a default. He had suggested that a lower percentile should only be selected if a BSA complaint audiogram had been obtained prior to noise exposure and supported the use of a lower percentile (which would have the effect of reducing the amount of hearing loss which could be attributed to noise exposure). However he had supported the use of a higher percentile (which would give a more favourable result to the Claimant) where only one frequency in only one ear showed better than average hearing.

The Court held as follows:

> ***474.*** *Mr Platt was also correct in his submissions in respect of Prof. Moore's 2022 paper. He said first that by "reliable" Prof. Moore means "BSA compliant". It is clear that is what he meant. In cross-examination, Prof. Moore accepted that, in practice, it is "vanishingly rare" for an individual to have a BSA compliant audiogram taken prior to the start of military service, and indeed he had never seen such a case. But for the reason set out in chapter 6 that seems to me too stringent a position. Occupational audiograms should not be discarded and, particularly when part of a series, can provide good evidence of hearing ability. They should be so considered when considering the relevant percentile.*
>
> ***475.*** *Mr Platt also makes a good point when he submits that the scheme advocated by Prof. Moore in MLC is unfairly constructed to favour Claimants. On the one hand, as Mr Platt submits, the likelihood is that in practice, a user of the Moore method would never adjust the percentile downwards and every*

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Consultant Cardiologist

Dr Duncan S Dymond has been a consultant cardiologist at St Bartholomew's Hospital, now a part of Barts Health NHS Trust since 1987.

He has been undertaking expert witness and medicolegal work for more than 12 years and has completed his Cardiff University Bond Solon expert Witness course.

Dr Dymond currently completes 1-2 medicolegal reports per week, for personal injury and medical negligence, with roughly a 60/40% split claimant/defendant.

He has also completed expert witness work for the General Medical Council, the Medical Defence Union and the Crown Prosecution Service as well as accepting private instructions directly for solicitors. He has also provided mediolegal opinions for cases in Singapore.

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Dr. Gerald Coakley

Consultant Rheumatologist & Physician

MB BS FRCP PhD

Private Practice

I have expertise in inflammatory rheumatic diseases including rheumatoid and psoriatic arthritis, spondyloarthritis and connective tissue diseases such as lupus, scleroderma, Sjögren's syndrome and myositis. I chaired the British Society for Rheumatology National Guideline group on the hot swollen joint including septic arthritis. I have had an interest in fibromyalgia and ME/ chronic fatigue syndrome for a number of years. In August 2007, I set up The Fatigue Clinic, at Keats House, London Bridge. My colleagues include occupational therapists and psychologists, and we offer treatment along the lines advocated by the 2021 NICE guidelines on management of ME/CFS. My role is to confirm or refute the diagnosis, and discuss therapeutic options. I have worked purely in private practice since September 2023, focussing on the management of ME/CFS.

Medicolegal Practice

I have been assessing medicolegal personal injury cases since 2005, and currently assess slightly more defendants than claimants. I am happy to see claimants at my rooms in London, or where appropriate at the claimant's home or a nearby hotel anywhere in GB for those unwilling or unable to travel to London, or by video where suitable.

I have assessed over 600 personal injury cases affecting claimants with various sorts of inflammatory arthritis, as well as those relating to fibromyalgia, complex regional pain syndrome, spinal pain, post fracture pain and various other chronic pain syndromes, as well as ME/CFS

Since 2019, I have been preparing clinical negligence medicolegal reports in the same areas as well as in septic arthritis.

I prepare claimant / defendant / joint reports in a ratio of roughly 20/70/10.

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Dr Irshad Mohamed Ali

Consultant in Stroke Medicine and Acute & General Internal Medicine

MBBS, FRCP(Edin), CCT (dual) , PG Dip (Medical Toxicology), MRCP (UK)

Dr Irshad Mohamed Ali is an experienced Consultant in Stroke Medicine and Acute Internal Medicine, and a recognised expert witness in matters of medical negligence, personal injury, and hospital care standards. With over 13 years service in senior NHS consultant posts, he has built a strong reputation for delivering evidence-based, impartial, and robust medico-legal opinions for coroners' courts, civil litigation, inquests, and clinical negligence cases.

Areas of Work:

- Stroke Medicine
- Acute & General Internal Medicine
- Expert Witness & Medico-legal Reporting

Dr Ali provides detailed and objective medico-legal reports, drawing on his extensive clinical expertise. He is skilled in case analysis and court-compliant reporting, with particular experience in:

- Acute and hyperacute stroke management, including thrombolysis and mechanical thrombectomy
- Assessment of hospital standards of care in complex acute medical cases
- Inquests and coronial hearings requiring a nuanced interpretation of clinical records
- Personal injury claims where neurological or acute medicine expertise is required

He works collaboratively with solicitors, barristers, and legal teams, ensuring clarity, impartiality, and precision in all reports and testimony.

Dr Ali continues to practise as a senior NHS Consultant, leading services in stroke and acute medicine. His clinical practice spans:

- Hyperacute stroke services, TIA clinics, rehabilitation, and inpatient stroke care
- Same Day Emergency Care (SDEC) and ambulatory medicine
- Management of a wide range of acute medical presentations: chest pain, sepsis, venous thromboembolism, delirium, seizures, poisoning, alcohol dependence, gastrointestinal bleeding, endocrine emergencies, trauma, falls, and head injuries
- Long-term disease management, preventative health strategies, and complex diagnostics

He is highly regarded for his meticulous and empathetic approach, ensuring patient-focused, high-standard care supported by the latest clinical evidence.

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individual on a percentile below the 50th would thus be overcompensated. But on the other, the percentile might be adjusted upwards (i.e. in favour of the Claimant) by the operation of paragraphs 2 and 3, if an individual shows better than average hearing at only one threshold and, if that threshold is in the better hearing ear, in only one ear. That is plainly unjustified.

***476.** In my judgment, the proper course is that the choice of the percentile in the relevant dataset should be dictated by the clinical judgment of the medicolegal ENT surgeon based on the hearing profile of the individual as ascertained from all the available audiometry.*

Secondly, as to appropriate frequencies over which to calculate disability, the Claimants had sought to argue that the Court should depart from the conventional use of an average over 1, 2 and 3 kHz to an average over 1, 2 and 4 kHz. Having considered the literature at length, the Court concluded that:

***498.** ...On the evidence I have seen, it is clear that the traditional 1, 2, 3 kHz average remains a reliable, if conservative, measure of hearing disability, supported by longstanding practice and by parts of the literature that continue to recognise its adequacy. At the same time, the scientific material relied upon by the Claimants, notably Smoorenburg and Moore, suggest that frequencies above 3 kHz, and 4 kHz in particular, play an important role in the perception of speech in noisy environments, sound localisation, and recognition of environmental sounds.*

***499.** I conclude that, while the conventional 1, 2, 3 kHz average should continue to serve as a baseline descriptor, it is entirely legitimate to consider 1, 2 and 4 kHz, particularly where speech-in-noise difficulty is a prominent feature of a Claimant's disability. It should be for the ENT expert to identify which metric best represents the Claimant's disability. The modest numerical differences do not undermine the utility of either approach; rather, they indicate that both metrics should potentially be available to the Court, with the weight to be attached to each depending on the factual and audiometric circumstances of the individual Claimant.*

Latency

The Claimants had sought to argue that exposure to impulse noise accelerates the future progression of age-associated hearing loss. The Defendant stood by the 'orthodox' view that noise damages hearing at the point of exposure.

This was an extremely significant issue in the litigation, particularly when taken together with the reliability of military audiometry, and is likely to be determinative of a significant number of claims in the cohort.

The Defendant's position was accepted by the Court. The Learned Judge agreed that there is insufficient scientific evidence to support the notion that noise causes latent damage to hearing. The Learned Judge went on to conclude that:

***554.** I also agree with Mr Platt that even if the acceleration theory was sufficiently plausible as to be viewed as "probable", which in my view it certainly cannot at present, it cannot properly be applied to the circumstances of any given case or individual. Furthermore, Mr Platt is right that even if the theory is demonstrable and a mechanism can be conceived whereby it could be identified in a given individual, there is no way in which accelerated loss can be accurately quantified in such a fashion as to make a secure foundation for any award of damages.*

***555.** In those circumstances, it is my conclusion that the theory that hearing loss may continue to develop after exposure is plausible, intellectually coherent but a very long way from being proven in human beings. The orthodox view that hearing loss does not progress after exposure ceases has not, at least at yet, been displaced.*

Cochlear Synaptopathy

As set out by the judge at [557], t*he expression "cochlear synaptopathy" refers to a loss in the connections ('synapses') between inner hair cells in the cochlea, the part of the ear which detect sounds, and the auditory nerve fibres, which carry the signals from the inner hair cells to the brain. The relevance of this issue to this litigation is that such synaptopathy might lead to individuals experiencing hearing difficulties (sometimes referred to as 'hidden' hearing loss), even if they have audiometric thresholds within the normal range.*

The alleged presence of cochlear synaptopathy has been used by Prof Moore in a number of cases to explain the presence of noise damage in individuals with normal audiograms. He also suggested that it was likely that both remaining lead Claimants had a degree of cochlear synaptopathy. The Claimants accordingly proposed that cochlear synaptopathy in the context of military noise, is both plausible and a potential contributor to speech-in-noise difficulty and tinnitus, and should be weighed accordingly.

The Defendant contended that for none of the lead Claimants (or anyone in the wider cohort), can noise-induced cochlear synaptopathy be (i) definitively demonstrated, (ii) persuasively demonstrated by proxy measures, (iii) quantified, (iv) disentangled from age-related synaptopathy, or (v) connected to any particular adverse effect.

In order to determine whether such a phenomenon could be proven in a particular individual, and indeed quantified/apportioned, the Court heard evidence from Professors King and Plack, Auditory Neuroscientists, whose evidence was taken by 'hottubbing'.

The fundamental issue for the Claimants was that cochlear synaptopathy can only be diagnosed post-mortem and there has only been one study in this area, Wu et al 2021. Accordingly, there is no diagnostic gold standard for a living individual and, given that cochlear synaptopathy likely occurs with age, no way to know how much synaptopathy is to be attributed to noise exposure.

The Defendant's arguments were accepted and the Court found as follows:

> ***605.*** *In conclusion, in my view the Defendants are correct when they submit that cochlear synaptopathy cannot definitively be demonstrated, let alone quantified, in humans before death. 'Proxy measures' of cochlear synaptopathy are less than certain and there is no gold standard test for the condition. Studies on military personnel suggest noise may lead to cochlear synaptopathy but there is no certainty of that and these studies have no application to the circumstances of individual Claimants. In any event, cochlear synaptopathy occurs with ageing in humans and there is no mechanism for stripping out 'synaptopathy of ageing' from 'synaptopathy of noise exposure' or of establishing that noise exposure made an identifiable difference to hearing ability either in the presence of audiometric hearing loss or in its absence.*

Tinnitus

It was common ground between the experts that tinnitus which begins during or shortly after noise exposure could be attributed to it. A question arose, however, as to the extent to which tinnitus which arose many years after cessation of noise exposure could be attributed to it. Having reviewed all of the evidence, the Court concluded that:

> ***738.*** *Tinnitus normally begins during exposure to noise or shortly after the cessation of noise. It is not possible to identify an arbitrary time after exposure to noise beyond which a claim should not be considered. The most that can be said is that the closer the onset of tinnitus is in time to the exposure to dangerous noise, the more likely it is to be caused by it. The longer the period between the end of exposure and the onset of tinnitus the greater should be the intensity of the examiner's scrutiny of the circumstances of the case and the veracity of the informant. And the Court, faced with a disputed claim will have to be equally circumspect.*

De Minimis

It was common ground between the ENT surgeons that a hearing loss of 4-5 dB would be clinically significant. It follows that a hearing loss of less than 4 dB, with no other consequences, should be considered de minimis:

> ***681.*** *A hearing loss of less than 4dB without other consequences should be regarded as de minimis. It will be a matter to be determined on a case-by-case basis whether exposure to noise which causes loss below that cut off nonetheless causes appreciable damage.*

Damages for Future Loss of Earnings

The Claimants had sought to argue that, where an individual is disabled by reason of their hearing loss, they will be entitled to damages for future loss of earnings calculated on an actuarial basis using the data set out in the Ogden Tables. It has become commonplace in these cases for large future loss of earnings claims to be advanced on this basis, including by individuals who were discharged from the military many years ago and who have suffered no past loss of earnings.

This issue arose specifically in the case of Mr Lambie who, having left the Royal Navy in 2021, has gone on to have a successful career as a management consultant in defence intelligence. Despite having suffered no past loss of earnings, Mr Lambie advanced a claim for £370,000 for future loss of earnings and pension, calculated on a multiplier-multiplicand basis.

The Learned Judge heard employment evidence on behalf of both parties, unhesitatingly preferring the evidence of the Defendant's expert Mr Hailstone that, as regards future promotion prospects, it was Mr Lambie's aptitude which was likely to dictate his career progression; not his hearing loss.

