

MB NEWS

PERSONAL INJURY & CLINICAL NEGLIGENCE NEWSLETTER

Welcome to the Winter edition of our Newsletter. This quarter we have some interesting contributions relating to product liability and post-traumatic stress disorder.

There has long been a debate about whether referral fees should be banned but the SRA has apparently opted for trying to take steps to improve poor compliance, with the possibility of re-introducing a ban left open if their efforts are unsuccessful.

Personal injury litigation appears to be forever in the news and we think that 2008 will be no exception. Certainly at the time of going to print, we think that 3 aspects of our work will be subject to much scrutiny over the following year:

Firstly, as reported in our last edition, the Ministry of Justice has signalled its intention to reform low value personal injury claims by raising the fast track limit to £25,000 and introducing further fixed fees. Following extensive consultation over the last few months, which led to about 300 responses, there is a feeling that these will be watered down or possibly even dropped altogether. Certainly, there is pressure to reform the system in some way so it is inevitable that there will be some changes in that regard.

Secondly, the question of referral fees is to be examined again by The Solicitors' Regulation

Authority (SRA). There has long been a debate about whether referral fees should be banned but the SRA has apparently opted for trying to take steps to improve poor compliance, with the possibility of re-introducing a ban left open if their efforts are unsuccessful. Suggestions for improved compliance include expanded guidance for solicitors, a requirement for users to use a specific form of referral arrangement, greater publicity and requiring firms to make an annual return of their referrals.

Finally, a word about Coroner's Reform. The draft Coroners Reform Bill was passed as long ago as 2006 with the intention to address issues such as funding for bereaved families and an extension in the remit and powers of the Coroner. Rather disappointingly, plans to include the Bill in the current parliamentary session have been shelved, possibly because of the

high costs that would be involved in undertaking such reforms. Nevertheless, it is likely that this year will see further developments in this area. The ongoing high profile inquest into the death of Diana, Princess of Wales and Dodi Al Fayed has already thrown up a number of interesting issues such as when a jury can be called and is likely to raise more issues yet.

As always, we will keep you abreast of the latest news.

Sarah Stanton
Editor & Senior Solicitor

Psychologist's contribution to **Personal Injury Cases** and **Post-Traumatic** **Stress Disorder (PTSD)**

By Dr Jill Neilson, Consultant Psychologist

A good Psychological report should describe a Psychological formulation of the current difficulties and prognosis, identifying any need for Psychological treatment and the most effective type of Psychological treatment.

In this article I will focus on the Psychological formulation and opinion in personal injury cases. I was once told by a Medical Colleague that all Psychologists who write Medico-Legal reports in personal injury cases, especially RTAs, always state that the person has Post-Traumatic Stress Disorder (PTSD) and recommend treatment. I hope that this was his own personal myth and not a more commonly held opinion. If it is, I hope you will read on...

When a Psychologist takes an instruction in a personal injury case they will assess the individual's level of pre-morbid and current functioning and from this formulate ideas about prognosis and make recommendations. Thus, the same conclusion can't be reached for all people, and not all people who experience a personal injury develop PTSD. There are specific criteria used to determine if someone has PTSD. One of the most commonly used diagnostic manuals is Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). The DSM-IV criteria for PTSD specifies symptoms that need to be present for a person to be diagnosed as experiencing PTSD.

DSM-IV Criteria for Post Traumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following have been present:

- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
- (2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behaviour.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
- (2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
- (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions,

hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: In young children, trauma-specific re-enactment may occur.

- (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
- (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
- (3) inability to recall an important aspect of the trauma
- (4) markedly diminished interest or participation in significant activities
- (5) feeling of detachment or estrangement from others
- (6) restricted range of affect (e.g., unable to have loving feelings)
- (7) sense of a foreshortened future (e.g., does not expect

to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more.

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor.

Not all responses to an incident would meet the full criteria for PTSD, as described by DSM-IV. Although the individual may report current symptoms of an intrusive nature and use avoidance as a coping strategy, it may be that symptoms are not sufficient in number to meet the DSM-IV criteria for a diagnosis of PTSD. They may also have previously experienced higher levels of symptoms and the intensity and frequency of these symptoms has decreased. Despite the reduction in the symptoms, they may still experience symptoms of intrusion e.g. nightmares and use a coping mechanism that involves avoidance of situations or events, as a way to manage the impact of the incident on day to day life and functioning. If symptoms have been present for longer than three months, this suggests a more chronic condition. Additionally, whilst an individual may not currently or previously fulfill the criteria for PTSD, they have other symptoms e.g. depression, anxiety and phobias.

