



IN THE HIGH COURT OF JUSTICE
QUEENS BENCH DIVISION
LIVERPOOL DISTRICT REGISTRY

Case number E90LV001

BETWEEN

AURORA BROWN

(A protected party who proceeds by her litigation friend Mr Joe Brown

Claimant

And

LISA ALEXANDER

Defendant

Before His Honour Judge Graham Wood QC sitting as a Judge of the High Court

Mr Chris Barnes (instructed by Jones Kinvig Lawyers) for the **Claimants**

Mr Michael Lemmy (instructed by Horwich Farely, solicitors) for the **Defendant**

Hearing date: 18th July 2018

APPROVED JUDGMENT

Introduction

1. The issue for this court to determine is whether rehabilitation reports provided subsequently to an initial rehabilitation assessment are subject to legal professional privilege, and thus protected from disclosure or use in the litigation, or whether they can be referred to by medico-legal experts.

2. The issue was identified after the Claimant's application for an interim payment in relation to her damages claim arising out of serious personal injuries came before District Judge Jenkinson in May of this year. A number of the purportedly offending rehabilitation reports had been considered by the Claimant's two principal experts, Dr Doran, the neurologist, and Dr Ghadiali, the neuropsychologist. The district judge directed that the preliminary point was an issue of general importance and that it be determined by myself.

3. Clearly, if these reports are the subject of legal professional privilege they must be excluded from the expert reports either by redaction, or by the wholesale revision of their respective opinions without any reference to the rehabilitation process before the interim payment application can be resolved. This has been listed for hearing on 11th September in conjunction with the CCMC.

Background

4. The Claimant, who is now 22 years old, was knocked off her motorcycle in June 2015 sustaining several injuries, the most significant of which was a skull fracture with bilateral extradural haematomas requiring surgical intervention. She has been left with brain damage in the form of neurocognitive disability, with personality changes including loss of confidence and independence, and balance difficulties, although she remains capacitous. Primary liability was admitted at an early stage, although the Defendant has reserved its position on the question of contributory negligence.

5. This early admission of liability led to a significant degree of cooperation between the parties with the Defendant's insurer wishing to be involved in the rehabilitation process in compliance with paragraph 4 of the Pre-action Protocol for Personal Injury Claims. Although severely injured, the Claimant was young, and early intervention with proactive rehabilitation was in the interests of all concerned, not least the compensating party.

6. There are a number of agencies who provide rehabilitation schemes in conjunction with case management and if appropriate care provision. The chosen agency in this case was the Rehabilitation Network and a joint instruction was provided on 27th November 2015 (by the Claimant's solicitor and a representative of Esure motor insurers, the Defendant's insurance company) to carry out an Immediate Needs Assessment (INA) on a without prejudice basis. The assessor, and author of the assessment report, was Ailsa Reston, a rehabilitation case manager. The introduction to her assessment, and to which reference has been made in the submissions, reads as follows:

“The overall aim of the assessment is to assess Miss Brown's present and future needs and to ultimately enable her to get back to college or the open labour market as well as assisting her recovery in mobility. In accordance with the Rehabilitation Code of Best Practice (2015) my report will fall outside the litigation process. I believe rehabilitation and case management is appropriate in this case.”

7. The rehabilitation assessment expressed the opinion that the Claimant's immediate needs included the provision of a daily support worker, strategies for her family to assist with her cognitive problems, assistance with an application for PIP, and further rehabilitation which may be appropriate following assessments in neuro psychology, neuro physiotherapy and neuro occupational therapy. In other words, there were non-specific further rehabilitation treatments proposed depending upon the outcome of these assessments. In addition, a three-month rehabilitation plan was provided, setting out the timescales for the provision of a support worker, and referrals for the proposed assessments. It also provided an estimate of the costs of the rehabilitation plan (excluding external costs).

8. The rehabilitation plan was then agreed between the parties. By this the insurance company, as compensator, was providing funding for the rehabilitation. Up to this point there is no dispute that that the assessment report, which gave rise to the rehabilitation plan, was the subject of privilege. It has not been disclosed to the medical experts, nor is it referred to by them.

