EDITOR: **Lionel Stride**
Issue 2 November 2021

TGC Clinical Negligence

The Newsletter of the TGC Clinical Negligence Team

LONDON
1 Harcourt Buildings
Temple, London, EC4Y 9DA
T +44 (0)20 7583 1315

THE HAGUE
Lange Voorhout 82, 2514 EJ
The Hague, Netherlands
T +31 70 221 06 50

E clerks@tgchambers.com
W tgchambers.com
DX 382 London Chancery Lane

Index

Introduction
Lionel Stride 04

Procedure, Limitation & Expert Evidence

Calderdale & Huddersfield NHS Foundation Trust v Metcalf [2021] EWHC 611 QB
Systematic and shameless dishonesty will result in jail time (committal proceedings)
Marcus Grant 06

Wilkins v University Hospital North Midlands NHS Trust [2021] EWHC 2164 (QB)
I was only four years late, sir (limitation issues)
Ellen Robertson 08

PAL v Davidson [2021] EWHC 1108 (QB)
Seeking (early provision of) shelter (interim payment applications)
James Arney Q.C 10

Quick-Fire Summaries

Vinegrad v University College London Hospitals NHS Foundation Trust & Ors (2021)
Becky Henshaw 13

Dulson v Popovych [2021] EWHC 1515 (QB)
Becky Henshaw.. 13

Naylor v University Hospital of Leicester NHS Trust [2021] EWHC 340 (QB)
Philip Matthews 14

Iddon v Warner, Manchester District Registry (2021)
Philip Matthews 14

Breach of Duty & Causation

Khan v Meadows [2021] UKSC 21
Meadows Khan't (limiting the scope of the duty of care)
James Laughland 15

Post-Montgomery Case Law

The evolution of consent (how the Court is applying Montgomery)
Lionel Stride 17

Negus (1) Bambridge (2) v Guy's & St Thomas' NHS Foundation Trust [2021] EWHC 643 (QB)
Spare me the detail (a case study on the limitations of Montgomery for technical risks)
Robert Riddell 20

Index continued

Sheard v Cao Tri Do [2021] EWHC 2166 (QB)
Bound up by my notes (resolving conflicts between documents and recollection)
Nicholas Dobbs 22

Davies v Frimley Health NHS Foundation Trust [2021] EWHC 169 (QB)
Is material contribution enough? (matters of causation)
James Laughland 24

Jarman v Brighton and Sussex University Hospitals NHS Trust [2021] EWHC 323(QB)
"The oddity of his position" (the Bolam test and expert evidence)
Rochelle Powell 26

Brint v. Barking, Havering and Redbridge University Hospitals NHS Trust [2021] EWHC 290
Weighing up Fundamental Dishonesty vs. 'Unreliability'
Anthony Johnson 28

XM v Leicestershire Partnership NHS Trust [2020] EWHC 3102 (QB)
Check your measurements (the standard of care required of health visitors)
James Arney Q.C 31

Quick-Fire Summaries

King v Royal United Hospitals Bath NHS Foundation Trust [2021] 1576 (QB)
Philip Matthews 34

The Vaccine Damages Payment Scheme
Philip Matthews 34

Hughes v Rattan [2021] EWHC 2032 (QB)
Philip Matthews 35

Calculation of Damages

Reaney v. University Hospital of North Staffordshire NHS Trust [2015] EWCA Civ 1119
Looking back in anger (re-examining the relevance of the principles in Reaney)
Anthony Johnson 36

Owen v Swansea City AFC [2021] EWHC 1539 (QB)
Too much in his locker? (expert evidence required in sport's injury claims)
James Yapp 39

A note from the editor

By Lionel Stride

Welcome to the second issue of the TGC Clinical Negligence Newsletter.

As (some measure of) normality has returned to life, there has been an explosion of reported cases of interest to clinical negligence and personal injury practitioners.

We are all now getting used to some of the benefits of 'mixed working' (actually being able to work whilst waiting for a delivery!), combined with the relief of seeing friends and colleagues once more. Recent experience suggests that there will continue to be a combination of 'in-person' and remote conferences, JSMs/mediations and hearings but it would appear that the courts are unlikely to have as many remote trials as envisaged.

Medical negligence cases arising during the pandemic are now starting to be presented, with an added layer of complexity due to the strained resources during the pandemic. They are likely to keep practitioners busy in the months and years to come.

Whilst the volume of work dials up, however, we can at least now holiday abroad again (or, of course, somewhere equally as exciting like Kent), albeit with the novel fear of catching the lurgy just before, or during, the trip almost equalling any excitement.

Fortunately, if you have to self-isolate, you can now console yourself with this bumper edition of articles, case summaries and case reviews. This edition also includes a review of some older cases (such as ***Reaney***) to remind practitioners of their importance, as well as a study of how the seminal case of ***Montgomery*** is being (and has been) applied by the Courts.

To help you navigate this edition, here is an overview of what you can expect: -

Procedure, Limitation & Expert Evidence

- To kick us off on recent procedural developments, Marcus Grant considers ***Calderdale & Huddersfield NHS Foundation Trust v Metcalf*** [2021] EWHC 611 QB in which the Court handed down a six-month prison sentence against a claimant as punishment for contempt of court for signing statements of truth on court documents containing facts that she knew to be untrue.
- Ellen Robertson looks at ***Wilkins v University Hospital North Midlands NHS Trust*** [2021] EWHC 2164 (QB), which considers the old chestnuts of 'date of knowledge' for the purposes of limitation and the 'balancing exercise' undertaken by the Court when considering whether to utilise its discretion under section 33 of the Limitation Act 1980.

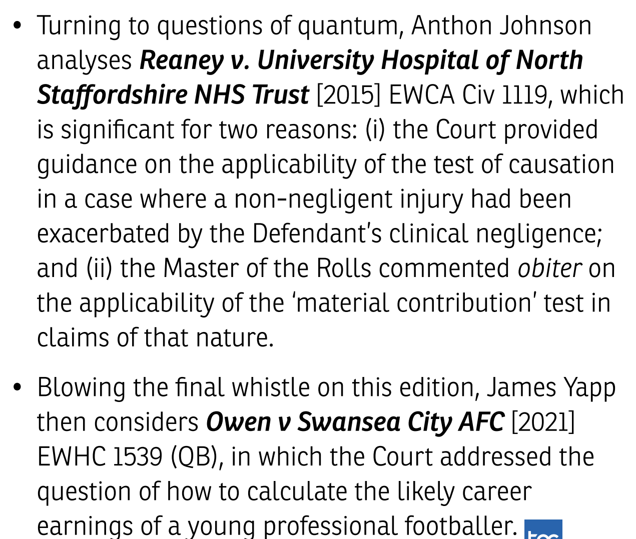
- James Arney Q.C. considers ***PAL v Davidson*** [2021] EWHC 1108 (QB), an application by a 13-year-old claimant who had suffered catastrophic injuries for an interim payment of £2 million to enable a suitable property to be purchased for her long-term accommodation needs.
- Fourthly – and this is itself a new development for the TGC Clinical Negligence Newsletter – we will take you through a quick-fire review of four key cases in the field.

Breach of Duty & Causation

- Turning to questions of liability, James Laughland first considers the Supreme Court's much awaited judgment in ***Khan v Meadows*** [2021] UKSC 21, in which the centrality of the 'scope of duty' principle was affirmed as a determinative factor in medical advice cases.
- I (Lionel Stride) then examine the battery of post-***Montgomery*** case law concerning patients' informed consent to treatment.
- Following on from the above, Robert Riddell analyses ***Negus (1) Bambridge (2) v Guy's & St Thomas' NHS Foundation Trust*** [2021] EWHC 643 (QB), which concerns the extent to which a doctor is under a duty to warn a patient before surgery of the material risk which may arise from intra-operative technical decisions.
- Nicholas Dobbs examines ***Sheard v Cao Tri Do*** [2021] EWHC 2166 (QB), which provides an instructive example of the difficulties in clinical negligence claims when resolving conflicts between witness evidence and contemporaneous medical notes.
- James Laughland analyses ***Davies v Frimley Health NHS Foundation Trust*** [2021] EWHC 169 (QB) in which the Court considered whether the making of a material contribution to harm was sufficient to establish liability in a clinical negligence claim.
- Rochelle Powell considers ***Jarman v Brighton and Sussex University Hospitals NHS Trust*** [2021] EWHC 323(QB), which provides an interesting exposition of the Bolam test in the context of an alleged failure to refer the claimant for an emergency MRI.
- Anthony Johnson considers ***Brint v. Barking, Havering and Redbridge University Hospitals NHS Trust*** [2021] EWHC 290 in which the Judge's consideration of the claimant's lack of credibility as a witness did not equate to a finding of fundamental dishonesty for the purposes of CPR 44.16.
- James Arney Q.C. analyses ***XM v Leicestershire Partnership NHS Trust*** [2020] EWHC 3102 (QB) in which the Court considered the standard of care to be expected from 'health visitors'; the judgment is a practical application of the principles established in ***Wilsher*** and ***Darnley***.
- We then have another round of quick-fire reviews of four interesting recent clinical negligence cases that did not (quite) make the cut for articles.

Calculation of Damages

- Turning to questions of quantum, Anthon Johnson analyses ***Reaney v. University Hospital of North Staffordshire NHS Trust*** [2015] EWCA Civ 1119, which is significant for two reasons: (i) the Court provided guidance on the applicability of the test of causation in a case where a non-negligent injury had been exacerbated by the Defendant's clinical negligence; and (ii) the Master of the Rolls commented *obiter* on the applicability of the 'material contribution' test in claims of that nature.
- Blowing the final whistle on this edition, James Yapp then considers ***Owen v Swansea City AFC*** [2021] EWHC 1539 (QB), in which the Court addressed the question of how to calculate the likely career earnings of a young professional footballer.



Systematic and shameless dishonesty will result in jail time: *Calderdale & Huddersfield NHS Foundation Trust v Metcalf* [2021] EWHC 611 QB

Clinical Negligence – Procedure – Surveillance Evidence – Dishonesty – Contempt of Court

Marcus Grant considers the implications of this committal application in which Griffiths J, sitting in the Leeds District Registry of the Queen's Bench Division, handed down a six-month prison sentence against Mrs Metcalf, of which she would be required to serve three months, as punishment for contempt of court for signing statements of truth on Court documents containing facts that she knew to be untrue, in such a way as to result in material injustice in a clinical negligence claim against the NHS Trust.

Background

This was an egregious case of dishonesty. This 37-year-old patient suffered a poor outcome from a cauda equina syndrome that developed in late June / early July 2012. She attended the emergency department of the Claimant hospital on four occasions over the course of six days. The condition was missed on the first three attendances.

Breach of duty was admitted with regard to the failure to diagnose and operate on the spinal condition on the penultimate attendance. It was conceded that the patient sustained additional pain, suffering and loss of amenity and consequential loss as a result of that breach. The Trust paid Mrs Metcalf £75,000 by way of an interim payment whilst the parties went away to prepare the quantum side of the claim.

Mrs Metcalf presented to her lawyers and the experts on both sides as a severely disabled lady dependent on walking aids to include walking sticks, a walking frame, a wheelchair and a mobility scooter. Those facts resulted in care and accommodation experts becoming involved. She signed a statement of truth to a Schedule of Loss claiming in excess of £5.7 million.

The Trust commissioned surveillance evidence, which demonstrated that she did not require mobility aids to walk; furthermore, the ambit of her levels of function far exceeded that reported to the experts and reflected in her damages claim.

In addition to the surveillance evidence, the court relied upon a filmed clinical assessment by the patient's medicolegal pain specialist in which she explained and demonstrated on film the limitations of her residual levels of mobility; in response to a question by the expert on film as to whether she would ever be seen mobilising to a greater extent than demonstrated on that day, she responded in the negative.

The Trust deployed its surveillance evidence together with an Amended Defence seeking a strike out order on the ground fundamental dishonesty, pursuant to Section 57 of the Criminal Justice and Courts Act 2015.

Mrs Metcalf persisted in her dishonesty after that evidence was deployed by serving a Reply verified with a further statement truth, denying the fundamental dishonesty allegation and reaffirming her reliance upon the full witness statements, expert evidence and other evidence served on her behalf. It was only after a failed round table meeting that she admitted her dishonesty, conceded that her claim should be dismissed and offered to re-pay the interim payment of £75,000 by way of instalments.

The Scales of Justice

The Trust commenced committal proceedings seeking Mrs Metcalf's committal to prison for contempt of court for signing statement of truth on a claim that she knew to be untrue. Mrs Metcalf admitted the contempt, though served an affidavit that sought to exculpate the full extent of her dishonesty, stating *"I was not thinking about my case in terms of cash value or as a way to obtain wealth or become rich. I saw it in terms of my future care needs"*. She went on to suggest that she did not know the full value of the claim, stating *"the figures in the final schedule of loss came as a shock to me"*.

That attempt to diminish the extent of her dishonesty was rejected by the Court, who found that she had 'systematically and shamelessly' set out to pervert the course of justice with a view to financial gain. Once her dishonesty had been admitted, it was agreed between the parties that the true value of the claim was in the region of £350,000.

Faced with an admitted case of contempt of court for signing a statement truth on a document that the signatory knew to be untrue, the Court turned to three cases for guidance on sentencing. The first was the Moses LJ's judgement in ***South Wales Fire & Rescue Service v. Smith*** 2011 EWHC 1749 (Admin); in particular the following passages from §§ 4-7:

"...Our system of adversarial justice depends upon openness, upon transparency and above all upon honesty. The system is seriously damaged by lying claims and in those circumstances that the courts have on numerous occasions sough to emphasise how serious it is for someone to make a false claim... Those who make such false claims, if caught, should expect to go to prison. There is no other way to underline the gravity of the conduct... The public and advisors must be aware that however easy it is to make false claims, ... if found out, the consequences for those tempted to do so will be disastrous... The lives of those tempted to behave in that way, of both themselves and their families are likely to be ruined."