In addition to DSM-IV checklist, measures such as the Impact of Events Scale Revised (IES-R) can be helpful. The IES-R is a self-rating scale, measuring the degree of psychological impact caused by a traumatic event. IES-R reflects the individual's experience of a traumatic incident, the degree of intrusiveness and impact that re-experiences have for them, as well as possible attempts by individuals to use avoidance and numbing mechanisms in dealing with the consequences of the event. The hyperarousal scale

Personal Injury Cases and Post-Traumatic Stress Disorder (PTSD)

signifies symptoms such as anger and irritability, heightened startle response and difficulty concentrating. There are three subscales: avoidance, intrusions and hyperarousal. The IES-R score is the sum of these three scales. The IES-R is not a formal measure of PTSD, but does however indicate whether the client experiences mostly intrusive, avoidance or hyperarousal symptoms. A full scale score above 33 or above is associated with significant emotional distress (Creamer; Bell & Failla, 2003). There are other Psychometric measures such as Beck Depression Inventory (BDI), a self report questionnaire designed to measure the severity of depression, and Beck Anxiety Inventory (BAI), a self report questionnaire designed to measure the severity of anxiety; these are useful assessment tools.

On the basis of the information available in the medical notes and the assessment consultation, a Psychological formulation and opinion is developed. The factors taken into account include the pre-morbid history, personality and coping style of the individual, how these pre-morbid features are relevant in the response to the incident and how they resulted in the impact the event had on the individual. From these aspects a psychological opinion and prognosis can be made. Psychological treatment recommendations are also developed in relation to these factors.

Different Psychological presentations and prognosis

depends on a number of factors including: pre-morbid factors, type of incident, presence and extent of physical injuries, disability affecting day to day life, the meaning of the incident to the individual. It is not always clear cut. Some people may have a number of symptoms that affect their day to day functioning but these symptoms are not sufficient to make a diagnosis of PTSD, depression, anxiety or phobia. Others may attempt to hide their difficulty in functioning, feeling ashamed that they have difficulty completing once basic tasks. Thus, whilst an individual may not currently fulfill the criteria for PTSD, depression, anxiety or phobia etc. they can be suffering psychologically and in need of therapy to return to their re-morbid state of mental health.

Finally, you may wonder what use is a Psychological opinion? A good Psychological report should describe a Psychological formulation of the current difficulties and prognosis, identifying any need for Psychological treatment and the most effective type of Psychological treatment. It may also help to identify if Psychological factors are important in the presentation and treatment of physical injuries – this can be clearer in some cases e.g. permanent physical disability or scarring – and if these factors are likely to have a deleterious impact on treatment. Psychological treatment recommendations are aimed at the enabling the individual to return to their pre-morbid level of functioning in the most expeditious manner.

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Moore Blatch Cases

By Simon Pimlott - Solicitor

We recently settled a case on behalf of a young man that we have been acting for over the last 6½ years who suffered a significant head injury in a road traffic accident on 21st August 2000.

On that date, our client, a 15 year old school boy and air cadet, and had been on a weekend training with the Air Cadets when the coach in which he was travelling broke down. Unfortunately, a passing lorry struck the offside of the coach. He suffered significant head injuries and was immediately taken to Addenbrokes Hospital in Cambridge where his body was cooled and subsequently he was operated upon. He was unconscious for several weeks before being taken to the Children's Trust Hospital in Tadworth, Surrey.

Our client had been an exceptionally bright student who was in the top 5% of students for his academic group, and was intent on going to university and then into the RAF as a pilot. As a result of the injuries sustained, this career path became impossible.

He made a remarkable recovery and is now in a position where he has trained for a diploma in horticulture as well as arboriculture. However, he will never work for a full week and tires easily.

We had to delay settlement until our client had physically reached maturity as the brain can recover from significant injury over a period of time up until people are in their early 20s. Fortunately, this

was the case but, of course, his long term earning capacity and future care requirements were paramount in any settlement.

The matter was set down for trial for a week in the Royal Courts of Justice in London, commencing on 10th December 2007, but we concluded a settlement with the defendant's solicitors for £1.575m a week before trial. The money will be invested in the Court of Protection (initially) to secure our client's future and provide for the lost earnings and any care needs he will require over the remainder of his life.

Our client has gone on to be an ambassador for young people who have suffered head injuries; speaking recently in the House of Lords, and he has so far raised well over £1,000,000 for the Children's Trust charity. He is quite a remarkable young man.

We acted in a case involving a 79 year old Claimant, who on 4th June 2005 was injured in a road traffic accident on a garage forecourt involving a car which was driven by her husband. As the Claimant's husband was reversing into the space, unfortunately his foot slipped off the wet brake pedal and on to the accelerator, with the result that the car shot back and crushed the Claimant against a brick wall, causing her to suffer serious injuries.

In summary the Claimant suffered some bruising and lacerations to her face, contusions and abrasions of her ribs, a haemorrhage of the

oesophagus, abrasions of her neck and back, a crushing injury to her right leg involving a fracture of the fibula, and a fracture of the left ankle. She was not knocked out in the accident but in the ambulance on the way to hospital she lost consciousness and went into a deep coma as a result of a dramatic drop in her blood pressure due to clinical shock and internal bleeding. In consequence she suffered severe and irreversible brain damage.

Following a round-table meeting held in January 2008 and attended by representatives of both sides a settlement was negotiated whereby the Claimant would receive £125,000.00 for her injuries as well as her past losses including care home fees, together with future care needs for the rest of the Claimant's life.

