EDITOR: **Lionel Stride**
Issue 3 May 2022

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

Index continued

Procedure

Alternative Dispute Resolution

Rehabilitation

A note from the editor

By Lionel Stride

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

The last six months have seen a steady stream of important decisions with direct or indirect implications for medical negligence practitioners. There has been some disappointment at the initial outcome in the conjoined appeals in ***Paul & Ors*** (see below), where the Court of Appeal held that it was bound by earlier precedent in setting an arbitrary limit of 'proximity' in secondary victim claims; but the excitement of anticipation that the matter will now be reconsidered by the Supreme Court, who have effectively been invited (by the presiding judges) to re-clarify the law in this area. This is a long-awaited development that will have wide-ranging implications in clinical negligence cases, particularly where there has been negligent misdiagnosis, because there is inevitably significant delay between the act of negligence and any resulting traumatic event that might be witnessed by a close relative and trigger psychiatric injury.

More widely, practitioners will be aware of the Ockenden Report and the consultation on extending the Fixed Costs Regime to clinical negligence cases valued up to at least £25,000, as well as preliminary moves towards stricter enforcement of ADR. This edition therefore includes an opinion piece from Peter Freeman, an expert on Early Neutral Evaluation (ENE), who strongly advocates for this type of ADR but on a voluntary rather than compulsory basis. It is notable that ENE can now be ordered by the Court under CPR 3.1(2)(m) and it can be anticipated that, where parties refuse to engage in other forms of ADR, such an order will increasingly be sought. This is likely to result in more streamlined and effective justice than further extension of the fixed costs regime that would inevitably limit access to justice in complex but important cases of limited financial value; classic examples would be those involving the deaths of minors.

ENE would also be a far better and fairer solution to reducing litigation costs than the new drive to introduce some form of 'no fault scheme' (as now advocated by the House of Commons' Health and Social Care Committee). There is no doubt that battles lie ahead on this issue.

These are just some of the matters that are considered in this edition. To help you navigate the contents with greater ease, here is a more detailed overview of what you can expect: -

Breach of Duty & Causation

- To kick us off, I will be discussing the Court of Appeal's determination of the combined appeals in ***Paul v The Royal Wolverhampton NHS Trust, Polmear v Royal Cornwall Hospital NHS Trust*** and ***Purchase v Ahmed*** **[2022] EWCA Civ 12**, which grapple with the thorny issue of secondary victim claims for psychiatric harm (specifically the requirement of 'proximity').
- Dominic Adamson Q.C. and Rochelle Powell dissect the tragic case of ***Traylor & Anor v Kent*** *and* ***Medway NHS Social Care Partnership Trust*** **[2022] EWHC 260 (QB)** which concerned the overlap of civil litigation and convention rights (as well as the defence of illegality).
- Emma Jane Hobbs analyses ***Toombes v Mitchell*** **[2021] EWHC 3234 (QB)** which touches on the vexed principle of 'wrongful birth' in the context of pre-conception advice.
- James Arney Q.C. analyses ***Thorley v Sandwell & Est Birmingham NHS Trust*** [2021] EWHC 2604 in which the High Court invited an *"authoritative review"* of the principles governing 'material contribution' as it relates to causation in clinical negligence cases.

Evidence

- Anthony Johnson breaks the duck of the Newsletter's new section specifically on evidentiary issues with analysis of ***Watson v Lancashire Teaching Hospitals NHS Foundation Trust*** [2022] EWHC 148 (QB).
- James Laughland considers ***Dalchow v St George's University NHS Foundation Trust*** [2022] EWHC 100 **(QB)**, which underscores the importance of proving factual causation as an element of establishing liability in medical cases.
- James Yapp, analyses ***HTR v Nottingham University Hospitals NHS Trust*** [2021] EWHC 3228 (QB) in which the trial judge had to assess the accuracy of a witness' recollection and the utility of (neutral) entries in medical records.
- Marcus Grant considers ***Radia v. Marks*** [2022] EWHC 145 **(QB)**, a professional liability case pertaining to the scope of liability for expert witnesses.

Procedure

- Turning to procedural issues, Philip Matthews highlights the updated clinical negligence standard directions.
- Richard Boyle explores the interplay between capacity and limitation via the case of ***Aderounmu v Colvin*** [2021] EWHC 2293 (QB).
- As to costs issues specifically, Anthony Johnson analyses ***Gibbs v King's College NHS Foundation Trust*** [2021] EWHC B24 **(Costs)**, which related to remission of court fees and failure to mitigate.
- Philip Matthews summarises the Practice Note by the Senior Costs judge which sets out some helpful practical guidance on the approval of costs settlements, assessments under CPR 46.4(2) and deductions from damages, as it relates to children and protected parties.
- Finally in this section, I consider ***Ho v Adelekun*** **[2021] UKSC 43** in which the central question before the Supreme Court was: in claims to which Qualified One Way Cost Shifting ('QOCS') applies, is it permissible to order set-off of a defendant's costs against a claimant's?

Alternative Dispute Resolution

- Peter Freeman makes a guest appearance to consider recent developments away from the Courtroom, which will affect the way claims are resolved in future. In particular, he considers the Ockenden Report and the Fixed Costs Regime for Clinical Negligence, as well as arguing for a greater emphasis on voluntary Early Neutral Evaluation.

Rehabilitation

- To conclude, Philip Matthews and I set out the new NICE guidelines on 'Rehabilitation After Traumatic Injury', which provide a set of useful recommendations for best practice.

