Challenges for claimants

Deirdre Goodwin examines the pitfalls in quantifying brain injury claims

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'Careful investigation is required of the claimant's pre-accident employment, not only evidenced by payslips but – in respect of the future – the likely career trajectory.'

This is a time of rapid change: the discount rate, appropriate accommodation claims methodology, as well as significant advances in clinical diagnosis and understanding of brain injury mechanisms.

This article is principally concerned with traumatic brain injury (TBI) or acquired brain injury (ABI) suffered by adult claimants and considers how to approach the many challenges and pitfalls in gathering the necessary evidence to maximise awards and hence the quality of the life of claimants in serious and catastrophic brain injury cases. Of necessity this article is an overview rather than in-depth analysis, the intention being to provide guidance on the progression of claims and to identify areas of particular importance.

Funding

This is an obvious challenge: limited resources; the NHS in crisis, no bottomless insurers' purse and (sometimes) questionable costs budgeting decisions. Lord Sumption has called for 'no fault' compensation and capped awards and fees (PIBA Annual Lecture November 2017), whereas Irwin LJ has emphasised the importance of 'justice' and litigants requiring assurance they are being properly compensated (PIBA Annual Lecture November 2018).

Claimants are bedevilled by constraints on investigation, variously imposed by before-the-event/after-the-event insurers, financial risks of conditional fee agreements, judicial case management limitations on expert disciplines and costs budgets, and the minefield of QOCS. The balancing required is further aggravated by the recent Ministry of Justice consultation (published on 27 March 2019 – see www.legalease.co.uk/fixed-recoverable-costs), following the July 2017 recommendations of Jackson LJ, for the introduction of fixed recoverable costs and a new 'intermediate track' for claims valued up to £100,000. This does not extend to clinical negligence but would impact upon personal injury traumatic head injury claims including those where subtle, but nonetheless serious, injury, requiring skilled litigation management, could be caught within the £100,000 bracket.

The 100% principle

This is a contentious area for defendants but regarded by many as non-negotiable provided due account is taken of reasonableness and proportionality:

> ... the aim of an award of damages for personal injuries is to provide compensation. The principle is that 'full compensation' should be provided... this principle of 'full compensation' applies to pecuniary and non-pecuniary damages alike... the compensation must remain fair, reasonable and just. Fair compensation for the injured person. The level must also not result in an injustice to the Defendant, and it must not be out of accord with what society as a whole would perceive as being reasonable.

(*Heil v Rankin* [2000] per Lord Woolf.)

> The claimant is entitled to damages to meet his reasonable needs arising from his injuries. In considering what is 'reasonable', I have had regard to all the relevant circumstances, including the requirement for proportionality as between the cost to the defendant of any individual item and the extent of the benefit which would be derived by the claimant from that item.

(*Whiten v St George's Healthcare NHS Trust* [2011] per Swift J.)

That these statements of principle are not viewed as absolute, is reflected in the Lord Chancellor's announcement on 19 March 2019 that when setting the revised discount rate under the Civil Liabilities Act 2018, he would uphold the 100% principle 'as best he can'. The new rate must be announced by 5 August 2019 and is in response to the call for evidence which concluded in January 2019 and upon which much has been written. As part of his review, the Lord Chancellor must consult with both the Government Actuary and HM Treasury. His balancing of the interests of injured parties and insurers, as well as NHSResolve, will almost certainly involve some erosion of the 100% principle and the caveat 'as best he can' provides an escape route to balancing the conflicting interests of injured parties and a beleaguered treasury. It is important to bear in mind the cutting of this Gordian knot when quantifying brain injury claims in future.

Whatever the outcome, it is unlikely to reflect the halcyon times of a negative rate or to bring comfort to injured parties. In significant claims, the route is increasingly likely to be periodical payments extending beyond future care and case management and deputyship costs. As to the latter, these are usually indexed to the RPI but there is a valid argument (yet to be adjudicated) that these too should be subject to the ASHE 6115/6116 survey rates applied to care and case management.

Nature of the injury

A skilled multi-disciplinary clinical assessment of the nature and extent of the injury is required before attempting quantification of the claim and it is important to resist siren calls for early settlement.

It is important to determine whether the claimant has suffered a static condition from which no improvement or deterioration is expected or one which is progressive where, for example, there are significant dementia and/or epilepsy risks which impact upon the quality and level of future provision. This enquiry is not limited to the initial/immediate needs assessment reports (by an experienced case manager with associated therapeutic reports) or assessment by medico-legal and quantum experts; it is also essential to take detailed statements from relatives at an early stage when the full extent of the impact of the injury on the claimant and close family is still fresh in their minds.

