

MRSA – reducing the risk

In July, the NHS paid damages to a patient who contracted MRSA after the Princess of Wales Hospital in Bridgend, South Wales, accepted that it had not followed its own guidelines on infection control. How can hospitals minimise the risk of similar claims?

MRSA cannot be eradicated it can only be controlled. The increased use of antibiotics and extended stays in hospital mean that treatment costs can escalate dramatically. It is therefore vital that efforts are made to prevent the disease from spreading.

Legislation

The government is planning new legislation in an attempt to tackle the problem. There are four key components to the new proposals:

- (1) There will be a Code of Practice on the prevention and control of infections associated with healthcare.
- (2) NHS bodies will be under a duty to follow the Code, while the Healthcare Commission (HC) will have a parallel duty to assess compliance with it.
- (3) The HC will have a discretionary power to issue an improvement notice.
- (4) Those who breach the Code may be given directions for improvement; or sanctions may be imposed.



MRSA claims

It is worth remembering that, despite all the media attention given to the superbug, there have only been a limited number of successful MRSA cases. Apart from the case involving the Princess of Wales

Inside this issue:

Page 2

Changing places

Subrogation is often the last decision made when settling an insurance claim. But it is a very important one.

Page 4

It may pay to delay

Sometimes insurers should wait until proceedings have begun before incurring substantial pre-action costs.

Page 5

Written offers in money claims

Insurers and public bodies can now make protective post litigation Part 36 offers rather than lodging money with the court.

Page 6

Open and co-operative

FSA regulated firms need to display both openness and co-operation during the enforcement process.

Page 7

Compulsory recall: are you ready?

A new product safety regime imposed on UK manufacturers and distributors.

Page 8

Compensation in Ireland

Are there lessons to be learned from Ireland's Personal Injuries Assessment Board?

Hospital, there are no other reported cases where the primary allegation has been the claimant patient contracting the infection as a consequence of inadequate hospital procedures.

The main reason for this dearth of legal authority is that MRSA-related claims are hard to get off the ground. Even if a patient can show that the hospital is in breach of its duty of care and that appropriate procedures were not in place, he or she must then show (on a balance of probabilities) that the breach of duty caused the infection. This is difficult. The claimant has to establish that the MRSA originated in the hospital and developed as a consequence of the hospital's failure to follow local protocols.

Investigating MRSA claims can be costly. A hospital will need to provide infection control evidence showing the processes that are in place to avoid MRSA and that it has complied with infection control protocols. It may also need to produce:

- evidence of infection rates in the hospital generally and in relation to a particular ward;
- details of the location of MRSA cases;
- evidence of decontamination procedures in relation to infected patients and staff;
- hygiene inspection records; and
- documentary evidence of compliance with an appropriate infection control protocol.

Best practice

Leading microbiologists have made the following recommendations for hospitals:

- appoint a multidisciplinary infection control team;
- screen patients (especially those admitted to high-risk units) and staff;

- treat MRSA patients and carriers in single occupancy units with separate staff, who are trained in controlling infections;
- avoid moving patients to maximise bed usage, which spreads MRSA – patients of individual medical and surgical teams should be kept together;
- restrict movement of staff;
- implement laundry contracts in accordance with the 1970 guidelines for keeping soiled and clean laundry separate;
- continue training in the principles of infection for all staff, including agency nurses;
- issue clear infection control guidelines/ protocols;
- control hand washing and cleaning (although this alone will not prevent the spread of MRSA); and
- develop antibiotics to treat infected patients.

Need for government lead

The implementation of some of the above recommendations will have far reaching cost consequences, in particular, for hospitals without the capacity to keep MRSA patients and carriers separate from others. Patients and staff are constantly moved from ward to ward to maximise bed capacity and a departure from this way of operating would be a colossal change in NHS practice. The lead and momentum for change, which improves infection control, will need to be government led for any real change to take place in the NHS.

Christopher Malla

London

c.malla@kennedys-law.com

Changing places

Subrogation is often the last decision made when settling an insurance claim. But it is a very important one.

The damage has been repaired. The loss adjusters have issued their final report. The claim has been settled. So, what do you, the insurer, do next?

