LAYERING CLAIMS, PSYCHOLOGICAL INJURY AND TINNITUS

FOIL
FORUM OF INSURANCE LAWYERS

Informing Progress - Shaping the Future

3PB BARRISTERS

Effective Approaches to Combatting Claims Layering in PI Litigation

Sharan Sanghera

Today's Agenda

1. Managing litigation
2. Undermining C's evidence
3. Early Applications
4. Skeletons
5. Bottom line

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Managing Litigation

- Data gathering is key but how best to use the data?
- Intel statements are helpful but there is general reticence on part of Judges to deal with issues across different claim numbers
- Most Judges are prepared to make findings in relation to an Expert's evidence in relation to extant matter only
- Court time/resources are often a driving factor

Undermining the players

- Where there are concerns about quality of the evidence of a particular expert (doctor, engineer, physio):
  - obtain similar fact evidence as broad and across as many claims as possible
  - instruct own expert to prepare report
  - call expert(s) for XX
  - Make an early application to SO
  - Multi Track

Early Applications

- Applications to Strike Out
  - Put the similar fact evidence in front of the Judge in an early application i.e. Directions/post exchange of witness statements
  - seek to strike out the layers (or the whole claim)
- Target key courts/players to build judicial awareness
  - we have seen success in London courts with one key player already

Skeletons

- In Claims where SO unsuccessful or no permission to XX the Expert is given consider instructing Counsel to prepare a Skeleton Argument referring to the similar fact evidence
- Counsel can refer to previous findings/helpful Authorities in the Skeleton
- Avoids criticism of lengthy statements from Solicitors compiling the data

Bottom Line

- No easy solution; there will be Judges who are just not interested in the bigger picture
- But it just takes one or two to become interested and make helpful comments, which can then be used in combatting other Claims

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It’s time for Questions & Answers

Questions Welcome

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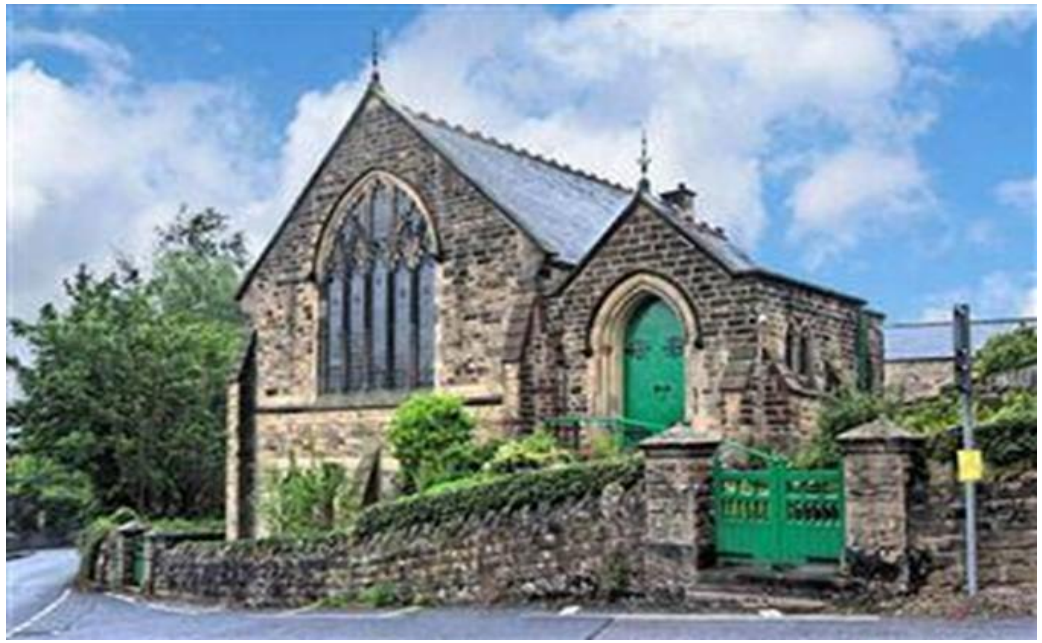
DR MICHAEL ISAAC

CONSULTANT PSYCHIATRIST AND SENIOR LECTURER IN PSYCHOLOGICAL MEDICINE

Otological Aspects of Cervical Whiplash Injury



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AWARENESS DAY
CRASH
FOR CASH
29 JANUARY 2018

