Aiding recovery

Robert Weir QC talks tactics in securing compensation in catastrophic injury cases

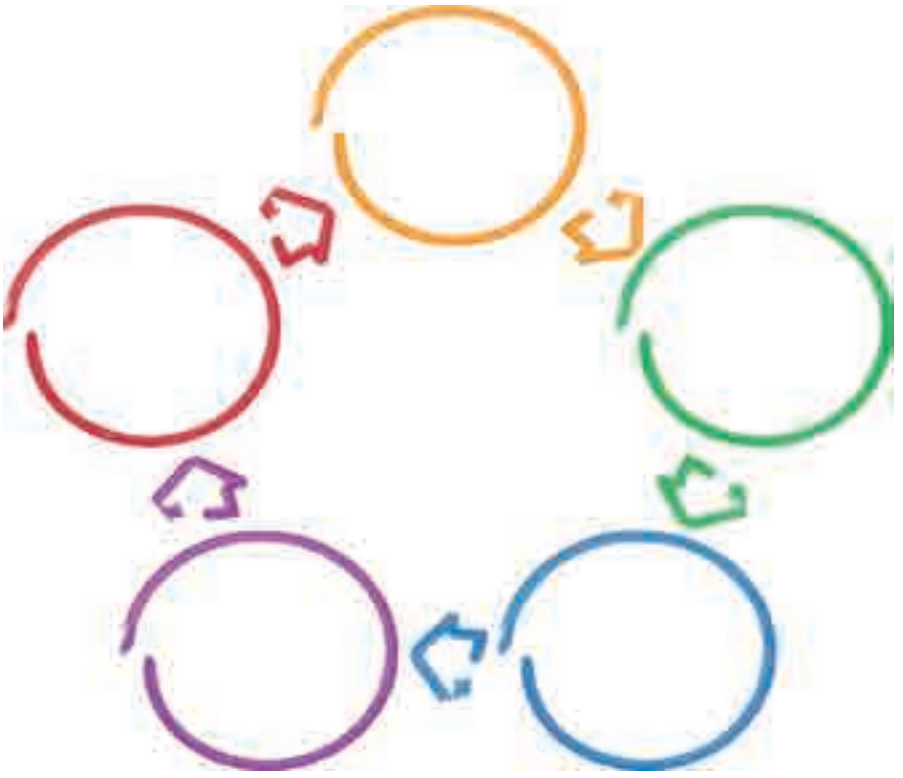
When I first met Miss W in 2006, she was lying flat on her back in a small, overly heated room at Stoke Mandeville Hospital, attached to a ventilator. Miss W had suffered possibly the worst kind of injury: she was tetraplegic and had a brain stem injury which meant that she could not speak, eat or drink. At the same time her mental faculties were wholly unimpaired. She was 21 years old, locked-in and able to communicate only by blinking and wrinkling one side of her nose.

Miss W had suffered this awful injury one night in 2005 when she had tried to cross a dual carriageway after an evening out with friends in a pub. She was hit by a car driven by an uninsured driver who chose not to stop at the scene but instead to drive on into some woods and burn the car.

Breaking the deadlock

The claim was brought against the Motor Insurers' Bureau as the driver was uninsured. The MIB contested liability in full. The extreme high value of the case and the strongly held conflicting views of both sides made this an obvious case for a mediation rather than a joint settlement meeting involving only clients and their legal teams. The mediation was a success in that liability was resolved on the basis of 70 per cent recovery.

What the claimant wanted quite naturally was to be discharged from hospital and to be provided with a suitable and sufficient care regime in her own home, giving her peace of mind that her needs would be provided for in the long term. Achieving these apparently straightforward aims is what took until 2012. Here is why.



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Partial recovery and state funding. The liability settlement meant that there would be a 30 per cent shortfall in meeting the costs of any privately paid care package. So Miss W was prepared, certainly at the outset, to see if the NHS, through its provision of continuing healthcare, would provide her with a free home package of care that would meet her considerable care needs.

If the NHS was prepared to organise her discharge and to set up a workable care regime, then Miss W could protect herself from any future changes in the state provision of home care by means of an indemnity from the MIB. This approach appealed to the MIB for the obvious reason that it would not have to meet the very considerable expenses unless state funding rules changed.