The Court ultimately concluded that to adopt a multiplier-multiplicand approach in this case would produce an obviously unreal result. Having

considered the dicta of Jackson LJ in Billet v MOD, as well as the more recent judgment of Johnson J in Barry v MOD and other cases in which the applicability of the actuarial approach was discussed, the Court held:

> ***852.*** *In my view, Mr Lambie is disabled within the meaning of the Disability Discrimination Act 1995 but, his case is far from the average, even an "adjusted" average. His case is not one where it is appropriate to apply the 8th Ogden table. Unlike, for example, Mr Barry, Mr Lambie has been able to pursue his chosen career throughout and will, in all probability, be able to do so until retirement. His disability has not, thus far, affected the career choices open to him or the earnings he has been able to make. His hearing loss is serious and progressive with age, but as things currently stand, he is not suffering any loss of earnings, nor will he if, as seems likely, he remains in his current employment until retirement.*
>
> ***853.*** *To award a man in Mr Lambie's position the sort of sum proposed by Mr Steinberg would, in my judgment, be unconscionable. His current net take home pay is about £60,000. Including bonus but excluding pension, the sum claimed for loss of future earning amounts to more than six times his current annual net salary. And that for a man who has not been unemployed for a single day since he was 18, who is in steady employment with a reputable employer, whose work in under no threat and in respect of which there is no evidence of any future likely threat, who is highly valued by his current employers and who wishes to stay in his current job until retirement.*

The Court recognised that Mr Lambie would be at a disadvantage on the open labour market and there was a residual risk that his future promotion prospects might be harmed by his hearing loss. A *Smith v Manchester* award of one year's net salary was accordingly made.

It follows that the Courts are likely to be circumspect when dealing with claims for future loss of earnings advanced by those who have had lengthy careers following military discharge which have hitherto been unaffected by hearing loss, whether or not that hearing loss meets the criteria for disability.

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CHAMBERS

How are personal injury awards treated on divorce?

by Jenny Bowden, Partner, Divorce and Family & James Philpott, Associate, Personal Injury at Stewarts Law LLP.

Sustaining a personal injury can be a serious and life-changing event. When an accident or injury occurs, the primary focus is on the person directly affected by the injury, as they require the most immediate care and support. However, the reality is that a serious incident rarely impacts one person alone, as the lives of everyone around them, their spouse, children, parents, friends and carers, can also be deeply affected. In part one of this two-part article, Divorce and Family partner Jenny Bowden and Personal Injury associate James Philpott consider personal injury awards in the context of divorce.

The impact of serious injury can ripple through many aspects of an injured person's life. Serious injury often brings with it financial worries and practical difficulties, while also placing additional pressures on relationships, marital or otherwise.

Research has shown that following a traumatic injury, the strain on a relationship can, for many, prove too difficult to overcome. One UK study, undertaken by brain injury charity Headway, collected responses from more than 1,000 individuals affected by brain injury. While 35% of brain injury survivors felt that their relationship with their partner had strengthened after the injury, the research also found that 38% felt that their relationship with a partner or spouse had broken down, and 28% said that the relationship had categorically ended. Of spouses and partners surveyed, 27% felt that their relationship with the injured survivor had broken down, while 12% reported that their relationship had categorically ended.

These results corroborate research on the rates of divorce and separation post-injury in the US. One study conducted in the USA tracked marriages of 120 patients in the 30 to 96 months following a traumatic brain injury. The research uncovered divorce rates of 17% and separation rates of 8%. At the end of the evaluation, 25% of marriages had broken down in the two to eight years after the traumatic brain injury.

While the research findings do not support contentions that an individual with a brain injury is at greater risk of divorce relative to the general population (the average divorce rate in England and Wales currently stands at 42%), it illustrates just how important it is to understand not only the emotional and physical toll of a serious injury but also the impact on relationships and the financial consequences should a marriage break down.

This first part of the article examines the financial implications of relationship breakdown, the division of assets on divorce and the treatment of personal injury damages. Part two will explore the practical steps you can take to protect personal injury awards to preserve the funds for the injured person's future needs.

How are a divorcing couple's assets treated on divorce?

The Matrimonial Causes Act 1973 (MCA 1973) sets out the legislative provisions that govern the distribution of assets between divorcing couples, with priority given to the welfare of any minor children. The court has powers to make financial awards on divorce under the MCA 1973, such as transfers of property, lump-sum payments and maintenance payments. It will strive to achieve a 'clean break' where possible to avoid any ongoing financial ties between the couple. In determining the appropriate financial outcome, the court will consider a wide variety of factors as set out in section 25 of the MCA 1973. The 'section 25 factors' include: the income and earning capacity of both parties, the parties' present and future needs, their standard of living during the marriage, the age of the parties,

the duration of the marriage, any physical or mental disabilities and each party's contribution to the family.

As established in the House of Lords in White v White [2000] 2 FLR 981, the court's overarching objective is to achieve a fair outcome between the parties. A departure from an equal division of assets will only be justified where there is a good reason for doing so. In order to achieve fairness, the court is guided further by the principles of needs, sharing and compensation as set out in Miller v Miller; McFarlane v McFarlane [2006] UKHL 24.

In the majority of cases, the division of assets will be determined on the basis of the parties' needs (generously interpreted). Where there is a surplus of assets over and above what is required to meet their needs, the principle of sharing will come into play. Sharing will, however, apply to matrimonial property only, ie, property that is a product of the marital endeavour, as opposed to non-matrimonial property, which may only be invaded (ie used) to satisfy the principles of needs and compensation. This was recently confirmed in the Supreme Court case of Standish v Standish [2025] UKSC 26.

Examples of matrimonial property might include the family home and savings that have accrued since the date of marriage. Non-matrimonial property might include inheritance received, assets built up since the couple separated or assets that a spouse owned before marriage and kept entirely separate during the marriage. For the purposes of this article, personal injury damages would likely start from a presumption that they are non-matrimonial. However, as explored in the case of Standish, assets can be 'matrimonialised' and there are therefore many scenarios in which the categorisation of those assets is not clear cut.

The principle of compensation is rarely engaged, but would be relevant where it could be shown that there is a relationship-generated disadvantage that should be taken into account (for example, significant career sacrifices made by one spouse to bring up the children). (Note, compensation in this context refers to an adjustment to the financial outcome to reflect that disadvantage and not the damages a party has been awarded following an injury.) In high net worth divorces, the matrimonial property often exceeds what is required to meet needs, in which case the court can determine the extent to which surplus assets should be shared between the parties.

While this article addresses the financial claims that can be made on divorce, it is worth noting that cohabiting couples are the fastest-growing family type according to the Office for National Statistics. When unmarried couples separate, however, the financial claims that can be made are limited to those under Schedule 1 of the Children Act 1989 (financial provision for children) and the Trusts of Land and Appointment of Trustees Act 1996 (for property ownership disputes). An individual in receipt of a damages award may therefore still have some exposure to a financial claim by a former partner even if they were not married.

So, how does a personal injury award fit into this distribution of assets on divorce?

The legal treatment of a personal injury award on a divorce

On divorce, personal injury awards (ie, the compensation that an injured person receives after making a successful personal injury claim) are not automatically ringfenced for the sole benefit of the injured spouse.

As with other assets, damages awarded in a personal injury claim must be disclosed as part of the financial remedy process. This was expressly dealt with in the case of Wagstaff v Wagstaff [1992] 1 FLR 333. Whether the award is reserved solely for the injured spouse or split between the parties will depend on whether the court considers it to be a matrimonial or non-matrimonial resource. That, in turn, may depend on when the award was received and how the award has been used. If the award is deemed to be non-matrimonial, it may nonetheless be invaded if the other assets available are insufficient to meet the uninjured party's needs. Due to the overarching principle of fairness and the requirement to meet both parties' needs in financial remedy proceedings, personal injury awards may therefore be considered when meeting the needs of the financially weaker party on divorce.

An award that has been used as a joint resource or intermingled with other matrimonial assets (for example, one that has been invested into a joint asset, such as the family home) is more likely to be treated as matrimonial property. It follows that the court, as part of its discretionary exercise in determining an appropriate division of assets, has the power to make an order in relation to the personal injury award (or property derived from the award) for the benefit of either spouse, even if that outcome is undesirable for the injured party. The personal injury award may therefore be at risk of redistribution.

On the other hand, an award that has been used solely to the benefit of the injured spouse (for example, for their care or rehabilitation) is more likely to be excluded from the matrimonial pot and reserved only for the injured spouse on the divorce, so far as is possible.

The form of the award is also likely to be a relevant factor: whether a simple lump sum, ongoing payments or a hybrid of both.

Given the wide discretion afforded to judges in

making financial orders on divorce, and the fact that there is no automatic ringfencing of a personal injury award, it is important to understand the practical and proactive steps you can take to protect your personal injury award on divorce.

In part two of this article, we consider the steps you can take to protect your personal injury award and plan for your future.

As dispute resolution specialists with expertise in both serious and catastrophic personal injury claims and complex high net worth divorce, Stewarts is well-positioned to offer specialist advice while guiding you through the implications of separation post-serious injury. Please refer to our website for further information on how Stewarts can help with a personal injury claim or divorce and separation.

With thanks to paralegals Ellen Watson and Olivia Beauchamp for their assistance with this article on the original post.

www.stewartslaw.com/news/how-are-personal-injury-awards-treated-on-divorce/

STEWARTS

Navigating claims and managing experts: traditional professions verses emerging professions

by Anne-Marie Knight, Partner & Bronagh Irvine, Principal Associate at Weightmans.

The insurance landscape is continuing to change and with it, the types of professionals seeking professional indemnity insurance is shifting and growing. The sector has, for decades, insured and responded to claims against what are regarded as "traditional risks", such as surveyors, architects, engineers, solicitors and accountants. However, professional indemnity insurance is increasingly being sought by what are commonly referred to as 'emerging professions' and they are challenging the status quo when it comes to litigation risks. One aspect to consider in managing and responding to such claims is the key issue of identifying and managing expert witnesses.

The shift

Investigating and responding to claims against "traditional" professionals such as accountants, solicitors and architects, comes with the benefit of well-established statute, a developed body of case law and regulatory frameworks. The challenge in each professional indemnity claim of establishing compliance with the standard of reasonable skill and care to be expected of each professional is assisted by the availability of a multitude of experienced, tried and tested liability expert witnesses. Generally speaking, therefore, the standards to which these "traditional" professions are to be held is often relatively clear based on expert input. The strategy that is deployed to defend these claims has been honed year after year, claim after claim. Insurers, their "traditional" insured customers and the legal professionals representing them therefore benefit from a relatively high level of certainty as to the likely trajectory of any given claim and the level of risk/cost that is set to be incurred in defending it.

At Weightmans, we have been instructed in relation to claims made against a wide range of "emerging" professionals, such as archaeologists, interior designers, heritage consultants, process servers, letting agents and planning consultants. These professionals often operate in a less regulated arena or one where standards are developing and are not well established by reference to case law. The absence of established standards via case law may assist the policyholder in defending the claim, as it is for the claimant to establish breach of duty. However, when claims are brought, this creates a number of hurdles for their insurers and legal professionals alike, including assessing the risk with the assistance of an appropriate expert witness experienced in opining on such claims. Additionally, the fact that statutory and regulatory frameworks are still developing, means that legal professionals are often advising on a framework that is unclear and capable of changing. This in turn adds to the complexity of expert witness input.

Scarcity of expert witnesses

In emerging fields/professions, the pool of potential expert witnesses is often small leading to two specific challenges.

Conflicting out

The few available experts are often conflicted out early by other parties. This is particularly so where there is a multi-party dispute or an insured client is joined to proceedings late in the day. The corollary of this is that the insured client can be "on the backfoot" due to the most reputable experts already having been retained by the other parties.

Increased input from the legal team

It is often the case that experts in these emerging professions are very experienced practitioners in their own field but have little experience of litigation procedure, the preparation of expert reports that comply with the Civil Procedure Rules, meetings with their counterparts to narrow the issues and cross examination at trial. If this is not correctly managed, it can lead to expert reports which can

easily be undermined by the opposition's expert or counsel under cross examination. Guiding an expert, who is new to litigation, through the process is therefore a tactical necessity but this does not come without cost consequences for insurers, as it can be a resource heavy endeavour for legal representatives.

The role of the "emerging" professional

Rather than the legal team drawing from their pool of tried and tested experts (as they would in a claim against a "traditional" professional), the policyholder is often the best placed party to recommend a potential expert based on sector profiles, awareness of relevant professional organisations and also to assess the relevance of the specific skills expertise of a potential expert witness. Their input may be the primary vetting mechanism for expert witnesses and in many claims, they are key in terms of challenging a claimant's technical expert evidence on specific allegations.

Practical tips

- Make enquiries with potential expert witnesses regarding availability and conflict checks as early as possible — ideally as soon as a Preliminary Notice is received.
- Conduct "full and frank" discussions with potential experts to assess the extent of their ability to opine on the standard of reasonable skill and care to which the emerging professional will be held, to assess their experience of providing expert reports and to gauge whether the experience that they do have is transferable i.e. inquiry work is often similar to Civil Procedure Rules work, albeit with a different focus and different requirements/timeframes.
- Seek the policyholder's input on the identification and directly relevant expertise of any potential expert.
- Ensure that insurers are aware of the potential increased costs and time that may be incurred in instructing and managing an expert in an emerging field. This extra time will need to be factored into any reserving advice.