- **Mohamed Rahman, 27, staged collision in a crash for cash scam on M4 motorway**
- **Cut into queuing traffic and then blamed other driver in bid to get compensation**
- **But Rahman's scam was caught on cameras covering the busy M4 Severn Bridge**
- **He has now been jailed for six months after being convicted of fraud last week**
-

Read more: http://www.dailymail.co.uk/news/article-4530344/Moment-crash-cash-fraudster-staged-collision-M4.html#ixzz5EBJo6vw6
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Cervical Whiplash

- Deceleration, usually extension then flexion
- Claim can involve head ‘injury’
- Airbag detonation

- Tinnitus
- Vertigo
- Hyperacusis
- Hearing loss

Features to note

- Was there actually an injury?
- Loss of consciousness
- Got out of vehicle unassisted
- Vehicle written off
- Medical assistance & documentation
- Time off work

- Review of medical records is essential
- Triangulation of evidence
- Look for stylized reporting using stock paragraphs

Ear related features

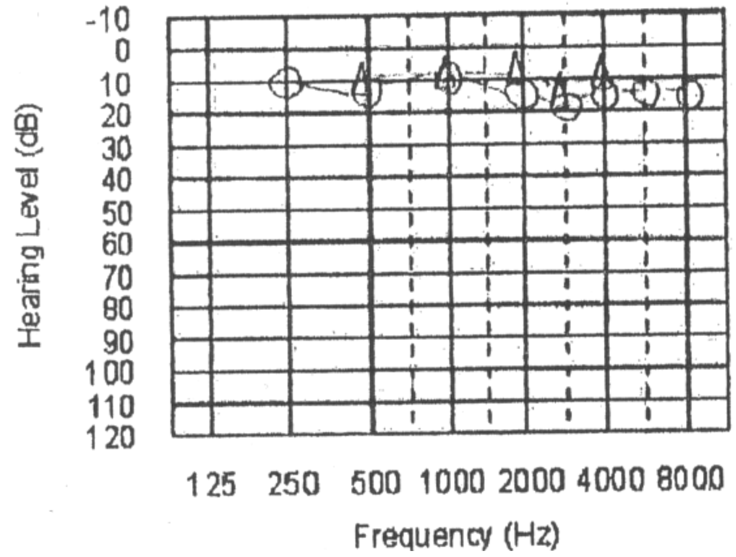
- Direct trauma to ear is unlikely
- Spurious examination findings
- Reporting of ear symptoms after initiation of claim
- Previous symptoms which may not be volunteered so check records

Causation

- Injury needs to be significant
- Onset of symptoms at time of or shortly after
- Symptoms subjective and so prone to exaggeration