The natural response is to try and recoup your loss. And the doctrine of subrogation has been developed to enable insurers to do just that.

Doctrine of subrogation

Subrogation is the name given to the right of an insurer, who has indemnified its policyholder, to take the place of that policyholder and try to recover the money paid out from any potentially liable third party. It is a quasi-automatic right that becomes available as soon as the insurer pays out on a claim.

In effect, it is the mirror image of the indemnity principle: once an insurer has paid the policyholder for a loss covered under the terms of the policy, it can step into the policyholder's shoes and seek to recoup that loss up to the extent of the indemnity. This prevents a possible double recovery by a policyholder – firstly from its insurers and then, secondly, from any liable third party it might choose to sue.

Obstacles to subrogation

There are, however, obstacles. An insurer's rights can never be better than its

policyholder's. This is a particularly important point for insurers as they may find that, despite the apparent merits of a policyholder's case, they cannot, in fact, pursue the third party because of the policyholder's position. For instance:

- the intended defendant is a co-insured – for example, under a JCT contract. An insurer cannot step into the shoes of one policyholder to sue another;
- the policyholder may have waived any rights of subrogation – for instance, a contractor policyholder may have waived any claim against its subcontractor and if the policyholder cannot sue its subcontractor, then neither can the insurer;
- an insurer will be bound by any contractual terms preventing recovery or limiting the amount that can be recovered;
- the policyholder may have already settled any claim with the third party, in which case the insurer will almost certainly be bound by the terms of the settlement;
- it may be that the policyholder's rights vest with a subsidiary or sister company or that the policyholder has been acquired by somebody else. In the absence of any transfer of such rights, the insurer may find that any claim has been lost; and
- a subrogated recovery is often considered after the loss, by which stage the policyholder may have been dissolved.

An insurer cannot step into the shoes of a company that no longer exists.

Assigning an alternative

It may be possible to get round some of these difficulties by assigning to the insurer the benefit of a policyholder's claim.

An assignment enables an insurer to sue a third party in its own name. The plus points of this include that:

- the insurer will not be limited to the amount it has paid its policyholder; and
- the insurer's chances of success will not depend on the insurance claim having actually been finalised.

On the down-side, the insurer may be unenthusiastic about the publicity. It will also need its policyholder's consent to such an assignment, and the policyholder may not want to give up its rights without some sort of compensation in return.

What happens next?

Once the insurer has indemnified its policyholder and established that a claim exists against a third party, the next step is to decide how to proceed.

Often, there will be express provisions in the policy giving the insurer full control of any proceedings taken, and enabling it to negotiate a settlement, providing it acts in a bona fide way. But even if there are no contractual terms to this effect, an insurer will still retain control if:

- (1) it has indemnified its policyholder in full; and
- (2) there are no uninsured losses.

At this point, it is important to note how the courts prioritise sums of money obtained in successful subrogation proceedings.

The leading House of Lords case of *Napier & Ettrick v Kershaw* (1993) established the



'pay up – recover down approach'. Insurers will be paid first, with the policyholder's deductible or excess recovered last. The fly in the ointment is where there are uninsured

losses. The courts regard such losses as having been expressly intended by the policyholder – or put another way, they treat the policyholder as having intended to self-insure in part. As a result, such uninsured

losses will be paid first out of any sums recovered from a third party. For example, a property is burnt down in a fire at a cost of £500,000. The insurer provides cover up to

£400,000, with a £25,000 excess. It pays its policyholder £375,000. £490,000 is recovered from a third party. The policyholder's uninsured loss of £100,000 is paid first. The insurer recoups its £375,000 second. The balance of £15,000 is then paid to the policyholder as a contribution towards the excess.

The policyholder will, therefore, have a vested interest in any action its insurer decides to take against any third party. In the absence of an express term in the policy, the insurer may, therefore, be left in a situation where, because of uninsured losses, it must obtain the policyholder's consent to any third party action and its settlement. Alternatively, the insurer may settle only a part of the loss without prejudicing its policyholder's entitlement to seek a separate recovery. A third party is unlikely to be enthusiastic about such a bit-part settlement.

Costs agreements

This potential problem is often best dealt with upfront in a costs agreement.