9. Thereafter, on a monthly basis (and, it should be noted, within the initial three months of the rehabilitation plan) progress reports were provided. These progress reports described the work which was being undertaken, and the referrals being made, and also provided ongoing recommendations. Each progress report had appended to it an “*ongoing rehabilitation plan*” thus making the rehabilitation a fluid process. There are progress reports provided within the bundle through until July 2017. The Defendant's insurance company continued to fund the rehabilitation.

10. In the meantime the Claimant's legal advisers were obtaining evidence in relation to the damages claim. Dr Doran, from the Walton centre, was instructed as the medico-legal

expert on neurology and provided a report in September 2016. He made reference to the reports from the Rehabilitation Network and in paragraph 39 notes the “first report” in February 2016. He does not make any reference to the January assessment report. More recently, in February 2018, Dr Ghadiali was instructed as a neuropsychologist. He was also provided with “rehabilitation reports”, as he described them, which included the various reports and assessments carried out from time to time on the recommendation of the case manager. Again, he was only given progress reports from February 2016, but referred to an agreement of the rehabilitation plan on 11th January 2016.

11. Proceedings were commenced at the beginning of this year. It would appear that the purpose and timing of the proceedings was associated with a need to apply for an interim payment, although if the Claimant is capacitous, the limitation period was by then rapidly approaching. Whilst the rehabilitation had up to this point been funded by the insurance company, I understand that that the Claimant and her family were unhappy with the progress, and the role of the case manager, and wanted a more bespoke or extensive package of rehabilitation. For the purposes of this preliminary issue, the real reason is immaterial, although it is germane that the Defendant is entitled to object to the extent and nature of any rehabilitation which it is funding and of course to oppose the application for an interim payment.

12. The court has not been made aware as to how these medico-legal expert reports were disclosed to the Defendant (presumably in anticipation of the application for an interim payment) but it would appear that when they were considered by the Defendants’ legal advisers, the reference to the rehabilitation progress reports was noted and the current denouement was arrived at. The Defendant opposes any such reference, as I have indicated, on the basis that the rehabilitation reports were the subject of legal professional privilege, in that they involved ongoing and immediate assessment of the Claimant’s needs which were constantly evolving, whilst the Claimant’s position is that only the initial assessment, upon which the agreed rehabilitation plan was based, is so protected.

13. I shall consider counsel’s respective positions later in this judgment.

The Rehabilitation Code and Legal Professional Privilege

14. Although the Pre-action Protocol for Personal Injury Claims is described in its introductory paragraph as primarily designed for those claims likely to be allocated to the fast track, the Rehabilitation Code (the “Code”) which it references at paragraph 4.1 in the context of the duty of both parties to consider the meeting of a claimant’s reasonable needs by medical treatment or other rehabilitation, is of wider application across the entire spectrum of personal injury claims. It is a stand-alone code which circumscribes the duties and

responsibilities of claimant and defendant in the spirit of cooperation and in a collaborative approach which avoids expensive and drawn-out litigation.

15. However, there is a specific and relevant reference to an *immediate needs assessment* in paragraph 4.4 of the protocol which specifically provides that **an immediate needs assessment report and the documents associated with it obtained for the purposes of rehabilitation are not be used in the litigation other than by consent**, and are exempt from the provisions relating to experts set out in paragraph 7 of the Protocol.

16. The Code itself defines its purpose in the opening paragraphs thus:

“The Code’s purpose is to help the injured Claimant make the best and quickest possible medical, social, vocational and psychological recovery. This means ensuring that his or her need for rehabilitation is assessed and addressed as a priority and that the process is pursued on a collaborative basis. With this in mind, the Claimant solicitor should always ensure that the compensator receives the earliest possible notification of the claim and its circumstances whenever rehabilitation may be beneficial.”