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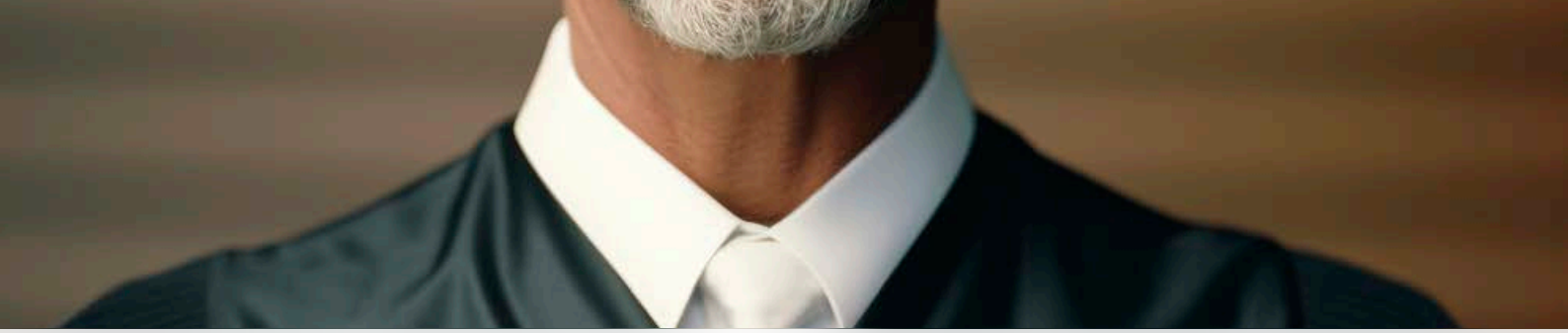

Cognitive Bias and Expert Evidence

by Tom McNeill, Partner at BCL Solicitors LLP.

Daniel Kahneman famously said that people are machines for jumping to conclusions. This is (usually) helpful when trying to avoid predators, for example, but less so when forming a view on complex policy issues.

On most occasions we reach our conclusion intuitively and then use the analytical part of our brain to justify that conclusion. More intelligent people might be better at explaining their position but no better at reaching the right conclusion – unless they have the discipline to follow an evidence-based approach.

Political bias is a good example because it is easily understood. We all know of people on the other side of the political spectrum whose opinions are obviously tribal or misconceived – while our political opinions are as objective and well-founded as the laws of physics.

There is no magic about political bias, however. If we are emotionally attached to an opinion (such as that she is a good person; or that I am a good person) the brain's capacity to ignore or distort evidence to preserve that opinion is almost limitless. The same is true if we are attached to an opinion that a person is bad.

Even where emotion is not engaged, we are subject to many powerful heuristics that make us partial and error prone in systematic and predictable ways i.e. biased. Should we take the trouble to learn these biases we are still liable to being partial and error prone, unless we adopt robust methods to guard against bias – and usually even then. This is the human condition.

Criminal Justice

The criminal justice system recognises the issue of bias, in a general sense, and over the years has developed systems and rules which provide some safeguards – jury trials are one (take note, Mr Lammy)!

However, no safeguards can guard effectively against the relentless tide of human fallibility; and there are parts of the criminal justice system that are particularly susceptible to risks from cognitive bias. The use of expert witnesses is one.

Witnesses generally cannot give 'opinion evidence' about matters that the jury can reasonably assess for themselves. Were it otherwise, witnesses could effectively tell jurors what to conclude, undermining their independence.

Expert witnesses, however, are permitted to give opinion evidence if a subject matter lies outside the experience and understanding of ordinary jurors and the witness has the necessary expertise to express a reliable opinion.

This can make expert witnesses especially compelling. As well as being able to give opinion evidence often of fundamental importance to a person's guilt or innocence, jurors will often not have the technical expertise to independently evaluate that evidence (nor do judges, coroners, or chairs of public inquiries, by the way).

Sally Clark

Sally Clark's first baby son died of Sudden Infant Death Syndrome. When her second child died similarly two years later, the police were called in and the investigation proceeded on the assumption that two cases of SIDS in the same family was highly improbable: murder, they thought, was the only plausible explanation.

Experts concluded that both deaths were caused by deliberate acts, either by shaking or smothering

the babies. Defence experts subsequently found the evidence inconclusive and the causes of death not established – however, by that stage, Sally Clark was a defendant in a criminal prosecution.

The police, the prosecutors, the state (it would appear) thought her guilty of murder. The jury had to reach its conclusion on the basis of a mass of contradictory expert medical evidence. There were nine experts – four for the prosecution and five for the defence. Some prosecution experts had changed their minds on fundamental issues.

How are juries to decide between competing experts? Fortunately, people are machines for jumping to conclusions, and no evidential uncertainty is too great to overcome.

Evaluating expert evidence

Daniel Kahneman and his colleague, Amos Tversky, found that people often solve difficult questions by (unconsciously) finding an easier question and answering that instead. Rather than conducting a forensic analysis of the technical and scientific evidence, a juror is liable to substitute **a** question like: which expert seems more authoritative?

The juror will be aided by all manner of cognitive shortcuts. As well as authority bias causing jurors to prefer experts who appear to have a higher status, or simply a more impressive courtroom demeanour, anchoring bias may lead to jurors using the first expert opinion they hear (usually prosecution experts) as their reference point – if the initial expert provided compelling evidence any expert providing contradictory evidence might be viewed as less credible; the availability heuristic means that jurors may be more influenced by evidence that is easier to understand, vividly presented, or emotionally compelling; confirmation bias might come into play, with jurors favouring experts who support their intuition as to the defendant's guilt or innocence.

There is another major problem. Expert witnesses are as susceptible to bias as everyone else, sometimes more so. Alternatively, they might just be wrong.

Sally Clark (Part 2)

Cutting through the noise of Sally Clark's trial the eminent paediatrician, Sir Roy Meadow, gave evidence that there was a 1 in 73 million chance of two cot deaths. It was, he said, something that would happen only 'once in every 100 years'. He later compared the chances of both children dying natural deaths to picking four 80 to 1 winners of the Grand National in successive years. That a defence expert witness pointed out that these figures involved an illegitimate oversimplification is unlikely to have been so impactful.

In fact, Professor Meadow's figures were entirely bogus, and misleading in any event. Recognising that the infants were related, the chances of two cot deaths was orders of magnitude higher than 1 in 73 million, possibly as high as 1 in 200. Even if a much lower figure were correct, it was wrong to imply that this equated to the chance of innocence (the 'prosecutor's fallacy'). As the Royal Statistical Society explained to the Lord Chancellor, the fact that two deaths by SIDS is quite unlikely is, taken alone, of little value. Two deaths by murder may be even more unlikely. What matters is the relative likelihood of the deaths under each explanation, not just how unlikely they are under one explanation.

Sally Clark was convicted. When the statistical errors were explained to the Court of Appeal in Sally's Clark's first appeal, they were not fully understood and not acted upon. The Court of Appeal only recognised the significance of Professor Meadow's misleading evidence in Sally Clark's second appeal – when supported by new medical evidence pointing to natural death based on previously undisclosed microbiological tests performed at post-mortem. Sally Clark's convictions were finally overturned.

A wider problem

This is just one example, of course, but there are many others. We do not have to wade too far into the Letby debate to note that Dr Dewi Evans, the lead prosecution expert, identified deaths as suspicious on the basis of medical records that had not been 'blinded' and when Letby was the only suspect. That the allegedly suspicious nature of those deaths has now been challenged (robustly) by a panel of international experts leaves the prosecution case perilously circular – 'Letby was the only one present for all suspicious deaths' becomes 'deaths were suspicious because Letby was present'.

This issue is far broader than the Sally Clark and Lucy Letby cases. Peoples' preconceptions and motives shape their interpretation of the world around them. Not merely by noting and giving weight to evidence that supports pre-existing theories and disregarding evidence that does not (confirmation bias) but in differing interpretations of the same evidence. Even for something that might be thought as open and shut as fingerprint analysis, if examiners are told that a suspect has an alibi, they are less likely to conclude that a print found at the crime scene came from the suspect.

The more subjective the assessment, the greater the potential for bias. For example, determining whether deaths are suspicious when the causes of death are unclear. Or determining whether there has been a failure in care in contentious and difficult areas of medicine. Now add to that uncertainty a suspicion, whether warranted or not, against a

particular individual. Perhaps death rates have been unusually high, or perhaps not. Perhaps a medical practitioner is unorthodox or has upset some of their colleagues.

Once an investigation has begun, it could end in a criminal prosecution even in the absence of reliable evidence. There is an all too human tendency to blame people for bad outcomes. People generally have a poor intuitive understanding of statistics. Group think creates a snowballing effect: as investigations gain momentum, biases shape understanding and it is ever less likely that dissenting voices will change its course.

A blind eye

Once a case comes to court, the usual approach is to pretend that cognitive bias does not exist or is inconsequential: These are experienced experts who understand their duties to the court. It is for the jury to assess the evidence: they can choose to give less weight to the evidence. Or a simple finding that there is no evidence of bias, especially if it might derail proceedings to find otherwise.

The misunderstandings here are that bias is something exceptional rather than part of the human condition; and that bias can be identified and managed by ordinary common sense. If it could, we wouldn't have been lobotomising patients late into the twentieth century. Or handing over billions of our savings to (with hindsight) obvious fraudsters. Or regularly locking up people for crimes they did not commit.

The UK's judicial system is not without safeguards. We have an adversarial system, so that different perspectives are heard and contested. We have independent arbiters of fact. We have burdens of proof. We have certain rules of evidence, such as the exclusion of evidence which is more prejudicial than probative.

To some degree, judges might reasonably say: It's not perfect, but this is the system. My role is to help it function, guarding it from those who would attack its foundations. We must, after all, live in the real world.

What is wrong with that?

There have been various reforms to help guard against cognitive bias since, for example, the Birmingham Six were wrongly convicted in the mid-1970s, not least the introduction of PACE 1984 to protect against false confessions. The unscientific approach to expert evidence however leaves a major risk of miscarriages of justice.

To produce reliable evidence, science uses rigorous controls, precise definitions, robust statistical analysis, and adopts the hierarchy of evidence to prioritise the highest quality data over mere 'opinion'. Of course, real world investigations would be untenable if scientific gold standards had to be met in all circumstances. There is a problem, however, when 'science', in the form of expert 'opinion' evidence, is relied upon when little more than credentialled bias.

In most cases, for example, prosecution experts should be subject to strict 'blinding' controls; their evidence independently assessed rather than adopting methods that encourage 'group think'; professional statisticians should be instructed much more frequently; experts should be held to their duties to act independently and impartially, to make clear when issues fall outside their expertise, to identify anything that might undermine their opinion and any reasonable range of opinion – failing which they should not be excused in order to 'keep the show on the road': their evidence should be rejected.

Courts should understand that when there is dispute between experts, it is best resolved by evidence-based methods, rather than a mere exchange of expert 'opinions'. If high quality data is available, opinions should be based on a structured review of high quality data, not 'cherry picking' lower quality data (or even misrepresenting data) to support their case.

Of course, the justice system is populated by lawyers (and former lawyers) and not scientists and statisticians. There will be incomprehension and resistance to such proposals. We do, however, have an adversarial system. It will be the role of some lawyers, and the experts they instruct, to persuade other lawyers (and former lawyers), or the jury directly, that opinion is not evidence: that what matters is the quality of the evidence underlying that opinion. That any expert who does not follow evidence-based methods, who does not comply with their expert duties, should be rejected.[1]

Reference

[1] For further discussion of this topic, read the excellent report by the Royal Statistical Society, 'Healthcare serial killer or coincidence? Statistical issues in investigation of suspected medical misconduct'. See also the Forensic Science Regulator Guidance on 'Cognitive Bias Effects'.

Loss and scope of duty in professional negligence claims: Afan Valley Ltd v Lupton Fawcett LLP

by Caroline Brown, Partner & Christina Evered, Associate at Burges Salmon.

A recent Court of Appeal decision provides a useful illustration of the application of the principles of loss & scope of duty in professional negligence claims.

> *"It is a principle of the law of negligence that a defendant found to be in breach of a duty of care is not liable for all the losses which the claimant has sustained as a result of acting on their advice, but only for those within the scope of their duty."*

In Afan Valley Ltd & Ors v Lupton Fawcett LLP [2024] EWHC 909 (KB), the Court of Appeal dismissed the Claimants' appeal against reverse summary judgment and strike out on their substantial professional negligence claim against a firm of solicitors, Lupton Fawcett. The Claimants' application to the Supreme Court for permission to appeal this decision has been refused.

Background

The Claimant companies were used as special purpose vehicles ("SPVs") in connection with investment schemes ("Schemes") promoted to the public, under which investors were offered the opportunity to buy long leasehold interests in individual rooms in hotels, care homes or student accommodation.