If there are substantial uninsured losses, an insurer may be able to persuade its policyholder to act on a pro-rata basis. Alternatively, if the policyholder only has to recover its excess, then it may be prepared to hand over the conduct of the case to its insurer, on the basis that the insurer will meet the costs of the recovery. This way, the insurer will have a free hand when it comes to negotiations and settlement.

An agreement of this kind can ensure that distribution of the money recovered – and

the resolution of any disputes – are dealt with at the outset so as to avoid any difficulties later in negotiations.

Practical steps

Subrogation is usually the last decision that is made when settling an insurance claim. Obviously, the priority is to repair the damage and to indemnify the policyholder. But, as highlighted above, a great deal can happen in the interim to affect an insurer's ability to pursue recovery later on.

There are a number of steps, however, that an insurer can take to improve its position.

Firstly, it is important to identify any key documentation that is likely to be in the hands of the policyholder. For instance, if a fire causing loss occurs through negligent works undertaken by another, then those works may be governed by a contract with insurance and/or liability provisions that affect the insurer's ability to seek a recovery. The contract, and any related documentation/information, must be obtained promptly.

Then there is limitation to think about. Any claim in negligence must usually be brought within six years from the date of the loss. A contractual claim, however, must be brought within six years of the breach of contract. If a contractor undertook works giving rise to the loss four years before the damage actually occurred, then the insurer's ability to pursue a subrogated contractual claim will expire that much earlier.

Staff of the policyholder may prove a useful source of information, not only in terms of obtaining documentation, and establishing

what losses have been suffered, but also as to whether any third party is at fault. Obtaining staff accounts promptly, preferably in witness statement format, can prove invaluable later on in the claim when solicitors are instructed and a decision has to be taken about whether or not to issue proceedings.

Claims will often involve expert assistance in establishing why particular damage has occurred. Such contemporaneous expert evidence should also help to establish:

- (1) whether the damage is covered under the terms of the policy; and
- (2) whether any fault lies with a third party (or even with the policyholder).

This kind of information may prove invaluable when decisions on subrogation and the issue of proceedings have to be taken.

Subrogation may not be the top of an insurer's To Do list, but taking into account some of the things discussed here, should make life easier in the long run.

Emma Goodchild

London

e.goodchild@kennedys-law.com

It may pay to delay

Sometimes insurers should wait until proceedings have begun before incurring substantial pre-action costs.

Should insurers who fund the pre-action defence of unfounded claims be able to recover wasted costs from the claimant? The answer to this question should be “yes” but the recent decision in *McGlinn v Waltham Contractors (2005)* suggests otherwise.

Pre-action protocol costs

The significance of pre-action protocols for parties and their Insurers is the potential resolution of disputes without the need for litigation, and the impact of such protocols on the recovery of costs at the end of an action.

Parties to a claim have to follow pre-action protocols. Sanctions imposed for failing to do so include adverse costs awards. A further incentive is that successful parties have, in the past, been able to recover their reasonably incurred protocol costs.

As a result, defendants and their Insurers have been prepared to fund the pre-action investigation and the defence of all claims brought by a claimant, however spurious.

The decision in *McGlinn v Waltham Contractors* may, however, result in a change of attitude and a limitation on costs incurred in the pre-action process. This is because *McGlinn* says that, where a claimant abandons a pre-action issue before

proceedings are actually started, the costs of defending that issue will not be recoverable unless there are exceptional factors.

The facts

Mr *McGlinn* retained a building contractor, architect and engineer in respect of building works carried out on his property in Jersey. He subsequently claimed that there were such serious defects in the works that the property had to be demolished and he sued all three professionals for approximately £4.5m.

In following the pre-action protocol, Mr *McGlinn* claimed for sums allegedly wrongly certified by the architect and paid to the contractor. This claim was denied by the architect and, ultimately, the allegation was not pursued in the subsequent litigation.

Not surprisingly, the architect sought to recover the costs incurred in defending the allegation. However, the application was denied.

Irrecoverable pre-action costs

The court's power to award costs is set out in section 51 of the Supreme Court Act 1981. This allows the court to order a party to pay costs 'of and incidental to' the court proceedings.