If the injury is primarily one of motor dysfunction with a relatively well-preserved intellect, this can pose problems through residual lack of insight and impaired higher executive function (particularly in those persons with a previous 'superior' intellect) even if the injured person presents as 'normal' and desires to lead a less prescriptive life than the experts consider to be safe or possible. Behavioural and/or psychiatric problems and issues of deprivation of liberty safeguards (DoLS – see www.legalease.co.uk/DoLS) need to be identified at an early stage with appropriate involvement of the Court of Protection and an experienced court-appointed deputy, with a multi-disciplinary care 'package' to accommodate these problems. Neuropsychology input is often at the heart of this package and the care plan.

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Capacity

This must be addressed early in the process. If in doubt, the default position with a serious head injury is to assume inability to conduct litigation (protected party) and, possibly thereafter, inability to manage financial affairs (protected beneficiary).

Assessment of capacity is often fraught with difficulties which include:

- the wooliness of the definition under the Mental Capacity Act 2005;
- the requirement for capacity assessment by a suitable healthcare professional;
- completion of a COP 3 application for approval of a deputy by the Court of Protection;
- delays by the Court of Protection in making formal appointments; and
- the need for CPR Part 21.10 approval: *Masterman-Lister v Brutton & Co* [2003] and *Bailey v Warren* [2006].

It is therefore important to instruct experienced expert(s) in neuropsychology and/or neuropsychiatry and neurology and to retain an experienced deputy.

Although a member of the family often wishes to assume this role, it is rarely advisable and HHJ Lush's encouragement to retain professional deputies in these cases should be heeded.

It is essential to ensure that the deputy:

- possesses the necessary level of skill and experience regarding brain-damaged litigants and the challenges posed by the injury to the claimant and the family;
- is fully aware of the medical evidence and attends multidisciplinary team meetings; and
- maintains comprehensive and comprehensible accounts.

The deputy and (if required by the court) deputyship expert should:

- include a contingency for crises: this arose in *Robshaw v United Lincolnshire Hospitals NHS Trust* [2015] and *JR v Sheffield Teaching Hospitals NHS Foundation Trust* [2017] and both judgments repay reading for how such claims should be conducted; and
- fully reflect in the report/witness statement the substantial costs involved including DoLS contingency.

'Protection' of the vulnerable is the key to this exercise. In *EXB v FDZ* [2018], Foskett J held that a claimant's rights may be bypassed by *not* informing them of the level of the award which is approved under CPR Part 21 as it was not

considered to be in their 'best interests' (thereby demonstrating the sometime conflicting duality of the Queen's Bench and Court of Protection jurisdictions). Foskett J noted that this issue is often dealt with informally, which begs the question whether it should be.

Life expectancy

This is another difficult area, requiring careful balancing of statistical analysis and clinical judgement. Recent practice has been for neurologists to draw on statistical cohort interpretation by Strauss and others and then to apply their clinical assessment of the cohort into which the claimant falls. Recently however defendants have been questioning this approach, preferring a more nuanced interpretation, customised to the circumstances of the injured party. In *Mays v Drive Force (UK) Ltd* [2019] Deputy Master Hill QC reiterated that it is ultimately for the trial judge to determine whether the statistical evidence was of assistance, citing *The Royal Victoria Infirmary & Associated Hospitals NHS Trust v B (A Child)* [2002] and *Lewis v Royal Shrewsbury Hospital NHS Trust* [2007]. He nonetheless held that parties in a relatively high value personal injury claim (between £1m to £2m) should be permitted to adduce expert evidence on the impact on life expectancy of non-accident factors specific to the claimant in *Mays* (smoking, hypertension, obesity and ulcerative colitis) – preferring an interdisciplinary approach. He considered that such evidence might assist the trial judge in *Mays*, given the number of potential co-morbid factors in issue, the fact the consultant neurologists had not been able to address them all, and the fact that the evidence might make a significant difference to quantum. The Master considered admitting such evidence was proportionate although he added that this would not lead to similar experts being instructed in all cases. This is probably wishful thinking: the door has been opened and defendants are already serving life expectancy evidence without prejudice in advance of any order for disclosure of reports. Where this happens late in the litigation process, objection may properly be taken to the lack of the spirit of openness required by the CPR Part 1 overriding objective: this was successful in *OBI v Patel* [2018] before HHJ Cotter.