Pure Tone Audiometry

- Subjective test
- Look for non-organic factors, bone – air gaps etc
- Repeatability of response
- Evoked response audiometry (CERA)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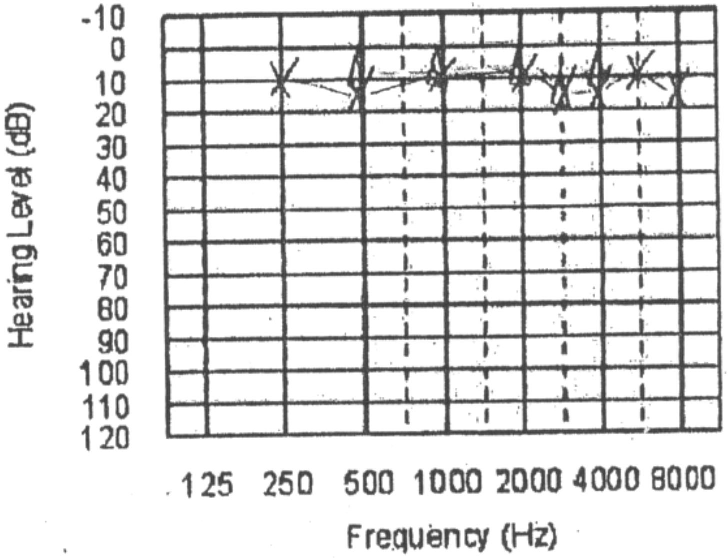
125 250 500 1000 2000 4000 8000
Frequency (Hz)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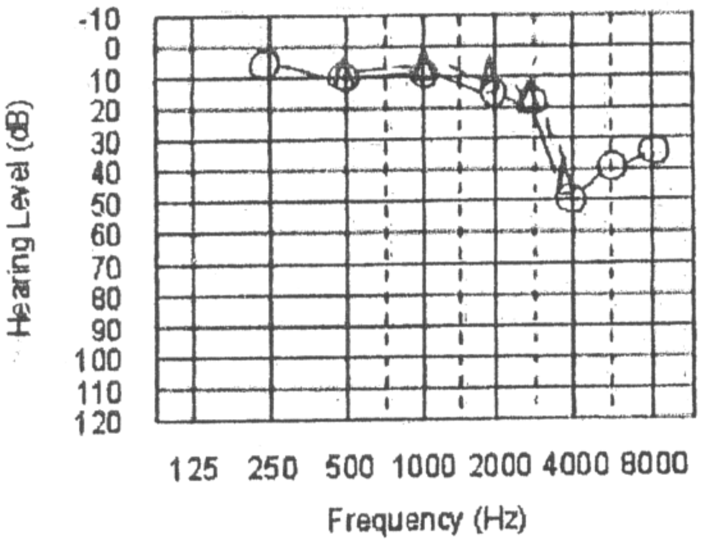
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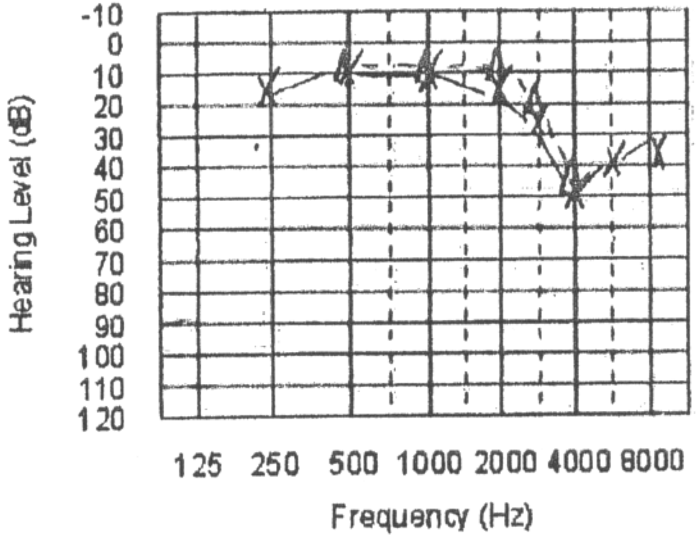
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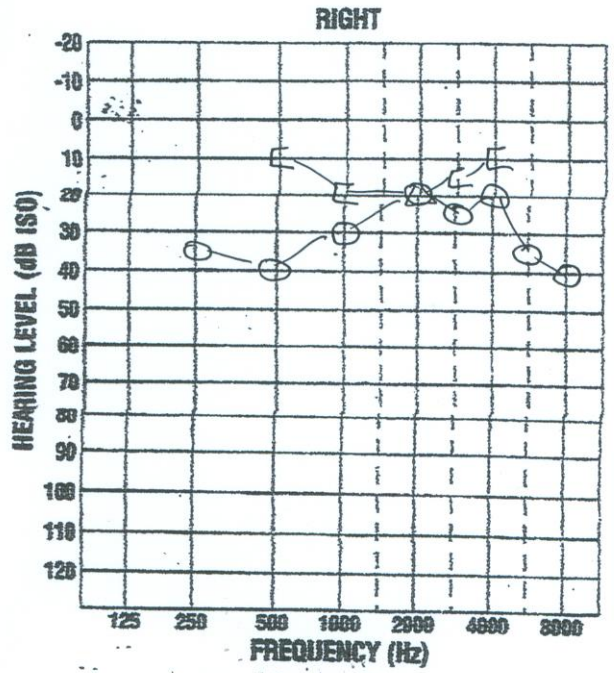
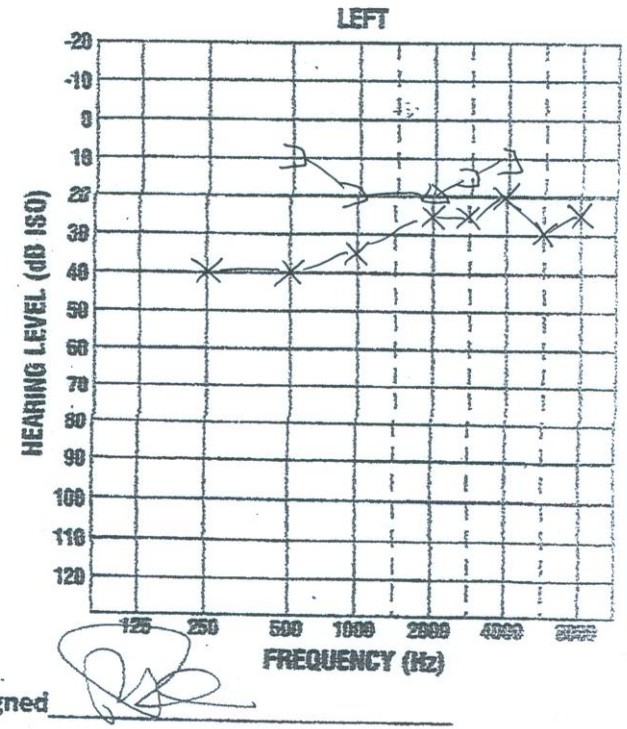