In considering the meaning and effect of section 51, the judge in *McGlinn* relied on the decision of *In re Gibson's Settlement Trusts (1981)*. The *Gibson* case – which was decided

before the introduction of pre-action protocols – dealt with the recoverability of pre-action costs. The judge in that case ruled that, where court proceedings were framed narrowly, previous disputes with no real relation to the subject matter of the proceedings could not be regarded as costs of the proceedings.

In *McGlinn*, the judge applied this principle and refused the architect's application for costs, saying that:

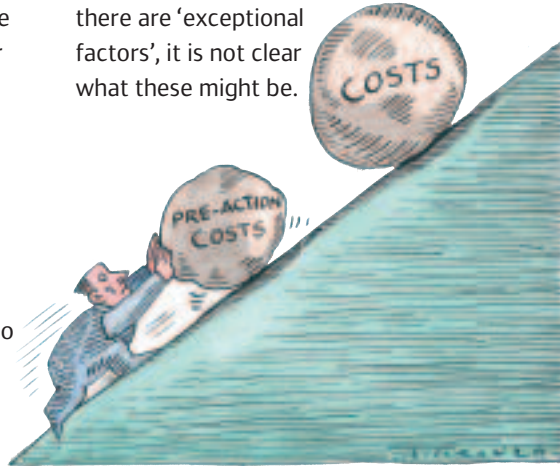
- the costs of complying with a protocol would normally be 'incidental to' subsequent proceedings and therefore recoverable under section 51;
- however, in this case Mr *McGlinn* had narrowed the proceedings sufficiently so that the claims relating to certification (which had previously been made against the architect but later abandoned) bore no relation to the subject matter of the proceedings;
- it would be contrary to the purpose of the pre-action protocol to penalise claimants in costs if they decided not to pursue claims originally included in their protocol letter of claim.

The effect of *McGlinn*

The decision in *McGlinn* effectively gives claimants the opportunity to set out their claims in minute detail, whatever the merits, and to decide later which of the claims (if any) they want to pursue in litigation. And all this without any risk on costs should they subsequently choose not to pursue any particular allegation.

For defendants and their insurers, the position is far less helpful. Under the protocol process, a defendant has to provide a substantive

response to pre-action issues raised by the claimant. In order to meet this obligation, a defendant and its insurers will probably carry out a full investigation and possibly obtain expert evidence, thereby incurring substantial costs. Under *McGlinn*, some of these costs may not be recoverable. While the judge in that case did say that costs could be awarded if there are 'exceptional factors', it is not clear what these might be.



Conclusion

The effect of *McGlinn* is to penalise defendants and their insurers for embracing the spirit and letter of pre-action protocols. In doing so, the decision threatens to undermine the primary aim of the pre-action regime – the resolution of claims without the need for litigation.

In future, where significant sums are likely to be spent on issues such as experts' fees and the litigation risk is considered worth taking, there may be a significant cost advantage in waiting until proceedings have been started before incurring costs.

Sushma MacGeoch
London
s.macgeoch@kennedys-law.com

Written offers in money claims

Insurers and public bodies can now make protective post litigation Part 36 offers rather than lodging money with the court.

The Court of Appeal has recently ruled in the case of *The Trustees of Stokes Pension fund v Western Power Distribution (Southwest) PLC [2005] EWCA civ 854 (The Stokes case)* that, an offer to settle a money claim should usually be treated as having the same effect as a payment into court if the the following conditions are met:

- (1) The offer must be expressed in clear terms, stating which parts of the claim it covers, whether it takes into account any Part 20 claim, and whether the offer includes interest. In addition, the Compensation Recovery Unit (CRU) position will have to be spelt out clearly when any offer is made. It would be a good idea if a copy of the CRU certificate accompanied any such offer.
- (2) The offer must be open for at least 21 days and otherwise accord with the terms of a *Calderbank* offer to settle (that is to say, the offer should be made 'without prejudice save as to the issue of costs').

(3) The offer must be both serious and genuine.

(4) When making the offer, the defendant must have the funds to meet it.