It is also worth bearing in mind that life expectancy experts now anticipate the riposte of double discounting, arguing that the methodology adopted has factored in double counting by using tailored actuarial databases taking account of common conditions such as hypertension and obesity. This is not something which can be countered *in vacuo*: the claimant must obtain their own life expectancy evidence.

When considering statistical data, ensure that this refers to UK cohorts and that the ONS tables relied upon adopt current (2016-based) mortality projections which incorporate local geographical variants (Gloucester city centre for example carries an overall lower life expectancy than the surrounding villages).

Life expectancy assessment will assume greater relevance with a positive discount rate (anticipated to be between 0% and 0.5%) as the disparity widens between multipliers obtained using actuarial tables and those obtained from adopting an arithmetical table. Encourage the claimant's expert (if possible) to express the precise projected life expectancy in years (which allows the more favourable Table 28 to be used). If however life expectancy is expressed as a percentage of or reduction in the number of years from the statistically evidenced unimpaired life expectancy obtained from ONS tables, actuarial tables will be adopted: see *Smith v LC Window Fashions Ltd* [2009] (6½ years anticipated reduction, Table 1 Ogden adopted). Contrast this approach to that taken in *Whiten* where a precise projection of 35 years' life expectancy allowed the more favourable Table 28 to be applied.

Causation

It is essential to establish material cause, including consideration of the 'extended' material contribution test in *Williams v The Bermuda Hospitals Board* [2016] and *Sido John v Central Manchester Children's University Hospitals NHS Foundation Trust* [2016]. Dependent upon the primary cause of traumatic or acquired brain injury, account may have to be taken of underlying pathologies whereby the claimant would already require a high level of care, therapies, aids and equipment and adapted accommodation, as well as having no or a reduced working capacity.

Examples include multiple sclerosis; AVM (arterio-venous malformation); Down's Syndrome; Parkinsonism; dementia and learning disabilities.

The 'scope' of the duty of care owed also requires close consideration following the Court of Appeal decision in *Khan v MNX* [2018].

The role of experts

The parameters of areas of expertise and overlapping of constructive comment should be carefully controlled with a conference at an early stage before the schedule of loss and supporting reports are served.

In *HJ v Burton Hospitals NHS Foundation Trust* [2018] Turner J observed that:

> It would be artificial in the extreme automatically to treat the evidence of each and every... expert as occupying non-overlapping magisteria. There will, of course, be areas in which an expert in one discipline will obviously speak with far greater, or even exclusive, authority when compared to an expert in another discipline. There will also be others in which experts of different disciplines may, although from different perspectives, be capable of speaking with some significant, or even equal, authority. The extent of the overlap will vary on the facts of any given case.

In this Erb's Palsy claim the judge preferred the occupational therapist (OT's) assessment of care needs to that of the jointly instructed orthopaedic expert, observing that the OT's 'hands-on' experience was a 'tipping factor'.

Medical expert reports

Reports on causation (where appropriate) and quantum include:

- neurology;
- neuroradiology;
- neuropsychology – including a full pre-morbid and clinical assessment as well as psychometrics;
- neuropsychiatry;
- if causation is in issue, an expert in the underlying discipline, for example, a vascular surgeon where there has been a failure timeously to diagnose and treat a stroke; and

- on quantum, experts in other relevant disciplines; for example, orthopaedics, ophthalmology, audiology, urology or endocrinology.

Where possible, avoid being cajoled in case management conferences (CMCs) to 'one size fits all' with specialist assessment only being provided by one expert, such as the neurologist. Current judicial sentiment reflects an acute awareness that every expert adds at least £20,000 to the costs and a need to drive down costs in the interests of proportionality. This argument is somewhat hollow in multimillion-pound claims but is likely to gain traction and be deployed more frequently once the discount rate alters. Try to avoid this by ensuring that before the first CMC, cogent, well-reasoned evidence is available from the experts concerned which is persuasive of the need for separate experts.

All experts should consider and advise on annual medical reviews – particularly necessary given rationed NHS time and resources.

Non-medical expert reports

These include:

Neuropsychology

This is very often the core discipline that pulls the other therapies together, especially where there are serious behavioural issues. Psychotherapy recommendations are usually an essential part of the care package and should not readily be compromised.