Lupton Fawcett had been instructed by the Claimants to advise on whether the Schemes were collective investment schemes (CISs) under the Financial Services and Markets Act 2000 ("FSMA"). If so, then the Schemes would fall within the FSMA general prohibition under which no person may carry on regulated activity unless they are authorised or exempt. The Claimants were not so authorised, meaning that adverse consequences would follow if the Schemes were deemed CISs.

The Claimants, which were all in insolvent liquidation and acted by their joint liquidators, argued that as a result of Lupton Fawcett's failure to advise earlier that the Schemes were CISs, they had incurred significant liabilities of over £60m. The principal loss claimed stemmed from the Claimants' obligation to return investors' payments to them. Had the Claimants been advised earlier that the Schemes were CISs, they argued, then they would not have received investor money and would not have incurred FSMA liabilities. Also relevant was the Claimants' further argument that none of the Schemes made a profit; they were in fact a "Ponzi" scheme, dishonestly operated by a shareholder/director of one of the claimant companies.

Lupton Fawcett applied to strike out, or for reverse summary judgment on, the claim against it on the basis that even if negligence were established then the Claimants would be unable to prove any recoverable loss. Primarily, this was on the basis of a "£ in £ out" argument; the Claimants had received investment funds in, which set off the requirement to return investors' money.

The High Court struck out the claim and granted summary judgment against the Claimants, who then appealed.

Appeal

The crux of the appeal was whether the Judge was wrong to decide that the Claimants' losses were not attributable to Lupton Fawcett's alleged negligence. The Court of Appeal dismissed the appeal, ruling that even if the firm's advice had been negligent as the Claimants alleged, they could not demonstrate any recoverable loss falling within the scope of the solicitors' duty of care.

Scope of duty

The leading Supreme Court decision in Manchester Building Society v Grant Thornton LLP [2021] UKSC 20, [2022] AC 783 sets out a structured framework for the resolution of claims for damages for negligence, as follows:

"When a claimant seeks damages from a defendant in the tort of negligence, a series of questions arise:

1. Is the harm (loss, injury and damage) which is the subject matter of the claim actionable in negligence? (the actionability question)
2. What are the risks of harm to the claimant against which the law imposes on the defendant a duty to take care? (the scope of duty question)
3. Did the defendant breach his or her duty by his or her act or omission? (the breach question)
4. Is the loss for which the claimant seeks damages the consequence of the defendant's act or omission? (the factual causation question)
5. Is there a sufficient nexus between a particular element of the harm for which the claimant seeks damages and the subject matter of the defendant's duty of case as analysed at stage 2 above? (the duty nexus question)
6. Is a particular element of the harm for which the claimant seeks damages irrecoverable because it is too remote, or because there is a different effective cause (including novus actus interveniens) in relation to it or because the claimant has mitigated his or her loss or has failed to avoid loss which he or she could reasonably have been expected to avoid? (the legal responsibility question)"

The Court of Appeal applied these principles in considering the Claimants' three grounds of appeal, which were explained in the judgment as follows:

i. The "£ in £ out" analysis was challenged on the basis that once an investment was completed, the Claimants paid out commission together with legal and professional fees, and so had suffered loss over and above any liability to refund investors;

ii. The Claimants had also incurred necessary expenditure in the early years of operating the Schemes; and

iii. The liability incurred by the Claimants under FSMA was not just to repay the investors the amounts received but also to pay them compensation.

Applying the Manchester Building Society principles, the Court of Appeal held that Lupton Fawcett was not responsible for the losses suffered; and that such losses did not fall within the risks of harm against which Lupton Fawcett's duty of care was intended to guard.

Lupton Fawcett's duty of care concerned the impact of FSMA if the Schemes were CISs. More specifically:

i. The payment of commissions and fees had nothing to do with whether the Schemes were CISs or not. That the Claimants might make these payments did not mean that the risks of their doing so were within the risks of harm for which Lupton Fawcett could be responsible.

ii. The same goes for the claim for expenditure incurred in operating the Schemes. In a counterfactual world in which the Schemes were not CISs, then they would have been operated in the same way, incurring the same expenditure.

iii. The potential FSMA compensation did, in principle, fall within the scope of Lupton Fawcett's duty. However – had the Schemes not been CISs then, whilst the potential FSMA compensation may have been avoided, the Schemes would still have been run as a Ponzi scheme, ultimately failing, and investors would still have had valid claims in contract or tort against the Claimants which were at least as good as any FSMA compensation claim.

Conclusion

This judgment reinforces and illustrates, in practice and on a number of bases, the principle that solicitors' liability is limited to losses which fall within the scope of the legal advice that they are instructed to provide. This decision will be of interest to professionals and insurers alike, offering a clear example of how the established scope of duty principles in *Manchester* continue to be applied.

Burges Salmon has extensive experience acting in high-value and complex professional negligence matters. If you would like to discuss this further, please get in touch with:

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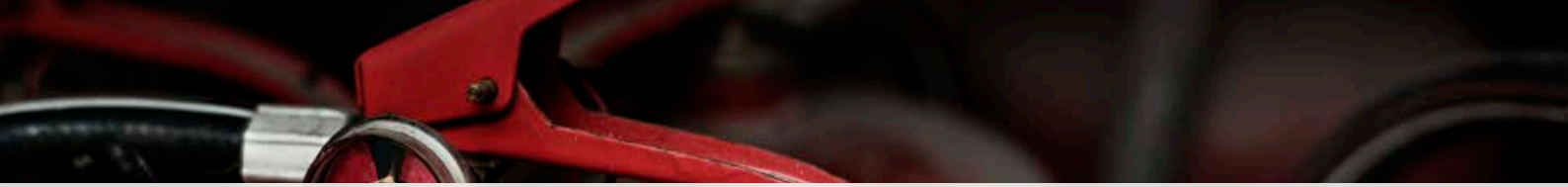
References

1. Afan Valley Ltd & Ors v Lupton Fawcett LLP [2026] EWCA Civ 2 (05 January 2026)



Update on costs award to Defendant for Prosecution case that "should not have been started"

by Tom McNeill, Partner at BCL Solicitors LLP & Colin Todd, MBE, Managing Director at C. S. Todd & Associates Ltd.

We have previously written of costs being awarded against a fire and rescue authority ("FRA") for a prosecution case that "should not have been started" (February 2025 edition). We now update on costs.

Our client ("the contractor") was prosecuted in relation to the installation of flat entrance doorsets ("FEDs") at housing association properties. The FRA charged the contractor with a breach of article 8 of the Fire Safety Order (duty to take general fire precautions), such as to place relevant persons at risk of death or serious injury in case of fire, alleging various defects purportedly identified during an FRA inspection.

Notwithstanding the "expert" evidence of the investigating officer, the experts subsequently appointed to assist the Court concluded that the evidence did not establish a breach of duty nor a risk of death or serious injury in case of fire. Belatedly, the FRA offered no evidence, and a not guilty verdict was entered.

The contractor then applied to the Court for an order for costs against the FRA, under section 19(1) of the Prosecution of Offences Act. Being a case that was brought on the basis of "expert" evidence by the investigating officer, the test in R v Aylesbury CC [2018] applied: was the "expert" evidence "plainly wrong in a way that should have been obvious to the Crown"?

The judge concluded that the evidence was plainly and obviously wrong, accepting the evidence of defence experts, Colin Todd and Lin Parry, that the prosecution case was founded on an incompetent inspection of the premises (including looking in the wrong place). The judge also found that this incompetence was compounded by a misstatement by the investigating officer that there were no intumescent strips in a critical location (between the door frame and the surrounding structure), a central dispute when an earlier judge was deciding whether the case should be "dismissed" for insufficient evidence – a later inspection confirmed the presence of the strips.

Ultimately, the judge concluded that the prosecution should never have been started and, exceptionally, ordered the FRA to pay defence costs.

As to the amount of costs payable, the general rule under section 19(1) is that "the assessment must be of an amount that reasonably compensates the receiving party for costs actually, reasonably and properly incurred as a result of the unnecessary or improper act or omission identified". The judge ordered that defence costs be assessed by the relevant government department and no issue was taken with their assessment of the amount of costs reasonably and properly incurred (a sum comfortably into six figures).

The FRA argued that the judge had a discretion to discount the amount otherwise payable on the basis that the FRA was a public authority with limited resources. Following defence submissions, the judge concluded that the FRA did not have a protected status by reason of being a public authority, and no submissions had been made on its behalf in relation to ability to pay or financial effects.

What was further contended, and ultimately the only argument advanced on behalf of the FRA, was that requiring them to pay the full amount, as assessed, would risk a "chilling effect on prosecutorial functions". Following further defence submissions, the Court did not accept this argument either:

"There was agreed expert evidence here that the very foundation of the prosecution was flawed... In

other words, this was a prosecution which shouldn't have been brought without further and better evidence of breach. I do not agree that that has a chilling effect, but rather, serves as an appropriate warning, namely: do not bring a prosecution without an appropriate and competent inspection which reveals a breach of the regulations."

Quite!

About the Authors

Tom McNeill is a partner in BCL Solicitors LLP. **Colin Todd** is Managing Director of leading fire safety consultants, C.S. Todd and Associates Ltd. Counsel instructed for the contractor were Richard Matthews KC, of Mayfair Place Chambers, and Tom Doble, of QEB Hollis Whiteman.

The Montgomery Standard in Primary Care: My GP Expert Witness Perspective on the Evolution of Informed Consent

by Dr Samah Boulis, GP Expert Witness.

From Bolam to Montgomery

Historically, disclosure of risk was judged by the Bolam standard: a doctor would not be negligent if supported by a responsible body of medical opinion. This extended to what risks were discussed with patients, reinforced by Sidaway. The approach was, in essence, clinician-centred.

Montgomery's case changed that.

The shift from Bolam to Montgomery was more than a legal pivot; it was a cultural revolution in the consultation room. For the GP Expert Witness, it moved the goalposts from "What would a reasonable doctor say?" to "What would this specific patient want to know?"

In the high-pressure environment of primary care, where ten-minute consultations are the norm, the "Montgomery standard" is frequently where clinical negligence claims are won or lost. Adherence to the principles established in Montgomery v Lanarkshire Health Board is frequently central to determining liability in clinical negligence claims concerning informed consent.

The Facts That Changed the Law

Mrs Montgomery, a diabetic woman of small stature, faced an increased risk of shoulder dystocia during vaginal delivery (approximately 9–10%). She was not advised of this risk, nor offered a caesarean section. Tragically, her child suffered cerebral palsy following complications during birth.

The Supreme Court found that had she been properly informed, she would have opted for a caesarean section. The failure to disclose was therefore causative—and negligent.

The Modern Legal Standard

Montgomery establishes that clinicians must take reasonable care to ensure patients are aware of:

- **Material risks** of proposed treatment
- **Reasonable alternatives**, including no treatment

A risk is "material" if:

- A reasonable person in the patient's position would likely attach significance to it, or
- The clinician knows (or ought to know) that the particular patient would find it significant

What This Means in Practice

From an expert witness perspective, several principles are now critical when assessing breach:

- Patient-centred disclosure: The focus is no longer on what a responsible body of clinicians would ordinarily disclose under the Bolam test, but on whether a reasonable patient in the claimant's position would regard the information as significant, or whether the clinician knew (or ought to have known) that this particular patient would do so.
- Dialogue over documentation: Consent is now properly understood as an ongoing communicative process rather than a discrete event evidenced by a signature.
- Materiality is driven by consequences as well as probability: The assessment of material risk is not confined to statistical frequency. Even low-probability risks may require disclosure where the potential consequences are serious and therefore likely to influence a reasonable patient's decision-making.

- Individualised assessment of risk: The clinician is required to take reasonable steps to understand the patient's values, concerns, and circumstances, and to tailor disclosure accordingly. Materiality is therefore context-specific rather than purely clinical.
- Obligation to discuss reasonable alternatives: The duty extends beyond disclosure of risks of a proposed intervention to include reasonable alternative treatments (including no treatment). Failure to evidence such discussion remains a frequent and legally significant feature in breach analysis.

Causation: Still the Battleground

Although breach of duty in consent cases may be established through inadequate disclosure, causation frequently remains the most contested issue.

The central question is not simply whether the patient was inadequately informed, but whether that failure materially altered the outcome: Would the patient, if properly informed, have made a different decision that would have avoided the harm suffered?

This requires a balanced, forensic analysis of the patient's prior medical history and records, their expressed concerns at the time, and their risk profile from a GP expert witness.

General Practice is unique. In primary care, the longitudinal nature of the GP–patient relationship is particularly significant. A GP expert is often uniquely placed to comment on what the clinician knew, or ought reasonably to have inferred, about patient preferences over time.

The Therapeutic Exception

Often raised, rarely justified. The threshold—serious harm to the patient's health from disclosure—is high and narrowly applied.

Conclusion

Montgomery is not just a legal milestone. It aligns the law with modern expectations of shared decision-making and reinforces the centrality of patient autonomy.

For those providing expert opinion, it requires a disciplined and structured analysis:

- Was the risk material in the circumstances of this patient?
- Was that risk adequately disclosed?
- If disclosed, would it have altered the patient's decision?