Following on from the *Stokes* case – and providing they satisfy the conditions outlined above – insurers, local authorities, solvent self insured organisations and public bodies will now be able to make offers to settle money claims after proceedings have started while still protecting themselves as to costs.

Consequently, public bodies, insurers and self insured organisations will be able to spend more of their resources on things they think are important instead having to pay some of their money into court. Of course, any offers that are accepted will have to be paid promptly and therefore appropriate accounting steps must be taken to reserve the money required.

Richard West
Chelmsford
r.west@kennedys-law.com

Open and co-operative

FSA regulated firms need to display both openness and co-operation during the enforcement process.

The duty to be open and co-operative with the Financial Services Authority (FSA) is a cornerstone of the regulatory system and is consistent with the FSA's overall risk-based approach. As the FSA now turns its attention to newly authorised mortgage and general insurance intermediaries with a view to carrying out investigations and possible enforcement proceedings, it is more important than ever for firms to bear this fundamental duty in mind.

But, however, extensive its sphere of influence and its resources, the FSA cannot be all-seeing or all-knowing. It relies on firms to inform it of problems. Regulated firms cannot simply wait for the FSA to discover such problems for itself (or, alternatively, hope that it never does). Following the extension of regulation to insurers, intermediaries and general mortgage businesses – and the reduction of routine inspection visits – the FSA has reiterated the importance it places on notifications from firms.

Duty to be open and co-operative

The duty to be open and co-operative is set out in PRIN 11 and APER 4. A firm (and an approved person) must deal with its regulator in an open and co-operative way, and must disclose to the FSA anything relating to the firm of which the FSA would reasonably expect notice. It is also an offence under

section 177 of the Financial Services and Markets Act (FSMA) 2000 to supply the FSA knowingly or recklessly with information that is materially false and misleading.

Some newly regulated firms can find it difficult to come to terms with this obligation, particularly as it conflicts with a natural instinct for self-preservation. In rare cases, firms may be tempted to destroy papers to try and remove potentially incriminating material from regulatory scrutiny.

However, this runs the risk not only of discipline for breach of Principle 11 (the duty to be open and co-operative) or Principle 1 (the need for integrity) but also of withdrawal of the firm's authorisation altogether for not being 'fit and proper'.

Credit for co-operation

In an enforcement context, the FSA will give firms some credit for being open and co-operative but businesses should understand that this will not necessarily mean that they escape censure altogether. In the FSA's risk-based approach to enforcement, other factors such as the seriousness of the breach are also taken into

account. According to comments made by the FSA's counsel in the recent L&G case before the FSMA tribunal, the FSA will give credit by reducing a financial penalty or fine by 10%-45%, depending on the level of co-operation received. However, the FSA has made it clear that, before giving credit in these circumstances, it will expect extensive and pro-active co-operation rather than minimum resistance or mere acceptance of the FSA's case.

Where credit is given by the FSA, this is made clear in the press release accompanying the final notice of enforcement action, although the amount of credit is currently not specified. However, credit was given in recent enforcement cases, resulting in each case in a lower fine, for the following action on the part of the firm being disciplined:

- a willingness to contact customers and provide redress;
- an agreement to review systems and controls;
- improving relevant systems and procedures;
- retraining staff;
- a thorough investigation into – or an independent report on – the subject matter of the complaint or problem;
- a positive and pro-active agreement of facts put forward by the FSA so as to reach a prompt conclusion;
- withdrawal of the criticised product and the promotional campaign behind it;
- the voluntary cessation of relevant activities pending retraining; and



- the full consideration of the complaint or problem by the board of the disciplined company.

In one recent case, credit was expressly given for co-operation during the enforcement process, even though the charges included breach of PRIN 11.

Enforcement process review

The FSA has recently completed an enforcement process review. This review recommends the introduction of an explicit discount – of up to 30% of the fine which would otherwise be imposed – for those who settle their cases early in the proceedings. Any such discount will be stated on the face of the final notice.

The review makes it clear that, when deciding the size of the penalty, the FSA will continue to take into account other forms of co-operation, such as the disciplined firm taking the initiative to compensate consumers who have suffered detriment. This means that financial services organisations and approved persons can potentially achieve a double discount by proactive co-operation with the FSA.