The second case was ***Liverpool Victoria v. Bashir*** [2012] EWHC 895 (Admin) in which Sir John Thomas stated that the starting point for prison sentences for people involved in injury claims contaminated by dishonesty *'should be well in excess of 12 months even [for] those who played the role of foot soldiers'*.

The third case was the more recent decision of the court of appeal in ***Liverpool Victoria insurance v. Khan & Zafar*** [2019] 1 WLR 3833 where the Court of Appeal stated that prison sentences in contempt of court cases should not be suspended, save in exceptional circumstances. The other principal point of importance arising from the *Zafar* case was to remind the profession that experts who sign statements of truth dishonestly or recklessly should expect to be treated more harshly than witnesses who do not have expert status, because experts are imbued with a presumption of independence and professionalism, breach of which amounts to a greater contempt of the Court's process. This latter point did not apply in Mrs Metcalf's prosecution.

The Court, having apprised itself of these legal principles, conducted a balancing exercise taking into account the fact that: -

i. Mrs Metcalf did have a genuine claim which she had now lost;

ii. She had suffered disastrous financial consequences not only in having to pay repay the interim payment but also the cost implications of her civil claim;

iii. She was in poor health by reason of her underlying condition before the Trust's admitted negligence, which was compounded by that negligence;

iv. She was a lady of previously good character;

v. There were family members, including a young child, who would be affected by a custodial sentence for her; and

vi. She had admitted her contempt.

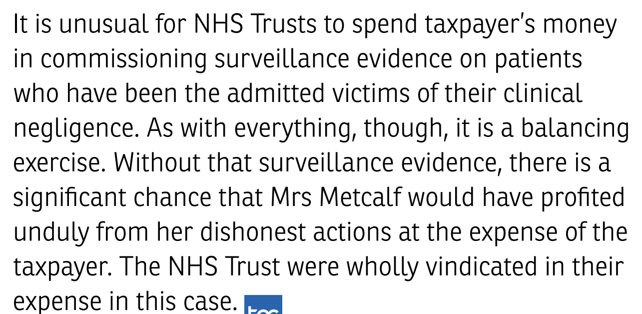
Notwithstanding such mitigation, it would appear that her admission was rather diluted by her delay in making a clean breast of her dishonesty once she was rumbled, and a misguided attempt to exculpate her actions with the affidavit referred to above.

The Weight of the Crime

Against that backdrop, Mrs Metcalf was sentenced to six months imprisonment of which she would be required to serve at least three months. It may well have been longer but the Court also took into consideration that a prison sentence during the time of the pandemic was likely to be more onerous than normal.

This was a serious case of contempt in which the decision to exaggerate the claim was objectively shameless and systematic. Interestingly, the Trust did not bring committal proceedings against Mrs Metcalf's family members who signed witness statements substantiating her dishonest claim.

It is unusual for NHS Trusts to spend taxpayer's money in commissioning surveillance evidence on patients who have been the admitted victims of their clinical negligence. As with everything, though, it is a balancing exercise. Without that surveillance evidence, there is a significant chance that Mrs Metcalf would have profited unduly from her dishonest actions at the expense of the taxpayer. The NHS Trust were wholly vindicated in their expense in this case.



By Marcus Grant (MarcusGrant@TGchambers.com)

I was only four years late, sir: *Wilkins v University Hospital North Midlands NHS Trust* [2021] EWHC 2164 (QB)

Clinical Negligence – Procedure – Limitation

Ellen Robertson considers the recent High Court case of *Wilkins*, which highlights the dangers of a *"lackadaisical approach"* to important issues such as the date of knowledge for limitation. The case is also a reminder of the weight placed by courts upon whether a fair trial remains possible, when conducting the "balancing exercise" to decide whether to exercise the Court's discretion under section 33 of the Limitation Act.

Background

In 2007, Mr Wilkins was diagnosed with bilateral knee osteoarthritis. He underwent a right knee replacement in late 2008 and a left knee replacement in early 2009. He had ongoing difficulties following the left knee replacement, with a possible infection noted a few weeks after the operation. He required revision surgery in June 2010. He subsequently developed cellulitis. Mr Wilkins underwent further surgery and a revision of the left knee replacement in 2012.

Mr Wilkins first contacted solicitors on 8 June 2012, expressing his concern about his left knee replacement and subsequent infection. His pain was ongoing. His solicitors obtained disclosure of his medical records and instructed an appropriate expert to prepare a report on liability. That report did not support a case on negligence. Mr Wilkins accepted the advice of his solicitor that his claim did not have sufficient merits to proceed. He was reminded about the importance of the limitation period by those solicitors in 2014.

The damaged knee continued to deteriorate to the extent that he underwent above the knee amputation of the left leg in June 2016. Mr Wilkins had contacted new solicitors shortly before that amputation, and entered into a Conditional Fee Agreement in September 2016. Matters then progressed, as the High Court noted, *"very slowly indeed"*. His new solicitors formed the view that the date of knowledge for limitation purposes ran from the amputation, and that limitation would therefore expire on 22 June 2019.

Proceedings were issued on 30 June 2019 and served on 4 October 2019. Mr Wilkins' pleaded case alleged that he had suffered from chronic infection following the left knee replacement in 2009, with inadequate care provided from the left knee replacement in March 2009 up to 22 June 2010.

The Defendant argued that the claim was statute-barred, and the question of limitation was ordered to be heard as a preliminary issue. The High Court considered that s.14 of the Limitation Act 1980 should be ***"capable of ready and sensible application by primary reference to the plain statutory language and sparing use of those cases designed to serve as general guidance."***

It's a Test of General Knowledge

Mr Richard Hermer QC, sitting as a Deputy High Court Judge, held that the date of knowledge arose in 2012. The Court followed the guidance given by the House of Lords in ***Haward & Other v Fawcetts*** and the Supreme Court in *AB & Others v Ministry of Defence*. It was not necessary for a Claimant to appreciate all the details of a claim that they might later formulate in order to have the requisite knowledge for the purposes of s.14 of the Act. It was sufficient that a Claimant understood, ***"in general terms"***, the ***"essence"*** of the factual claim upon which a later claim might be founded. In the context of a clinical negligence case, it was not therefore necessary for the Claimant to appreciate the particular mechanism of injury but simply to have an understanding in general terms that the medical care was a possible cause of injury.

Given that Mr Wilkins had discussed a potential claim for substandard medical care in June 2012, he knew in broad terms the essence of his case at that date, even if he had not appreciated that the issue might be one of infection management rather than surgical technique. Although instructing a solicitor was not automatically determinative of the date of knowledge, on the facts of the present case, the date of knowledge occurred by June 2012 at the latest. **The claim was therefore brought at least four years after limitation had expired.**

You Failed (But Have Another Go)

However, the Court exercised its discretion in favour of Mr Wilkins under section 33 of the Act. The Court declined to enter into consideration of the merits, noting that a merits assessment should only be conducted as part of the s.33 balancing exercise in ***"the clearest of cases."***

The Court identified two periods of delay. The first period followed the advice of his first solicitors that his claim did not have sufficient merits to proceed, and the second period was from the time of instructing new solicitors in 2016 until issue three years later. The Court found that Mr Wilkins could not be criticised for the first period; he had received reasoned and professional advice that his claim had insufficient prospects and was preoccupied with the pain and disability that led to the amputation. However, the Court was critical of the Claimant's present solicitors for failing to issue a claim form for three years, describing it as a ***"lackadaisical approach".*** The length of delay was unjustified and was a factor to be taken into account in the s.33 balancing exercise, but the Court noted the delay was caused by the solicitors and not Mr Wilkins.

An important factor was the lack of prejudice to the Defendant. The Court rejected the argument that the introduction of QOCS since the expiry of limitation could be considered as a material prejudice, noting that parties have to take the funding regimes as they find them. Given the lack of concrete prejudice, a fair trial remained possible.

Considering the lack of prejudice together with the seriousness of the underlying claim and the lack of culpability of Mr Wilkins personally for the delay, the Court held that it was equitable to exercise its discretion under s.33 of the Act and allow the matter to proceed.

By Ellen Robertson
(ERobertson@tgchambers.com)

Seeking (early provision of) shelter: *PAL v Davidson* [2021] EWHC 1108 (QB)

Clinical Negligence – Procedure – Interim Payments

James Arney Q.C considers the judgment of Mrs Justice Yip following an application for an interim payment for a 13-year-old claimant, who had suffered catastrophic injury (including a severe brain injury), in a road traffic accident. Between the accident on 27 December 2019 and the application before the Court, the Claimant had already received payments totalling £1,025,000. She sought a further sum of £2 million to enable a suitable property to be purchased for her long-term accommodation needs. The Defendants offered the sum of £1,250,000. Liability between the parties was not in issue.

Background

It was not contested that the Claimant's pre-accident family home was unsuitable. The Claimant had been discharged from hospital into a rental accommodation that the landlord had agreed could be adapted, on the basis of a 12-month tenancy. It was apparent to the Court that this property was also unsuitable. The tenancy was due to expire shortly after the hearing, and only oral agreement to a further lease had been agreed by the landlord.

After commissioning an accommodation report, the Claimant's team conducted a property search. Only one property was identified, and the interim payment was sought to allow that property to be purchased, at £1,190,000. The Claimant's accommodation expert considered, by way of an addendum report, that adaptation costs of this property would be around £612,000.

The Defendants had not sought any accommodation evidence. They noted that the application had been expedited and that they had had less than three weeks to respond to the evidence served by the Claimant. The judge said that the Defendants cannot (and did not) claim to be taken by surprise by an application for a substantial interim payment for accommodation.

Further, the judge found that ***"they cannot then complain about being required to respond quickly to an application that was readily foreseeable."*** The Defendants then obtained a desktop report from their accommodation expert, which was served on Friday 23 April 2021. By working over the weekend, the Claimant's advisers responded to that evidence, serving further evidence on behalf of the Claimant on the day before the hearing.

The Defendants' expert acknowledged that the current rental property was not suitable for the claimant in the longer term and supported a move to a more suitable property. He identified four properties at varying costs, all lower than the Claimant's expert.

The Parties' Positions on the Interim Payment

The further payment was being sought, as above, to pay for the purchase and adaptation of a suitable property. The Claimant's team made it clear they would anticipate seeking further interim payments before trial.

The Defendants accepted that the claimant required funds to meet her immediate needs other than for accommodation. In offering a further sum of £1,250,000 they acknowledged that this would not be sufficient to allow the claimant to purchase and adapt a suitable property, even on their own costings.

Eeles: Stage 1

The judge then turned to the Court's approach in ***Eeles v Cobham Hire Services Ltd*** [2009] EWCA Civ 204. It can be summarised as follows: -

- The judge's first task is to assess the likely amount of the final judgment, leaving out of account the heads of future loss which the trial judge might wish to deal with by PPO;
- Strictly speaking, the assessment should comprise only special damages to date and damages for pain, suffering and loss of amenity, with interest on both;
- The practice of awarding accommodation costs as a lump sum is sufficiently well established that it will usually be appropriate to include accommodation costs in the expected capital award;
- The assessment should be carried out on a conservative basis. The interim payment will be a reasonable proportion of that assessment;
- A reasonable proportion may well be a high proportion, provided that the assessment has been conservative. The objective is not to keep the claimant out of his money but to avoid any risk of over-payment;
- For this part of the process, the judge need have no regard as to what the claimant intends to do with the money. If he is of full age and capacity, he may spend it as he will; if not, expenditure will be controlled by the Court of Protection.

Mrs Justice Yip noted that a judge should not, at the interim payment stage, embark upon a mini-trial or seek to determine issues which are properly to be left to the trial judge.

Further, taking a conservative approach to the assessment does not necessarily mean adopting the Defendant's figures. The Court must also be alert to the possibility that the Defendant's contentions will be accepted at trial and keep in mind the risk of allocating too much to the lump sum element, so fettering the trial judge's freedom to allocate damages as he or she thinks fit.

In PAL, Counsel raised a ***"point of principle"*** as to whether the calculation at the first stage of Eeles involved assessing the likely special damages to trial or only to the date of the interim payment application.

The judge found there would be many instances where it is entirely appropriate to make the conservative assessment at the first stage to bring in special damages which have not yet accrued but will do so before trial.

There are examples where special damages yet to accrue will form part of the likely amount of the lump sum, for example future loss of earnings, or the provision of gratuitous care. Even these examples can risk over-payment. The longer the estimated period to trial, the greater the uncertainty and so the greater the risk. The assessment of this risk must depend on all the circumstances. Such an approach will allow the claimant's rehabilitation to continue while still leaving it open to the defendants to argue at trial that costs were not reasonably incurred.

The Claimant's approach to the current application was to include all the likely costs to trial in the Stage 1 calculation. The court did not agree and left out of account the special damages which were likely to accrue in relation to the Claimant's other needs when considering this application. This was done to avoid prejudicing future interim payment applications and/or the availability of funds to meet the Claimant's ongoing care and rehabilitation. Further, in this case, the evidence was far from complete and had not been subject to testing through cross-examination.