17. In paragraph 1 the role is further defined:

The Code provides a framework for the Claimant solicitor and compensator to work together to ensure that the Claimant’s health, quality of life, independence and ability to work are restored before, or simultaneously with the process of assessing compensation.

18. It is clear that at the very outset of the rehabilitation process, there is an *initial* assessment carried out by a case manager. The use of the word “initial” in some of the evidence in this case has been a little unfortunate, because it has incorrectly formed part of the abbreviation INA which means an Immediate Needs Assessment as it is defined this way in the Code. In respect of medium, severe and catastrophic injuries, paragraph 7.1 is relevant:

7.1 The need for and type of rehabilitation assistance will be considered by means of an Immediate Needs Assessment (INA) carried out by a Case Manager or appropriate rehabilitation professional, e.g. an NHS Rehabilitation Consultant.

19. The subsequent two paragraphs, it seems to me, are also relevant. In paragraph 7.2 there is emphasis of the need for independence in the assessment, and detachment from the medicolegal aspect.

7.2 The case manager must be professionally and suitably qualified, experienced and skilled, and they must comply with the appropriate clinical governance... The individual or organisation should not, save in exceptional circumstances, have provided a medicolegal report to the Claimant nor be associated with any person or organisation that has done so.

20. Paragraph 7.3 confirms that the collaborative approach extends to the letter of instruction in which both the Claimant solicitor and the compensator should be free to define the parameters of the instruction:

7.3 The Claimant's solicitor and the compensator should have discussions at the outset to agree the person or organisation to conduct the INA as well as topics to include in the letter of instruction.....

21. Section 8 of the Code deals in more detail with the immediate needs assessment. In particular, paragraph 8.5 describes the process leading to the agreement of the rehabilitation plan on the basis of the INA. It is noted that it allows the raising of questions in respect of the assessment:

8.5 the case manager will, on completion of the report, send copies to the Claimant solicitor and compensator simultaneously. Both parties will have the right to raise questions on the report, disclosing such correspondence to the other party. It is, however, anticipated that the parties will discuss the recommendations and agree the appropriate action to be taken.....

22. Paragraph 8.6 confirms the privileged nature of the immediate needs assessment:

8.6 For this assessment report to be of benefit to the parties, it should be prepared and used wholly outside the litigation process, unless both parties agree otherwise in writing.

23. It is the following two paragraphs upon which the legal argument in this case has focused for the most part and which are relevant to the issue which the court is called upon to decide:

8.7 The report, any correspondence related to it, and any notes created by the assessing agency will be deemed to be covered by legal privilege and not disclosed in any proceedings unless the parties agree. The same applies to notes or documents related to the INA, either during or after report submission. Anyone involved in preparing the report or in the assessment process will not be a compellable witness at Court. (This principle is set out in the protocols).

8.8 Any notes and reports created during the subsequent case management process will be covered by the usual principle in relation to disclosure of documents and medical records relating to the Claimant. However, it is open to the parties to agree to extend the provisions of the Code beyond the INA to subsequent reports.

24. Reference has also been made by counsel to the guide which is intended to supplement the rehabilitation Code and to assist in its application: "*A guide for case*

managers and those who commission them". Specifically, reliance has been placed upon the section which deals with records, and which reminds case managers that their records may be the subject of scrutiny by other medical professionals, lawyers, insurers and the court.

25. Legal professional privilege has a broad scope extending from the right to prevent disclosure of communication relating to legal advice in contemplation of litigation to the protection of confidential material given to a legal adviser or flowing from a legal adviser or litigant to a third party. For the purpose of this judgment it is unnecessary to consider the nuances of the privilege or the way in which it is applied as an evidential rule, because the principles are agreed. It has to be considered here in the context of the without prejudice involvement in the rehabilitation process of a compensator, whose collaborative approach is secured by an assurance that any concessions in relation to a particular type of rehabilitation will not prevent an issue being taken in relation to causation, the need for rehabilitation or treatment, or its reasonableness, for example.