Audiologist ROB PARKER

Signed

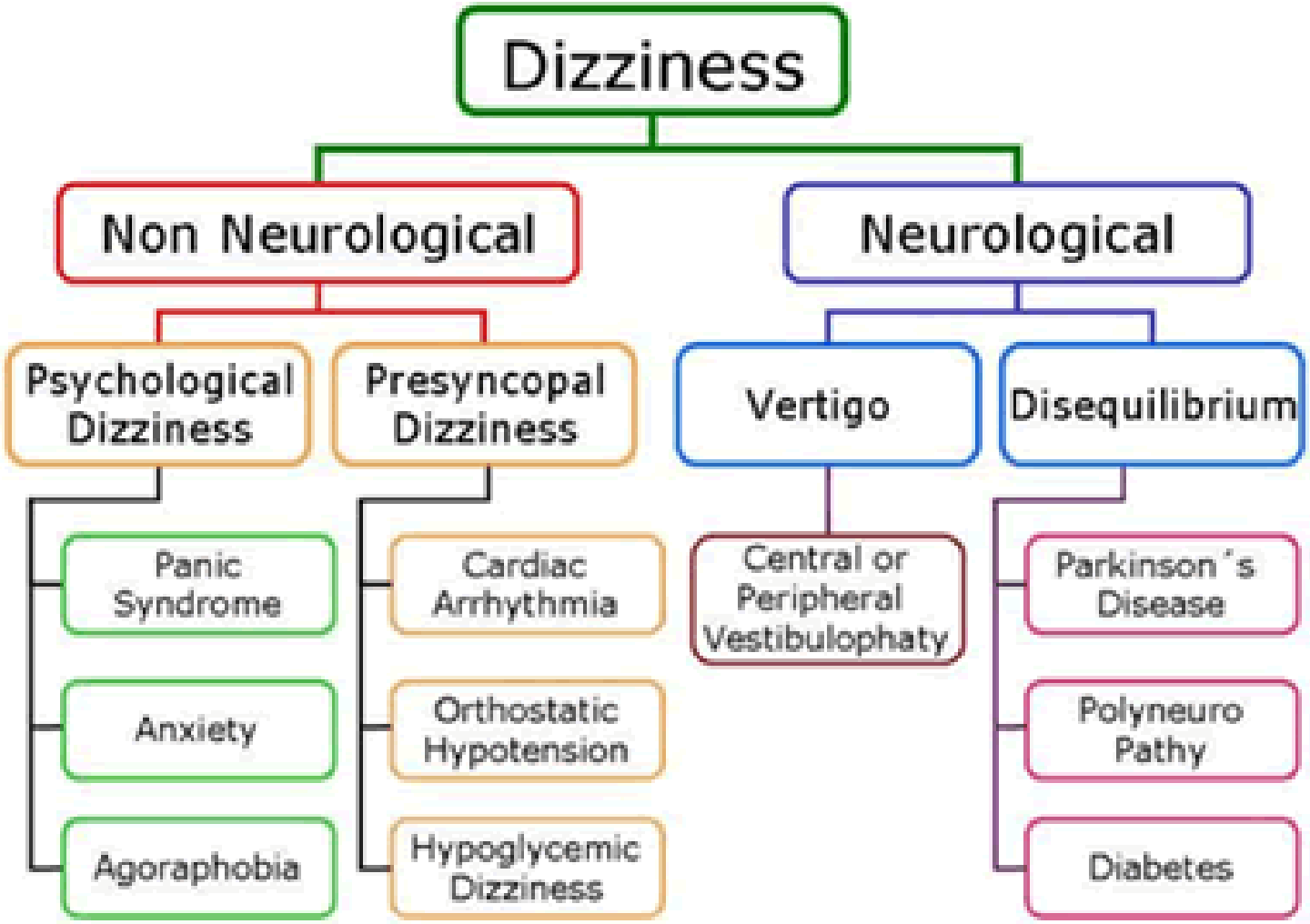
	.25	0.5	1	2	3	4	6	8		.25	0.5	1	2	3	4	6	8	KHz
AIR	35	40	30	20	25	20	35	40		40	40	35	25	25	20	30	25	dB
BONE		10	20	20	15	10					10	20	20	15	10			dB