These questions lie at the core of every consent case assessed in clinical practice.

Dr S. Boulis, GP Expert Witness

As a GP expert witness, I prepare independent reports in clinical negligence cases, with a focus on informed consent, standards of care and decision-making in primary care.

My overriding duty is to the Court. All reports are prepared in accordance with CPR Part 35, Practice Direction 35, and the Guidance for the Instruction of Experts in Civil Claims (2014).

I welcome instructions from clinical negligence solicitors and counsel in England, Scotland and Northern Ireland.

If you would like to discuss a potential instruction or expert witness query, please feel free to get in touch: **spboulis@doctors.org.uk**

Expert Evidence in Family Proceedings: Getting It Right Where It Matters Most

by Mani Singh Basi, Barrister at 4PB & author of 'A Practical Guide to Expert Evidence in Proceedings Concerning Children'.

Those practising in the field of family law will be well accustomed to the presence of expert evidence in proceedings. In cases concerning children, where decisions may have permanent and long-term consequences, such evidence often plays a pivotal role. Its value, however, depends not simply on its inclusion, but on how expert evidence is even pursued in the fast place, and then considered and ultimately understood.

Difficulties frequently arise at each stage of this process. Questions emerge as to whether expert input is justified at all, how instructions should be framed, whether the chosen expert is appropriately qualified, and how conclusions should be evaluated or, where necessary, challenged.

A defining feature of expert evidence is the expert's overriding duty to the court. This obligation exists irrespective of who has instructed or funded the report. It is a principle that underpins the integrity of the process and ensures that expert opinion is directed towards assisting the court, rather than advancing a particular case that a party is advancing. All such considerations sit within the framework of the Family Procedure Rules 2010, which govern both the admissibility and conduct of expert evidence in family proceedings.

Is it 'necessary': a disciplined exercise

The rules impose a clear restriction: expert evidence is only to be admitted where it is necessary. This requirement, found in Part 25, is stringent. It reflects a wider concern to avoid unnecessary delay and to keep the court's focus firmly on the welfare issues at stake.

In practical terms, this demands careful justification. The decision to seek permission should follow a structured analysis, not habit or convenience. Key considerations include whether the issue truly lies beyond the expertise of the court and existing professionals, and whether resolving it is essential to determining the child's welfare.

Applications that succeed tend to be those that are tightly focused. They identify a clearly defined question, explain why expert input is indispensable, and demonstrate that the proposed instruction is proportionate. Vague or overly broad requests, by contrast, are unlikely to assist the court and may result in an application failing.

Equally significant is the choice of expert. The alignment between the issue in dispute and the expert's specific area of knowledge is critical. An opinion offered outside an expert's proper field, or one that only partially addresses the relevant question, is unlikely to carry substantial weight.

Evaluating expert opinion: a critical approach

While expert evidence can be highly relevant in terms of the weight that a judge can attach to it in proceedings, it is not determinative. Its persuasive force depends on its quality. Courts are increasingly attentive to shortcomings that may diminish reliability, such as a weak evidential foundation, failure to address competing explanations, or reasoning that is difficult to follow.

For those involved in preparing and presenting cases, early and careful evaluation is essential. Accepting expert conclusions at face value can lead to flawed decision-making, particularly in safeguarding contexts. Equally, overlooking deficiencies may result in important issues going insufficiently tested.

Challenging expert evidence, whether through targeted questions or cross-examination, should be understood in this light. It is not about discrediting the expert, but about ensuring that their analysis

withstands scrutiny. This process enables the court to determine what weight, if any, should properly be attached to the opinion offered.

It must also be recognised that the significance of expert evidence will vary from case to case. Its role is to assist on matters requiring specialist knowledge, not to supplant the court's own judgment.

Keeping sight of the ultimate objective

The use of expert evidence must always be viewed through the lens of the child's welfare. This has been a key focus of my book. Unnecessary reports can introduce delay and prolong uncertainty, while reliance on unsound analysis can lead to decisions that fail to reflect the child's true needs and circumstances. Equally, a delay in applying for expert reports can also be a problem.

A measured and principled approach is therefore essential. By ensuring that expert evidence is only used where genuinely required, that it is provided by appropriately qualified individuals, and that it is subjected to proper scrutiny, practitioners can help ensure that it fulfils its intended purpose: to support informed, fair, and welfare-driven decision-making.

Mani Singh Basi is a barrister at 4PB and the author of A Practical Guide to Expert Evidence in Proceedings Concerning Children, which examines the procedural and practical dimensions of these issues in detail.

Paragon Group Ltd v FK Facades Ltd

by Claire Kilpatrick, Managing Associate at Stevens & Bolton LLP.

The right to adjudicate can be assigned with the construction contract...for now

It has long been established by the Housing Grants Construction and Regeneration Act 1996 (the Construction Act) that a party to a construction contract can refer a dispute to adjudication at any time. But what about in circumstances where the original party has assigned the benefit of the contract to someone else? Has the right to adjudicate been assigned along with the other benefits and rights under the construction contract? This was recently considered by the Technology and Construction Court (TCC) in the case of Paragon Group Ltd v FK Facades Ltd [2026] EWHC 78 (TCC)

Background

- On 17 October 2018 FK Facades Ltd (FK/the Contractor) entered into an amended form of JCT Minor Works Building Contract 2016 with Office Depot Internation (UK) Limited (ODI/ the Employer) for some remediation works to a roof installation at a commercial property in Greater Manchester.
- The contract included an adjudication clause, allowing either party to refer a dispute or difference to adjudication in accordance with the Scheme under the Construction Act.
- The contract also included a clause allowing the Employer to assign or charge the benefit of the contract at any time without the Contractor's consent (although the Contractor was unable to assign without the Employer's prior written consent).
- There were subsequently two assignments, the first in 2021 from ODI to OT Group Ltd (OTG) and the second in 2024 from OTG to the Paragon Group Ltd (Paragon). Both assignments were notified to FK and included an assignment of "all of [the employer's] rights, title, interest and benefit in and to" the building contract.
- Paragon terminated the contract in April 2025 and in May 2025 notified FK that it was liable for liquidated damages due to delays. This was disputed by FK who referred the dispute to adjudication.
- The adjudicator awarded Paragon the sum of £80,500 and directed that his fees of £17,787 should also be paid by FK. FK refused to pay either sum on the basis that the adjudicator did not have jurisdiction over the dispute. Paragon issued enforcement proceedings in the TCC.

Who is a "party" to a construction contract?

Neither party disputed that the assignment was valid. The key point raised before the court was the question of who can be a "party" to a construction contract in the context of the assignment of the contract and the wording of Part 1 of the Scheme for Construction Contracts (the Scheme)?

The Scheme (which applied in this case by reference in the contract, but which would otherwise have been implied the absence of any compliant alternative) refers at s.1(1) to "any party to a construction contract". FK argued that if the "party" in the construction contract is defined as 'the employer' or 'the contractor' and if the Scheme gives the right to adjudicate to "any party to the construction contract" then only the employer or the contractor can refer a dispute to adjudication. Paragon argued that the Scheme does not differentiate between the position of an original contracting party and that of an assignee when referring to "a party to a construction contract".

The court confirmed that the right of adjudication (whether by a direct provision in the contract, or whether implied into the contract via the Scheme) is contractual in nature and is therefore subject to the general rules of contractual interpretation. The

court also noted that while the rights and benefits under a contract can be assigned, the assignee does not become a party to the contract (and therefore become subject to the obligations of the original party) which would instead require novation.

However, the judge commented that while, "in strict legal analysis" an assignee does not become a "party" to the original contract, the legal rights and other remedies are transferred to the assignee as if they had been theirs from the beginning "and which would thus in my judgment – absent express provision to the contrary – include the right to adjudicate" unless such rights were expressly excluded.

FK also raised some practical objections to the assignee being given the right to adjudicate, along the lines that 1) FK could not bring a counterclaim against Paragon as the assignee, as Paragon has none of the obligations or burden of the contract 2) there would be an issue over whether the findings made between Paragon and FK would be binding against a future adjudicator if FK then were to bring its 'counterclaim' adjudication against the original employer party and 3) adjudication is confidential so there would be a difficulty in sharing the outcome with the original contracting party and/or using that against the original contracting party in a future adjudication by FK.

In response, the judge pointed out that adjudication does not usually afford the right to bring a counterclaim anyway, but in any event, FK could rely in defence upon all equities which it could have relied if the claim had been brought by the original party and the confidentiality argument was not a compelling reason not to allow an assignee to adjudicate. In practical terms, the court suggested that any contracting party concerned by this risk could stipulate for any assignment to require consent and/or specifically exclude the assignment of adjudication rights.

Balanced against FK's practical objections, the judge also noted the practical difficulties and delay that would arise if an assignee were forced to attempt to persuade the assignor (as the original contracting party) to lend its name to an adjudication by the assignee against the other party.

Ultimately, the judge confessed that the point was finely balanced but was ultimately satisfied that on the basis of objective contractual interpretation, an assignee can adjudicate against the other original party to the construction contract. Therefore, the court found that the adjudicator in this case had jurisdiction to decide the dispute and the adjudication award was enforced by way of summary judgement.

Key takeaways

While the decision in each case will, to an extent, rely on its own particular facts and circumstances, the contract used in this case is of a standard type within the construction industry and the wording of the assignment was similarly common. The main questions in this case turned upon the interpretation of the wording of the Scheme which is also in common use as the default adjudication procedure for referring disputes. Therefore, this decision has potentially wide application across the construction industry where a construction contract has been assigned by an original party to an assignee.

Under this decision, an assignee of a construction contract has the right to refer a dispute to adjudication, whether such right is specified in the contract and/or is implied by the Construction Act and/or the Scheme.

If a party wishes to avoid this result, then it would need to insert into the underlying construction contract either the right to object to an assignment or to agree the wording of an assignment (e.g. an assignment can only be made with prior consent) or to specify that the right to refer a dispute to adjudication does not form part of any assignment and is expressly excluded.

However, we understand that the court has granted FK permission to appeal the judgement to the Court of Appeal, on the basis that the arguments were finely balanced and there is no existing direct authority on this point. So, while the TCC's decision stands for the time being, this could be subject to change on appeal. Ultimately, if a party is really concerned by this issue, the most practical action would be to expressly exclude the right to adjudicate from any future assignment (if the construction contract allows them to do so).

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Clive Morley
Clive started as a contractor's Quantity Surveyor moved onto Contracts Management. He progressed into management in the Design and Build sector.

James Hargreaves
Rights of Light Associate Director
James is a specialist in the area of practice known as Neighbourly Matters.

Hari Hirani
Hari has been a practicing surveyor since 1976 [over 42 years] having a wide range of experience in Capital & Rental Valuations.

Neil Maloney
aving started his career in property management, Neil has also worked as a building surveyor across the South-East.

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The importance of reinvestigating cold cases

by Forensic Access.

Channel 4's recent 24 Hours in Police Custody special has brought renewed public attention to the role that forensic science can play in complex investigations, especially within cold cases. James Beard, Forensic Scientist at Forensic Access, features in the filming, and the programme provides a glimpse of the work possible through new scientific methodologies and investigative techniques. It also reinforces the importance of reviewing all available avenues, including old lines of investigation and new potential leads.

Broadcast on 13th and 14th April 2026, the documentary follows the reopened investigation into the 2013 murder of Una Crown, exploring how forensic evidence contributed to the case many years after her death. While the programme centres on the investigation itself, it also highlights the detailed scientific work that underpins the examination, interpretation and presentation of biological evidence in complex cases.

What is Forensic Biology?

Forensic biology is a key area within forensic science. It covers the identification, examination and interpretation of biological material that may be relevant to a criminal investigation, including blood, semen, saliva, hair and DNA. In practice, the discipline goes far beyond the recovery of samples or the production of a laboratory result. Biological evidence must be considered carefully within the context of the case, the circumstances in which it was recovered, the potential routes by which it may have been deposited, and the limitations of what the findings can properly demonstrate.

Working with Forensic Biology Experts at Forensic Access

James Beard is part of the Forensic Access biology team and contributes to this work through both casework and technical engagement. He has featured in several Forensic Access webinars covering

important areas of forensic biology, including DNA evidence, the examination of items for body fluids, and the evaluation of complex evidence within the context of the case. These are all areas that regularly arise in criminal cases and can have a significant impact on how biological evidence is understood and applied.

DNA evidence is often viewed as one of the most definitive forms of forensic evidence, but its interpretation is rarely straightforward.

Questions can arise around:

- How DNA was deposited
- How long DNA may have been present
- Whether transfer may have occurred directly or indirectly
- Whether contamination is a possibility
- The significance that should be attached to the findings in the context of the issues in dispute.

A scientist working in this field must be able not only to understand the technical science, but also to apply it carefully to the facts of a case. They must also keep abreast of both current research and development, and improvements in applicable scientific methodologies.

James Beard's contribution to discussions around these issues reflects the kind of expertise needed in modern forensic biology. Cases can involve disputed accounts, limited material, historical evidence, mixed DNA profiles, complex reporting structures and competing interpretations. In those circumstances, careful scientific review and balanced interpretation are essential. They help ensure that evidence is neither overstated nor misunderstood.