The review also reiterates that enforcement action will be less likely if a firm has built up a strong track record of:

- taking its senior management responsibilities seriously;
- being open and co-operative with the FSA; and
- (where necessary) taking prompt remedial action.

Claire Hitchcock

London

c.hitchcock@kennedys-law.com

Compulsary recall: are you ready?

On 1 October 2005 a new product safety regime was imposed on UK manufacturers and distributors when the European-led General Product Safety Regulations 2005 ('the GPSR') came into force.

The GPSR for the first time gives enforcement agencies in the UK the power to recall all unsafe products from the market.

The legislation is wide reaching and applies to almost all consumer products (including some second-hand goods). It also will cover so-called 'migrating products' i.e. products which under reasonably foreseeable conditions could be used by consumers even if not intended for them. In their guidance document the DTI has specifically indicated that labelling a product 'for professional use only' is unlikely on its own to be sufficient.

Obligations

There is a new obligation on both manufacturers and distributors to notify the enforcement authorities when they discover that they have placed an unsafe product on the market. They must also be in a position to recall the product if these authorities require it.

Manufacturers must take additional measures to ensure their products can be traced, such as identifying them with a reference and batch number, keeping a

consumer complaints' register, and informing distributors of those complaints.

Some manufacturers feel that this latter obligation to inform their distributors of all complaints could stifle their trade and will affect their competitiveness in the global market place.

Distributors must also keep and provide documentation so they can trace the origin of unsafe products, and must take part in monitoring the safety of the products they supply.

This tracing obligation lasts for the life of the product which could mean that in some cases records will need to be retained for many years which is likely to prove a logistical nightmare for some companies.

Export Bans

As well as the powers of the enforcement authorities to order a product recall, the EU Commission can impose an emergency ban on the export of dangerous products within and outside the EU. These export bans are valid for up to 12 months and can be extended further.

Penalties

There are hefty penalties for non-compliance

with the GPSR. The penalties apply to the companies themselves and to 'any director, manager, secretary or other similar officer of the body corporate or any person purporting to be acting for the body corporate'. These penalties are as follows:

- For supplying, offering or agreeing to supply a product which is dangerous: up to 12 months' imprisonment or £20,000 fine.
- For failing to keep records so that a product can be traced: up to three months' imprisonment or £5,000 fine.

Practical implications for manufacturers and distributors

The GPSR is likely to place significant administrative and financial burdens on



manufacturers and distributors alike. Many companies will need to make significant adjustments to their internal organisation,

labelling and packaging of products, quality control and crisis management systems if they are to be able to comply with the new legislation.

Manufacturers and distributors are also going to need to look carefully at their existing contracts to ascertain whether they contain adequate traceability provisions if they are to be able to comply with their obligations.

It is perhaps surprising that charities are not exempt from these obligations. Whilst charities

are not required to keep documentation to trace the origin of goods that are donated free of charge by members of the public, they must keep records on 'any other product obtained through commercial channels that they may from time to time supply.' This means that, where charities purchase goods from secondary markets for sale through their retail outlets or where goods are either donated or bought in from a known source, they are required to keep records so that the origin of the product can be traced. This will be a sizeable burden for charities.

Implications for insurers

Demand for recall insurance is likely to increase substantially with the introduction of the GPSR. Insurers may see this as an opportunity to expand their portfolio. However, they would be well advised to ensure that their insureds are in a position to comply with the new legislation and have adequate risk management procedures in place. It will be important to check that their insureds are doing all they can to prevent recalls in the first place e.g. making sure that products are carefully labelled and adequate warnings are in place. Their insureds should also have in place properly planned recall procedures to enable a swift and efficient recall should this be ordered by the enforcement authorities.

They ought also to consider their existing policy wordings/premiums and whether they will need to alter these in the light of the GPSR and the inevitability that recall claims are likely to increase both in volume and value post the implementation of the GPSR.

Marie-Claire di Mambro

London

m.dimambro@kennedys-law.com

Compensation in Ireland

Are there lessons to be learned from Ireland's Personal Injuries Assessment Board?