Hearing loss

- Conductive loss, no! (unless skull fracture or penetrating injury)
- Sensorineural, very controversial
- ‘Concussive’ type losses often improve
- Losses do not get worse
- Hydrops

Tinnitus

- Disorganised sound in the ears or head which is not from an external source.
- Entirely subjective
- No test for it
- Mechanism of onset uncertain
- Usually pre-existing hearing loss
- ‘Trigger’ theory
- Severity- BAOL guidelines

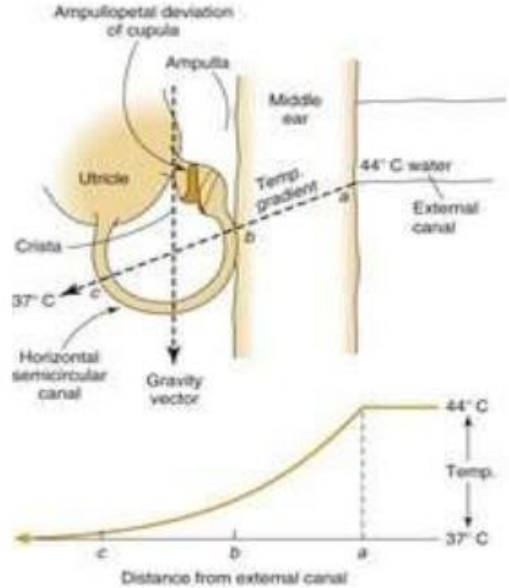


1% of GP consultations (RCGP 1986)

Vertigo

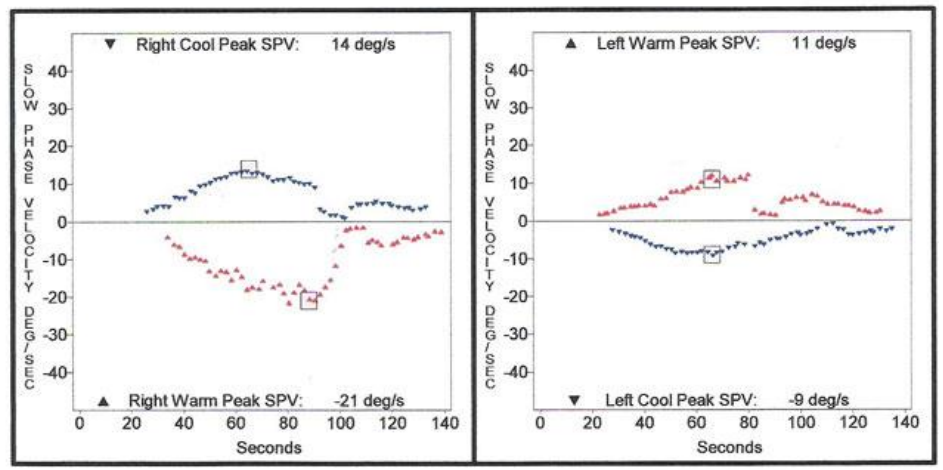
- Audiogram
- Vestibular function tests: ENG/VNG, calorics, vHIT, VEMPS, posturography
- MRI/CT Scan