Care and case management

Care is the most significant, and often most contentious, head of loss and in larger claims this is almost invariably the subject of a periodical payments order. The choice of experienced experts on care and case management issues is key and they should operate on a 62-week year to allow for holidays/sickness and other contingencies as well as costing for a lead carer to oversee day-to-day management and training. Expect at least three carers where 24-hour care is envisaged including waking care.

Occupational therapy and rehabilitation costs

Assessment requires an experienced expert who also properly understands transport claims. Increasingly only one expert is being permitted for occupational therapy and care and case management. Many highly skilled occupational therapists however have neither the training nor experience to assess care so a check is required prior to instruction.

Assistive technology

This is highly relevant in this AI age and can transform the lives of many brain injury sufferers, providing a level of independence which was unimaginable ten years ago. This includes electric wheelchairs which can be operated by different sounds from non-vocal claimants, and robotic 'slaves' like Alexa which respond to commands. It is however important to plead such devices as an adjunct to and not a substitute for an environmental control system. As with other aids and equipment, there can be a tendency to underestimate the costs of replacement with inadequate account being taken of wear and tear by claimants when calculating the replacement periods and annual maintenance costs.

Speech and language therapy

This has seen similar technological advances, such as TOBII eye-tracker technology. It is important therefore to ensure the expert does not roll out 'cut and paste' recommendations but is au courant with the latest developments and brings along examples of equipment when assessing the claimant. Where possible, this equipment should be brought to court to demonstrate to the judge if the defendant remains obdurate in trying to side-track this head of claim.

Physiotherapy

Physiotherapy needs to avoid a 'blind' mindset to a claimant's wishes and knowledge on what they need. A fresh approach is to be looked for without reliance upon a Microsoft Word template but being open to 'thinking outside the box' on equipment and allied therapies such as aquatic therapy/hot tubs/home gym. It is important (as in all disciplines) to be satisfied that the selected expert is not 'expert' in being an expert but in active and current practice, accepting instructions from claimants and defendants alike. They should also have specific neurophysiotherapy qualifications and experience.

Hydrotherapy

This remains a highly contentious area: strong evidence is required that:

- the injured person truly benefits from this therapy (effective prior provision in a rehabilitation unit is helpful); and
- a local pool is not easily accessible (or the water temperature is inappropriate), or that the claimant's behavioural problems do not render this a realistic alternative.

'Soft' therapies

These should only be recommended by experts with appropriate skills. Examples include: music therapy requiring HPCP registration, a postgraduate qualification *and* musical proficiency; and art therapy requiring a diploma in integrative arts psychotherapy. The court will need persuasion that 'soft' therapies are proportionate and represent 'reasonable need' as opposed to a discretionary luxury; again, robust evidence is required from the expert of the efficacy of the proposed therapy, supported by a clinician (neuropsychologist/neurologist).

Loss of earnings

The debate continues on whether the speculative nature of some claims is better met by a *Blamire/Smith v Manchester* lump sum award for loss of earnings capacity and disability on the open labour market or whether a conventional multiplicand/multiplier approach is justified. Careful investigation is required of the claimant's pre-accident employment, not only evidenced by payslips but – in respect of the future – the likely career trajectory. In teaching and the health service, for example, there are online platforms (NASUWT and NHS pay scales) providing guidance to likely career progression which, if carefully pleaded, provide cogent and persuasive evidence. It is also important not to neglect lost years claims (including pension) where there is a reduced life expectancy, even where the claimant is a child. The opportunity to resolve this issue was ducked by the defendant in *JR v Sheffield* where, on a compromised appeal on the appropriate methodology for the calculation of accommodation needs, the defendant declined to

pursue an appeal on the cross-appeal in relation to lost years.

Practice points to bear in mind are:

- It is vital to portray the claimant's characteristics, hopes and aspirations.
- The importance of evidence from the family of the type of person the claimant was before and after the brain injury.
- The importance of family comparables in terms of educational achievements and career trajectory.
- This 'real' evidence is always preferred by the court to that of vocational experts (to which the courts are resistant) and where there is a real risk of reliance upon a Word template and regurgitation of statistical charts. There is sometimes justified objection to whether such experts represent value for money but they are helpful where there is a clear pattern of career progression and achievement prior to injury and it is especially useful if they possess a dual qualification of psychology/neuropsychology.
- It may be necessary to compromise the reduction factor applied to the disabled employment multiplier where the disability is modest: *Billett v Ministry of Defence* [2015].