Stage 2

The second stage as set out in ***Eeles*** is as follows:-

The judge will be entitled to include in his assessment of the likely amount of the final judgment additional elements of future loss when:-

- The judge can confidently predict that the trial judge will wish to award a larger capital sum than that covered by general and special damages, interest and accommodation costs alone;
- The judge must be satisfied by evidence that there is a real need for the interim payment requested;
- The judge must not make an interim payment order without first deciding whether expenditure of approximately the amount he proposes to award is reasonably necessary. If the judge is satisfied of that, to a high degree of confidence, then he will be justified in predicting that the trial judge would take that course.

In *PAL*, it was not in dispute that it was necessary for a property to be purchased and adapted for the Claimant. The Judge said it was sensible that it had not been suggested that the Claimant rent another property. Further, the evidence suggested that leaving the accommodation issue unresolved would risk real disruption to the Claimant and her family. Therefore, the Court was satisfied "to a very high degree of confidence" that the purchase of a property is reasonably required at this stage. In fact, the judge went further and said that it was essential.

The Defendants conceded they could put forward no suitable property. With other properties highlighted by the Defendant's expert having fallen away, the judge decided that it was necessary to purchase a property for the Claimant now, and that the only available option was the property which had been identified at £1,190,000.

She noted that she was not deciding that the Claimant should purchase that property, nor that the Claimant would ultimately be entitled to damages assessed on the basis of that property. Further, the decision would not fetter the trial judge's freedom to allocate future loss.

Analysis

The judgment handed down is a helpful application of both stages of the test set down in ***Eeles,*** with consideration given to what can be included in the calculation at the first stage of ***Eeles*** 1.

Aside from this, it contains important lessons for both claimants and defendants on the scope and depth needed in accommodation reports to direct the evidence before the Court, as well as the importance of addressing issues evidentially in advance of the application hearing. The Claimant benefitted from her team's proactivity and responsiveness in respect of their accommodation evidence. Readers may also note the reluctance of the Court to consider a further rental term.

By James Arney Q.C. (jarney@tgchambers.com)

Quick-Fire Summaries

1. *Vinegrad v University College London Hospitals NHS Foundation Trust & Ors* (2021)

The Claimant suffered a severe psychotic breakdown arising from injuries sustained in an RTA. The following breaches were alleged against the Defendants: -

- Lack of proper assessment and monitoring;
- Lack of access to a psychiatrist prescribing anti-psychotic medication which would have prevented his breakdown.

The claim was dismissed.

Whilst HHJ Cooper found all members of the Claimant's family to be honest and conscientious in giving evidence, their testimony was inconsistent with contemporaneous medical evidence, which the judge thought showed that thorough investigations had taken place. They also struggled to recall events of over 8 years ago: ***Gestmin SGPS v Credit Suisse (UK)*** *Ltd* [2013] EWHC 3560 was considered on the fallibility of memory.

The judge raised a number of concerns about the Claimant's expert. Firstly, he was defensive in justifying his opinion. This approach led to the logic of his answers being difficult to follow, and he was not objective in his views. Perhaps most critically, he was not aware of the test in *Bolam*, and he had not considered the underlying medical records when writing his reports.

The judge found that the Claimant was exhibiting prodromal psychiatric symptoms prior to the accident, and that he was not exhibiting "obvious" psychotic symptoms during the material period. There would not have been a referral to psychiatric services. Had there been one, he was far from persuaded that anti-psychotic medication would have been prescribed, taken, or prevented the breakdown.

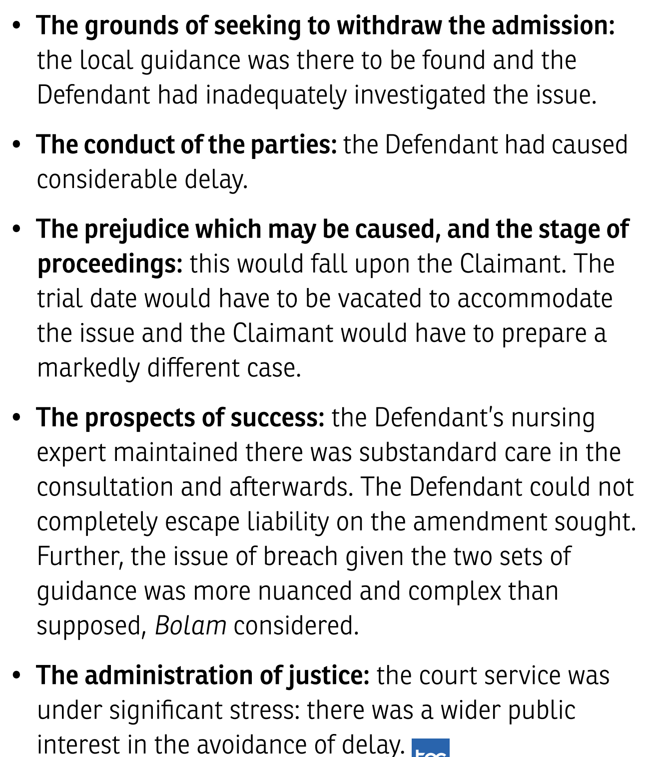
An invitation by the Defendant to draw adverse inference from the Claimant's own failure to give evidence was neither justified nor appropriate.

2. *Dulson v Popovych* [2021] EWHC 1515 (QB)

This was an application made by the Defendant pursuant to CPR 17.1(2) to resile from an admission of breach of duty. The Defendant had admitted liability for a delayed referral to cancer services, the eventual treating surgery leaving the Claimant injured.

The Defendant had sought causation evidence from an ENT surgeon who, of his own volition, volunteered that local protocol suggested patients should be referred after 3 weeks. This put the guidance at odds with national guidelines, meaning that the failure to refer at an early consultation was not of itself a breach of duty. This was supported by the Defendant's nursing expert.

The application failed, on the test set out below: -



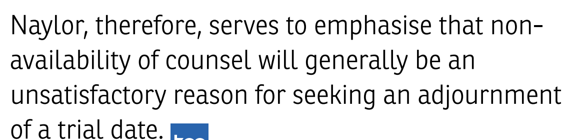
- **The grounds of seeking to withdraw the admission:** the local guidance was there to be found and the Defendant had inadequately investigated the issue.
- **The conduct of the parties:** the Defendant had caused considerable delay.
- **The prejudice which may be caused, and the stage of proceedings:** this would fall upon the Claimant. The trial date would have to be vacated to accommodate the issue and the Claimant would have to prepare a markedly different case.
- **The prospects of success:** the Defendant's nursing expert maintained there was substandard care in the consultation and afterwards. The Defendant could not completely escape liability on the amendment sought. Further, the issue of breach given the two sets of guidance was more nuanced and complex than supposed, *Bolam* considered.
- **The administration of justice:** the court service was under significant stress: there was a wider public interest in the avoidance of delay.

3. *Naylor v University Hospital of Leicester NHS Trust* [2021] EWHC 340 (QB)

The claimant brought an action for clinical negligence against the defendant NHS trust. The claimant applied for permission to rely on supplementary expert reports, an extension of time for service of the parties' updated schedules and an adjournment of trial due to the unavailability of counsel. The application was heard two months before the start of the trial window.

Fordham J first considered the issue relating to counsel's availability. Claimant's counsel, who had acted for the claimant throughout the proceedings, had become unavailable due to Covid-19 timetable changes relating to a separate public inquiry matter. The consequences were set out in the claimant's solicitor's witness statement, in which they claimed that the prospects of securing counsel with ***"commensurate skills and experience and the availability to deal with the preparation of expert evidence"*** were slim. Citing Bates v Post Office Ltd, Fordham J found counsel's unavailability came ***"nowhere near [to] providing a basis for adjourning the trial"***, with adjournment of trial being a ***"last resort"***.

Naylor, therefore, serves to emphasise that non-availability of counsel will generally be an unsatisfactory reason for seeking an adjournment of a trial date.



4. *Iddon v Warner, Manchester District Registry* (2021)

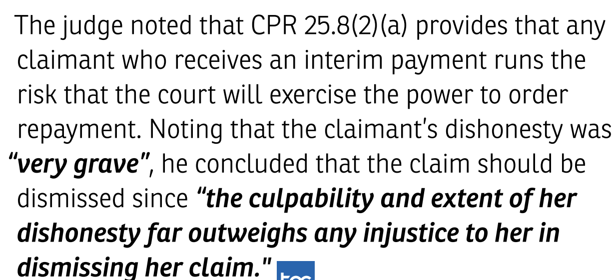
The claimant brought a claim for damages against her GP, alleging that a cancer diagnosis had been negligently missed. The defendant ultimately admitted liability on the basis that, but for the delayed diagnosis, the claimant would only have required a lumpectomy, avoiding the need for more extensive treatment.

The claimant commenced proceedings and claimed damages in the sum of £941,182. Her witness statement contended that she was disabled due to chronic pain so as to require ongoing care, and also that she could no longer undertake the running and swimming that she used to enjoy.

The defendant served surveillance evidence which showed that the claimant had in fact taken part in numerous sporting events, including 10 km runs and open water swims. The defendant sought to have the claim dismissed on grounds of the claimant's fundamental dishonesty.

The claimant submitted that her claim should not be dismissed, however, as this would result in her suffering substantial injustice. She relied on the fact that she had used interim payments from the defendant to buy her home, which would have to be sold if the claim was dismissed.

The judge noted that CPR 25.8(2)(a) provides that any claimant who receives an interim payment runs the risk that the court will exercise the power to order repayment. Noting that the claimant's dishonesty was ***"very grave"***, he concluded that the claim should be dismissed since ***"the culpability and extent of her dishonesty far outweighs any injustice to her in dismissing her claim."***



Meadows Khan't: *Khan v Meadows* [2021] UKSC 21

Clinical Negligence – Breach of Duty & Causation – Scope of Duty – 'Wrongful Birth' Claims

James Laughland (re-)considers the case of *Khan v Meadows* [2021] UKSC 21 in which the Supreme Court revisited the principles to be applied to a 'wrongful birth' claim and affirmed the centrality of the 'scope of duty' principle as a component of the tort of negligence more broadly.

Now we know for sure. Mrs Meadows cannot recover from Dr Khan for the additional costs (£7.6m) of having given birth to a child with autism as well as haemophilia when she had sought the doctor's advice, negligently given, to avoid giving birth to a haemophiliac child.

The Supreme Court has upheld the decision of the Court of Appeal that had overturned the trial judge's award of the full £9m sought. The Court of Appeal's decision was discussed in the previous edition of this newsletter *("Being Born Is The Leading Cause of Death")*.

The Supreme Court has confirmed that clinical negligence claims were no different to other forms of negligence claims, in that a defendant was only liable in damages in respect of losses of a kind which fell within the scope of his or her duty of care.

When one is assessing the scope of a defendant's duty of care in the context of the provision of advice or information (as opposed to the application of treatment such as surgery) the court had to identify the purpose for which the advice or information was given. In the case of a medical practitioner, it would be necessary to consider the nature of the service which the practitioner was providing in order to determine what were the risks of harm against which the law imposed on the practitioner a duty to take care. This is a more nuanced approach than a simple 'but for' assessment.

On the particular facts of this case, the issue about which Mrs Meadows had sought Dr Khan's advice was the risk that she might pass haemophilia on to a child. Dr Khan admitted that she had negligently advised about that and conceded a liability assessed at £1.4m. The dispute was whether Dr Khan was also liable for the unrelated risk that might arise in any pregnancy.

Whereas lawyers are used to summarising the essential components of the tort of negligence as Duty → Breach → Damage, the Supreme Court has now provided a more sophisticated, six-part list of questions to be asked when determining the extent of a claimant's entitlement to damages:

(1) The actionability question: is the harm (loss, injury and damage) which is the subject matter of the claim actionable in negligence?

(2) The scope of duty question: what are the risks of harm to the claimant against which the law imposes on the defendant a duty to take care?

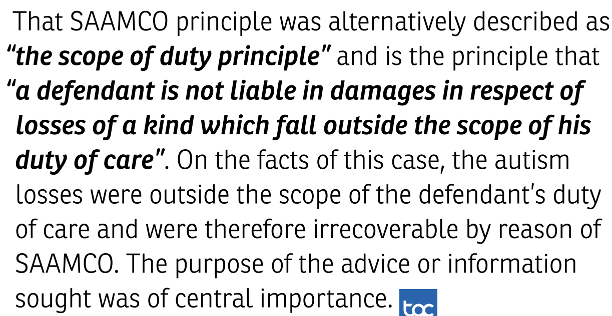
(3) The breach question: did the defendant breach his or her duty by his or her act or omission?

(4) The factual causation question: is the loss for which the claimant seeks damages the consequence of the defendant's act or omission?

(5) The duty nexus question: is there a sufficient nexus between a particular element of the harm for which the claimant seeks damages and the subject matter of the defendant's duty of care as analysed at stage (2)?

(6) The legal responsibility question: is a particular element of the harm for which the claimant seeks damages irrecoverable because it is too remote, or because there is a different effective cause (including *novus actus interveniens*) in relation to it or because the claimant has mitigated his or her loss or has failed to avoid loss which he or she could reasonably have been expected to avoid?

Not all the justices were fully signed up to this formulation, albeit all agreed in the result of the appeal and their differences of opinion were relatively restrained. The appeal itself had been heard alongside another and both had restated the principle established in ***South Australia Asset Management Corpn v York Montague Ltd*** [1997] AC 191 ("SAAMCO").



That SAAMCO principle was alternatively described as ***"the scope of duty principle"*** and is the principle that ***"a defendant is not liable in damages in respect of losses of a kind which fall outside the scope of his duty of care"***. On the facts of this case, the autism losses were outside the scope of the defendant's duty of care and were therefore irrecoverable by reason of SAAMCO. The purpose of the advice or information sought was of central importance.