How forensic biology supports criminal cases

The work of the Forensic Access biology team spans a broad range of forensic matters. The department supports cases involving body fluid evidence, DNA interpretation, blood pattern analysis, case review, critical appraisal of forensic findings and expert reporting. The team's work can be relevant at many different stages of an investigation or legal proceeding, from early review of evidential issues through to report preparation and court testimony.

This work is carried out across a wide range of case types. Biological evidence may be central in offences such as murder, assault and sexual offences, but it can also be significant in historical cases, cold case reviews, appeals, disputed allegations, and matters where the presence or absence of biological material forms part of the evidential picture. Each case requires close attention to detail and careful consideration of what the available findings do, and do not, support.

The Forensic Access biology team works with both defence and prosecution teams as well as directly with law enforcement investigators. That breadth of instruction reflects the importance of robust scientific expertise across the justice system. In some cases, the team may be asked to review evidence on behalf of defence solicitors or counsel, examining the strength of the scientific findings, the way they have been interpreted, or whether alternative explanations have been properly considered. In other cases, forensic expertise may assist investigative teams where biological evidence is complex, contested or requires specialist evaluation.

Working across both areas requires the same scientific discipline in every case. The value of forensic biology lies in objective analysis, careful review and clear reporting. The role of the forensic scientist is to assist with the interpretation of the evidence, explain its significance within the case context, and identify limitations where they exist. This is particularly important in criminal proceedings, where the way forensic evidence is presented can have a profound effect on how it is understood by those making legal decisions.

Forensic biology also poses wider questions around case strategy and evidence review. Biological findings are often considered alongside other types of forensic evidence, including witness accounts, timelines and digital material. The forensic biologist therefore needs to understand not only the laboratory science, but also how that science fits within the broader evidential picture. A finding that appears compelling in isolation may require more cautious interpretation once the wider circumstances are considered.

Independent Review and Expert Interpretation

The experienced forensic scientists at Forensic Access can play an essential role in the review and interpretation of active cases and cold cases. They can provide feedback from a holistic perspective beyond their own discipline, to the potential wider forensic opportunities which may have not been available at the time, or potentially even missed at the first time of asking.

Their work does not stop at the point of analysis. It also involves reviewing evidence in detail, considering the reliability and significance of findings, identifying issues that may require further scrutiny, and presenting conclusions in a clear and balanced way that can be understood by investigators, legal teams and the court.

A second opinion on biological evidence may identify points that require clarification, highlight where further work may be needed, or bring a more measured interpretation to a finding that has been expressed too broadly. This is one reason why independent review remains so important. In some cases, it can also help ensure that the evidential significance of biological material is properly explored where it may otherwise be overlooked.

Forensic Access has long supported legal professionals, investigators and organisations with independent forensic expertise across a range of disciplines, and the biology team forms an important part of that offering. The team's role is not limited to laboratory science alone. It includes critical review of evidence, interpretation of results, assessment of case circumstances, preparation of expert reports and, where needed, giving of evidence in court.

The combination of technical expertise and practical casework understanding is particularly valuable in complex criminal matters. Biological evidence can carry considerable weight, but it must always be interpreted with care. The presence of DNA does not automatically answer every question about how it came to be there or what conclusions can properly be drawn from it. The recovery of body fluid may

be highly relevant, but its meaning depends on where it was found, how it was deposited, and how it relates to the issues in dispute. Equally, the absence of biological evidence does not necessarily exclude an allegation or proposition. These are the kinds of questions that forensic biologists are routinely asked to address.

The 24 Hours in Police Custody special documentary provides a useful opportunity to highlight this work in a broader way. Public attention often turns to forensic science in high-profile cases and television coverage, but much of the discipline depends on detailed scientific reasoning carried out away from public view. Forensic biologists contribute by examining evidence carefully, applying specialist knowledge to the facts of the case, and ensuring that conclusions are expressed with accuracy and restraint.

The programme also highlights the breadth of work carried out within forensic biology. In this case, the Forensic Access biology team contributed to the Y-STR DNA profiling work carried out on fingernail clippings from Una Crown, working in conjunction with another forensic laboratory as part of the wider forensic examination.

Build understanding through training and webinars

Alongside casework, Forensic Access also supports professional learning by delivering training and webinars that explore forensic evidence, interpretation and the practical considerations that arise in criminal proceedings. Topics such as DNA interpretation, transfer and persistence, body fluid identification, and the use of streamlined reporting can affect how evidence is approached at an early stage. Greater understanding across a broad range of forensic topics supports more informed questioning, stronger preparation and more effective instruction within criminal cases. This is particularly important where legal teams, investigators and courts need to understand what a result shows, but also the potential limitations and conclusions that can be drawn from the evidence.

Contact Us

If you require expert support in cases involving DNA evidence, body fluids, blood pattern analysis or a wider range of forensic evidence, get in touch with our casework team on 01235 774870 or at science@forensic-access.co.uk.

Compulsory small claims mediation update

by Emma Fuller, Peter Allchorne, Jade Batstone, Partner & Owen Manze, Solicitor at DAC Beachcroft.

Overview

Compulsory mediation in small claims cases in the county court has been with us now for almost two years, albeit that the scope of cases has varied over that period and certain types of claim, such as those involving personal injury, continue to be excluded.

It would perhaps not be unfair to say that, while some theoretical benefits of the change could be identified, there was a prevailing sense that, in practice, the downsides would outweigh any advantages, with little positive emerging from the process. However, it now seems that those who expressed scepticism were, perhaps, being overly cautious: in our view, the changes have been broadly positive.

Since the new mediation step was introduced, experiences with the service have changed as both parties and mediators have become more experienced with the process. The following are a number of observations gleaned from our experiences:

- With the vast majority of claims now being issued through the DCP or OMC systems, there has been a large increase in the number of mediation appointments.
- As a result of the courts listing an increased number of mediations, lead in times are increasing with most cases being listed with a mediation date some six to eight weeks in the future.
- Mediators are becoming more confident and comfortable with the process leading to the average time for a mediation to be concluded dropping, particularly in cases where there are limited differences between the parties and settlement ought to be achievable.
- Particularly in claims brought by litigants in person where requests to them for information have not been satisfactorily answered prior to the mediation, it is helpful where the mediator can, as an independent person, identify to the claimant what is necessary for them to prove their claim.
- A further effect of the increased experience of the mediators is that they are more prepared to ask at the outset whether there are prospects of a matter being settled within the call window and if there are not, for example where liability is disputed, being prepared to conclude the mediation quickly.
- Claimants are still engaging and, in some cases, reaching settlements prior to a mediation appointment.
- We are aware of courts ordering claimants to provide explanations of failures to engage with the mediation process but no such cases have yet gone to trial and, therefore, the effect is yet to be observed.
- Where claims have not settled at a mediation appointment, some claimants remain engaged with a settlement process and agreements can be reached post-mediation. This can, for example, occur where it has been suggested to a claimant during the mediation that they provide further information to enable the defendant to assess the claim and they have done so.
- Of matters where the mediation appointment takes place, approximately 25% of matters handled by our vehicle hire and damage team where liability is not in dispute, are settled during the call.

While the introduction of compulsory mediation cannot be described as an unqualified success, it has certainly delivered some clear benefits. Any attempt to determine what might otherwise have happened to cases referred to mediation would be speculative; however, it is reasonable to assume that some would have proceeded to trial and that mediation has helped bring about a quicker resolution.

The current small claims track compulsory mediation process is a pilot scheme due to run until the 6 April 2026. However, in our opinion, compulsory small claims mediation is here to stay. We do not anticipate any restriction of its current parameters; rather, future developments are more likely to involve expansion into other areas of small claims and potentially into higher-value claims.

Claims involving personal injury, where an assessment of damages is required, are nevertheless likely to remain unsuitable for this form of mediation. If the court system were to require personal injury claims to proceed via compulsory mediation, a process more closely aligned with the standard mediation model would be necessary, together with a significant increase in available judicial and court resources.

In conclusion, while compulsory mediation remains in its infancy, there have been positive experiences and we will be following any developments closely, ensuring that our clients remain briefed of any forthcoming changes.

DAC BEACHCROFT

The role and impact of polysaccharides in plaster on the colonisation of Stachybotrys Chartarum in buildings.

by Dr Aaran Marriner-Clark & Mr Kieran R. McColl.

Introduction

Gypsum plaster is a widely used construction material, valued for its smooth finish, fire resistance, and ease of application. Traditionally, gypsum plaster consists mainly of calcium sulphate hemihydrate, but modern formulations often include various additives to enhance performance. One such group of additives is polysaccharides, which are complex carbohydrates composed of long chains of monosaccharide units.

What are Polysaccharides?

Polysaccharides are naturally occurring or synthetically produced polymers, including substances such as cellulose, starch, dextrin, xanthan gum, and guar gum. They are known for their ability to modify the physical properties of materials due to their high molecular weight and ability to interact with water.

Functions of Polysaccharides in Gypsum Plaster

- Water Retention: Polysaccharides improve the water-holding capacity of plaster. This slows the rate of water evaporation, allowing for better curing and reducing the risk of cracks.
- Workability: By increasing viscosity, polysaccharides make plaster easier to mix and apply, providing a smoother finish and improved spreadability.
- Setting Time Adjustment: Some polysaccharides can regulate the setting time of gypsum plaster, allowing for longer working periods or faster setting, depending on the requirements.
- Improved Adhesion: Certain polysaccharides enhance the adhesive properties of the plaster, ensuring better bonding to surfaces such as brick, concrete, or wood.
- Reduction of Shrinkage: By controlling water loss and setting characteristics, polysaccharides help minimise shrinkage, which can prevent cracking and increase the durability of plastered surfaces.

Common Types of Polysaccharides Used

Cellulose Derivatives: Methyl cellulose and hydroxyethyl cellulose are often used for their thickening and water-retaining properties.
Starch and Dextrin: These provide both water retention and improved workability.
Gums (e.g., Xanthan, Guar): Used to enhance viscosity and stability, especially in ready-mix plasters.

Environmental and Health Considerations

Polysaccharides are generally considered safe and biodegradable, making them environmentally friendly additives. Their use can reduce the need for synthetic chemicals in plaster formulations, contributing to more sustainable building practices.

Conclusion

The incorporation of polysaccharides into gypsum plaster formulations significantly improves performance by enhancing water retention, workability, adhesion, and durability. These natural or semi-synthetic additives are a key component in modern construction materials, supporting both technical and environmental advancements.

Polysaccharides in Paint: Functions and Benefits

Polysaccharides are complex carbohydrates, often derived from natural sources, and are increasingly used as additives in modern paint formulations. Their inclusion is driven by both performance and sustainability goals.

Key Functions in Paint

- **Thickening and Rheology Modification:** Polysaccharides such as cellulose derivatives, starches, and gums (e.g., xanthan, guar) are used to adjust the viscosity of paint. This improves application properties, making paint easier to spread and reducing drips.
- **Emulsification and Stability:** Special polysaccharide resins (like Polyresin 100) help emulsify and stabilise water in oil-based paints, allowing for the incorporation of water without compromising paint quality. This leads to smoother, more uniform films and prevents defects such as pinholes.
- **Film Formation and Hardness:** By interacting with other resin components, polysaccharides can enhance the hardness and durability of the dried paint film.
- **Improved Application and Finish:** Paints containing polysaccharides often exhibit better brushing qualities, smoother dried films, and improved freeze-thaw stability.
- **Pigment Dispersion:** Some polysaccharides assist in wetting and stabilising pigments, leading to more consistent colour and coverage.

Environmental and Economic Advantages

- **VOC Reduction:** Polysaccharide-based technologies allow manufacturers to reduce volatile organic compounds (VOCs), making paints more environmentally friendly and compliant with regulations.
- **Bio-based and Renewable:** Many polysaccharide additives are derived from renewable resources, such as agricultural waste, making them a greener alternative to petroleum-based resins.
- **Cost Savings:** Incorporating polysaccharides can lower raw material costs while maintaining or improving paint quality.

Typical Applications

- **Water-based and Solvent-based Paints:** Polysaccharides are used in both types, with specific formulations designed for enamels, primers, stains, and specialty coatings.
- **Specialty Coatings:** Applications include fire retardant coatings, sound insulation, and temporary coatings.

Polysaccharides are multifunctional additives in paint, offering benefits in application, performance, and sustainability. Their use supports the development of greener, more efficient coatings for a wide range of applications.

The question is does Stachybotrys Chartarum digest Polysaccharides once sodium is reduced and nitrates are available to the mould within the plaster?

Stachybotrys chartarum is well known for its ability to digest and grow on polysaccharide-rich materials, especially cellulose.

Key Points

- **Substrate Preference:** Stachybotrys chartarum thrives on materials that are high in cellulose, a polysaccharide. This includes substances like paper, drywall, wood, and other plant-based materials commonly found in water-damaged buildings.
- **Growth Requirements:** The fungus requires moisture and a source of cellulose to grow. It is rarely found in nature but is commonly detected in damp, cellulose-rich building materials.
- **Cellulolytic Activity:** Stachybotrys chartarum exhibits strong cellulolytic activity, meaning it produces enzymes that break down cellulose and other polysaccharides, allowing it to use these as a food source.