26. The application of the right to protection from disclosure of the immediate needs assessment and associated reports and their without prejudice nature is affirmed by the Code. The issue for this court is essentially concerned with the scope of the immediate needs assessment, i.e. how it is to be defined.

The respective arguments

27. The Defendant's counsel, Mr Lemmy, submits that the assessment of a seriously injured Claimant is likely to be a fluid process, constantly evolving as needs change. If an assessment is to be objective, of benefit to both parties and part of a collaborative approach, it should be wholly outside the litigation process and there is no reason why the privilege in the initial assessment report should not apply similarly to subsequent assessment reports. There is nothing in the Code, he says, which so restricts privilege, and his argument is supported by the fact that paragraph 4.4 of the pre-action protocol refers to the privileged nature of *any* immediate needs assessment report or documents associated with it.

28. It does not matter, it is submitted, that the case manager's subsequent reports are not described as "assessment" but as "progress" reports, because in fact what is happening at each stage is that the Claimant's evolving needs are being assessed by the case manager and other professionals and the plan will change from time to time.

29. If the process involved is one of ongoing assessment, and yet material which could prejudice any subsequent challenge to the claim is going to be disclosed to medicolegal experts and ultimately the court, this could have a chilling effect on the insurers' role in funding the rehabilitation.

30. Alternatively, counsel argues that subsequent reports are *documents related to the INA* and thus protected by privilege. This is because the initial needs assessment identifies an ongoing requirement to review the needs of the injured party. The format of the initial assessment report is repeated in the subsequent reports, all of which make it clear that the rehabilitation plan depends upon the fluidity of assessment. In other words, the landscape is constantly changing, and if the insurer is funding the rehabilitation when the future needs are open to such change, it should be on the basis that the acceptance of those needs can still be challenged in subsequent litigation, which would not be the case if these reports were the subject of disclosure.

31. Mr Lemmy accepts that the case managers' notes would be disclosed in due course in accordance with the principle in (**Wright v Sullivan [2006] 1 WLR 172**) and that the case manager would be a compellable witness, but there was no justification for construing the progress reports as simply a restructuring of the notes, because the reports expressed opinions and made recommendations which were not necessarily accepted.

32. On behalf of the Claimant, Mr Barnes of counsel submits that the Defendant's interpretation of "immediate needs assessment" as applying to ongoing or evolving needs as and when they arise is strained and contrary to the intention of the Code. Although the description of the needs assessment at a stage when the insurer or compensator was not committed to paying for the rehabilitation as "initial" was not intended in the Defendant's witness evidence, this in fact is what is meant by an immediate needs assessment. It is in the interests of all the parties that an injured person is put on the road to recovery by a rehabilitative process as soon as possible, and that rehabilitation can only be commenced when there is an immediate needs assessment, or INA, which sets out the rehabilitation plan, and makes a number of recommendations. It is open to the parties to agree or disagree with the plan and its recommendations, which may include further specialist assessments.

33. It is submitted that paragraph 8.8 of the Code specifically references the subsequent case management process beyond the INA, anticipating that there will be progress reports created once the rehabilitation has been embarked upon. Mr Barnes says that if each and every progress report was to be construed as an immediate needs assessment addressing the ongoing requirements which may change, then there could be no continuity of treatment. He is reinforced in his argument by the fact that payment for the INA is required within 28 days. This could only be workable if it was a single and discreet assessment and not one which was subject to constant review.

34. He refers the court to the guide to case managers, which describes the INA as the "starting point" of the rehabilitation process. Further, the guide draws a distinction between immediate needs assessment and the subsequent post case management, acknowledging that case management records are likely to be the subject of scrutiny by the court. The case

management records are highly relevant to an understanding by the medico-legal expert of the way in which treatment is progressing.

35. Mr Barnes says that it is specifically open to the parties to extend privilege to the subsequent rehabilitation process by agreement. In other words, if it wishes to object to being prejudiced by a commitment to ongoing rehabilitation, the insurer can make it a condition of continuing funding that privilege applies to subsequent reports even if they are in the nature of assessments.