By James Laughland

(jlaughland@tgchambers.com)

The evolution of consent: Post-*Montgomery* Case Law

Clinical Negligence – Breach of dDuty & Causation – Informed Consent – Duty to Disclose Material Risks of Treatment

The judgment in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 is arguably the most important development in the field of clinical negligence law since the formulation of the *Bolam* test. As is well known, *Montgomery* established the requirements for patients' 'informed consent' grounded in clinicians' duty to disclose the material risks involved in recommended treatment (and to set out alternative options).

Lionel Stride addresses below the following question: *how has the principle originally articulated in Montgomery been interpreted and applied in subsequent case law?*

Scope of Duty

Firstly, the post-***Montgomery*** jurisprudence has plainly expanded the concept of informed consent. Consider, for example, ***Spencer v Hillingdon Hospitals NHS Trust*** [2015] EWHC 1058 (QB), in which the claimant sustained a post-operative pulmonary embolism ('PE'). The defendant Hospital Trust was held liable for failing to advise him of the significance of the symptoms and signs of PE and the consequent need urgently to seek medical care if he experienced them. **In *Spencer*, therefore, the duty to warn of risks attached to certain treatments was extended to the duty to warn of risks *arising from* potential post-operative complications.**

Further, in ***Gallardo v Imperial College Healthcare NHS Trust*** [2017] EWHC 3147 (QB), a case concerning a failure to inform a patient that he had a malignant tumour which required regular follow-up, the court held that patients had the right to be informed of the outcomes of any treatment, prognosis and options for follow-up care; and that such discussions should take place as soon as possible and be clearly recorded. **This is a marked development of the *Montgomery* duty to warn against isolated risks, and appears to signal a trend towards a broader *duty to inform*.**

Materiality of Risk

The ***Montgomery*** duty was to warn against a 'material' risk. The test of materiality was determined as being simply whether a reasonable person in the patient's position would be likely to attach significance to the risk. Subsequent case law has grappled with this principle. In ***A v East Kent Hospitals University NHS Foundation Trust*** [2015] EWHC 1038 (QB), a case concerning a severe foetal abnormality, the High Court considered that a risk of 1/1,000 was *"theoretical"* or *"negligible,"* and that there was no duty on medical practitioners to warn against such risks; in ***Tasmin v Barts Health NHS Trust*** [2015] EWHC 3135 (QB) a similar level of risk was considered to be *"too low to be material"*. However, in Spencer (referenced above), the risk of PE was only 1/50,000 on the defendant's evidence but, as the potential outcome was so severe, the judge considered that the risk was nevertheless a material one against which the claimant ought to have been warned. **This demonstrates how 'materiality' is inextricably entwined with 'severity', not just likelihood.**

Lastly, in ***Duce v Worcestershire Acute Hospitals NHS Trust*** [2018] EWCA Civ 1307, which involved chronic post-surgical pain ('CPSP') following total abdominal hysterectomy ('TAH'), it was found that the surgeons did not know the risk of CPSP post-TAH at the material time. The Court of Appeal unsurprisingly concluded, therefore, that as the risk was not reasonably known about, it could not be material. This is an appropriate application of the standard principle in clinical negligence claims under which the relevant standard of care is determined in the context of the state of medical knowledge at the time of the index event.

Patient Characteristics

The subjective element of materiality concerns the characteristics of the individual patient; in ***Montgomery*** itself, for example, the risk of shoulder dystocia was of particular significance to the claimant's mother due to her short stature and pre-existing diabetes.

This issue was picked-up in ***Jones v Royal Devon and Exeter NHS Foundation Trust*** [2015] 9 WLUK 420, which involved a claimant suffering from cauda equina syndrome. The claimant in ***Jones*** was referred to a consultant ('C'); C was an experienced surgeon with a national reputation. C suggested bilateral decompression surgery, to which the patient agreed. In the event, another surgeon ('S') performed the operation. During the operation, the patient sustained an injury to her cauda equina, causing several serious ongoing symptoms. The patient alleged that she had consented to the operation on the basis that C would be performing it and that she had not been told that he was not performing it until shortly before going into theatre. It was held that, in order to satisfy the requirements of informed consent in these circumstances, the patient should have been told which surgeon would be undertaking the operation and been given the choice as to whether to proceed on that basis. The case of ***Crossman v St George's Healthcare NHS Trust*** [2016] EWHC 2878 (QB) further demonstrates how the court may apply the subjective element of ***Montgomery***. In this instance, the court held that, as the Claimant did not find it easy to express himself and was intimidated by medical professionals, there was a particular onus on the hospital staff to communicate clearly with him (rather than the other way around).

These cases emphasise the importance of individual concerns and characteristics when consenting a patient. Consent for the goose is *not* consent for the gander.

Alternative Treatments

There have been a number of reported clinical negligence cases regarding the duty on clinicians to advise as to reasonable alternative treatments. In ***Thefault v Johnston*** [2017] EWHC 497 (QB), a neurosurgical spinal case, Green J. emphasised that the requirement to set out reasonable alternative treatment plans **included, where appropriate, the requirement to advise as to the option of not having surgery at all and to pursue a conservative course of management.**

In addition, Green J. concluded that it was necessary to give *"adequate time and space"* for the patient to digest such advice, and that a discussion shortly before surgery was not sufficient, even if earlier written information had been provided.

Likewise, in ***Hassell v Hillingdon*** [2018] EWHC 164 (QB), another spinal cord injury case, it was found that there had been a failure to inform in respect of the alternative conservative treatment of physiotherapy; there was an interesting subjective element to this case in that the claimant's particular life circumstances (of needing to look after her children) meant that conservative treatment would have been an especially attractive option to her.

Lastly, in ***Bayley v George Eliot Hospital NHS Trust*** [2017] EWHC 3398 (QB), a case concerning ilio-femoral venous stenting as an alternative treatment for DVT, the court held that medical practitioners only have to inform patients as to treatments about which they would have reasonably known at the material time; if a treatment was the subject of research published in a well-respected medical journal, that might be an important factor in this determination.

Causation

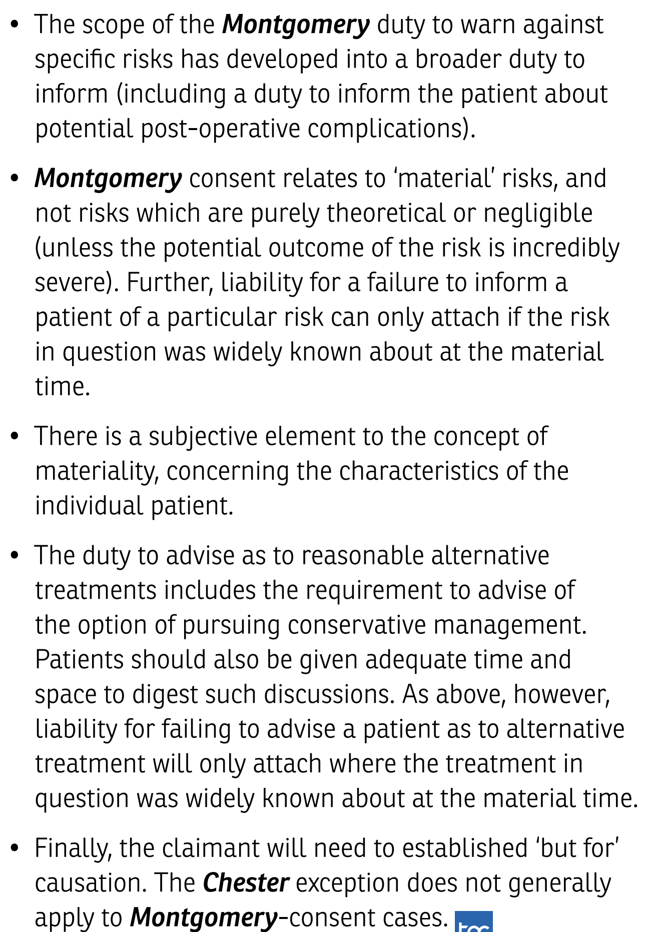
Finally, let us consider how the post-***Montgomery*** authorities have grappled with the issue of causation – i.e. what the claimant would have done if properly informed.

Take ***Diamond v Royal Devon & Exeter NHS Foundation Trust*** [2017] EWHC 1495 (QB), a hernia mesh repair case. The court found that, although the claimant's evidence was that she would have had a primary suture repair if offered, in the face of the mesh repair having very high prospects of success, *"it would have been irrational for the claimant to opt for suture repair; and I find that she is not a person who would act irrationally."* Accordingly, the claimant's case failed on causation.

Duce (referenced above) is another instructive case on causation, both factual and legal. On factual causation, the Court of Appeal considered that the claimant had been urged on several occasions by doctors to consider less invasive alternatives but still elected for surgery, she was willing to proceed despite some serious risks and she also had a long history of symptoms from which she wanted relief, so she would still have chosen surgery when she did in any event. On legal causation, the Court of Appeal took the opportunity to deal with the application of the test of causation in ***Chester v Afshar*** [2004] UKHL 41 to Montgomery cases and dismissed it in no uncertain terms. The court concluded that a claimant still needs to establish 'but for' causation, and that ***Chester*** is a specific exception to 'but for' causation on its own set of facts of deferring surgery which needs to be expressly pleaded and for which evidence must be provided.

Conclusion

The above is whistle-stop overview of some of the most significant principles that can be distilled from the post-***Montgomery*** case law. More than five years on, it is becoming clearer how ***Montgomery*** is being interpreted by the courts, but it remains likely that its application will continue to be contested and refined for many years to come, and that will remain a fertile ground for litigation. For now, some key take-away points for clinical negligence practitioners are as follows: –



- The scope of the ***Montgomery*** duty to warn against specific risks has developed into a broader duty to inform (including a duty to inform the patient about potential post-operative complications).
- ***Montgomery*** consent relates to 'material' risks, and not risks which are purely theoretical or negligible (unless the potential outcome of the risk is incredibly severe). Further, liability for a failure to inform a patient of a particular risk can only attach if the risk in question was widely known about at the material time.
- There is a subjective element to the concept of materiality, concerning the characteristics of the individual patient.
- The duty to advise as to reasonable alternative treatments includes the requirement to advise of the option of pursuing conservative management. Patients should also be given adequate time and space to digest such discussions. As above, however, liability for failing to advise a patient as to alternative treatment will only attach where the treatment in question was widely known about at the material time.
- Finally, the claimant will need to established 'but for' causation. The ***Chester*** exception does not generally apply to ***Montgomery***-consent cases.

Lionel Stride Lionel.Stride@TGChambers.com
With assistance from Philip Matthews

Spare me the detail: *Negus (1) Bambridge (2) v Guy's & St Thomas' NHS Foundation Trust* [2021] EWHC 643 (QB)

Clinical Negligence – Breach of Duty & Causation – Informed Consent – Duty to Warn – Material Risks

To what extent is a doctor under a duty to warn a patient before surgery of the material risks which may arise from intra-operative technical decisions? This was the central issue addressed by the High Court in *Negus (1) Bambridge (2) v Guy's & St Thomas' NHS Foundation Trust* [2021] EWHC 643 (QB), examined here by Robert Riddell.

Background

TN was a qualified nurse with a history of heart problems. In January 2014, she suffered a cardiac arrest and was subsequently diagnosed with significant aortic stenosis. During the initial consultation with the consultant cardiothoracic surgeon employed by the defendant Trust ("the Consultant") in February 2014, TN agreed to proceed with the recommendation for aortic valve replacement surgery. This involved implanting a mechanical prosthetic valve in place of TN's native aortic valve. There was a discussion of the relevant risks.

While the Consultant had in mind the possibility that, during surgery, TN might be required to undergo a rare and more complex procedure known as aortic root enlargement ('ARE'), this was not broached with TN. The Consultant's evidence was that he did not consider this procedure to be elective, but that it would be undertaken if necessary to save life or prevent harm, and was therefore covered by the general consent provided by TN.

On 5 March 2014, TN underwent surgery implanting a 19mm mechanical valve, which appeared to be successful. However, later that year she began experiencing tell-tale symptoms of cardiac dysfunction and, on further investigation by a different cardiothoracic consultant, was diagnosed with prosthetic-patient mismatch. On 18 March 2015, she underwent revision surgery during which she was subject to an ARE. TN suffered post-operative complications from which she never fully recovered. She subsequently died of heart failure on 29 January 2020.

The Claim

The Claimants (TN's executors) argued that the use of a 19mm mechanical valve during the first surgery was negligent in that an ARE should have been used to implant a larger prosthetic, thereby escaping the need for the later revision surgery, and avoiding TN's subsequent deterioration. Further, the Claimants alleged that the Consultant had failed adequately to explain to TN the benefits of implanting the largest possible prosthetic, and that this might require an ARE.

The trial was heard before Mrs Justice Eady.

The Agreed Issues

The parties agreed the following four issues for the Court's determination:

1. Was it negligent to implant a 19mm mechanical reduced valve during TN's surgery on 5 March 2014?
2. Alternatively, was there a negligent failure to explain, as part of the consent process that the largest possible valve should be implanted to avoid the risk of cardiac dysfunction (although this would involve an ARE, which was more complicated and involved higher risk)? If so, would TN have opted to undergo ARE?
3. If an attempt had been made to implant a larger valve, would TN have suffered the same complications that she did during surgery on 18 March 2015?
4. Did the failure to implant a 21mm valve cause the cardiac dysfunction requiring re-do surgery on 18 March 2015, with associated complications, and TN's subsequent death on 29 January 2020?