Achieving discharge from hospital. Given the severity of Miss W's injuries, it was inevitable that it would take at least a couple of years to achieve discharge from hospital. In fact, it took fully five years. In part this was down to the difficulties of managing Miss W's condition. However, what appeared to lie behind the delay was the NHS's reluctance to pay for and manage a complex home package of care. Unfortunately, the longer the NHS delayed, the more frustrated Miss W became. Here was a young woman

who was having to come to terms with her devastating injury and at the same time cope with an ongoing impasse with the NHS leaving her trapped in hospital when medically she did not need to be. The relationship between Miss W and her family on the one hand and the staff in hospital on the other inevitably soured.

When Miss W was discharged to rented accommodation in 2010, she developed a chest infection within days. She was whisked back to hospital and deemed unsafe to be discharged. There she languished while limited efforts were made by the NHS to employ sufficient carers and nurses to allow her to be discharged back home.

The decision to convert to a private care regime. By early 2011 it became clear that, so long as Miss W relied on state funding, she was most unlikely ever to be permitted to leave the confines of hospital. Furthermore, Miss W was in something of a vicious circle. The longer she stayed in hospital, the more upset she became with her predicament and the more conflict arose with the care staff, thus permitting the NHS to blame Miss W for the failure to achieve discharge from hospital. Once Miss W decided to go down the private route, her resolve to not rely on the state hardened.

Achieving discharge from hospital: interim payment. In 2011 Miss W made a crucial interim payment application seeking enough funds to allow her to pay for her own private care regime. This application was heavily contested. It was essential to Miss W's case to be able to show that she was medically sufficiently well, albeit disabled, to live at home with a suitable care regime.

In the event the application succeeded and Miss W was discharged in early autumn 2011 back to the same rented home she had briefly lived in the previous year. An agency care regime costing £650,000 per year, involving a 24-hour waking ICU nurse and a 24-hour waking carer, was put in place. Miss W has thrived at home, the conflict with the NHS being a thing of the past.

Life expectation and PPOs. As trial in May 2012 loomed, numerous medical experts, eight in all, expressed opinions as to Miss W's life expectation. They ranged from a matter of a few years to more than 30 years. It was a case crying out for compensating more than just future care and case management on the basis of a periodical payments order (PPO). The MIB has shown itself to be a keen advocate of PPOs in many cases and this was no exception. It actually proposed that every future head of loss be assessed on a PPO basis. The difficulty for Miss W, however, was that she understandably wanted the security of knowing she had her own property, which would need to be adapted for her. All this was expensive and required a lump sum payment.

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Settling the claim. The parties benefitted from having another mediation to achieve settlement with the mediator this time being a very senior personal injury silk. The parties came to terms on the figures. Miss W stood to recover, taking into account the liability division, a lump sum of £2,273,000 together with two PPOs: the first, index-linked to ASHE 6115, was for future care and case management in the sum of £330,000 per annum for life (representing a package of care on full liability costing £471,000); the second, index-linked to RPI, was for a proportion of the other future losses, not already compensated through the lump sum payment, in the sum of £55,000 per annum for life.

The sticking point between the parties was over the need for the claimant to provide what is known as a reverse indemnity, that is an indemnity to the MIB agreeing to pay back to it sums recovered from the state for future care. Our position was that there was no requirement to provide such an indemnity, not least in a case where Miss W had set her face against state funding and where she had not recovered 100 per cent of her damages. In the event, compromise was reached on the above terms without there being any reverse indemnity or undertaking or the like.

Care regime

If a claimant wants to recover the costs of a substantial home care regime, then she needs to be in a position to prove that she can be cared for at home. Given Miss W, who requires ventilation for 12 hours a day, can be looked after at home, albeit at great expense, then it should be possible for almost all catastrophically injured claimants who want to come home to do so.

This is a paradigm case for the application of the PPO regime, which has quite simply transformed litigation in top-end personal injury cases. Claimants are well advised to avoid signing any reverse indemnities or undertakings unless there are cogent reasons why they should. The peace of mind for a claimant that a PPO and the absence of any claw-back provision from the defendant gives should not be underestimated. ■

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