We have bound hands, please untether: *Paul v The Royal Wolverhampton NHS Trust, Polmear v Royal Cornwall Hospital NHS Trust* and *Purchase v Ahmed* [2022] EWCA Civ 12

Clinical Negligence – Breach Of Duty & Causation – Psychiatric Harm – Secondary Victims – Remoteness / Proximity

In the first edition of the TGC Clinical Negligence Newsletter, Lionel Stride discussed the High Court judgment in *Paul v The Royal Wolverhampton NHS Trust*[1] (and the complex jurisprudence in the area of psychiatric harm and secondary victims). Since then, the Court of Appeal has handed down its determination of *Paul*[2] in a combined appeal alongside *Polmear v Royal Cornwall Hospitals NHS Trust*[3] and *Purchase v Dr Ahmed*. At its invitation, the ruling (adverse to the Claimants) is now under appeal to the Supreme Court. Given the strong wording in the judgment, it seems highly likely there will now be long-awaited change to/ clarification of the law relating to secondary victim claims. Lionel Stride examines the Court of Appeal ruling in anticipation of this evolution.

Facts

The basic facts in each of the cases under appeal were that the defendant was alleged to have failed to diagnose the primary victim's life-threatening condition; and that, following a period of delay after the negligent omission, the primary victim suffered a traumatic death. In two of the cases (***Paul*** and ***Polmear***), the shocking death occurred in the presence of close relatives, causing them psychiatric injury. In the case of ***Purchase***, the close relative came upon the primary victim immediately after her death, again causing her (the mother in that case) serious psychiatric injury.

The critical question in each appeal was whether the necessary legal 'proximity' existed between the defendant's negligence and the event that triggered the psychiatric injury of the secondary victims (i.e., the close relatives who had witnessed the shocking deaths).

Argument

The issue of legal proximity, in the Court of Appeal's distillation, turns on the relevance of any time intervals between the clinical negligence, the damage caused by it, and the horrific event that ultimately causes psychiatric injury to the claimant.

The legal representatives of the parties put forward three possible answers. They suggested that, as a matter of law, a defendant to a claim for damages for clinical negligence can be liable to a secondary victim who has suffered psychiatric injury by witnessing the death or other horrific event affecting the primary victim caused by the negligence in the following circumstances: -

i. Only where that horrific event is the damage completing the primary victim's cause of action in negligence (the defendant's position);

ii. Only when that horrific event is the first manifestation of damage to the primary victim caused by the negligence (the position of the claimants in ***Paul***); or

iii. Whenever that horrific event occurs (the position of the claimants in ***Polmear*** and ***Purchase***).

Judgment

The Court of Appeal, overruling the High Court in two appeals, declined to follow any of the proposed formulations, holding that the horrific event witnessed such as to trigger psychiatric illness must be contemporaneous with the act of negligence itself unless it can be proven that the negligence and the horrific event were part of a continuum (i.e., the negligence was ongoing). Central to the Court's ratio was the recognition of ***Taylor v A Novo (UK) Ltd***[4]

(an accident, rather than clinical, case) as binding authority for the principle that if the horrific event occurred beyond the immediate aftermath of the defendant's negligence a secondary victim claim could not succeed.

Sir Geoffrey Vos (Master of the Rolls)) reasoned as follows: -

*"96. ... **For a secondary victim to be sufficiently proximate to claim for psychiatric injury against the defendant whose clinical negligence caused the primary victim injury, the horrific event cannot be a separate event removed in time from the negligence.***

*If the negligence and the horrific event are part of a continuum as seems to me the best possible explanation of Walters, there is sufficient proximity. It may be that the negligence was continuing in Walters at the time the 36-hour shocking event began. **Either way, Novo is binding authority for the proposition that no claim can be brought in respect of psychiatric injury caused by a separate horrific event removed in time from the original negligence, accident or a first horrific event."***

Invitation to Appeal

Despite this reasoning, it is clear from the judgment that all the Justices – Sir Geoffrey Vos MR, Lord Justice Underhill and Lady Justice Nicola Davies – reached their conclusion with a heavy heart: *"If I were starting with a clean sheet, I can quite see why secondary victims in these cases ought to be seen to be sufficiently proximate for the defendants to be allowed to recover damages for their psychiatric injury."*[5]

Indeed, the Master of the Rolls went so far as to invite an onward appeal to the UK's highest court to bring clarity to the *"patchwork quilt of distinctions"*[6] which characterises the common law in this area: ***"Since, however, this court is bound by Novo, it is for the Supreme Court to decide whether to depart from the law as stated by Lord Dyson in that case."***[7]

The invitation to appeal has been accepted and the case is being appealed to the Supreme Court.

Discussion

Sir Geoffrey Vos MR's lead judgment provides ample ammunition for the Claimants' lawyers when appearing in the Supreme Court, including the following observations: -

i. In clinical negligence cases, it is very common for a misdiagnosis to occur at one time and for the death or serious injury to the patient caused by that misdiagnosis to occur much later. But medical negligence is not the only type of case where that can occur. The court postulated the case of a negligent architect designing a door in a load-bearing wall without specifying an RSJ, causing masonry to fall on a primary victim's head years later.[8]

ii. Looking at the matter without regard to the authorities, it is hard to see why the gap in time (short or long) between the negligence (whether misdiagnosis or door design) and the horrific event caused by it should affect the defendant's liability to a close relative witnessing the primary victim's death or injury that it caused.[9]

iii. Nuanced approaches, such as limiting claims to the first manifestation of negligence-related damage to the primary victim, or limiting claims to instances where the horrific event is the damage that would complete the primary victim's cause of action in negligence, would affect liability in particular cases, but are *"distinctions without real differences"*, with the potential to cause unprincipled and complex factual disputes.[10]

iv. It is illogical to make the liability of a defendant for psychiatric injury caused to a secondary victim depend upon whether the primary victim's cause of action is complete, or whether the primary victim had sustained manifest damage before the horrific event caused by the defendant's negligence: even more so when actual injury or damage to the primary victim is not even necessary to found liability to the secondary victim.[11]

v. Considering the control mechanisms originally set out in ***Alcock v Chief Constable of South Yorkshire***[12],it was stressed that, if *strictly* applied to the clinical negligence situation, despite the delay it should be sufficient to establish liability where (a) the fact and consequence of the negligence (i.e. the horrific event witnessed) was close in time and space to the moment when the secondary victim suffered psychiatric injury, and (b) the secondary victim was either personally present at the scene of the horrific event or was in the more or less immediate vicinity and witnessed the aftermath shortly afterwards.[13]