Our clinical negligence team has just concluded a clinical negligence claim arising out of a delay in diagnosing and treating spina bifida. Our client was born with a spinal cord defect which could have been corrected in an operation. Sadly the failure to spot the problem led to serious injury and though liability was initially denied the value of our client's claim at settlement was £3.42 million.

We have recently settled a claim for a lady who had her thyroid gland removed unnecessarily. This resulted in a life long need to take thyroxin and considerable stress and anxiety. After denying negligence initially the claim was settled for £70,000.

We are currently acting for a parent of a 12 year old girl who was injured whilst she was attending practice with her cheerleaders club. Whilst performing a lift called the "Scorpion Extension" our client was dropped by 4 of her colleagues and suffered a fracture to her tibia and fibula as a result. We have successfully argued that as a result of inadequate supervision, training, instruction and risk assessment the Defendants have failed in their duty to our client and liability has been duly admitted in full. We are in the process of finalising the overall settlement figure.

Personal Injury Claims for Defective Cosmetic Products

**Damian Horan -
Head of Insurance Division**

The days of looking good for some now come at a price. The Moore Blatch personal injury team find themselves dealing with an increasing variety of compensation claims for clients injured using cosmetic and so-called beauty products. The increase in media pressure through reality TV shows and fashion magazines has led to a public who have an increasing fascination with skin care and hair products.

There are now so many different types of soap, creams, hair colourants and hair removal products on the market that it is likely there will be an increase in this type of personal injury claim.

In 1987 the law was changed to make it easier for consumers to seek compensation where they had suffered injury and loss as a result of a defective product. The Consumer Protection Act 1987 confers rights on consumers to seek damages where they have suffered injury due to the use of a product which causes a reaction which would not be expected from every day use. Skin inflammation, burn injuries and damaged hair are the most common injuries reported by our clients. These can leave lasting effects including both physical and emotional scarring. The law seeks to ensure that when we buy or use any product we should be able to expect certain high standards to have been used in the manufacture and packaging of the product.

Compensation claim awards for scarring can range from as little as £1,000 for a single noticeable scar to £7,500 for a number of noticeable scars or a single disfiguring scar. Facial disfigurement

qualifies for significantly higher awards. The most severe scarring in a relatively young woman where cosmetic effect is very disfiguring and the psychological reaction serious can result in awards up to £50,000. Compensation awards for damage to hair range from £1,000 to £7,000 and the level awarded will depend on the extent of damage and how long it takes for the hair to grow back. In many cases clients are more interested to ensure that others are made aware of the defective product and that change will occur as a result. Financial recompense is only one consideration. In all cases it is strongly recommended that expert medical evidence is obtained. In hair damage cases a report from a trichologist is required and in scarring cases from a plastic surgeon.

The Moore Blatch specialist product liability team has dealt with claims, including:

- Hair products, such as hair dyes and hair removal creams;
- Food stuffs, which can cause salmonella, e-coli etc
- Medical devices, such as hip joints, heart valves and contraceptive devices.

We have seen recently an increase in cases involving hair dyes and hair removal creams. One case involved the well known Clairol 'Nice n' Easy' hair colourant manufactured by Procter and Gamble. Our client's plight was profiled on GMTV. Our client had used Clairol hair dye products for nearly 30 years and had experienced no previous difficulties. On this particular occasion in July 2007, having carefully followed the user

instructions, she experienced a sudden reaction, causing considerable skin irritation, swelling to her face and hair loss. She was forced to shave her hair off entirely on medical advice.

Our client immediately reported the incident to Procter & Gamble. They arranged for her to be examined by a dermatologist but despite our client's best efforts to deal with the company directly, Procter and Gamble failed to provide a full explanation or make an offer of compensation.

Following our instruction, a letter of claim was submitted to Procter & Gamble and within 2 weeks they responded with an offer of settlement. An offer of £2,250.00 was made without an admission of liability and in their words, as a "gesture of goodwill". Our view was that the potential of the claim was more than the offer proposed but our client was eager to settle the claim promptly following her terrible ordeal. She chose to accept the offer within 4 weeks of our instruction and without medical evidence having been obtained.

Our client said: "I had been using this product for many years and I had built up a trust and loyalty with the manufacturer. I was devastated by

what happened to me and I am desperate to prevent this happening to anyone else. I had no joy in pursuing the manufacturer myself and I was basically being ignored. It all really took its toll on me and I realised that I needed a professional legal team to help me pursue a claim.

"The Moore Blatch team were fantastic. They took the heat out of the situation and removed the massive burden from my shoulders. They were professional throughout every stage of the negotiations and as a result of the team's determination and efficiency I received an offer in just two weeks. I would not hesitate in recommending Moore Blatch to anyone."

Another client has also now consulted us with a similar complaint arising from the use of the same product.

These cases can be difficult cases from a legal and medical point of view. It is important that evidence is preserved and that a positive connection can be made between the exposure to the defective product and the injury complained of. The Moore Blatch team is well placed to help with these cases. We can offer a free assessment of any claim and offer funding on a "no win – no fee" basis.

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