Stachybotrys chartarum is a fungus that "eats" or digests polysaccharides, especially cellulose, which is why it is commonly found on water-damaged, cellulose-rich materials in buildings. Its ability to break down these complex carbohydrates is central to its ecological role and its presence in indoor environments.

Sodium's Effect on Stachybotrys Chartarum and Polysaccharide Digestion

What We Know About Stachybotrys chartarum

- **Stachybotrys chartarum** is a fungus that thrives on cellulose-rich, damp building materials and is well known for its ability to digest polysaccharides, especially cellulose.
- Its growth and mycotoxin production are influenced by environmental factors such as moisture, temperature, and nutrient availability.

Recent research using chemically defined media found that **increasing concentrations of sodium nitrate** (a sodium-containing compound) actually **promoted mycelial growth, sporulation, and mycotoxin production** in Stachybotrys chartarum. It is hypothesised that the it is in fact the nitrate that enables the growth as the limiting factor once sodium is leached and the nitrate remains as a food source. In contrast, ammonium nitrate and ammonium chloride had inhibitory effects. Indeed, this is the reason why Stachybotrys chartarum is

able to grow even when concentration of sodium are delivered to samples. As it increases the levels of nitrate available to the mould as a food source.

As polysaccharides are frequently found in association with gypsum in two main contexts:

As additives in commercial products: Polysaccharides such as starch ethers, cellulose ethers (like carboxymethylcellulose or CMC), and dextrin are widely used as additives in commercial gypsum-based materials (plasters, mortars, wallboards). They are added to modify the material's properties, such as controlling setting time, improving rheology (flow and workability), and enhancing water retention for specific applications like 3D printing or plastering.

In natural microbial environments: In nature, microbial communities can colonize gypsum outcrops. The organic matter embedded within these natural gypsum deposits has been shown to contain polysaccharides, which are components of microbial extracellular polymeric substances (EPS). Certain bacteria isolated from gypsum dunes are even known to synthesize extracellular polysaccharide

Polysaccharide Digestion

- Stachybotrys chartarum's ability to digest polysaccharides is linked to its production of cellulolytic enzymes, which break down cellulose and other plant-derived polysaccharides. It is the nitrate that is in short supply in the gypsum which is delivered to the surface through efflorescence processes.
- Stachybotrys chartarum can metabolize polysaccharides in plaster and other cellulose-rich materials, once sodium id broken down and nitrates are available to it to feed upon. but this process is not directly triggered by sodium reduction itself but as a by-product of leaching. Instead, the fungus thrives when nitrate cellulose and polysaccharides are available, and competing salts or alkaline conditions are at a positive ph., which makes the substrate more accessible for enzymatic breakdown

  Nutrient Source:
  Stachybotrys chartarum is a **cellulose-degrading fungus**. It colonizes gypsum-based plaster, drywall, wallpaper, and other building materials because these contain **polysaccharides (cellulose, hemicellulose, starch)** which serve as its primary carbon source once sodium is broken down and nitrate is available through leachiung.

- **Role of Sodium in Plaster**:
  - Plaster and gypsum often contain sodium salts (e.g., sodium sulfate).
  - High sodium concentrations can create **osmotic stress** or alkaline conditions that allow for fungal growth.
  - When sodium levels are reduced (through leaching, chemical reaction, or environmental changes), the substrate becomes **less hostile**, allowing fungal enzymes (like cellulases and hemicellulases) to act more efficiently on polysaccharides. Once nitrates are releases due to leaching.
- **Mechanism of Polysaccharide Breakdown**:
  - S. chartarum secretes **hydrolytic enzymes** that degrade cellulose and other polysaccharides into glucose and oligosaccharides.
  - These sugars are then metabolized via glycolysis and other fungal metabolic pathways, supporting growth and sporulation.
  - This explains why the fungus is most often found in **water-damaged plaster and drywall** as moisture activates enzyme activity reduces salt crystallization barriers and releases nitrates.

- **Forensic Building Pathology**: In plaster systems, sodium reduction (e.g., efflorescence leaching) can inadvertently **increase fungal colonization risk** by exposing polysaccharides and nitrates making available it food source.

Summary: Stachybotrys chartarum does not "eat sodium," but when sodium salts are reduced in plaster, the fungus gains easier access to **polysaccharides (cellulose, starch)**, which it actively metabolizes for growth

Hypothesis of how to stop Stachybotrys Chartarum from colonising buildings

To block or immobilize nitrate in gypsum, you typically need to use **additives or chemical binders** that either trap nitrate ions or reduce their mobility. Common approaches include **aluminium or iron salts, pozzolanic additives (like fly ash or metakaolin), and specialized admixtures** that bind anions. These are used in gypsum board or plaster formulations to control unwanted nitrate migration and efflorescence. Saturation of buildings releases the nitrate and reduces the sodium to a point where the Stachybotrys Chartarum can colonise.

- **Source**: Gypsum ($CaSO_4 \cdot 2H_2O$) can contain impurities such as sodium nitrate or potassium nitrate, especially in recycled or industrial gypsum.
- **Problem**: Nitrate salts are highly soluble. They migrate to surfaces, causing **efflorescence, staining, and increased moisture retention**, which in turn promotes mould colonization.

Methods to Block or Immobilize Nitrate in Gypsum

1. Chemical Binding Agents

- **Aluminum sulfate (alum)** or **ferric salts** can precipitate nitrates into less soluble complexes.
- These additives are sometimes used in cement and gypsum systems to immobilize anions.

2. Pozzolanic Additives

- **Fly ash, silica fume, or metakaolin** react with calcium hydroxide and create additional binding phases.
- These phases can trap nitrate ions within the microstructure, reducing leaching.

3. Ion Exchange Additives

- Certain **zeolites or clay minerals** can exchange ions and immobilize nitrates.
- This is more common in environmental remediation but can be adapted in gypsum formulations.

4. Polymeric Barriers

- **Acrylic or latex admixtures** can reduce porosity in gypsum plaster, physically blocking nitrate migration.
- This is a practical solution in board production where efflorescence control is critical.

5. Commercial Gypsum Additives

- Companies like Sika and British Gypsum supply **performance additives** (plasticizers, retarders, water reducers) that indirectly reduce nitrate mobility by lowering water demand and tightening the matrix

Practical Considerations

- **Moisture Control:** Even with additives, nitrate migration is driven by water. Keeping gypsum dry is the most effective prevention.
- **Compatibility:** Not all additives are compatible with gypsum chemistry; some can interfere with setting times or strength.
- **Testing**: ASTM C471M outlines chemical analysis methods for gypsum products, including nitrate and sodium content British Gypsum.

Summary: To block nitrate in gypsum, you can use **aluminum/iron salts**, **pozzolanic additives**, **zeolites**, **or polymer admixtures**. The most effective strategy is combining chemical binders with **moisture control** to prevent nitrate migration and efflorescence.

Polysaccharides in gypsum plaster can be blocked or neutralized by using **additives that reduce organic nutrient availability** and by modifying the plaster matrix to make it less hospitable to microbial enzymes. The most effective strategies involve **polymeric binders, pozzolanic additives, and chemical modifiers** that either encapsulate or denature polysaccharides, preventing fungi like Stachybotrys chartarum from metabolizing them.

Why Polysaccharides Matter

- **Source:** Gypsum plaster often contains cellulose, starch, or paper fibres as part of its formulation.
- **Problem:** These polysaccharides act as a nutrient source for Stachybotrys Chartarum , especially under damp conditions.
- **Mechanism:** Fungi secrete cellulases and amylases that break down polysaccharides into sugars, fuelling colonization of the Stachybotrys Chartarum.

Methods to Block Polysaccharides in Gypsum Plaster

1. Polymeric Encapsulation

- Additives such as **acrylics, styrene-butadiene latex, or PVA emulsions** can encapsulate cellulose and starch particles.
- This reduces bioavailability by creating a hydrophobic barrier around organic matter.

2. Pozzolanic Additives

- **Metakaolin, silica fume, or fly ash** react with calcium hydroxide to form secondary binding phases.
- These phases immobilize organic particles within a denser matrix, reducing fungal access.

3. Enzyme Inhibitors

- Certain **borates or phosphates** can inhibit fungal cellulases and amylases.
- Borates are already used in wood preservation and can be adapted for gypsum systems.

4. Superplasticizers & Water Reducers

- Products like **Sika® ViscoCrete® (PCE-based)** reduce water demand and porosity
- Lower porosity means less moisture transport, which indirectly blocks polysaccharide degradation by fungi.

5. Surface Treatments

- **Silane/siloxane coatings** can be applied to gypsum plaster surfaces.
- These repel water and reduce microbial colonization, even if polysaccharides remain in the matrix.

Practical Considerations

- **Moisture is the trigger:** Even if polysaccharides are present, fungi cannot metabolize them without sustained dampness.
- **Compatibility:** Additives must not interfere with gypsum setting ($CaSO_4 \cdot 2H_2O$ crystallization).
- **Regulatory Note:** In housing pathology, blocking polysaccharides is part of a **non-biocide remediation protocol**, aligning with sustainability and public health standards.

To block polysaccharides in gypsum plaster, use **polymeric binders (acrylics, latex, PVA), pozzolanic additives (metakaolin, silica fume), borates/phosphates as enzyme inhibitors, and superplasticizers to reduce porosity**. Combined with moisture control, these measures prevent fungi from accessing and metabolizing cellulose or starch in plaster.

Hygroscopic salts are **soluble salts (commonly nitrates and chlorides)** that absorb moisture directly from the air. In buildings, they concentrate in plaster or masonry where water has evaporated, and they can cause **persistent damp patches, tide marks, and staining** even when the original water source is removed.

What Hygroscopic Salts Are

- **Definition:** Hygroscopic salts are salts that **attract and hold water molecules** from the surrounding environment.
- **Common Types:** Nitrates (sodium, potassium, calcium) and chlorides.
- **Formation:** They accumulate in walls when water carrying dissolved salts evaporates, leaving the salts behind.
- **Behaviour:** Unlike efflorescent salts (which crystallize on surfaces), hygroscopic salts remain in solution and can repeatedly absorb moisture from humid air.

Impact on Buildings

- Persistent Damp Appearance: Even if the wall is structurally dry, hygroscopic salts can make it look damp by absorbing atmospheric moisture.
- Tide Marks: Dark horizontal lines or patches on plaster, often changing intensity during the day depending on humidity.
- Damage:
  - Bubbling or peeling paint and plaster.
  - Weakening of plaster cohesion.
  - Continuous damp conditions that encourage mould growth.

Hygroscopic salts are **nitrates and chlorides that absorb moisture from the air**, causing walls to appear damp even when dry. They are a by-product of damp problems and must be treated by **removing contaminated plaster, applying salt-resistant renders, and controlling moisture sources.**

In Building Materials (Gypsum Context)

- **Organic additives in plaster:**
  Gypsum plaster often contains starch or protein-based additives (polysaccharides and polypeptides) to modify workability.
- **Chloride contamination:**
  Chloride salts (from groundwater, cement admixtures, or efflorescence) are highly soluble and hygroscopic. They can interact with organic additives, altering moisture retention and microbial susceptibility.
- **Effect on mould growth:**
  Chloride salts can increase water activity in plaster, making polypeptide or polysaccharide additives more available to fungi like Stachybotrys chartarum.
- **Blocking strategies:**
  - Use pozzolanic binders (metakaolin, silica fume) to immobilize chloride.
  - Apply polymeric encapsulation (acrylics, latex) to shield organic additives.
  - Introduce borates or phosphates to inhibit enzymatic breakdown of polypeptides.
- **In biology:**
  Chloride ions interact with polypeptides via electrostatics, hydration, and enzyme modulation.
- **In gypsum plaster:**
  Chloride salts can mobilize moisture and interact with organic additives (polypeptides, polysaccharides), indirectly promoting fungal colonization.
- **Control measures:**
  Immobilize chloride with mineral additives, encapsulate organics, and reduce moisture pathways.

Carbohydrates in Gypsum Plaster

Carbohydrates — mainly **polysaccharides** such as starches and cellulose derivatives — are deliberately added to gypsum plaster formulations. They play important roles in **workability, adhesion, and water retention**, but they also introduce vulnerabilities in damp housing environments.

Why Carbohydrates Are Added

Starch ethers & cellulose ethers are common additives.

– They act as water-retaining agents, slowing evaporation and improving plasticity during application. They help control the setting time and improve the plaster's spreadability. They can also enhance bond strength between plaster and substrate.

Problems in Damp Environments

The polysaccharides form a nutrient source for the Stachybotrys Chartarum, Carbohydrates provide carbon that the Stachybotrys chartarum can metabolize. This makes available not only calcium but also carbohydrates, nitrates and cellulose all of which Stachybotrys Chartarum consumes.

It is thought that stachybotrys chartarum is not moisture dependent but is reliant on the moisture breaking down the sodium making available the nitrate and carbohydrates that In dry conditions, remain inert. In damp conditions, they become bioavailable.