Discussion and conclusion

36. The opening words of the Code emphasise the promotion of the collaborative use of rehabilitation and *early* intervention in the compensation process. Traditional adversarial litigation before the protocols and associated codes were put in place would often involve collaboration at the later stages of the litigation, when the parties had completed their investigations, and obtained all the necessary evidence. The battle lines had thus been drawn, and whilst compromises could still be achieved, the downside was that in many instances a seriously injured claimant would have lost the opportunity to embark on the road to recovery at a much earlier stage by intensive rehabilitation, either because there was no funding available or because the compensator did not want to prejudice any later arguments as to attributability, reasonableness of treatment etc before it had obtained evidence on the claim. However, it was recognised that it was in the interests of both the injured party and the compensator to start the rehabilitation at the very earliest possibility. If a claimant can return to work or can achieve a level of independence this will have a profound effect on future loss claims. Further, as the rehabilitation progresses, the financial needs become clearer.

37. It is correct, as counsel for the Defendant says, that an injured party's rehabilitative pathway will be the subject of regular reassessment. Not only can there be no "one size fits all", but also it is in the nature of serious illness or injury that progress is unpredictable. Some methods of rehabilitation will work, whilst others will not, and specialist assessment will be required along the way to address how progress is being made. However, the fact that rehabilitation is a fluid process does not mean that the involvement of the compensator at the outset when an INA report is commissioned and a rehabilitation plan drawn up should be considered a provisional one if that plan is agreed, with the question of collaboration to be revisited each and every time there is a reassessment of need. In my judgment this would be completely contrary to the purpose and context of the Code.

38. In relation to severe or catastrophic injuries, as paragraph 8.6 makes plain, the intention of the INA report is that it should be of benefit to the parties. This can only be achieved if the compensator can have an opportunity to agree to what is proposed or recommended without fear that it is prejudicing a liability or quantum defence to the claim.

When the INA is completed, according to paragraph 8.5, it is sent to the parties for any questions to be raised as considered appropriate, or for the recommendations to be discussed in a collaborative fashion. It is then that agreement is anticipated, and the rehabilitation course embarked upon. Even after agreement, the report remains privileged from disclosure, i.e. outside the litigation process.

39. However, all of this in my judgment presupposes one single and yet comprehensive procedure to commission, consider, if necessary question and ultimately agree on the rehabilitation course which is to be embarked upon. It does not suggest that this is a procedure which should be repeated each and every time it is necessary to revise the plan subsequently to the INA, which is the effect of the Defendant's overall submission.

40. There are several further reasons why I do not accept the Defendant's interpretation of the Code and in particular the proposed meaning of an "immediate needs assessment".

41. First, there is a clear distinction drawn between "the assessment process" and the subsequent case management process. Paragraph 8.8 specifically excludes legal professional privilege from the latter, and nowhere within the Code is there any reference to ongoing "assessment" in this case management process. The term "assessment" is plainly associated with the steps taken initially and the production of the INA. The reference by Mr Barnes to the "starting point" of the rehabilitation process in the case managers' guide by is validly made.

42. Second, as paragraph 8.3 makes clear, the INA may well make recommendations for further investigations, as long as they are clinically justifiable. These investigations are all described in the three month rehabilitation plan to which the Defendant, as compensator, agreed in this case. The fact that the further investigations in respect of physiotherapy and occupational therapy comprise "assessments" does not mean that the agreement was in some way qualified, and dependent upon an extension of privilege to that which they contain. The compensator was agreeing to fund a particular type of rehabilitation, the full extent and cost of which could not be finalised until specialist input had been obtained.