Lord Justice Underhill echoed the sentiments of the Master of the Rolls. He also highlighted the arbitrariness of the law as it stands – i.e., that a doctor who negligently prescribes a fatal medicine would be liable to a secondary victim if the patient took the medication and died in requisitely shocking circumstances straightaway, but not if that event occurred a few days or weeks later. [14]

Conclusion

Once these appeals make their way up to the Supreme Court, the stakes will be high for all relevant litigants: victim, medical provider and insurer alike. Restatement of the law would mean that secondary victims in many cases, especially those arising from the clinical context, will continue to face considerable difficulties in establishing liability for psychiatric harm. By contrast, if the Supreme Court takes a more liberal approach, there will be inevitable 'flood gate' arguments about a potential avalanche of secondary victim claims at a time of stretched NHS budgets. Such concerns are likely in this writer's view to be overstated. It is time for the illogicality of the current law in relation to psychiatric damage sustained by secondary victims to be addressed.

Lionel Stride LionelStride@TGchambers.com

---

1. [2020] EWHC 1415
2. [2022] EWCA Civ 12
3. [2021] EWHC 196 (QB)
4. [2013] EWCA Civ 194
5. [2022] EWCA Civ 12, paragraph 12
6. Lord Steyn in *White v Chief Constable of South Yorkshire Police* [1998] UKHL 45
7. [2022] EWCA Civ 12, paragraph 12
8. [2022] EWCA Civ 12, paragraph 79
9. [2022] EWCA Civ 12, paragraph 80
10. [2022] EWCA Civ 12, paragraph 82
11. [2022] EWCA Civ 12, paragraph 83
12. [1991] UKHL 5
13. [2022] EWCA Civ 12, paragraph 87
14. [2022] EWCA Civ 12, paragraph 102

Treating mental illness: what is the scope of duty to patients and their families? *Traylor & Anor v Kent and Medway NHS Social Care Partnership Trust* [2022] EWHC 260 (QB)

Clinical Negligence – Breach Of Duty & Causation – Convention Rights – Illegality

On 8 February 2015 Marc Traylor (MT) suffered a psychotic episode. He threatened to stab his daughter, Kitanna Traylor (KT). On 9 February, he stabbed KT several times, causing serious injuries. He was shot by armed police officers and later prosecuted for attempted murder but found not guilty by reason of insanity.

This awful scenario formed the basis of claims by MT and KT against the Kent and Medway NHS Social Care Partnership Trust ("the Trust"). MT alleged that the Trust was negligent in its treatment of his mental illness, and this caused the events of 9 February and his resulting injuries. KT brought a separate claim alleging that the Trust failed to take positive steps to protect her right to life (art.2), as well as her right not to be subjected to inhuman or degrading treatment (art. 3). Dominic Adamson QC and Rochelle Powell analyse the case and consider any wider legal implications from the judgment.

Facts

MT had a troubled history which included numerous attacks and threats to his wife Nicole Traynor (NT). Records suggested he had also threatened to *"kill the kids"*. He had previously been detained under the Mental Health Act 1983 ("the 1983 Act").

A risk assessment carried out in 2013 described MT's history of violence and convictions. He was diagnosed with paranoid schizophrenia manifesting in the form of morbid jealousy syndrome with a *"definite/serious lack of insight"*. The risk assessment indicated that there was a risk of violence, hostage taking and threats to life, in particular to NT. It was noted that both *"[NT] and her children [were] at risk of psychological difficulties as a consequence of her husband/their father's behaviour."* He had a *"history of non-compliance with his medication"* and a failure to comply with his psychotropic medication was likely to cause *"a relapse of his mental illness, thereby increasing his risk to self and others."*

On 26 June 2013 MT was the subject of a Community Treatment Order ("CTO") – a type of order under the 1983 Act – on the condition that he attend for administration of psychiatric medication. MT received depot injections (a means of administering a slow-release antipsychotic medication). On 13 February 2014, a locum psychiatrist, described the consequences of CTO discharge: -

"there is a potential risk that he would decide to reduce and eventually cease the pharmacological treatment, which puts him at significantly heightened risk of relapse… without such treatment it would seem almost inevitable that his mental state and health will deteriorate … This is likely to lead to chaotic behaviour where he is likely to put himself at risk…the risk to others will also increase…"

On 4 June 2014 MT was reviewed, for the first time, by Dr Pisaca. The outcome was that MT agreed to have one further depot injection, but thereafter he would take medication orally. On 18 June 2014 MT was again seen by Dr Pisaca. He agreed to inform the mental health clinicians if he changed his mind regarding oral medication so that he could be closely monitored. The CTO was discharged. MT was visited by the mental health care team on numerous occasions from July 2014 onwards and was discharged from secondary mental health care in December 2014.

In fact, MT never took his oral medication. He threw the tablets away. He lied to his wife and healthcare professionals, claiming that he was taking the medication. He suggested that if Dr Pisaca had advised him to remain on the depot injections, he would have accepted that advice.

The Expert Evidence

The independent experts agreed:

i. That MT ought to have been advised to continue with depot injections because it is more efficacious. Failure to give such advice would be a breach of duty.

ii. From 4 June 2014, there was a risk that MT would not take the medication.

iii. Non-compliance increased the risk of a further psychotic episode and gave rise to a risk to MT and his family.

iv. If MT had continued with depot injections it is unlikely that he would have relapsed.