Accommodation

The appropriate methodology for assessing a reasonable sum to reflect the capital loss (as opposed to adaptation/extension, equipment and additional annual costs) has been in the judicial melting pot for some time. To recap, the traditional approach is to apply the rate of return (historically 2.5%) to the capital cost to obtain the multiplicand and then apply the life multiplier. The *Roberts v Johnstone* methodology was soon recognised to be artificial and unworkable – not only by reason of the negative discount rate but because of the disproportional rise in property prices in relation to the RPI and CPI indices. Equally rental rarely proved to be satisfactory: available property is scarce, landlords are reluctant, and the extent of any permitted adaptations is usually extremely limited. See my article 'Room for rent' in *PILJ*143 (March 2016) p12 on the obstacles presented by the *Roberts v Johnstone* test in the valuation of accommodation claims for catastrophic injuries.

In *JR v Sheffield* William Davis J followed the *Roberts v Johnstone* [1989] and *George v Pinnock* [1973] methodology (which, with a negative discount rate, would result in the defendant being in credit) and made no award, proposing that the capital element of the accommodation claim was not recoverable, and that any net loss should be met from other non-hypothecated heads of loss such as past and future loss of earnings and/or general damages. The appeal was compromised: the Court of Appeal, accepting a well-reasoned skeleton argument and written advice from claimant's counsel, approved an award of £800,000, as representing the net capital loss between £100,000 that the claimant would otherwise have spent on property purchase, and £900,000 which was the actual cost of a suitable property to accommodate his disability. This approach was subsequently adopted by claimants and defendants alike with the latter taking the stance that they would treat each claim on a case-by-case basis but in practice accepting the *JR v Sheffield* methodology.

In 2018 Lambert J resurrected the debate in *Swift v Carpenter*, clinging tenaciously (and probably correctly) to the *Roberts v Johnstone* methodology: while recognising this was an 'imperfect formula', she rejected other methodologies and awarded nothing for capital loss, observing that to do otherwise would result in a significant 'windfall' to the claimant. The appeal in *Swift* has been listed to be heard in July 2019, in good time for large accommodation claims to be brought into the Lord Chancellor's ambit of consideration of all the issues when setting the new discount rate, although it would have been preferable for the Court of Appeal to have ruled after this: the prospect of this appeal being deferred until after the Lord Chancellor's announcement cannot be dismissed.

It is not feasible in an article of this generality to examine the minutiae of the competing arguments but it is increasingly clear that a good accommodation expert is essential who is neither too creative (resulting in a 'disability Downton' disproportionate to the likely 'reasonable needs' of the claimant) or aesthetically closed to sound argument of other less costly reasonable alternatives by the defendant's expert. Save for the methodology argument, in most cases a reasonable agreement on the figures should be achievable.

Interim payments

Applications are in limbo: the applicable *Eeles* principles (from *Cobham Hire Services Ltd v Eeles* [2009]) await the discount rate change and determinative appellate ruling on accommodation claims methodology. It is nonetheless important that parties do not 'make do'. Even where liability has been compromised, an interim payment should be sought at an early stage (and certainly upon completion of rehabilitation), with a case manager and deputy engaged to organise the full multi-disciplined community-based care package in appropriately adapted accommodation. This has the added benefit of being in situ when the need for this level of provision is assessed at trial. This is however a difficult evidential hill to climb: in *Farrington v Menzies-Haines* [2019] Martin Spencer J refused an interim payment application, holding that the gap between the claim and what the defendant was conceding was too great, such that there was a risk of overpayment; contrast *Flanagan v Battie* [2017], a 75:25 liability compromise claim where Master Davison recognised there was a real, reasonable and immediate need for accommodation which 'altered the footing' of the *Eeles* calculation, and that even though *Roberts v Johnstone* would produce a nil award 'it could confidently be expected that by the time of the trial the courts, or legislation, or both would have addressed this problem' (para 22).

Witness statements

These require careful planning: a thoughtfully expressed witness statement will often sway the court even where expert evidence is to the contrary. Important points are:

- where possible obtain a witness statement from the claimant on how life-changing the injury has been;
- avoid repetition – robust editing may be required;

- diaries (including video) of a 'day in the life of' are difficult to challenge; and

- videos – demonstrating walking ability; efficacy of therapies; aquatic therapy sessions.

These all help the court to get a 'feel' of the claimant's disability more than the two-dimensional dryness of written reports.