The Decision

Following the oral evidence of the experts, Eady J considered that the real question in issue (1) was whether the Consultant breached his duty to TN by failing to carry out an ARE to accommodate a larger valve than the one he had in fact implanted. Notwithstanding that the Claimants accepted that this procedure could give rise to complications, it was contended that the Consultant had negligently failed to provide a rational basis for the choices he made (by reference to ***Bolitho***). Specifically, the Consultant had failed to take account of the obvious benefits of ARE.

Eady J rejected these submissions, finding that the Consultant had reasonably exercised his professional judgment in the circumstances. Further, he had taken an entirely logical view, balancing the relevant benefits and risks. While some surgeons may have concluded that the risks of an ARE were worth taking, a responsible body of cardiothoracic surgeons faced with the same circumstances would have reached the same decision.

Issue (2) will have wider interest.

It was agreed between the parties' experts that it is not standard practice in this type of surgery to discuss with a patient the precise size of the valve that would be implanted, or that there might be a risk of prosthetic-patient mismatch: not only are they matters that can only be decided during the operation, but they are technical issues which most patients could not reasonably be expected to grasp (following ***Montgomery v Larnarkshire Health Board*** [2015] UKSC 11). Nonetheless, the Claimants identified a single omission during the consent process by the Consultant: namely, the failure to warn TN of the possibility that ARE might become necessary, and the associated risks. This was not, in the Claimants' submission, something that was encompassed by the provision of general consent.

Eady J weighed up several relevant factors in considering this matter. First, TN was a qualified nurse who had undergone several previous surgeries and may reasonably have been seen as someone with a greater appreciation of the potential risks and benefits of surgical choices. Second, TN's constitution was an indicator of the potential for a mismatch. Third, the Consultant's evidence was that he had the potential for an ARE in mind at the relevant time.

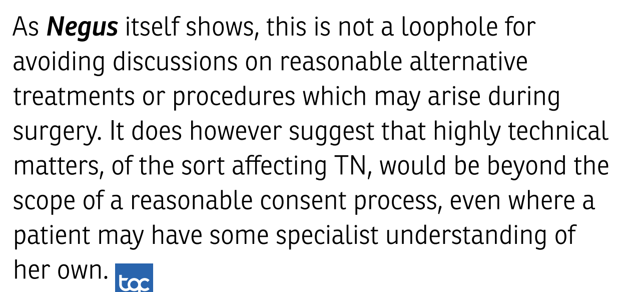
In these circumstances, Eady J found that the Consultant had a limited duty to warn TN of the risks that ARE might become necessary, which, on the expert evidence, would double the risks involved in that surgery. However, she was not prepared to accept that this duty extended to presenting TN with the various possible choices that might arise intra-operatively and could only be properly determined by the surgeon at that stage. These choices went beyond merely the bilinear decision as to whether to implant a 19mm valve or perform an ARE: the Consultant also had to consider (for instance) the size, make, and design of valve; whether he could be assured of a better outcome if a bigger valve could be inserted; and what the risks were of doing so. This involved highly technical decision making, requiring a specialist-level of understanding and experience.

On causation, Eady J rejected the assertion that there was any evidential basis to conclude that TN would have acted differently had she been provided with different advice. While there was a negligent failure to warn TN of the potential risk than an ARE may have to be undertaken, there was no breach of duty in failing to go beyond that and no causation of loss in any event.

While strictly unnecessary given her findings on issue (2), Eady J went on to consider issues (3) and (4) and rejected the Claimants' submissions on both grounds. The case was therefore dismissed.

Comment

While ***Montgomery*** represented a shift of emphasis in the patient/ doctor relationship, this decision demonstrates the limits of the doctor's duty to bring to their patient's attention any material risks associated with the recommended treatment. As Lords Kerr and Reid in the Supreme Court observed, the patient's ability to reach an informed decision depends on the clarity of the information provided: ***"The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form"*** (paragraph 90).



As ***Negus*** itself shows, this is not a loophole for avoiding discussions on reasonable alternative treatments or procedures which may arise during surgery. It does however suggest that highly technical matters, of the sort affecting TN, would be beyond the scope of a reasonable consent process, even where a patient may have some specialist understanding of her own.

By Robert Riddell (RRiddell@tgchambers.com)

Bound up by my notes: *Sheard v Cao Tri Do* [2021] EWHC 2166 (QB)

Clinical Negligence – Breach of Duty & Causation – Witness Evidence – Medical Notes

Nick Dobbs considers the case of *Sheard v Cao Tri Do* [2021] EWHC 2166 (QB), which provides an instructive example of the difficulties in negligence claims of resolving conflicts between witness evidence and contemporaneous medical notes, especially when memories of crucial conversations have faded.

Background

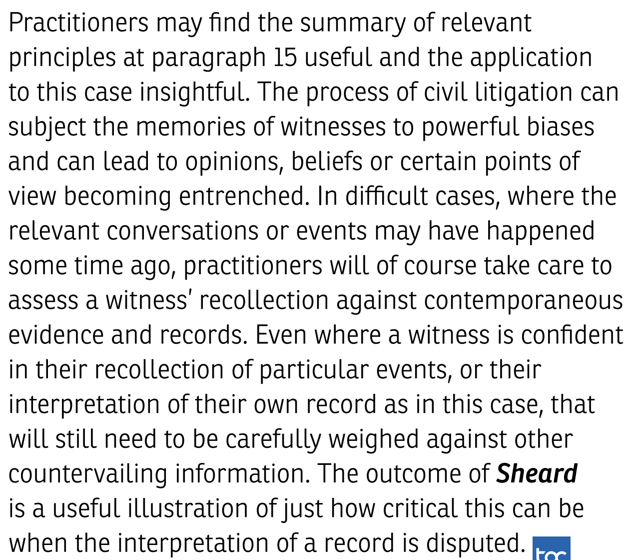
In ***Sheard***, the claimant claimed damages for personal injury and other losses arising out of alleged clinical negligence on the part of two defendants. The claim against the second defendant settled and so the claim proceeded only against the first defendant, a General Practitioner. Liability and causation were disputed. The claimant was seen by the first defendant. He claimed that he presented with severe neck and shoulder pain, together with a two-week history of a pyrexial viral illness such that he should have been referred to hospital. He alleged that this failure amounted to a breach of duty of care. The dispute over liability rested significantly on what was said in that consultation about the symptoms and their duration. By the time of the hearing in April 2021, that consultation had taken place well over 6 years previously.

The notes made by the first defendant during the consultation were obviously of crucial importance. The critical passage stated, "for past 2 weeks, been unwell with viral illness – pyrexia and dizziness." The claimant argued this was an unambiguous statement that at the time of the consultation, he had been, and still was, unwell with a pyrexial illness. The first defendant disputed this, arguing that that was not the correct interpretation of the note. He accepted however, that given the length of time which had passed since the consultation, he had no particular recollection of the claimant or of the consultation itself. The Judge was referred to the line of authority including ***Gestmin SGPS SA v Credit Suisse (UK) Ltd*** [2013] EWHC 3650 (Comm) and ***R (Dutta) v GMC*** [2020] EWHC 1974 (Admin). The principles derived from those cases are usefully summarised in some detail from paragraph 15 onwards in ***Sheard***.

The Decision

HHJ Robinson held that the evidence on this issue was "all one way apart from the interpretation put on the relevant note by the defendant". His Honour was satisfied that: (1) the claimant told the defendant that for the past two weeks he had been unwell with a viral illness which, as interpreted by the defendant, included symptoms of pyrexia and dizziness; (2) the note made by the defendant accurately recorded that history; and (3) the defendant knew at the time he made the note that he was recording the presence of an ongoing complaint. This interpretation was held to be consistent with ***Gestmin***, and in particular, there was no need to "strain to interpret the ordinary and natural meaning of the recorded complaint". The fact that the defendant recorded "no red flags of note" did not alter this; there were 'red flags', but the evidence as a whole tended to suggest that he failed to appreciate their presence.

The defendant was held to be in breach of his duty for failing to refer the claimant to hospital at the conclusion of the consultation.



Comment

Practitioners may find the summary of relevant principles at paragraph 15 useful and the application to this case insightful. The process of civil litigation can subject the memories of witnesses to powerful biases and can lead to opinions, beliefs or certain points of view becoming entrenched. In difficult cases, where the relevant conversations or events may have happened some time ago, practitioners will of course take care to assess a witness' recollection against contemporaneous evidence and records. Even where a witness is confident in their recollection of particular events, or their interpretation of their own record as in this case, that will still need to be carefully weighed against other countervailing information. The outcome of ***Sheard*** is a useful illustration of just how critical this can be when the interpretation of a record is disputed.

By Nicholas Dobbs (ndobbs@tgchambers.com)

Is material contribution enough? *Davies v Frimley Health NHS Foundation Trust* [2021] EWHC 169 (QB)

Clinical Negligence – Breach of Duty & Causation – Material Contribution

In *Davies v Frimley Health NHS Foundation Trust* [2021] EWHC 169 (QB), HHJ Auerbach (sitting as a Deputy High Court Judge) considered whether the making of a material contribution to harm, in a clinical negligence claim, was sufficient to establish liability. Here, James Laughland analyses the judgment.

The Claimant's wife had developed bacterial meningitis. Within 24 hours of seeing her GP for what was then thought to be a middle ear infection, she was declared brain stem dead. The hospital admitted that it ought to have administered intravenous antibiotics within 90 minutes of her arrival but argued that in fact such would not have altered the eventual outcome of death as the progress of the meningitis was (they argued) already so advanced.

The Judge found in the Claimant's favour on the main issue, concluding that earlier administration of antibiotics would have been successful, as she had not reached the tipping point at the time of the admitted breach of duty. By the time antibiotics had been commenced, it was too late.

In such circumstances it was not necessary for the Judge to determine the Claimant's alternative argument about material contribution, but as it had been fully argued the Judge chose to do so.

The Claimant had argued that even if the Court could not be satisfied on the balance of probabilities that earlier administration of antibiotics would have saved her life, the delay made a material contribution to her death. The Defendant had argued that the doctrine of material contribution was not applicable to cases of clinical negligence.

Having undertaken a thorough review of the authorities, the Judge stated his understanding of the position to be as follows.

First, where the harm is divisible, a party will be liable if their culpable conduct made a contribution to the harm, to the extent of that contribution.

Secondly, where the harm is indivisible, a party will be liable for the whole of it, if they caused it, applying 'but for' principles.

Thirdly, if two wrongdoers have both together caused an indivisible injury, in respect of which it is impossible to apportion liability between them, then each is co-liable for the whole of the injury suffered.

These were what the Judge called the orthodox routes to liability.

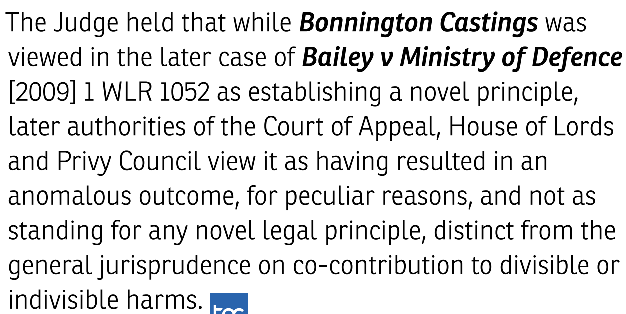
The mesothelioma case of ***Fairchild***, where there had been exposure to asbestos dust at multiple exposure sites by a number of defendants, was seen by the Judge as a further distinct route to liability in the limited types of case to which it applies, based on contribution to risk, but leading to liability for the actual harm.

In the instant case, Mrs Davies had died from a disease which, whilst it involved a process that took its course over a period time, led to the indivisible outcome of death. The sole task for the Court had been to determine on the balance of probabilities whether, in a but for sense, the failure to start IV antibiotics within 90 minutes of admission caused her death or not. The Judge concluded that had he not been so satisfied, there would not have been any other legal doctrine, such as material contribution to harm or to increased risk, that could have led to a finding in the Claimant's favour.

A disease or condition is 'divisible' where an increased dose of the harmful agent worsens the disease. In ***Bonnington Castings Ltd v Wardlaw*** [1956] AC 613 the claimant succeeded where the tortious exposure to silica dust had materially aggravated (to an unknown degree) the pneumoconiosis which he might well have developed in any event from non-tortious exposure to the same dust. The tort did not increase the risk of harm, it increased the actual harm.

In contrast, with cancer cases where one either has cancer or not, this is an indivisible condition. The condition is not worse because one has been exposed to a greater or smaller amount of the causative agent. Divisible injuries are those whose severity is proportionate to the amount of exposure to the causative agent.

The Judge held that while ***Bonnington Castings*** was viewed in the later case of ***Bailey v Ministry of Defence*** [2009] 1 WLR 1052 as establishing a novel principle, later authorities of the Court of Appeal, House of Lords and Privy Council view it as having resulted in an anomalous outcome, for peculiar reasons, and not as standing for any novel legal principle, distinct from the general jurisprudence on co-contribution to divisible or indivisible harms.



By James Laughland
(jlaughland@tgchambers.com)

"The oddity of his position" (the *Bolam* test and expert evidence): *Jarman v Brighton and Sussex University Hospitals NHS Trust* [2021] EWHC 323(QB)

Clinical Negligence – Breach of Duty & Causation – Bolam Test – Expert Evidence

Rochelle Powell analyses the case of *Jarman v Brighton and Sussex University Hospitals NHS Trust* [2021] EWHC 323(QB), which provides an interesting exposition of the Bolam test in the context of an alleged failure to refer the claimant for an emergency MRI.