MT's Claim: Duty and Breach

Ultimately, MT's case focussed on two allegations: (i) that Dr Pisaca did not undertake a sufficient assessment of the risk that MT would not take his medication and/or (ii) that Dr Picasa did not advise MT to remain on depot injections. Thus, the case hinged on the 4 June 2014 consultation. MT's account was that he had been advised not to remain on depot injections.

The Trust was arguably vulnerable because the experts agreed that the contemporaneous notes did not ***"represent a robust record of the risk assessment"***. Without doubting Dr Picasa's honesty, Johnson J. held that his subsequent account of his thought process was not to be regarded as a reliable record without external support.

Nevertheless, Johnson J. rejected both of MT's contentions. In his judgment, Dr Pisaca had appreciated that MT might not take oral medication and the consequential risks and did regard depot injections as preferable. Crucially, he held that Dr Pisaca had advised MT to remain on depot injections even though it was not explicitly recorded in the notes.

Causation and Voluntary Assumption of Risk

The Trust disputed causation and argued volenti non fit injuria. Johnson J. held that the claim would have failed on causation grounds but not volenti. He said ***"Even if Dr Pisaca had failed to advise [MT] to remain on depot medication, it was not shown that this made a difference to the outcome...it is unlikely that [MT] would have accepted such advice... he was determined to come off his medication. As soon as he had the opportunity to do that, he did. And he lied about it..."***

We observe that the *volenti* defence does not have a great track record of success. Here, the primary purpose of the duty (advising in favour of depot injections) was to guard against the risk that MT would not take oral medication. Johnson J. held that a successful *volenti* defence would ***"empty the duty of any meaningful content"***. He referred to Lord Hoffman's judgment in ***Reeves v Commissioner of Police of the Metropolis*** **[2000] 1 AC 360** that it would make a nonsense of the existence of a duty if the law were to hold that every occurrence of the very act which ought to have been prevented negatived the causal connection between breach and loss.

Illegality

The Trust's defence of illegality would also have failed. MT was found ***"not guilty by reason of insanity"*** but the Trust contended he was guilty of ***"a criminal act."*** Johnson J rejected this argument: ***"The common law background and legislative history show that those who satisfy the test in the McNaughten rules are not regarded in law as having committed the act or having any responsibility for the act."***

Contributory Fault

MT was advised about the risks of not taking his medication. By not taking his medication and lying about it, MT did not take reasonable care for himself. This amounted to contributory fault. If the claim had succeeded the damages would have been reduced by three quarters.

KT's Convention Claim

As a public authority, the Trust was bound to act compatibly with KT's Convention rights. The art. 2 positive duty has two components. First, the '*systems*' duty which, in a medical context, requires the state to provide hospitals that adopt appropriate measures for the protection of life. Second, in certain circumstances, an '*operational*' duty to protect against suicide or criminal violence (see ***Osman v United Kingdom*** **(1998) 29 EHRR 245**). The test for triggering the operational duty is whether the Trust knew, or ought to have known there was a real and immediate risk to life or physical safety. In which case, the state must take reasonable steps to avert the risk.

In our view Johnson J rightly held the positive duty arose in principle on the basis that there was a real and immediate risk to life/physical safety. Indeed, the Trust had identified it with respect to NT and there was a record of a threat to MT's children. The claim failed for the same reasons as MT's: an adequate risk assessment was undertaken and appropriate advice given. Thus, reasonable steps to avert the risk had been taken. The claims were therefore dismissed on conventional grounds but the legal analysis (particularly on the *volenti* and *illegality* issues) has wider application.

Dominic Adamson Q.C. and Rochelle Powell
DominiAdamson@TGchambers.com;
RochellePowell@TGchambers.com

Remedying pre-natal wrongs (part deux): *Toombes v Mitchell* [2021] EWHC 3234 (QB)

Clinical Negligence –Breach of Duty & Causation – Pre-Conception Advice

It is a well-established legal principle that a parent can bring a "wrongful birth" claim for the reasonable costs associated with their child's disability, if the disabled child would not have been born "but for" the defendant's negligence. However, the disabled child cannot bring a personal injury claim on the basis that, with proper advice, their mother would have chosen termination. In *McKay v Essex Area Health Authority* [1982] 2 All ER 771, the Court of Appeal confirmed that a disabled claimant cannot sue for "*wrongful life*".

In Toombes, the Court reconsidered the scope of that principle. What is the position where 'but for' the negligence, the disabled claimant would never have been conceived? May a claimant born disabled due to negligent pre-conception advice claim damages in their own right for their "*wrongful conception and birth*"?

Emma-Jane Hobbs considers how the Court addressed these questions.

The Facts

On 27th February 2021, the Claimant's mother attended the defendant General Practitioner ("GP") for pre-conception advice. In breach of duty, the GP failed to prescribe or give advice about folic acid. The Claimant was conceived shortly after that appointment, at a time when her mother was in a folic acid deficient state. She was born on 19th November 2001 with a lipomyelomeningocele ("LLM"), a form of neural tube defect leading to permanent disability.

The Claimant's case was that, had her mother been properly advised about folic acid, she would have delayed conception. In those circumstances, a genetically different child would have been born without the neural tube defect. The disabled Claimant would never have been born.

The claim was pursued by the Claimant in her own right in respect of her own *"wrongful conception and birth"*, as opposed to an action for wrongful birth brought by her parents.

Part 1 – The preliminary Issue (December 2020)

This was a landmark judgment [analysed in more detail in the TGC newsletter from March 2021]. The preliminary issue was whether the claim disclosed a lawful cause of action.