The Personal Injuries Assessment Board (PIAB) was set up in Ireland last year in response to what many considered to be an inefficient compensation system.

The principal objectives of PIAB are:

- to make significant reductions in the cost of delivering compensation due to claimants, without altering the level of awards; and
- to implement a less adversarial and faster process for settling personal injury claims.

PIAB

The PIAB is an independent statutory body, making independent assessments of compensation for personal injury claims. Since July 2004, all personal injury claims (excluding those for medical negligence) have had to be submitted to the PIAB before any resort to legal proceedings. The PIAB assesses the injury and recommends a compensation award – which both claimant and respondent have the right to accept or reject. If the award is rejected by either

party, the claimant may go to the courts. PIAB assesses the level of compensation by considering the claimant's medical evidence.

Where this is inconclusive or disputed by the respondent, the claimant may be required to attend an independent medical specialist chosen by PIAB.

Another important feature of the new system is the introduction of the Book of Quantum – a guide to compensation levels.

Advantages to insurers

The reform's proponents have praised the new system for its speed: PIAB boasts that its awards are made within nine months, compared to litigation, when the average time-frame is three to four years.

And the scheme is seen as a way of saving costs. PIAB will not fund the claimant's legal representation and so claimants have to pay any legal fees out of the award they receive. PIAB says that, under the old litigation system, 'delivery costs' on top of the award, including legal and medical expenses, accounted for around 46% of sums paid in compensation.

Opposition

Clearly, the scheme will have limited appeal for some insurers.

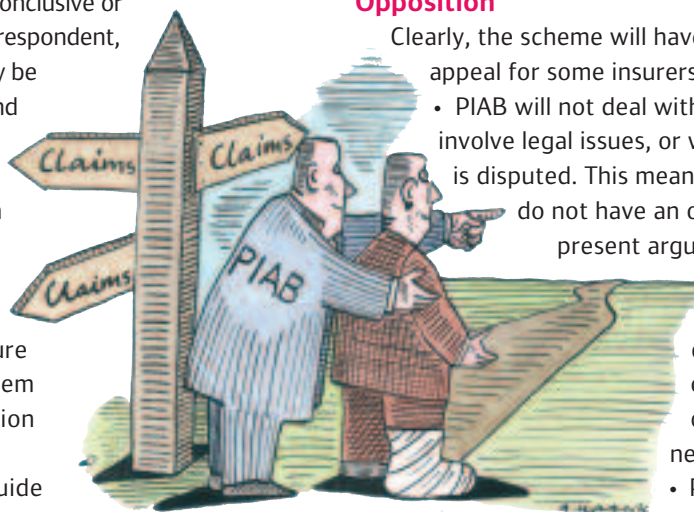
- PIAB will not deal with cases which involve legal issues, or where liability is disputed. This means that insurers do not have an opportunity to present arguments about mitigating

circumstances or contributory negligence.

- PIAB does not provide insurers

with a forum to argue about the reasonableness of claims for special damages such as those for future loss of earnings.

- there is a perception that the introduction of the Book of Quantum has led to an increase in the level of damages awarded, not only under PIAB scheme, but also in the courts.



UK
Longbow House
14-20 Chiswell Street
London EC1Y 4TW
T 020 7638 3688
F 020 7638 2212
DX 46628 Barbican
mailbox@kennedys-law.com
www.kennedys-law.com

Belfast
64-66 Upper Church Lane
Belfast BT1 4Q1
T 028 90 240067
F 028 90 315557
DX 490 NR Belfast 1

Hong Kong
11th Floor
The Hong Kong Club
Building
3a Charter Road
Hong Kong
T 00 852 2848 6300
F 00 852 2848 6333

Auckland
Level 6
70 Shortland Street
PO Box 3158
Auckland
New Zealand
T 00 64 9 379 9011
F 00 64 9 379 9025

Madrid
c/ Montalbán No 10
2^a Ext Dcha
28014 – Madrid
Spain
T +34 91 523 7210
F +34 91 523 7212

Associated offices
Beirut, Dubai, Dublin,
Karachi, Moscow,
Mumbai, New Delhi,
New York, Paris, Riyadh,
San Francisco and Sydney

Kennedys
Legal advice in black and white