Background

The Claimant suffered a right side and central L5-S1 disc prolapse after an accident at work on 17 February 2015. Following consultations with her GP and physiotherapists, on 3 March 2015 she attended the Accident and Emergency ('A&E') Department of the Royal Sussex County Hospital, operated by the Defendant (the Brighton and Sussex University Hospitals NHS Trust ('the Trust')). The Claimant was examined on the same day in the Trust's orthopaedics department. The Claimant was found to have several ***"very worrying symptoms"*** of Cauda Equina Syndrome ('CES') but, upon thorough examination, was found to have no clinical signs of CES. As a result of that examination, she was referred for an MRI scan on a *"routine"* timescale. The MRI scan was performed on 18 March 2015 and showed probable CES. The Claimant had urgent spinal decompression surgery on 21 March 2015, but this was unsuccessful; she suffered permanent neurological damage and long-term consequences of CES.

The Claimant alleged that the Trust acted negligently in failing to carry out an MRI scan within four days, thereby causing decompression surgery to be delayed. The Defendant maintained that the timing of the Claimant's scan and subsequent surgery was appropriate, as she was not showing any signs of CES upon examination.

The Expert Evidence

Jason Coppel QC (sitting as a Deputy Judge of the High Court) heard evidence from 7 different expert witnesses. Notably, they all agreed that they personally would have referred the Claimant for an emergency MRI scan upon her presentation at the hospital. The Claimant's orthopaedic expert, Mr Spilsbury, argued that an MRI scan should have been arranged within 48–72 hours of presentation to Hospital, rather than on an emergency basis (within 24 hours). Under cross examination, he accepted that ***"I would agree there is no logic in delaying it and I wouldn't have delayed it".***

Mr Chiverton, the Defendant's Orthopaedic expert gave evidence that, whilst he personally would have referred the Claimant for an emergency scan, there was a reasonable and responsible body of clinicians who would have arranged for the Claimant to have a scan within 14 days, whilst instructing her to return to hospital if her condition deteriorated.

The Legal Principles

Coppel J applied the ***Bolam*** test, whereby a doctor must provide care which conforms to the standard reasonably to be expected of a competent doctor and will not be in breach of the duty of care if a responsible body of medical opinion would have approved of the treatment given, even if other experts might disagree.

In considering the legal basis upon which it might be appropriate to reject the expert evidence in support of the Claimant, the court also considered the analysis of Green J (as he then was) in ***C v North Cumbria University Hospitals NHS Trust*** [2014] EWHC 61 (QB). The following were held to be the key principles and considerations to be applied in the assessment of expert evidence:

©TGChambers

i. Where a body of appropriate expert opinion considers that an act or omission alleged to be negligent is reasonable a Court will attach substantial weight to that opinion.

ii. This is so even if there is another body of appropriate opinion which condemns the same act or omission as negligent.

iii. The Court in making this assessment must not however delegate the task of deciding the issue to the expert. It is ultimately an issue that the Court, taking account of that expert evidence, must decide for itself.

iv. In making an assessment of whether to accept an expert's opinion, the Court should take account of a variety of factors including (but not limited to) whether the evidence is tendered in good faith; whether the expert is ***"responsible"***, ***"competent"*** and/or ***"respectable"***; and whether the opinion is reasonable and logical.

The Decision

Applying the ***Bolam*** test, Coppel J held that there was a body of reasonable opinion which would have supported arranging a scan for a patient in the apparent condition of the Claimant on an *"urgent"*, approximately two-week timescale, whilst giving the patient ***"safety netting advice"***, to return to hospital if there was any deterioration in her condition.

Special regard was given to the fact that Mr Chiverton was able to point to a reputable journal article which supported the decision not to send the Claimant for an immediate scan. In contrast, Mr Spilsbury was ***"unconvincing when challenged for failure to cite any literature or even previous case studies from his own practice in support of propositions which could and should have been supported in that way."***

Finding in the Defendant's favour, the court further held that the Claimant's primary case – that she should have been scanned within a few days – and the evidence on which it was based *"suffered from a fundamental flaw"*. Mr Spilsbury opined in his report that a scan within 48-72 hours would have been *"the medically correct treatment of this patient"*, however, later confirmed in the relevant joint statement that he would have sent the Claimant for an emergency MRI *"undermining his opinion on his report"*. *Coppel J commented: -*

"... such is the oddity of his position that I am driven to accept the Defendant's submission that Mr Spilsbury was guilty, to some extent at least, of framing his position to fit the Claimant's primary legal argument, that the Trust was negligent by not implementing Mr Khan's plan to scan within 'a few days'."

Comment

This judgment not only provides a useful reminder of the legal test that the Court will apply when determining breach of duty, it also highlights the need to rigorously test expert evidence in clinical negligence cases. Those experts who simply frame their position to fit the relevant legal argument will be caught out and this may undermine the entirety of their evidence. Reference should be made to the principles set out in ***C v North Cumbria*** when assessing the strength of an expert's position. Practitioners should also ensure that, where possible, experts cite literature, or at the very least previous case studies, in support of their evidence.

By Rochelle Powell
(RochellePowell@tgchambers.com)

Weighing up Fundamental Dishonesty vs. 'Unreliability': *Brint v. Barking, Havering and Redbridge University Hospitals NHS Trust* [2021] EWHC 290

Clinical Negligence – Breach Of Duty & Causation – Fundamental Dishonesty – Witness Credibility

Anthony Johnson considers the decision of HHJ Platts QC (sitting as a High Court Judge) in the case of *Brint*, which turned almost entirely on its unusual facts. However, the case has been fairly widely commented upon and discussed, chiefly due to the Judge's consideration of the Claimant's lack of credibility as a witness, which was nevertheless found to fall short of the threshold of fundamental dishonesty for the purpose of CPR 44.16. It is suggested, however, that the outcome was not necessarily particularly surprising on the basis of the findings of facts as they are presented in the judgment.

Background

The Claimant's claim arose following an extravasation injury following a CT scan with contrast carried out at the Defendant's Hospital. Her claim alleged, inter alia, that the treatment had proceeded without her informed consent to a needle being inserted into her left thumb, which it was averred amounted to negligence and, indeed, to an actionable assault. It was pleaded that, as a consequence of the alleged negligence and/or assault, she had developed Complex Regional Pain Syndrome (CRPS), Post Traumatic Stress Disorder (PTSD), and Depression.

The Defendant disputed the case on the basis of liability, causation and quantum and made a formal allegation of fundamental dishonesty.

HJJ Platts QC found that the claim failed at the first hurdle in that the Claimant had not made out her case on liability. Even if this had not been the case, he went on to hold that the claim would have failed in any event on the issue of causation given that the Claimant's complicated medical history meant that it was difficult to conclusively attribute her CRPS or PTSD to the extravasation injury. However, he rejected the Defendant's application for a formal finding that she had been fundamentally dishonest for the purposes of disapplying QOCS pursuant to CPR 44.16(1).

The two primary reasons that the Judge gave for rejecting the Claimant's claim were as follows: (i) her suggestion that she was 'fit, healthy and active' before the incident was inconsistent with her extensive medical history of significant and disabling physical and psychological symptoms; and (ii) her account of the incident was in many respects at odds with the agreed expert evidence and, in other respects, was inherently improbable. There were significant inconsistencies in her witness evidence and some of her explicit allegations were inherently unlikely and not supported by the contemporaneous medical records.

Analysis

Some eyebrows were raised in response to the Judge declining to find that the Claimant had been fundamentally dishonest, despite characterising her evidence at points in his judgment as misleading, unconvincing, wholly unreliable and inaccurate. Some reports about the decision in *Brint* have suggested that it raises the standard required for a Defendant to plead fraud in a clinical negligence case (or, indeed, in other types of case), or that it somehow moves the goalposts in such cases. It is respectfully suggested, however, that an analysis of the relevant parts of the judgment actually shows that the decision can be confined to the particular, unusual facts of the case, and that it actually represents an orthodox application of the relevant principles.

At paragraph 100 of his judgment, the Judge re-stated the test set out by Lord Hughes in the Supreme Court in ***Ivey v. Genting Casinos*** [2017] UKSC 67 where it was stated that:

"When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest."

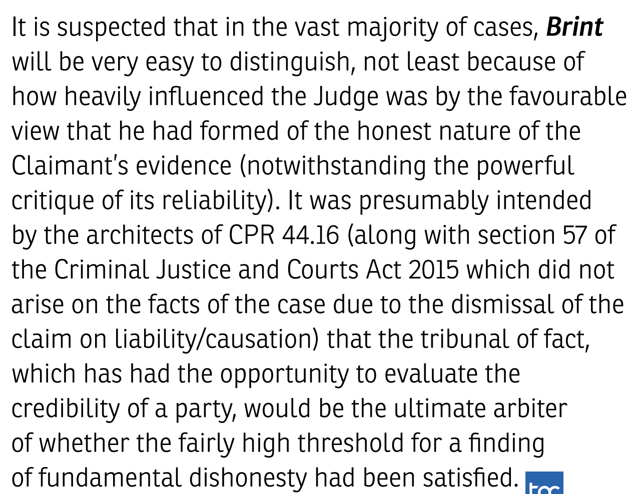
The Judge's reasoning for declining to make a fundamental dishonesty finding can best be seen at para.102 of the judgment where he stated:

"This has been an extremely complex case. However, when I stand back and look at the totality of the evidence, I am far from persuaded that the claimant has deliberately made up events that did not occur or that she has deliberately told lies about her condition in order to advance her claim. Applying the two-stage test, [from Ivey] I am satisfied that the claimant genuinely believed in the truth of the evidence that she gave and that, applying the standards of ordinary decent people I find as a fact that although her evidence was wholly unreliable in the sense that I do not accept it, she has not been dishonest. I therefore reject the allegation of fundamental dishonesty."

This extract should be read in the context of the previous paragraph (101) where he had said, ***"Finally, and importantly, my impression of her as a witness whom I heard and observed (albeit over video-link) during extensive cross examination when all these matters were put to her was that she was not a dishonest person. She has a genuine and significant disability which she firmly believes has been caused by the events of the 29th December 2013."*** It is extremely relevant to the outcome that it is stated elsewhere on the face of the judgment that the Claimant had been cross-examined for 1½ days of Court time. He commented that a 'failure to give a satisfactory account' (which is how the Defendant had put the point) is very different from giving a false account.

The Judge gave a litany of reasons for rejecting the argument that the Claimant was fundamentally dishonest. These included the following:-

- The allegation had first been raised extremely late in the litigation. The Defendant knew the Claimant's account when her witness statement was served, but did not allege that she was dishonest at that stage;
- It was not a case where the spectre of dishonesty had arisen for the first time during the live evidence. It was not clear what had justified the late change of approach;
- None of the experts in the case and none of the Claimant's treating clinicians had accused her of being dishonest in her presentation until very late in the litigation, and he had rejected the evidence of the one expert who had;
- The Claimant did not appear to have been motivated by the prospect of financial gain;
- She had made prompt and consistent complaints about her treatment. It is highly unlikely that she would have invented those complaints within such a short period of time and remained so consistent about them thereafter if they were pure invention;
- Her account had striking similarities to an event in which she was involved in 2010, suggesting that she had somehow conflated the two events in her own mind and genuinely believed that what she said happened had in fact happened;
- Although she was unreliable when she said that she was fit, healthy and active, this did accord with her perception of her own limitations;
- Her failure to be fully frank from the outset about her receipt of DLA for an unrelated issue was of more concern, but she had never denied receiving the benefit and had volunteered as much to the Defendant's care expert; and
- Her evidence had to be viewed against the background of her psychological profile, which had been discussed at length by the psychiatric experts.



The Judge also rejected an Application by the Defendant to adduce further evidence relating to the Claimant's alleged dishonesty after his dismissal of the primary claim. Although it would be impossible to tell conclusively without having access to the full evidence in the case, it may well have been that the outcome could have been different if all of the evidence that the Defendant wished to rely upon in relation to the point had been before the Court in the first place.

It is suspected that in the vast majority of cases, ***Brint*** will be very easy to distinguish, not least because of how heavily influenced the Judge was by the favourable view that he had formed of the honest nature of the Claimant's evidence (notwithstanding the powerful critique of its reliability). It was presumably intended by the architects of CPR 44.16 (along with section 57 of the Criminal Justice and Courts Act 2015 which did not arise on the facts of the case due to the dismissal of the claim on liability/causation) that the tribunal of fact, which has had the opportunity to evaluate the credibility of a party, would be the ultimate arbiter of whether the fairly high threshold for a finding of fundamental dishonesty had been satisfied.

By Anthony Johnson
(AnthonyJohnson@TGchambers.com)

Check your measurements: *XM v Leicestershire Partnership NHS Trust* [2020] EWHC 3102 (QB)

Clinical Negligence – Breach of Duty & Causation – Standard of Care – Health Visitors

James Arney Q.C. considers the case of XM, which examined the standard of care to be expected from health visitors. The judgment is a practical application of the principles established in *Wilsher* and *Darnley*; the role carried out by a professional is the material consideration, not the qualifications of the individual in question.

Background

In *XM*, a baby tragically suffered permanent, catastrophic brain injuries as a result of the Defendant Trust's negligence. The Claimant had a very rare and benign brain tumour, a choroid plexus papilloma, from birth until he was treated in January 2013.

The Claimant's case was that the Defendant had failed to identify and act upon the fact that his head was growing at an abnormally fast rate. The tumour caused overproduction of cerebrospinal fluid (CSF) which caused the Claimant's head to grow abnormally fast. Because of elasticity in a baby's skull, the Claimant was able to compensate for the rapid increase in the size of his head. In late December 2012 raised intracranial pressure began to cause symptoms. His parents took him to an emergency walk-in centre on 30th December 2012. He had massive hydrocephalus, and sustained permanent catastrophic brain damage.