In brief, the Defendant contended that the pleaded claim did not give rise to a lawful cause of action because, in arguing that she should not have been born, the Claimant was, in fact, putting forward a "wrongful life" claim which raised the same legal and public policy concerns that had troubled the court in ***McKay***. The Claimant maintained that her claim was not one for "wrongful life", but fell within section 1(2)(a) of the Congenital Disabilities (Civil Liability) Act 1976, which covers liability to a child born disabled as a result of an occurrence before conception. Lambert J found that the requisite elements of section 1 of the 1976 Act were established and that, in principle, the Claimant had a lawful claim for damages arising from her disability.

Part 2 – Liability (December 2021)

At the recent liability trial, therefore, the Judge (HHJ Coe QC, sitting as a High Court Judge) was concerned only with factual issues relating to breach of duty and causation, as follows:

i. What advice was the Claimant's mother given by Dr Mitchell at the February 2001 consultation?
ii. Was that advice negligent?
iii. Was the Claimant's mother pregnant at the time of the consultation?
iv. What would the Claimant's mother have done had she received the correct advice (i.e., would she have delayed conception)?

Findings of Fact

The evidence of the Claimant's mother was that the reason she made the pre-conception consultation was to find out everything that was recommended to ensure a healthy baby. She said that after the consultation she was left with the impression that folic acid was not something you had to take if you were maintaining a healthy, balanced diet, and that Dr Mitchell had not told her about the risks of spina bifida and neural tube defects from folic acid deficiency.

Not surprisingly, the Defendant could not recall the details of the consultation given the passage of time (over 20 years by the date of the liability trial). He relied on his brief contemporaneous note, which read: ***"Preconception counselling. Adv. Folate if desired discussed"***, and what he said was his usual practice, which was to tell patients that the relevant guidance recommended folic acid supplementation daily for women preparing for pregnancy and during the first trimester. He assumed that he had given the Claimant advice in accordance with his usual standard practice.

The Judge rejected this assertion, finding that the defendant's contemporaneous note was ***"completely inadequate"***. She also found that the defendant's evidence was ***"not as reliable as it would have been if the note had been as complete as it should have been"***. The Judge accepted the account of the Claimant's mother, finding that she ***"was not advised appropriately by the defendant"***. The defendant's advice was therefore negligent.

In relation to whether or not the Claimant's mother was pregnant at the date of the consultation, the Judge accepted the evidence of her parents as to abstinence from sexual intercourse and found ***"that she was not pregnant at the time of the consultation…"***

Finally, the Court found on the balance of probabilities that, had the Claimant's mother been provided with the correct, recommended advice, she would have delayed attempts to conceive. In reaching that decision, the Judge found that the Claimant's mother was *"a very careful person who was very concerned about doing the right thing"*. In the circumstances, there would have been a later conception which would have resulted in a normal healthy child.

In light of these findings of fact, the Claimant's claim succeeded on liability.

Comment

The decision in ***Toombes*** has undoubtedly broadened the legal landscape. In principle, a disabled claimant may now bring a claim in their own name, where it is alleged that but for the index negligence they would never have been *conceived* (subject to proving a causal link between the sexual intercourse and the disability). In practical terms, such claimants will no longer need to rely upon their parents to bring claims for "wrongful birth". The obvious benefit of the child bringing the claim in their own name is that the additional costs associated with their disability can be claimed for their lifetime, rather than being limited to the lifetime of their parent(s).

However, it is unlikely that this decision will lead to the floodgates opening because, as the defendant pointed out, most patients do not seek pre-conception advice.

On a practical note, this case reiterates the importance of medical professionals making a good quality contemporaneous note, which is often determinative if the case turns on factual issues.

For Claimant practitioners in particular, it is worth noting HHJ Coe QC's analysis (@ paragraphs 53 – 57 of her judgment) as to how the fact that the Claimant's case had changed over time (i.e.,***"evolved"*** and ***"crystallised"***) did not adversely affect credibility. The Judge's comments may be helpful in other clinical negligence cases, if a similar point is raised by a defendant in the context of complicated, possibly protracted litigation.

Emma-Jane Hobbs EJHobbs@TGchambers.com

Peering into muddy causation waters: *Thorley v Sandwell & Est Birmingham NHS Trust* [2021] EWHC 2604

Clinical Negligence – Breach Of Duty & Causation – Material Contribution

James Arney QC considers the case of *Thorley* and the Court's (obiter) analysis of causation where arguments on material contribution were advanced.

Factual Background

The Claimant ("CL") suffered from atrial fibrillation ("AF") carrying an increased risk of blood clots and consequent strokes. His treatment for this condition had been a daily 3.5mg dose of warfarin. In March 2 005, CL suffered chest pain for which a coronary angiogram was scheduled. Warfarin thins the blood, meaning that the procedure carries with it a bleeding risk. The procedure took place on 27 April 2005, CL being advised to stop taking warfarin for the 6-day period of 23–28 April, and to start taking it again at a lower dose on 29th April 2005.

Three days after the procedure, he suffered an ischaemic stroke which resulted in permanent and severe physical and cognitive disability.

CL alleged that the Defendant ("DEF") was in negligent breach of duty on the basis that his warfarin should have only been limited for 3 days, not 6; and he should have been restarted on warfarin at his usual dose.

DEF admitted that warfarin should have been restarted the day after the procedure and at CL's usual dose, but contended that CL would have suffered the stroke in any event.

Breach of Duty

In July 2020, the Trust disclosed a document entitled 'Anticoagulation and Surgery (Sandwell)' which was published in April 2004.

CL claimed the document was applicable to angiography and there was no good reason to depart from it in CL's case. Consequently, he should have only paused his warfarin intake for 3 days, and restarted it on the evening of the completion of the angiogram.