43. Third, the sensible interpretation of paragraph 8.6, in my judgment, to the effect that the INA should be wholly outside the litigation process, is that any report, recommendation or rehabilitation plan which has been undertaken as part of the collaborative approach prior to the compensator's agreement, even after it has been agreed upon, should be protected from disclosure. In other words, anything generated in the rehabilitation process after the agreement, and the commencement of the provision of funding by the compensator is considered differently, because it is a course of action mutually agreed upon. It is for this reason, I believe, that paragraph 8.7 and paragraph 8.8 when read in conjunction with each

other draw a clear line in the sand for the operation of legal professional privilege (excluding any agreement for its exclusion)

44. Fourth, it seems to me that if on every occasion when it was necessary to make changes to the rehabilitation plan, following ongoing “reassessment” of the injured party’s needs, it was necessary for the INA process to be repeated, with a further report being commissioned, submitted to the parties, questions asked and agreement obtained, effective rehabilitation would be rendered nugatory. The case management process would become ponderous, and almost unworkable because there could be no authorisation for a particular course when funding would have to be secured in the same way in which it was secured at the outset. Continuity of treatment is important for an injured party and is integral to the rehabilitation

45. Fifth, it would become unworkable in the context of the pursuit of the litigation itself. Whilst the case managers’ notes would be disclosable in any event, and accessible to the medico-legal expert, in my judgment when rehabilitation, funded by the compensator, and the investigation of the compensation claim with the use of medical experts, is coextensive, rehabilitation progress reports would also be essential for a proper evaluation of condition and prognosis. The expert is bound to want to know how a Claimant was responding to rehabilitation, be it the care package, occupational therapy, or whatever. If these reports were not disclosable, there would be a vacuum in the investigation.

46. Sixth, whilst there was an initial three month plan, it seems to me that this was not presupposing that there would have to be a reassessment, but merely identifying that needs would evolve as the work of rehabilitation was undertaken. In any event, in my judgment the language of the progress reports, even if occasionally referring to “assessing”, rarely, if at all, express opinions but instead make recommendations for progressing the rehabilitation to the next stage. It is highly likely that the reports do no more than encapsulate the working notes of the case manager, recording the steps which are taken from time to time.

47. Finally, it is to be noted that the Code provides for the written agreement of both parties either to permit the use of the INA in the litigation, or to exclude notes and reports in the subsequent case management process from the litigation. In my judgment this identifies the inherent flexibility in the collaborative approach. An insurer/compensator who is unhappy with the course which the rehabilitation is taking, can choose to withdraw funding at any time. It is not an obligation when agreement is given at the outset to continue payment indefinitely and at whatever cost. Invariably when recommendations are made for the next stage of the rehabilitation treatment plan the compensator will be consulted about the cost and invited to agree that cost which it is funding. For example, if the compensator does not agree the extent of care provision, or perhaps objects, say, to a residential head injury rehabilitation course, funding can be refused or withdrawn. Ultimately, non-compliance with the Code may be relevant to the question of costs, and if funding is not provided by way of collaboration it

will be open to a Claimant to make an interim payment application. It is for this reason that I do not accept, as the Defendant contends, that the disclosure would have a chilling effect on the collaborative approach of the compensator and the injured party's advisers. The ongoing provision of funding for rehabilitation will be the subject of constant monitoring.

48. The alternative argument of Mr Lemmy, which seeks to contend that the progress reports, or at the very least the subsequent occupational therapy, neuro-physiotherapy and neuropsychology assessments, "*amount to notes or documents related to the INA either during or after the report submission*", and thus come within paragraph 8.7 of the Code, is in my judgment without substance. If it was intended that notes or documents should be construed in this way, then there would be no need for paragraph 8.8 which provides a clear distinction with subsequent material. It seems to me that this is intended to refer to material generated after the report has been submitted, such as correspondence, questions of the case manager etc.

49. In all circumstances I have come to the conclusion that the progress reports of the case manager, and the subsequent specialist assessments, which were incorporated in the recommendations agreed upon in the original rehabilitation plan have all been properly disclosed to the medicolegal experts, and are not the subject of legal professional privilege. Thus, I accept the interpretation of the Code advanced by Mr Barnes of counsel in relation to "immediate needs assessment" and reject that of Mr Lemmy.

50. I invite the parties to agree any subsequent or consequential orders.

GW

30.7.2018