Schedules

Schedules are a core document; as the formal pleading of the quantum case, they can alter the entire course. They should be detailed and not left to the last minute when the service deadline is looming. Preparation includes a conference with the experts with final supporting reports upon which the schedule will be based.

Succinct presentation is the key:

- clarity in the narrative;

- adoption of the guidance in the relevant Fact and Figures stating the discount rate adopted;

- if a spreadsheet is used, multiplier calculations to be set out in a separate worksheet showing the calculations and interpolation formulae, and linked to the past and future losses spreadsheets and associated appendices where individual claims may be pleaded in more detail; and

- careful checking of the maths.

Yip J recognised the importance of schedules in *Wright v Satellite Information Services Ltd* [2018], observing (emphasis added):

> It seems to me that the importance of a schedule of loss is frequently overlooked. This is, or should be, the document that draws together the presentation of the claim. It ought to be presented in an accessible and easy to follow format. *The fact that the schedule of loss is required to be supported by a statement of truth highlights the need for it to be readily understandable by the claimant.* It also sets out the claim for the defendant and for the trial judge who will come to the case fresh... This means that it should not simply be a series of calculations. It needs to be supported by sufficient narrative to explain the case being presented by the claimant...
>
> It is very important that lawyers draft the schedule in such a way that the facts to which the client is attesting are clear. Failing to do so is failing in their duty both to the client and to the court.

Following service of the counterschedule and supporting evidence, a collaborative approach is required to agree and/or reach a reasonable compromise on heads of loss where there is uncertainty as to which approach will be preferred.

In *Whiten* Swift J commented:

> Many of the heads of damage are in issue and have required detailed consideration in this judgment, hence its length. Whilst some of the disputed matters involve questions of principle and/or large amounts of money, many of them are relatively minor. I cannot help feeling that, had the parties exercised a greater degree of co-operation and good sense, the number of issues to be determined could have been considerably reduced and the amount of time spent on the case in and out of court could have been shortened...

However elegantly expressed, inviting such judicial displeasure is to be avoided. Before trial, therefore, it is essential to:

- try to narrow the issues;

- provide a well-crafted summary; and

- recognise that failure to do so is likely to attract adverse comment (and associated costs sanctions).

There are undoubtedly stormy waters ahead in litigating these complex claims. Early planning and careful timetabling will assist in anticipating potential pitfalls and allow early identification of challenging issues as to achieve a proper level of compensation. ■

Bailey v Warren
[2006] EWCA Civ 51
Billett v Ministry of Defence
[2015] EWCA Civ 773
Blamire v South Cumbria Health Authority
(1993) PIQRQ1
Cobham Hire Services Ltd v Eeles
[2009] EWCA Civ 204
EXB v FDZ & ors
[2018] EWHC 3456 (QB)
Farrington v Menzies-Haines
[2019] 3 WLUK 157
Flanagan v Battie
[2017] EWHC 3044 (QB)
George v Pinnock
[1973] 1 WLR 118
HJ v Burton Hospitals NHS Foundation Trust
[2018] EWHC 1227 (QB)
Heil v Rankin & anor
[2000] EWCA Civ 84
JR v Sheffield Teaching Hospitals NHS Foundation Trust
[2017] EWHC 1245 (QB)
Khan v MNX
[2018] EWCA Civ 2609
Lewis v Royal Shrewsbury Hospital NHS Trust
[2007] 1 WLUK 628
Masterman-Lister v Brutton & Co
[2003] WTLR 259
Mays v Drive Force (UK) Ltd
[2019] EWHC 5 (QB)
OBI v Patel & anor
(2018) HHJ Cotter LTL 8/10/2018 extempore Document No. AC5004403
Roberts v Johnstone
[1989] QB 878
Robshaw v United Lincolnshire Hospitals NHS Trust
[2015] EWHC 923 (QB)
Sido John v Central Manchester Children's University Hospitals NHS Foundation Trust
[2016] EWHC 407 (QB)
Smith v LC Window Fashions Ltd
[2009] EWHC 1532 (QB)
Smith v Manchester City Council
[1974] EWCA Civ 6
Swift v Carpenter
[2018] EWHC 2060 (QB)
The Royal Victoria Infirmary & Associated Hospitals NHS Trust v B (A Child)
[2002] EWCA Civ 348
Whiten v St George's Healthcare NHS Trust
[2011] EWHC 2066 (QB)
Williams v The Bermuda Hospitals Board
[2016] UKPC 4
Wright v Satellite Information Services Ltd
[2018] EWHC 812 (QB)