DEF responded that the document was not applicable to angiography, being a "procedure" and not "surgery". In any event, a *Bolam/Bolitho* defence was not defeated by its existence, their treatment of CL being based upon the practice of a body of competent practitioners.

CL's expert conceded:

i. That angiography was not "technically" surgery;
ii. It was more common in 2005 than the present day for there to be no guidance for a procedure, *and that when guidelines do not exist, clinicians apply their experience and judgment;*
iii. That a 5–day omission from warfarin was not a breach of duty, subject to his opinion that the Trust should have followed their own guidance in treating the Claimant;
iv. A substantial body of material supported the proposition that it was acceptable to stop warfarin for 4–5 days before an invasive procedure.
v. In light of these concessions, it is perhaps not surprising that Soole J preferred the evidence of DEF's expert. If he was wrong on this point, the judge also concluded that the Trust could rely on a *Bolam/Bolitho* defence.

Adverse inferences

CL contended that adverse inference should be drawn against DEF for calling no evidence to explain or interpret the document, under the principles identified in ***Wisniewski v. Central Manchester Health Authority*** [1998] PIQR P324.

DEF responded by stating that there could be no expectation to call witnesses as to surgery, when this was not in issue. Further, the only witness adduced by CL was his expert on breach, which DEF had met with their own expert.

CL's submissions on this point were frustrated by the fact that, after the close of argument, the ***Supreme Court in Efobi v. Royal Mail Group Ltd*** [2021] UKSC 33 cast doubt on the scope of ***Wisniewski***. Whilst the criteria in ***Wisniewski*** were sensible, the clear guidance of the Supreme Court was that tribunals should be free to draw (or decline to draw) adverse inference using common sense. Given Soole J's finding on the guidance itself, there was no case to answer on this issue.

Causation

Material contribution

This is undoubtedly the aspect of this decision which has attracted most interest from clinical negligence practitioners.

Having dismissed CL's case on the "but for" basis, Soole J turned to whether DEF might be said to have materially contributed to CL's injury. CL had accepted that ischemic stroke is an indivisible injury, in the sense that it either happens or does not, with a severity unlinked to the dose of warfarin.

The judge found that, in cases where an injury is indivisible and there is a sole tortfeasor, this was a bar to causation based on material contribution. He was bound by "strict precedent" to follow the rulings of the Court of Appeal in both ***Ministry of Defence v. AB*** [2010] EWCA Civ 1317 and ***Heneghan v. Manchester Dry Docks Ltd*** [2016] EWCA Civ 86. The judge noted that when ***AB*** went to the Supreme Court, no question was raised as to the reasoning of the Court of Appeal on the issue of causation.

Soole J considered the cases of ***Williams v. The Bermuda Hospitals Board*** [2016] UKPC 4; [2016] AC 888, ***Bonnington Castings Ltd v Wardlaw*** [1956] AC 613 and ***Sienkiewicz v. Greif (UK) Ltd*** [2011] 2 AC to support the opposite contention, with ***Williams*** endorsing the statement that it was ***"trite law"*** that

> ***"where a defendant has been found to have caused or contributed to an indivisible injury, she will be held fully liable for it, even though there may well have been other contributing causes".***

Soole J found that material contribution would have failed in any event. When pressed in cross examination, CL's expert on causation stated he was referring to a material contribution to the *risk* of occurrence of a stroke, the judge noting:

> ***"...there is a fundamental difference between making a material contribution to an injury and materially increasing the risk of an injury."*** (Heneghan)

Despite this, CL submitted his case fell into the former category. The judge found that a simple relationship between omission from warfarin and stroke is confounded by the rarity of the risk of the stroke's occurrence. Further, the Claimant's expert had conceded he had gone no further than to discuss the *risk* of the occurrence of a stroke.

Comment

Whether the material contribution approach may apply in cases with single tortfeasors, and indivisible injuries, remains unclear, Soole J himself commenting this was a "***legal issue which is ripe for authoritative review***". Such review is unlikely to happen in Thorley, any appeal being deterred by CL's weak case on breach of duty and Soole J's finding on causation that the outcome would have been the same in any event.

Commentary on the ***Thorley*** decision suggests (with varying degrees of conviction) that it should be treated with caution as an authority on material contribution. The thrust of that concern can be summarised as follows: -

i. There is arguably confusion as to the meaning of *"indivisible injury"*, which can be different according to the context.

   (a) An outcome can be indivisible (e.g. death, a stroke, cancer), but can nonetheless result from several cumulative causes (see ***Bailey***).

   (b) An outcome can be indivisible in the sense that delay might have resulted in a greater level of disability, but it is not possible to quantify that additional element.

   (c) An outcome can be indivisible in that its severity is not dependent upon the extent of exposure to a potentially harmful substance (see ***AB v MOD*** and ***Heneghan***).

ii. There is ongoing debate as to whether ***AB v MOD*** and ***Williams*** need be inconsistent, as Soole J suggests: -

(a) If Soole J's reliance in ***Thorley*** on ***AB v MOD*** as authority for the proposition that material contribution does not apply to indivisible injuries is correct, then there does indeed appear to be conflict with ***Williams*** where it acknowledged that *"...where a defendant has been found to have caused or contributed to an indivisible injury, she will be held liable for it, even though there may well have been other contributing causes..."*

(b) Alternatively see Swift J's analysis in ***Jones v Secretary of State for Energy and Climate Change*** **[2012] EWHC 2936 (QB)**: *"...the Court of Appeal in [**AB v MOD**] regarded the 'injury' in the case of Bailey as having been the claimant's weakened state which had led to her cardiac arrest and brain damage. They regarded that injury as divisible. Yet, it seems to me that the 'injury' in Bailey was in reality the claimant's brain damage, which was indivisible. The defendant's negligence had made an unquantifiable contribution to the weakness that had led to the development of that brain damage. If that is right, the fact that an injury is indivisible does not necessarily preclude the application of the Bonnington principle."*