- Consider video surveillance

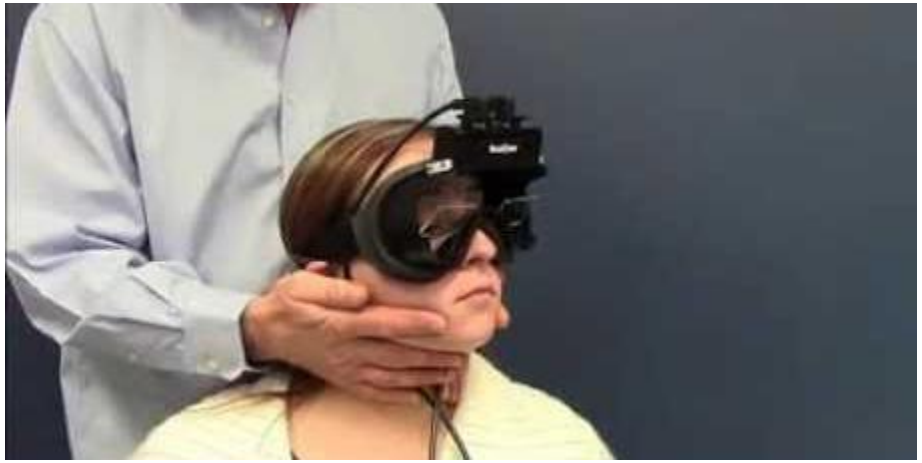


Patient Name: Patient ID: Session Date: 22/07/06

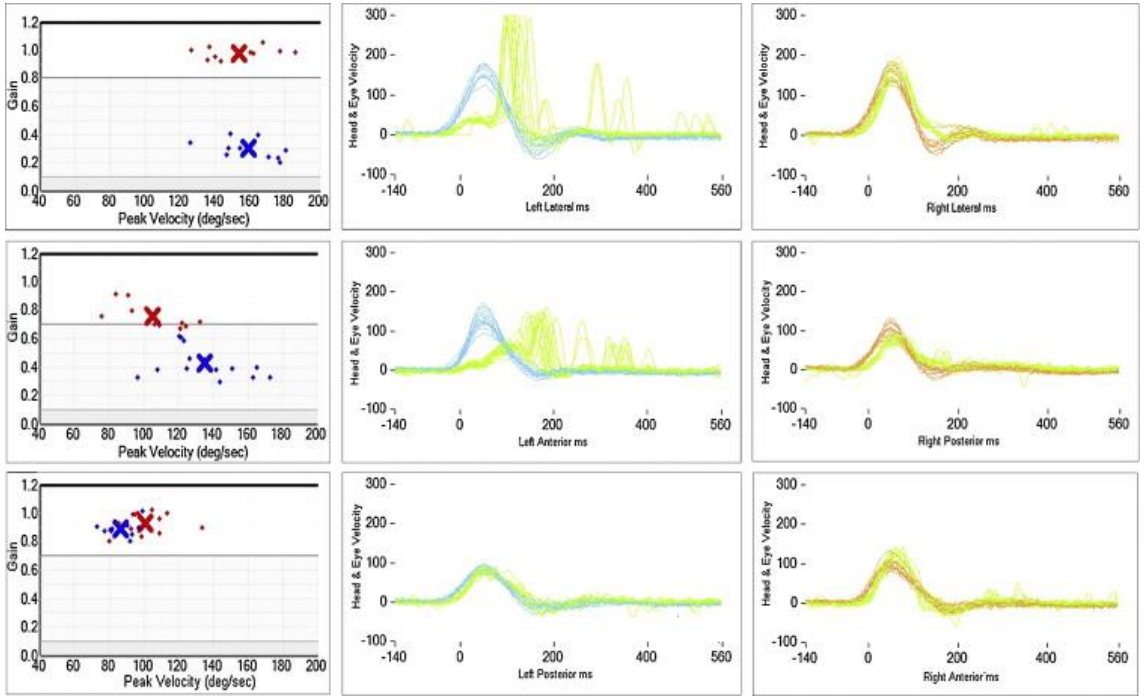
Caloric - Both Eyes



Caloric Weakness: 27% in the left ear
Directional Preponderance: 9% to the right