This article focuses on the negligence alleged by the inaction of both health visitors (HV) and nursery nurses who, the Claimant said:

- Failed to identify that his head circumference had crossed into such a centile that it was of concern;
- The Claimant argued that, at an assessment on 12th August 2012, the health visitor should have referred the Claimant to a GP/Paediatrician, or arranged for another measurement of the head two weeks later;
- The Claimant further alleged that the health professionals did not identify that the Claimant had not seen his GP for an important 6–8 week check, and then did not rectify this omission;
- Health professionals failed to refer the Claimant to hospital.

Legal Framework

The Court summarised the classic ***Bolam*** test, being of course that medical treatment will not be negligent if it is in accordance with a practice accepted as proper by a responsible body of opinion. This was later refined in ***Bolitho v City and Hackney Health Authority*** [1998] AC 232, where that responsible body of opinion had to have a ***"logical basis"***.

The Court also considered ***Williams v Cwm Taf Health Board*** [2018] EWCA Civ 1745, where it was held that it is, in principle, open to a judge to use his own judgement and reasoning to say that the evidence before him about the reasonableness of a clinical decision simply does not make sense, if any facts in the case which depend on specialist expertise are sufficiently clearly established and uncontroversial.

There was no authority before the Court on the standard of health visitors/nursery nurses. The Defendant noted that *Clerk & Lindsell* 23rd edn, under ***"liability for other medical and quasi-medical professionals"*** stated that the principles relating to doctors apply equally to nurses. The Claimant cited ***Wilsher v Essex AHA*** [1987] QB 730, where the duty of care related not to the individual, but the post that she occupies, and ***Darnley v Croydon Health Services NHS Trust*** [2019] AC 831, citing the legitimate expectations of patients to receive care given with a degree of skill appropriate to the task undertaken, and that the standard required was that of an averagely competent and well-informed person performing a function (there, of a receptionist).

Standard of Care – Health Visitors ('HV')

On the question of the standard of care to be expected in measuring head circumference and carrying out an initial interpretation of these measurements, the Court found that there is one standard of care, regardless of the qualification or post held by the health professional responsible for the task.

The Court assessed a range of evidence to determine this point. The Defendant's Standard Operating Procedure made clear that, in the context of this case, the HV was required to obtain a head circumference measurement at the initial contact and at the 6-week contact. Further, she was required to plot the head circumference on the centile chart, to interpret the head circumference size so as to ensure that its growth was along expected centile lines, considering future growth potential, and earlier growth. If she was concerned about rapid head growth, she was to consider hydrocephalus and urgently refer to a GP.

Whilst the judge said he was aware that one must think about "different levels of qualification, training and experience" between a HV and a GP, some of the allegations were ***"exclusively within the domain of health visitor expertise"***. Whilst the HV was not required to make a diagnosis, she was required to be aware, follow and interpret the guidance given to her.

The judge rejected the Defendant's argument that HVs carry out a more mechanistic set of tasks, essentially going through a tick box exercise. The judge responded to that point strongly: such exercises do not absolve health care professionals of their duties, or from exercising professional judgment.

Standard of Care – Nursery Nurses

The standard of care expected from these professionals is not the same as that of a HV. They are not qualified to measure or interpret head circumferences.

Breach of Duty

The Claimant alleged that the HV fell below the standard reasonably required of her by failing to realise or act upon the fact that, albeit not crossing centile lines, the Claimant's head circumference was on a steep upward gradient, having crossed a full centile space within a 4 week, rather than 6 week, period.

All apart from one of the Defendant's experts gave evidence that the birth head circumference was an important baseline for later measurements. The Defendant also argued that evidence before the Court indicated that little is known about the accuracy or value of regular head circumference measurements. These arguments were not accepted by the court.

The Court found that the HV had before her two measurements taken of the Claimant, 4 weeks apart. Whilst the Claimant's expert told the court these measurements showed a steep curve, the HV stood by her witness evidence that this was only a ***"steady gain"***. The Court found as a matter of fact that, the trajectory plotted in these measurements would have required the HV to either re-measure or to refer the Claimant to his GP. She had breached her duty.

The Court further found that the Defendant's expert's evidence was illogical, and not representing a body of opinion which was "responsible, ***reasonable, and respectable"***. The Judge seemed particularly struck that, whilst two measurements six weeks apart would have saved the Claimant from suffering his devastating injury, the expert seemed unduly influenced by her opinion that the focus on measurements in UK neo-natal care was a ***"historical artefact".***

Causation

This was not in issue, the Defendant having accepted that had there been a referral made to the GP on or after 8th August 2012, the outcome would have been a remeasurement, diagnosis and successful treatment.

Other Failings

The Court also found that another HV had a duty to remind the Claimant's parents to take him for his 6–8 week check-up, and to recommend he undergo it, albeit at a later stage.

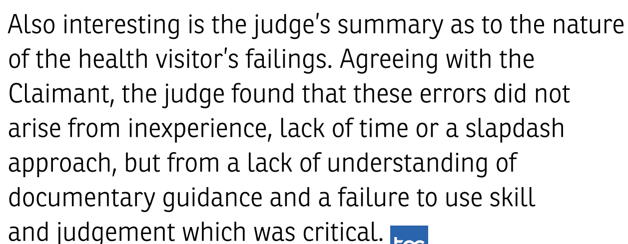
She was also in breach of her duty of care by not appreciating that there was disproportion in the Claimant's head size which should have led to him having his head remeasured and/or checked by a medical practitioner.

Analysis

This judgment is clearly a novel extension of the expression of the duty of care in health settings in ***Darnley***. It is perhaps not surprising that the health visitor's duty (and breach) was reasonably extensive, given the professional duties placed on receptionists in that case.

Helpful guidance is also found in the judgment as to the consideration of ***"responsible, reasonable, and respectable"*** expert opinion, and the failure of the Defendant's expert to meet the test as set out in ***Bolitho***. Those interested in that issue should read paragraphs 388–389 of the judgment, where the expert's key failing appeared to be primarily the distance between her opinion and that of the other experts. Her evidence appeared to be completely at odds with standard operating procedures as explained by others, and it is notable that the judge commented in particular on her disregard in general for measurements in the first weeks, despite the overwhelming evidence before the court to the contrary.

Also interesting is the judge's summary as to the nature of the health visitor's failings. Agreeing with the Claimant, the judge found that these errors did not arise from inexperience, lack of time or a slapdash approach, but from a lack of understanding of documentary guidance and a failure to use skill and judgement which was critical.



By James Arney Q.C.
(jarney@tgchambers.com)

Quick-Fire Summaries

1. *King v Royal United Hospitals Bath NHS Foundation Trust* [2021] 1576 (QB)

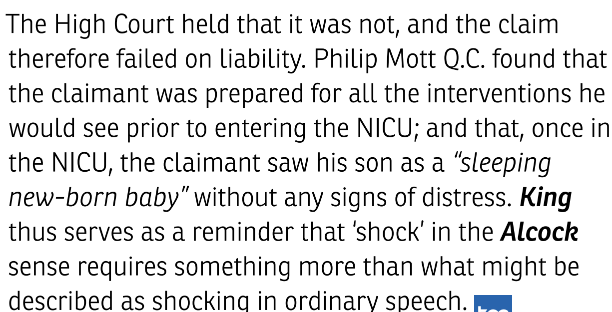
We previously considered ***Paul v Royal Wolverhampton NHS Trust*** [2020] EWHC 1415 and ***Polmear v Royal Cornwall Hospitals NHS Trust*** [2021] EWHC 196 (QB), which concerned 'secondary victims' of psychiatric harm; and this area of law has, once again, proved contentious in ***King v Royal United Hospitals Bath NHS Foundation Trust*** [2021] 1576 (QB).

The claimant and his wife were expecting a baby. The child was born by emergency caesarean section, and, tragically, died only 5 days later. The defendant admitted negligence in its care for the baby and his mother, and the primary victim claims were settled.

Mr King sought damages in his own capacity as a secondary victim. The agreed medical evidence was that he suffered PTSD as a result of seeing his new-born son in a Newborn Intensive Care Unit (NICU). Notably, a doctor told Mr King that *"we might lose him"*.

The critical issue in the case was whether the fourth ***Alcock*** criteria – that the psychiatric harm must have been induced by a 'sudden shocking event' – had been satisfied.

The High Court held that it was not, and the claim therefore failed on liability. Philip Mott Q.C. found that the claimant was prepared for all the interventions he would see prior to entering the NICU; and that, once in the NICU, the claimant saw his son as a *"sleeping new-born baby"* without any signs of distress. ***King*** thus serves as a reminder that 'shock' in the ***Alcock*** sense requires something more than what might be described as shocking in ordinary speech.



2. The Vaccine Damages Payment Scheme

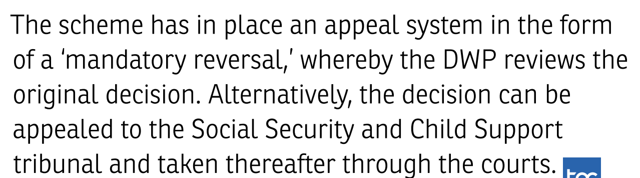
The Vaccine Damage Payment Scheme is a statutory programme which was created in 1979 to provide compensation to people who suffer a 'vaccine injury' as a result of inoculation against certain diseases (including measles, mumps and rubella). Since December 2020 the scheme has extended to those who become disabled due to the vaccine against Coronavirus.

The scheme allows for a one-off tax-free payment of £120,000.

It is not necessary to establish negligence in order to qualify. Prospective claimants will have up to 6 years from the date of the vaccination in which to claim (or the date they reach the age of 21, or would have if they had not died, if that date is later).

As to causation, claimants need to establish that the vaccine caused them a disability that amounts to at least a 60% disablement. Schedule 2 of the Social Security (General Benefit) Regulations 1982 provides a table with descriptions of injuries and the degree of disablement to which they amount. Further, a claimant must prove, on the balance of probabilities, that the index vaccine was the cause of said disablement.

The scheme has in place an appeal system in the form of a 'mandatory reversal,' whereby the DWP reviews the original decision. Alternatively, the decision can be appealed to the Social Security and Child Support tribunal and taken thereafter through the courts.

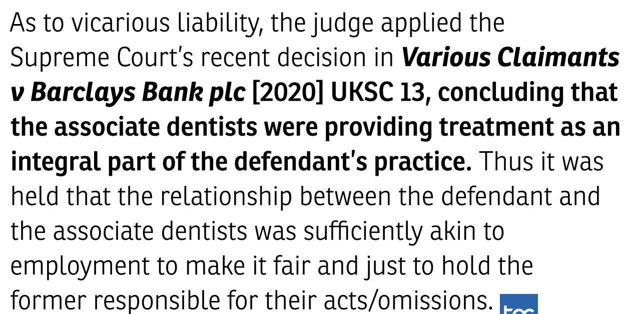


3. ***Hughes v Rattan*** **[2021] EWHC 2032 (QB)**

The claimant brought a claim against the former owner of a dental practice at which she had received treatment. The claim arose from NHS dental care provided to her by four dentists engaged at the practice, three of whom were self-employed associate dentists (vicarious liability for the fourth dentist, who was an employee, was admitted). A preliminary hearing was held to determine whether Mr Rattan was liable for the acts or omissions of the associate dentists, whether by virtue of a non-delegable duty of care or vicarious liability.

As to the issue of non-delegable duties, the five factors delimited in *Woodland v Swimming Teachers Association and others* [2013] UKSC 66 were considered and found to apply. The Claimant was a patient and therefore there was an antecedent relationship between her and the defendant placing her in his care in respect of the dental treatment she received at the practice; and she had no control over who the defendant chose to perform his obligations.

As to vicarious liability, the judge applied the Supreme Court's recent decision in ***Various Claimants v Barclays Bank plc*** **[2020] UKSC 13, concluding that the associate dentists were providing treatment as an integral part of the defendant's practice.** Thus it was held that the relationship between the defendant and the associate dentists was sufficiently akin to employment to make it fair and just to hold the former responsible for their acts/omissions.



Looking back in anger: *Reaney v. University Hospital of North Staffordshire NHS Trust* [2015] EWCA Civ 1119

Clinical Negligence – Quantum – Exacerbation of Pre-Existing Condition – Material Contribution

Anthony Johnson suggests that the Court of Appeal's decision in *Reaney* remains important in two key respects: (i) the Court provided guidance on the applicability of the test of causation in a case where a non-negligent injury had been exacerbated by a Defendant's clinical negligence; and (ii) the Master of the Rolls commented obiter on the applicability of the 'material contribution' test in claims of that nature.

Background

The Claimant was admitted to the North Staffordshire Royal Infirmary in December 2008 with an illness that caused her to become permanently paralysed below the mid-thoracic level. It was common ground that this was not caused by negligence. She would have had some fairly extensive care requirements and other needs in any event as a result of her condition.

During an extended period of hospitalisation, she developed a number of Grade-4 pressure sores with severe sequelae that significantly affected her physical wellbeing. It was undisputed that, following the development of the said pressure sores, she would now have far greater future care and other needs than otherwise.

Liability was admitted in relation to the pressure sores, which meant that the live issues between the parties in the litigation were the extent of causation and the quantification of damages.

Legal Analysis

In the Court of Appeal, the parties were effectively agreed that the correct approach was that the Defendant must only compensate the Claimant for her condition to the extent that it had been worsened by the compensable negligence, i.e., the pressure sores. Reference was made to the then current edition of Kemp & Kemp which stated (at 13-003):-

"It sometimes occurs that the Claimant who is injured had a pre-existing injury or disability which means that he was not capable of independent existence in the first place, and the effect of the injury for which a claim is made has been to increase or enhance the Claimant's need for care. What is the correct approach in law? In principle one would have thought that the correct approach would be to compare the Claimant's needs after the injury for which the claim is being made with his needs before he was injured, and to make a valuation of the difference between the two. Suppose for example, prior to the index injury, the Claimant needed 4 hours of assistance a day, but since the injury, he needs 12 hours of care a day. Instinctively, the correct approach is to say that the effect of the accident has been to increase the Claimant's needs by 8 hours a day, and the cost of the additional 8 hours a day represents the appropriate valuation of the injury which the Claimant has sustained."