As to how this ongoing uncertainty slots into the causation equation in any given case: -

i. Applying the 'but for' test, if there would be no injury but for DEF's negligence, CL will succeed in full. Conversely, if the same injury would have resulted even without DEF's negligence, CL's claim will fail. If neither scenario applies, proceed to (ii).

ii. If DEF's negligence materially contributes to CL's injury: -

(a) If the injury is divisible: -

- If the extent of harm is attributable to DEF's negligence, CL succeeds to the extent of that attribution;
- If the extent of harm is not attributable to DEF's negligence (for example, where science is incapable of resolving this), CL succeeds in full.

iii. If the injury is indivisible: -

(a) If Soole J's analysis in ***Thorley*** is followed, CL's claim fails;

(b) If material contribution applies, CL succeeds in full.

iv. If DEF's negligence merely contributes to the risk of injury: -

(a) If the extent of the increased risk is sufficient to infer causation, CL succeeds in full;

(b) If the claim can be brought within the very limited application of the ***Fairchild*** exception, CL succeeds;

(c) Otherwise CL's claim fails.

The stark contrast between the outcomes highlight the need for *"authoritative review"* of these issues.

James Arney Q.C. JamesArney@TGchambers.com

The importance of being credible: *Watson v Lancashire Teaching Hospitals NHS Foundation Trust* [2022] EWHC 148 (QB)

Clinical Negligence – Evidence –Factual Causation – Dismissal

The case of *Watson* makes interesting reading for any party on either side of clinical negligence litigation that involves disputed issues of factual causation. Anthony Johnson considers how Ritchie J's judgment analyses in detail the matters that led him to find for the Defendant and dismiss the case.

Background

The Claimant, who was aged 29 at the time, suffered a transient ischaemic attack (TIA, i.e. a serious stroke) in May 2015 having been treated at the Defendant's hospital in March 2015. It was alleged that a differential diagnosis and, in turn, prescribing Aspirin would have prevented the subsequent stroke. The Defendant admitted breach of duty, but asserted that the stroke could not have been avoided and that, therefore, its admitted breach did not affect the outcome.

It was agreed between the parties that the outcome of the case turned upon a number of factual issues: Was the Claimant's facial droop right or left-sided? What was the extent and timing of onset of her left-sided weakness? Were her symptoms in March as a result of TIAs or sporadic hemiplegic migraine? Would the prescription of Aspirin gave led to the TIA being non- or minimally injurious? The Claimant accepted that her case must fail if the presentation in March 2015 was not TIA.

Judgment

In his judgment, Ritchie J. analysed the pleadings and chronology, the medical records and the lay and expert evidence that he heard (both parties' instructed neurologists gave evidence at the trial) in some detail. This means that, although the case is extremely fact specific, it is still possible to understand the basis upon which he made the findings that he did.

The main finding of fact that led to the claim being dismissed was that the Judge found as a fact that he preferred the evidence of the Defendant's witness, Dr. Osborne, wherever it conflicted with that of the Claimant and her partner, Mr. Eastham. Dr. Osborne was a trainee doctor in her second year of training at the material time. She gave evidence that she had a vague recollection of the Claimant, in particular her quite pronounced photophobia, but most of her evidence was given in accordance with her clinical notes. The Judge found that she was *"a careful, fair, logical, intelligent, straight forward, well prepared and impressive witness."* The way in which her evidence was set out was said to be 'credible'.

In contrast, the Judge felt that there were some 'oddities' in the evidence found in the Claimant's statement. There was some debate about whether she had capacity, which had resulted in the statement being signed solely by her Litigation Friend; the Judge queried whether she could have signed it jointly. In any event, he noted that on two previous occasions when the trial had been listed, she had asserted via her lawyers that she wanted to come to Court to give evidence. She had not applied to amend her pleadings despite her Particulars of Claim and Witness Statement giving opposite accounts as to the side of her face on which the droop was found. He felt that Mr. Eastham was clearly an honest witness who was doing his best, but she noted that his recollection may have been affected by the trauma that the Claimant's stroke had caused him. Against all of that backdrop, the Claimant's written and oral evidence was incapable of outweighing the oral evidence of Dr. Osborne.

Comment

It is perhaps somewhat unsurprising that, having succeeded comprehensively in relation to factual causation, the contested issues of medical causation were also then resolved in the Defendant's favour. Going into some detail, the Judge emphasised that, even if it had been necessary for him to consider the questions in relation to Aspirin, on the balance of probabilities he would not have found that it would have avoided the Claimant's stroke.

Whereas findings of fact are obviously inherently difficult to predict, this case highlights the importance of ensuring that claimants and their witnesses are clear and consistent in their evidence in any case that is being taken to a contested trial. Whilst it may not have made a difference to the outcome of the index case, the judgment certainly highlights the importance of taking care to consider the manner in which evidence (both written and oral) should be provided in circumstances where the Claimant's level of capacity is close to the borderline.

Anthony Johnson
AnthonyJohnson@TGchambers.com

There is no case without causation: *Salchow v St George's University NHS Foundation Trust* [2022] EWHC 100 (QB)

Clinical Negligence – Evidence – Causation

Breach of duty is all well and good, but without causation it is nothing. James Laughland explores why the decision in *Dalchow* is a sobering reminder of the need to concentrate on all elements of the liability equation. There must be duty, breach and damage. The counterfactual, what would have happened had there been no breach, must also be carefully considered.

Background

The claim here was based on allegations of delay in taking steps that it is said would have resulted in the speedier diagnosis and treatment of Fournier gangrene, a form of necrotising fasciitis ("NF"), a life-threatening infection of skin and other soft tissues. More precisely, the Claimant's complaints were that there had been a failure to investigate his condition by means of an urgent ultrasound or CT scan and a failure to start broad spectrum antibiotic therapy at a time when such would have made a difference to the outcome.