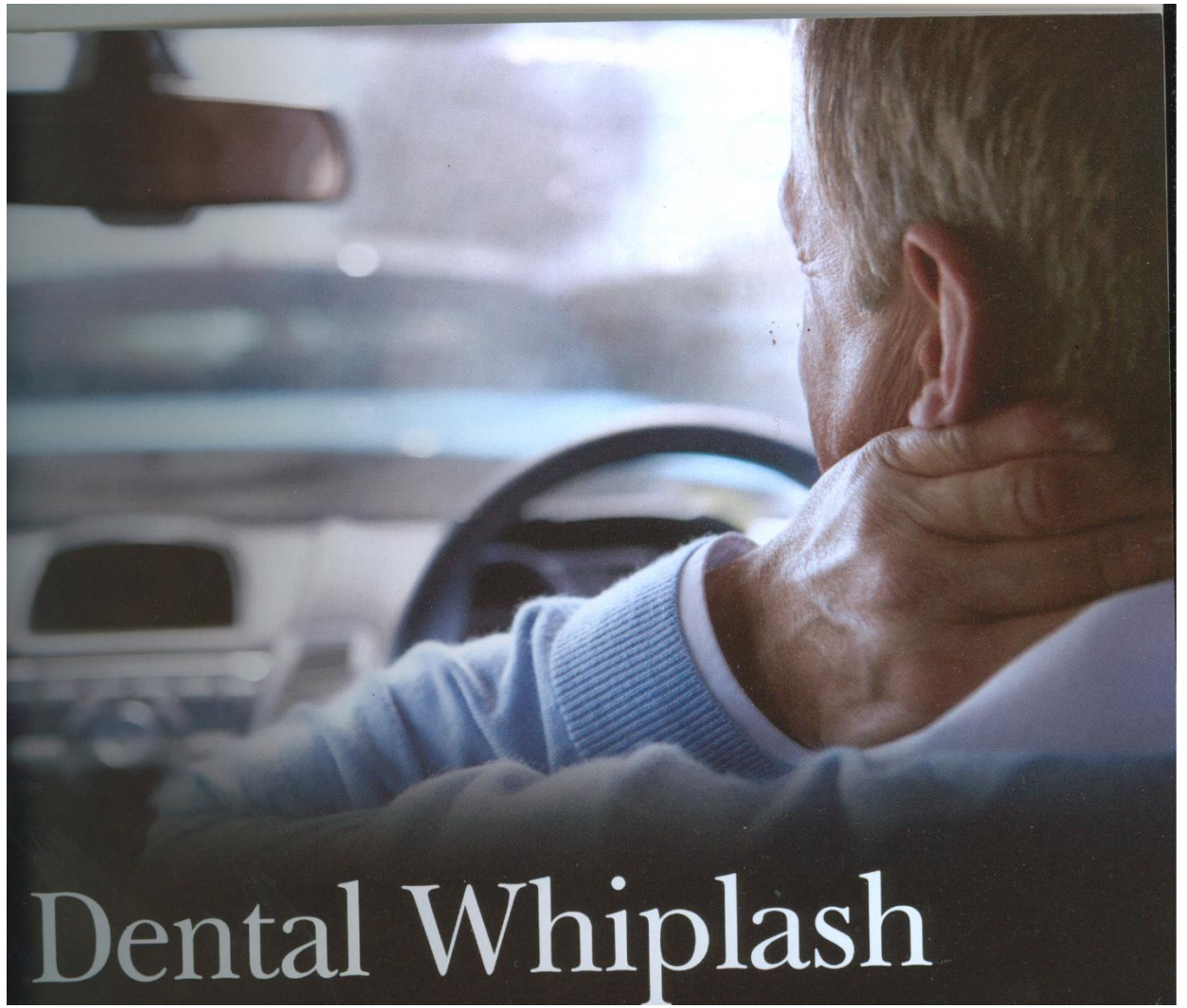


Video head impulse test



Prognosis

- Hearing aids
- Tinnitus therapy & maskers
- Vestibular rehab
- Personal trainer
- Audiovestibular follow up for life
- Home alterations or relocation


Dental Whiplash