Dyson MR noted that Foskett J. below had stated that if a tortfeasor makes the victim's current damaged condition worse ***"then he must make full compensation for that worsened condition"***, which he felt potentially gave rise to some potential confusion. He sought to clarify that this must be interpreted as meaning ***that the tortfeasor must only compensate for the injured person's condition to the extent that it was worsened by the negligence.***

He used the judgment in the case of ***Steel v. Joy*** [2004] 1 WLR 3002 to illustrate the point, where it was stated at paragraph 70 that:

"In the present case, the question is whether the second tortfeasor is responsible for the consequences

of the first injury. To that question, the answer can only be: no. It is true that, but for the first accident, the second accident would have caused the same damage as the first accident. But that is irrelevant. Since the claimant had already suffered that damage, the second defendant did not cause it. This is not a case of concurrent tortfeasors."

Although accepting the preceding principles, Counsel for the Claimant sought to argue that the care that she required as a result of the Defendant's negligence was qualitatively different to that which would have been required but for the negligence and that, therefore, there was no basis for disturbing the trial judge's overall conclusion on the issue of causation. **The Court of Appeal, however, rejected this contention, finding that the significant care package that was required as a result of the index negligence was *quantitatively* but not qualitatively different from what would have been required but for the negligence** (which was characterised in the course of the judgment as 'more of the same'.)

The rationale behind the judgment is probably best illustrated by the discussion of care and physiotherapy requirements at paragraph 25:-

"If the judge had made a reasoned finding that the care package required as a result of the negligence was different in kind from that which Mrs. Reaney would have required but for the negligence, it might have been difficult for Mr. Westcott to challenge it. But in my view the judge did not do so. *The undoubted fact that Mrs. Reaney's quality of life is now markedly worse than it would have been but for the negligence says nothing about whether the care that she now needs is qualitatively or quantitatively different from what she would have needed but for the negligence.* ***As for the carers themselves, the judge made no finding that Mrs. Reaney now requires specialist carers who have skills which are not possessed by carers of the kind who would have sufficed to satisfy her pre-existing needs.*** *I accept that there was evidence that her needs for physiotherapy were somewhat different in character as a result of the negligence. But the judge made no finding to this effect in paras 24 and 25 of his supplemental judgment. I do not consider that it is for this court to seek to fill the gap."*

Foskett J. had indicated in his judgment below that if he had had any doubts about the issue of causation in the 'but for' sense then he would nevertheless have 'been inclined to find that the Defendants had 'materially contributed' to the condition that led to the need for the 24/7 care [package]' that had been discussed earlier in his judgment. In comments that were *obiter* due to them not having affected the outcome below, but were nevertheless powerfully expressed, Dyson MR criticised this proposed application of the material contribution test on the basis that, as there was no doubt with regards to what the Claimant's injuries would have been but for the Defendant negligence, 'material contribution' could not assist the Claimant.

Dyson MR quoted paragraph 46 of the judgment of Waller LJ in ***Bailey v. Ministry of Defence*** [2008] EWCA Civ 883 where it was said:

"In my view one cannot draw a distinction between medical negligence cases and others. I would summarise the position in relation to cumulative cause cases as follows. If the evidence demonstrates on a balance of probabilities that the injury would have occurred as a result of the non-tortious cause or causes in any event, the claimant will have failed to establish that the tortuous cause contributed. Hotson's case exemplifies such a situation. If the evidence demonstrates that "but for" the contribution of the tortious cause the injury would probably not have occurred, the claimant will (obviously) have discharged the burden. In a case where medical science cannot establish the probability that "but for" an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the "but for" test is modified, and the claimant will succeed."

The judgment in *Reaney* approves that extract in paragraph 36 which states:-

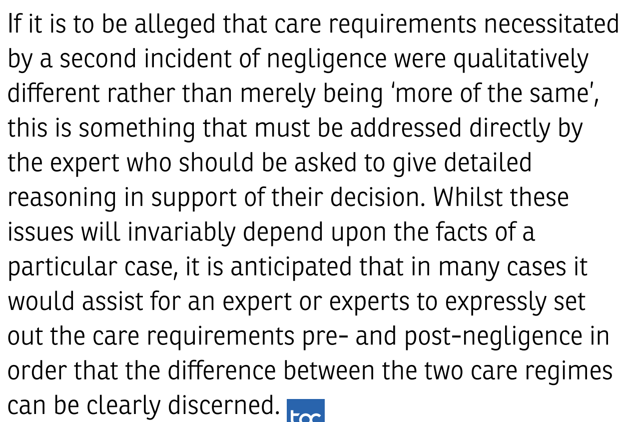
"This was an accurate distillation of the law as set out in cases such as Bonnington Castings Ltd v Wardlaw [1956] AC 623 and Fairchild v Glenhaven Funeral Services Ltd [2003] 1 AC 32 . In the present case, there was no doubt about Mrs. Reaney's medical condition before the defendants' negligence occurred or about the injuries that she suffered as a result of the negligence. There was, therefore, no need to invoke the principle applied in Bailey's case. The issue was as to the cause of the needs to which these injuries gave rise. The concept of material contribution had no part to play in resolving that issue."

Comment

It is suggested that the decision in ***Reaney*** should be borne in mind in any case involving two separate incidents or two separate injuries, whether or not the first or second of this was caused by negligence or otherwise.

It is suspected that many medico-legal experts may initially struggle with the conceptual legal analysis that forms the basis of this article, making it important to ensure that particularly clear letters of instruction are sent, potentially followed up by a conference once a draft version of the expert's report has been made available.

If it is to be alleged that care requirements necessitated by a second incident of negligence were qualitatively different rather than merely being 'more of the same', this is something that must be addressed directly by the expert who should be asked to give detailed reasoning in support of their decision. Whilst these issues will invariably depend upon the facts of a particular case, it is anticipated that in many cases it would assist for an expert or experts to expressly set out the care requirements pre- and post-negligence in order that the difference between the two care regimes can be clearly discerned.



By Anthony Johnson
(AnthonyJohnson@TGchambers.com)

Too much in his locker?: *Owen v Swansea City AFC* [2021] EWHC 1539 (QB) and *Collett v Smith & another* [2008] EWHC 1962 (QB)

Clinical Negligence – Quantum – Assessment of Future Earnings – Professional Athletes – Footballers

James Yapp asks (and clarifies) what expert evidence is reasonably required to assess the likely career earnings of a young footballer. This was recently the subject of a decision by Mr Justice Bourne in the case of *Owen v Swansea City AFC* [2021] EWHC 1539 (QB).

Background

The Claimant was a young goalkeeper, formerly employed by the Defendant. He injured his wrist during a training session in 2015. He alleges that there was a negligent failure to ensure that appropriate investigations and referrals were made, leading to permanent symptoms.

His case is that, but for the Defendant's negligence, he had a good chance of making a career as a goalkeeper in leagues up to and including the Championship. He values his claim at £2-£2.5million. The Defendant's case on quantum is that the Claimant would not have 'made the grade'.

At the CCMC Master Eastman allowed each party to rely upon expert evidence on football playing ability, as well as accountancy evidence. He refused the Defendant's application to rely upon expert evidence from a football agent. The Master's refusal was based on two grounds:

a) Cost – the total costs of the agent through to trial were estimated at £30,000.

b) Expertise – the Master was not persuaded football agency was a proper area of expertise in any event.

At the time of the CCMC, the Claimant's expert accountancy evidence had not yet been disclosed. When served, that report's projections were based upon the witness evidence of a former goalkeeper who is now a registered football agent. That lay witness identified the following pay ranges for goalkeepers:

a) League 1 – £1,250 to £3,000

b) Championship – £2,500 to £15,000

c) Premier League – £25,000 to £250,000

The Appeal

The Defendant appealed against the refusal to allow expert evidence from a football agent. It argued that its proposed expert was experienced in conducting negotiations and had knowledge of the market. This expertise, it argued, would assist the trial Judge in determining what factors were relevant to where an individual player would fall within those pay ranges. The Claimant argued that an agent could provide evidence of fact on this issue, but that it would not really amount to expert evidence.

Bourne J considered himself in a stronger position than the Master as he had seen the accountancy evidence. The question of how ability would translate into remuneration remained unanswered. It was clearer by the time of the appeal that there was a lack of evidence on how to place an individual within those broad ranges. In his view, evidence from an agent was 'reasonably required'.

Though the appeal was allowed, there was a sting in the tail for the Claimant. Bourne J, like many football managers before him, was critical of the agent's proposed fees. He limited the fees of the expert to £12,500. He granted permission for the Claimant to call an expert of like discipline.

Collett v Smith (the evidence)

Bourne J referred to the case of ***Collett v Smith & another*** [2008] EWHC 1962 (QB). Mr Collett was a promising young player for Manchester United. He had to retire from the game as a result of a bad tackle.

At trial, the Claimant called evidence from witnesses including Sir Alex Ferguson, Gary Neville and Brian McClair. The witnesses all praised the Claimant for his ability and work ethic.

In ***Collett***, Swift J had the benefit of published surveys of footballers' basic wages produced by The Independent and annual reviews of football clubs' total wage costs published by Deloitte. She was also able to compare the Claimant to his contemporaries and assess how they had progressed since the injury.

It was apparent from the data that there was substantial variation between the wages paid by different clubs in the same league. Amongst other things, aspirational Championship clubs would pay a premium in the hope of achieving promotion.

Both parties relied upon expert evidence on playing ability. Ultimately the Claimant's evidence was preferred. The Defendant's expert, who had not previously assumed that role, was considered to have given a somewhat one-sided report which gave insufficient weight to the Claimant's achievements and the lay evidence of those who knew him best.

The Defendants also relied upon the expert evidence of Mr Stein. Mr Stein was, amongst other things, a consultant to a company representing a number of footballers. The Judge found that the evidence of Mr Stein was unsatisfactory in a number of respects. She concluded that the Independent Surveys were a more secure basis on which to make her findings.

The Judge was not greatly assisted by the expert statistical evidence of the Defendant. This attempted to calculate the percentage chances of an average Manchester United scholar achieving success within the game. The Judge concluded that an assessment of Mr Collett's prospects was not susceptible to a mechanical statistical approach, particularly where there was good evidence of his own abilities and potential.

Collett v Smith (the outcome)

Swift J ultimately assessed Mr Collett's likely earnings on the basis that he was likely to play for a Championship club. She made a 25% uplift to account for the fact that he was likely to play for a club with promotion ambitions. She also made allowance for a 60% chance that Mr Collett would have played for a Premiership club for a third of his career.

The Judge then made a reduction of 15% to reflect the risk of injury and other contingencies. On appeal, two members of the Court of Appeal expressed the view that this seemed like a modest reduction at first blush. However, this assessment was not overturned: the Judge had factored into this reduction the chance that Mr Collett might in fact have done *even better* than her assessment.

Common Threads

What expert evidence is reasonably required to assessed a young player's lost chance of making a living as a professional footballer?

Playing ability is a crucial factor determining whether, and at what level, a player might have made a career within the game. In both ***Smith*** and ***Collett*** the court gave permission for expert evidence on playing ability. Such experts will rarely have personal knowledge of a claimant's abilities and will often be reliant upon video footage and lay evidence from coaches, fellow players and the like. It may be that football data analysts will come to be used more frequently to give evidence on this issue in due course.

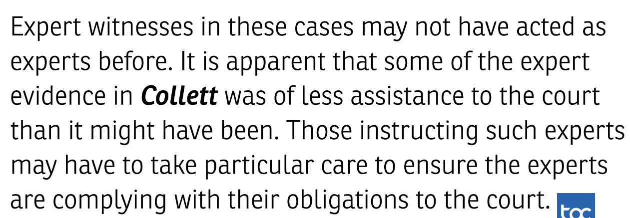
Similarly, statistical evidence regarding the earnings of players at various levels is likely to be required. However, given the variation between the sums paid by clubs at similar levels, this may not be sufficient. Some additional expert evidence from an agent or similar is often 'reasonably required' to assist the court in placing an individual claimant within these ranges.

Bourne J remarked that it was not apparent that information about footballers' salaries in the public domain was as helpful in 2021 as it had been in 2008. For those opposing the introduction of expert evidence from an agent or similar, it will be prudent to point to lay evidence which is sufficient to identify the various factors impacting upon a player's remuneration.

Statistical evidence as to the chance of an average player 'making it' is unlikely to be particularly illuminating for the reasons given by Swift J. A court is assessing a specific player's chances of success in light of their own abilities, not prospects of a notional benchmark player.

One trend in recent years has been the significant growth of the women's game. Remuneration levels in 15 years may be very different to those in the present day. Claims by young female footballers may reasonably require expert evidence on the likely growth of the women's game over the course of that player's career.

Expert witnesses in these cases may not have acted as experts before. It is apparent that some of the expert evidence in ***Collett*** was of less assistance to the court than it might have been. Those instructing such experts may have to take particular care to ensure the experts are complying with their obligations to the court.



By James Yapp (JamesYapp@TGchambers.com)

Disclaimer
These articles are not to be relied upon as legal advice. The circumstances of each case differ and legal advice specific to the individual case should always be sought.

Design by Mash: wearemash.com