Indeed, I am of the opinion that when combined with hygroscopic salts (nitrates, chlorides), carbohydrates create a microenvironment that sustains microbial colonization of the property.

The question is how we block this growth of Stachybotrys chartarum from occurring in the first instance and how do we block or reduce the carbohydrate consumption by the mould.

We can use formulation changes to replace starch/cellulose additives with the gypsum plaster and paint products. Or use Pozzolanic binders or metakaolin or silica fume can encapsulate organics within a denser matrix.

We can also moisture control the environment, the most critical factor — without water, carbohydrates cannot be metabolized.

We could use surface treatments Silane/siloxane coatings reduce water uptake, indirectly blocking carbohydrate activation.

However Long-term mould prevention in gypsum/paint systems comes from breaking the nutrient–moisture chain at source. First, reduce the digestible polysaccharide load by either lowering starch/cellulose-ether dosage to the minimum that still gives workable skim/flow, or replacing them with non-nutritive rheology modifiers (synthetic associative thickeners like polyacrylates/PU thickeners, or inorganic thixotropies/clays) so you keep spreadability, water retention and open time without supplying edible carbons to the stachybotrys Chartarum. Where rheology still needs organic additives, immobilise/encapsulate them so they're not water-extractable and can't migrate to the surface during humidity cycling.

Or we could add a breathable, hostile topcoat as a back-up (mineral/alkaline or acidic coating or approved dry-film antifungal agents, and if nitrate/chloride salts are present treat them as a moisture amplifier: stop the moisture path.

In short: minimise or substitute the food, stop it reaching the surface, and stop salts keeping the surface damp.

Summary

- **Stachybotrys chartarum** is a fungus that digests polysaccharides calcium and cellulose found in materials like plaster, drywall.
- **Sodium salts** (such as sodium sulphate) in plaster can create osmotic stress or alkaline conditions, which may initially make the environment less favourable for some fungal growth, however the sodium is not only a transport mechanism for the moisture, but also, as a byproduct of efflorescence make nitrates available to the Stachybotrys Chartarum as a food source.
- When **sodium levels are reduced** for example, through leaching or environmental changes the limiting factor in the formation of the mould, the substrate becomes less hostile, and fungal enzymes can more efficiently break down polysaccharides.
- **Nitrate availability** is key: Once sodium is leached and nitrate remains, Stachybotrys chartarum can digest the polysaccharides in the material and colonise the property.
- **Sodium itself does not directly inhibit the fungus from digesting polysaccharides**; rather, high sodium concentrations can slow down fungal colonisation, but as sodium is reduced and nitrate becomes available, the fungus gains easier access to its food source.

Steps needed to Minimise Polysaccharides in Plaster

1. Reduce Dosage of Organic Additives

Lower the amount of starch and cellulose ethers to the minimum required for workable plaster. This reduces the available nutrient source for fungi.

2. Substitute with Non-Nutritive Rheology Modifiers

Replace organic thickeners (like starch/cellulose) with synthetic alternatives such as polyacrylates, polyurethane thickeners, or inorganic thixotropes (e.g., clays). These maintain workability without supplying edible carbon.

3. Encapsulate Organic Additives

Use polymeric binders (acrylics, latex, PVA emulsions) to encapsulate cellulose and starch particles, making them less bioavailable to fungi.

4. Add Pozzolanic Binders

Incorporate metakaolin, silica fume, or fly ash. These additives immobilise organic particles within a denser matrix, reducing fungal access.

5. Use Enzyme Inhibitors

Add borates or phosphates to inhibit fungal enzymes (cellulases and amylases) that break down polysaccharides.

6. Reduce Porosity

Apply superplasticizers and water reducers (e.g., Sika® ViscoCrete®) to lower water demand and porosity, indirectly blocking polysaccharide degradation by fungi.

7. Apply Surface Treatments

Use silane/siloxane coatings on plaster surfaces to repel water and reduce microbial colonisation, even if polysaccharides remain in the matrix.

8. Control Moisture

Moisture is the critical trigger for fungal growth. Ensure the plaster and environment remain dry, as fungi cannot metabolise polysaccharides without sustained dampness.

In short it is hypothesised that if we could Minimise or substitute the food source (polysaccharides), block its accessibility, and control moisture to prevent fungal colonisation in plaster we could actually prevent mould formation in buildings in the first instance.

Brown v Sterne & Others

by Dr T. Walford, Banking Expert Witness at Expert Evidence International Limited.

In this Northern Irish case, the issue of an expert witness relying on a privileged document is explored, as well as considering how this should be addressed in future cases.

Background

This case is one of alleged medical negligence. Ms. Deborah Brown (the '**Claimant**') alleges that she was injured due to negligence whilst undergoing a routine smear test, performed by Dr Sterne (the '**Defendant**'). She also alleges further negligence in the subsequent treatment of the original injury.

Requesting access

In this hearing, the Claimant was seeking access to a statement made by the Defendant dated 13 September 2021 (the '**Statement**') which had been referred to by the Defendant's expert witness. Subsequently, the Defendant had refused to share this document on the grounds that it was privileged.

Legal privilege protects confidential communications between a lawyer and client from disclosure to third parties and can only be waived in narrow circumstances, unless it is considered that

the client has waived privilege either expressly or by implication.

> *"Wisdom is the right use of knowledge. To know is not to be wise. But to know how to use knowledge is to have wisdom."*
>
> **Charles Spurgeon**

The Court Rules

Under Order 24 rule 14 of the Rules of Court of Judicature (Northern Ireland) 1980 (the '**Rules**'), the court has power to order a party, at any stage of proceedings, to produce to the court any document in its possession, custody or power relating to any matter in question. This is tempered by the fact that no such order shall be made unless the court considers that it is necessary to deal with the matter fairly or for the purposes of saving costs. Where privilege is claimed, the court will inspect the document for the purpose of deciding whether such an objection is valid.

A Question of Privilege

It was clear that the Defendant's expert witness, Dr Alan Middleton had read the Statement. It was clearly listed that he had reviewed it whilst undertaking his report, along with seven other documents, including a mixture of medical notes, a chronology, the statement of claim and the relevant Statement. Therefore, the question for the court was not whether he had read the document, but whether he had relied on it, in the preparation of his report. This was confirmed in the case of Bourns Inc v Raychem Corp & Anor (1999) 3 All ER 15, which stated that mere reference to a document does not waive privilege in that document, but that there must have been reliance upon it.

Forming a View

At various points in his report, Dr Middleton made comments that he had "reviewed" and "considered" all of the documentation he had been supplied with, and cross referenced those in the production of his report. He also added that this was all the information that he had used in the formation of his opinion.

> *"Transparency increases credibility and accountability."*
>
> **Park Won-soon**

In the case of Orr v Crowe Building Contractors [2009] NIQB 17, it was held that a medical report should not be disclosed due to privilege. However, although it is a medical negligence case, the facts are not analogous to the present case, as it primarily dealt with questions of quantum and, most importantly, the judge concluded that the expert there had not referred to or relied on the document in question.

The judge concluded that in the context of a liability report, such as this, where the expert is being asked to comment on whether the doctor in question has been negligent, then phrases such as *"having reviewed all the documentation"* or *"having considered all the papers"* should be taken to mean exactly that. This means that an expert will be considered to have relied on all the material provided, including statements given by the person at the centre of the claim.

Outcome

On the present facts, it was considered that privilege had been waived. The judge concluded that it *"cannot be said to be fair or just to conceal relevant material on the basis of privilege when the ability to assert such a right has in my judgment been lost in the circumstances of this case."*

However, it was noted that legal professional privilege is a *"fundamental tenet"* and that nothing in this ruling changes that. The Defendant could have maintained privilege if they had wanted to, but by sending the Statement to Dr Middleton to be reviewed, referred to and relied on, they had effectively waived that privilege.

It was emphasised that the principles of fairness and ensuring all parties are on an equal footing must prevail here and the document must be shared. The judge concluded that the progress of this matter going forward would be *"severely undermined"* by one party's expert having access to material which their counterpart had not seen, due to privilege. It was further noted that this debate had delayed the matter further, and that by considering that privilege had been waived, it would help to move the matter forward towards a resolution.

Going Forward

There has been a greater emphasis recently in medical negligence cases for more transparency and fairness for all parties. Indeed, since the Orr case, there have been two further updates of the Clinical Negligence guidelines reflecting this and the guidelines of the Clinical Negligence Protocol of 1 October 2021 highlight the importance of a *"cards on the table"* approach to clinical negligence litigation, which again would require that all parties have access to all the documents where possible.

> *A lack of transparency results in distrust and a deep sense of insecurity."*
>
> **Dalai Lama**

The judge concluded that it cannot be *"fair or just"* that one party, here notably a healthcare provider, holds a document which they are happy to share with their expert when giving his opinion on liability,

but not with the other party. The Claimant's expert should be afforded the same opportunity to review the material and form their opinion.

Following this decision, expert witnesses will have to be aware that any documents they are asked to review could be regarded as no longer privileged, and it would be wise to make sure all parties are aware of this. Once a document has been seen, it is very difficult, if not impossible, for the expert to prove that it has not had an effect on their views.

Reference

Brown v Sterne & Ors [2025] NIMaster 15 (02 October 2025)

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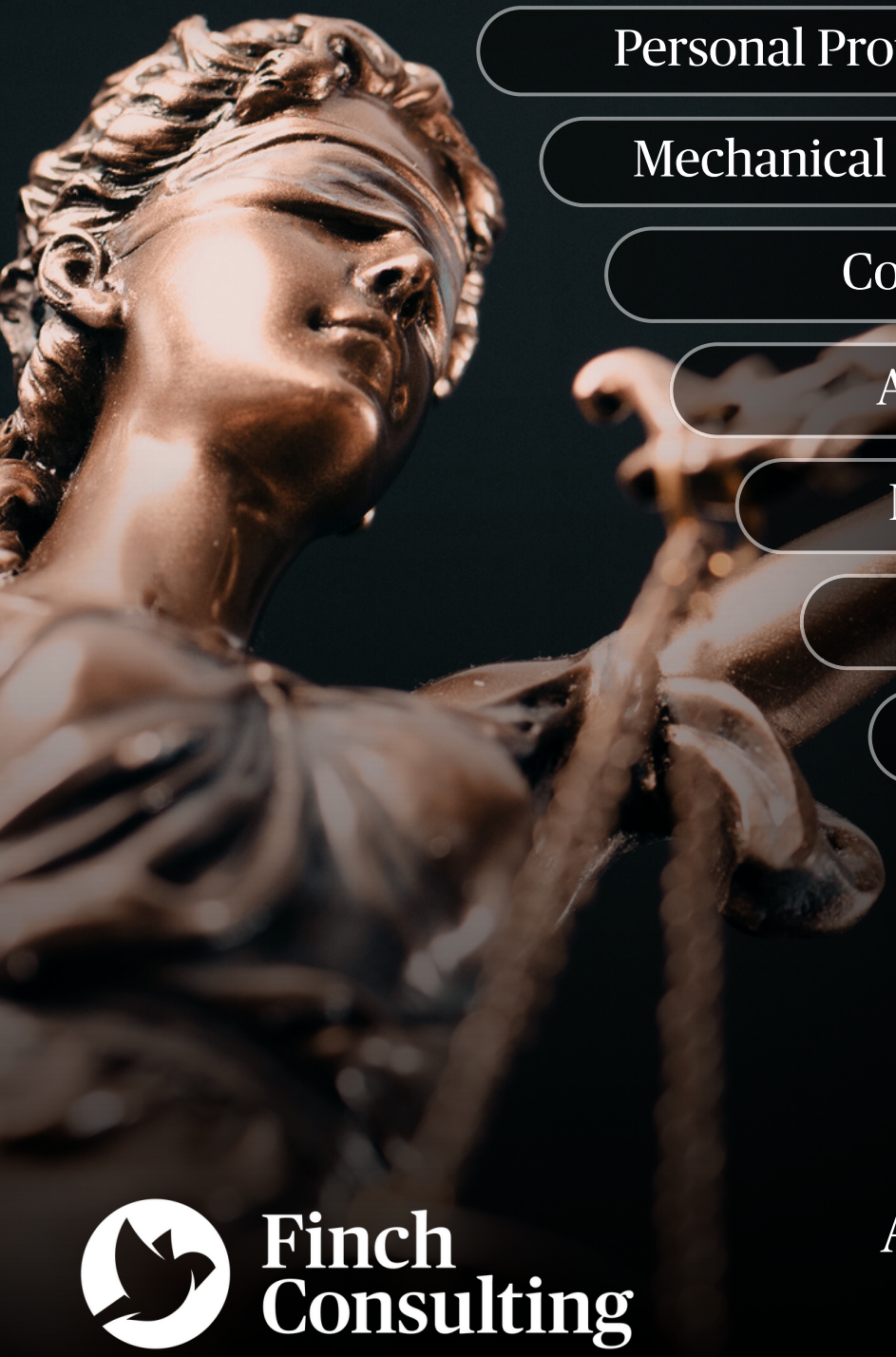

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