FORUM OF INSURANCE LAWYERS

9Informing Progress - Shaping the Future

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Layering Claims, Psychological Injury and Tinnitus

IN BRIEF

A panel of speakers looked at the extent which claims layering has increased; how to deal with claims from a procedural point of view; and what is needed from medical expert witnesses.

This roundtable event was held on 11th May 2023 and was hosted jointly by the FOIL Fraud and Rehabilitation SFTs. A link to the speakers' slides which were used is here.

Miles Hepworth of **DWF (Fraud SFT)** opened the session by pointing out that particularly since the introduction of fixed recoverable costs and the reforms of whiplash claims there had been a significant increase in the deliberate layering of claims to increase both damages and costs. This layering involved not just types of injury, such as psychological injury and tinnitus, but also heads of loss, such as rehabilitation and various therapies.

This event focused particularly on psychological injuries, which could add thousands of pounds to an otherwise seemingly minor claim. Miles was concerned also as to the extent to which the judiciary is aware of these practices and the way in which expert evidence is being deployed by claimants. Judges need to be alert to similar fact evidence appearing in numerous claims brought by the same solicitors.

Matthew Buck of **Keoghs (Rehabilitation SFT)** then looked at the duties that medical experts owe to the court, as set out in the rules and case law and particularly that the expert's duty to the court overrides that to the instructing party. A judge is entitled to refuse to accept the opinion of an expert and to reject their evidence. Examples were given of judges finding that experts had failed properly to justify the opinions they had expressed.

The difficulty claims handlers face is that these issues are now arising in high volume-low value claims, where experience may be lacking and there needs to be appropriate training, to increase awareness of possible layering, along with the development of appropriate strategies.

Sharan Sanghera of **3PB** Barristers looked at effective approaches to combatting claims layering in personal injury (PI) litigation.

These included:

How to manage litigation – once a case has been identified as suspect, the relevant data and evidence must be gathered and deployed effectively. The example was given of a large number of reports from one expert being analysed to show that in a majority of the reports they diagnosed PTSD when it would not normally be present in minor injury claims. Persuading the judge to deal with this evidence is another matter: some judges just want to deal with the case in hand, particularly given that court time and resources are limited. In appropriate cases an application for transfer to the multitrack may be warranted.

How to undermine a claimant's evidence – ensure that the sample size of same fact evidence is sufficiently broad and consider seeking permission for a defendant's report. There is also the option to call the claimant's expert for cross-examination. Same fact evidence can be in the form of a table showing each case relied on and where there are similarities and patterns developing with certain solicitors. However, sight should not be lost of potential data protection issues.

Making early applications to strike-out the evidence of concern (or even the whole claim) – this has the potential to save costs and increase judicial awareness of the issue and of the players involved.

Drafting skeleton arguments – to spell out to a trial judge the nature and significance of the same fact evidence that is before the court. The judge can then understand the issue as part of the pre-hearing reading.

Sharan concluded with her view of where we are at the moment. There is no easy solution at present. Some judges will just not be interested in these arguments but every opportunity needs to be taken to promote awareness of layering and gradually engaging the attention of the judiciary.

Dr Michael Isaac – Consultant Psychiatrist began by emphasising that these types of claims: psychiatric, pain and tinnitus are all 100% subjective. Defendants are therefore faced with the problem of proving a negative. Covert surveillance is of limited value, unless a person is doing things physically that they say they cannot do. Then the inaccuracy of their account of physical injury may undermine their subjective complaints.

In Dr Isaac's experience, there are two types of falsification. The first kind is very common: benign falsification, where someone wants to convey just how much they have suffered and in doing so over-egg it. With malign fabrication, it is blatant but there may be a psychiatric reason (factitious disorder); or it may be a deliberate intention to deceive (malingering). Malingering is very difficult to prove.

By their very nature expert psychiatric reports are lengthy and detailed and should not be reduced to an Excel spreadsheet format.

Dr Isaac then looked at PTSD with mild traumatic brain injury, where the circumstances of the accident are important and where in DSMIV and ICD11 the definitions of PTSD have been tightened and are more index specific. Dr Isaac was concerned about the cycle of treatment that was often triggered by a diagnosis of PTSD, which needs to be monitored and its effectiveness measured, rather than simply allowing it to continue and risking creating patient dependency.

Mr Andrew Parker, consultant ENT surgeon spoke on the topic of otological aspects of cervical whiplash injury.

Mr Parker explained that arising from whiplash injuries, there are four diagnoses, all of which are subjective: tinnitus, vertigo, hyperacusis (intolerance of loud noise, and hearing loss. The three possible components of this are the deceleration causing extension and flexion; an alleged head injury; and airbag detonation. He then listed the features that the expert should note, together with other items of evidence that may be available, of which the pre-existing medical records are essential.

He noted that direct trauma to the ear is unlikely in these cases, with the reporting of symptoms often arising after initiation of the claim.

Causation is the next issue to consider, part of which may involve pure tone audiometry (a subjective test). Hearing loss is highly unlikely to flow from a whiplash injury and any concussive losses often improve and losses do not get worse. It is difficult to understand how tinnitus arises from a whiplash injury but there is often pre-existing loss of hearing.

Dr Isaac also considered dizziness, which has many both neurological and non-neurological causes; and vertigo, and the testing that is available. When looking at prognoses, he also indicated the forms of aids that may assist a patient.

Questions

In response to a question, Dr Isaac confirmed that he will speak to any accompanying family member but does not interview them separately, but he is primarily concerned with what the patient has to say.

Mr Parker confirmed that tinnitus is a very common symptom, particularly in the over 60s, 50% of whom will either have it or will develop it. He is not convinced that a reported 10% incidence of tinnitus in whiplash cases is anything more than that which arises in the ‘normal’ population.

Dr Isaac was against his examinations being recorded. Mr Parker has less of a problem but will make his own audio recording as well.

Sharan Sanghera felt that the success in calling evidence about cases in which an expert had been discredited, again depended on the judge and whether they took the view that only the case they were hearing was relevant. That is why it is important to make an application early on, rather than risk dealing with the issue only before a trial judge.

Dr Isaac was content to carry out remote examinations in less complicated cases or where geography dictated that it was necessary but he was against telephone only assessments. Mr Parker had embraced remote examinations because of the pandemic but commented that the clinician cannot perform a physical examination, where it is important.

Dr Isaac saw little value in the notes from CBT sessions but Miles Hepworth requests them where there is concern that the treatment may never have taken place. Medical records are, however, vital and they have to be both pre and post incident. Mr Parker agreed that this was the same for ENT reports. He added that the notes should be complete and not be edited, or omit notes held elsewhere in a hospital.

Dr Isaac agreed that trying to apply percentages to the part played by an incident in a claimant's condition was risking being shot-down. He felt that is was better to quantify contribution/apportionment by the use of ordinary language (extremely likely, likely, etc).

Could a claimant look up symptoms of PTSD or some other condition online and present convincingly on examination? Dr Isaac felt that the point here was that the psychiatrist would always know more about psychiatry than the patient.

Mr Parker confirmed that in cases of unilateral tinnitus, MRI scans are occasionally used to exclude certain causes of the condition and so they are not required routinely. The cost is around £700 and the result is invariably negative. Blood tests are to rule out venereal disease but Mr Parker had never seen a positive result in a case of hearing loss and/or tinnitus. Mr Parker also provided guideline costs for aids for tinnitus and hearing loss.