The Judge was required to determine whether there was a breach of duty beyond that which had been admitted and whether any breach of duty caused or materially contributed to the Claimant's injuries.

The Defendant had admitted that there had been a breach of duty in that it accepted that the intravenous antibiotics ought to have been commenced earlier than had been the case (but not as early as contended for by the Claimant), but maintained that even if the antibiotic treatment had been commenced at the time the Defendant accepted it ought to have been done, that this would have made no difference to the eventual outcome.

As to the ultrasound complaint, the Defendant denied that there had been any breach of duty and argued that even if there had been an ultrasound, this would not have led to the differential diagnosis of NF such as would have been necessary for surgery to occur earlier than it had in fact been undertaken.

At the heart of the evidence was the fact that all agreed that the Claimant had presented with a *"very, very unusual presentation for post-operative pain or small haematomas"*. However, just because all now knew that this was a consequence of the progression of this form of NF, the issue was whether such was an appropriate diagnosis to make as matters had progressed. It was accepted that it is often easy to make a diagnosis in retrospect, but common conditions are common and rare conditions are rare and very difficult to diagnose even by experienced clinicians.

Judgment

The Judge concluded that he saw no evidence that justified the failure to prescribe antibiotics at the time for which the Claimant had contended. Indeed, the treating doctor had acknowledged as much during his cross-examination. What was more difficult to determine was the criticism about the appropriate timing of the ultrasound.

The treating doctor had explained the delay as partly due to his desire to consult a more senior practitioner first about the working diagnosis. The Judge held he could not categorise that decision as unreasonable, due to the unusual presentation. The senior doctor had agreed with the decision to proceed to an ultrasound, and consideration then turned to whether this had been implemented sufficiently promptly. The Judge concluded that it needed to be treated as an urgent matter, again something the treating doctors had accepted due to the uncertainty about diagnosis but held it had not been. The agreed evidence was that an urgent ultrasound should be conducted within 2

hours, whereas in fact even the referral form for the ultrasound was not completed within that time frame.

Of wider interest is the Judge's reasoning in reaching his conclusion on this point. He noted that there had been no evidence that any efforts had been made to obtain an urgent ultrasound. The expert evidence made it clear that it is unusual not to be able to conduct an ultrasound within 2 hours, but there had been no evidence adduced as to why there had been a delay in completing the referral form. Although there had not been direct evidence on this issue, the Judge had regard to the approach endorsed in ***Wisniewski v Central Manchester Health Authority*** **[1998] Lloyd's Medical Report 223** [although note that the Supreme Court in ***Efobi v. Royal Mail Group Ltd*** **[2021] UKSC 33** cast doubt on the scope of ***Wisniewski***.] There Brooke LJ had said by way of guidance:

i. *"In certain circumstances a court may be entitled to draw adverse inferences from the absence or silence of a witness who might be expected to have material evidence to give on an issue in an action.*
ii. *If a court is willing to draw such inferences, they may go to strengthen the evidence adduced on that issue by the other party or to weaken the evidence, if any, adduced by the party who might reasonably have been expected to call the witness.*
iii. *There must, however, have been some evidence, however weak, adduced by the former on the matter in question before the court is entitled to draw the desired inference: in other words, there must be a case to answer on that issue.*
iv. *If the reason for the witness's absence or silence satisfies the court, then no such adverse inference may be drawn. If, on the other hand, there is some credible explanation given, even if it is not wholly satisfactory, the potentially detrimental effect of his / her absence or silence may be reduced or nullified"*

Although the Judge held there was no reasonable excuse for the delay in procuring the ultrasound, he then had to consider whether that had in fact made any difference to the eventual outcome. The same consideration applied to the delay in commencing antibiotic treatment. Considering that the evidence of the microbiologists was that the destructive process from the NF was underway by no later than early morning (i.e., well before the first alleged negligent failure) this was always going to be a problematic issue for the Claimant.

In the event, as the Judge held that even if the ultrasound had been done more promptly this would not, in fact, have led to earlier surgery (as the observable effects of the NF – skin breakdown – were not apparent until mid-afternoon) that breach of duty had caused no loss.

Likewise, with the delay in provision of antibiotics. The only treatment that would have had an appreciable effect on the NF was surgery, but surgery ought not to be undertaken unless and until there is a good reason, a target. Speculative surgery to try and discern the problem can cause more harm than good. As the surgery in fact had occurred at or around the time it ought to have done, despite the various breaches of duty, the delay in provision of antibiotics made no difference. There was some discussion about whether the Claimant could recover on the basis that delay had made a material contribution to the poor outcome, but the Judge held that this was not an indivisible injury so the law on this issue was not of any application.

Accordingly, and despite the consoling words of the Judge, the claim was dismissed.

James Laughland
JamesLaughland@TGchambers.com

"He said, she said" – recollections and records: *HTR v Nottingham University Hospitals NHS Trust* [2021] EWHC 3228 (QB)

Clinical Negligence – Evidence – Medical Records – Witness Statements – Credibility

How should a court decide what an expectant mother said to a busy doctor 17 years ago? James Yapp considers why Mr Justice Cotter's judgment contains a 'cut out and keep' guide for practitioners. The Judge had to assess the accuracy of witness' recollection and the utility of medical records. Ultimately, the medical record from the key consultation was only one piece in the puzzle. The decision also shows that evidence on relatively minor issues may cast doubt upon the credibility of one witness and bolster that of another. It stands as a reminder as to the importance of preparing accurate witness statements.

Facts

The Claimant's mother (LJR) attended an antenatal appointment on 6th October 2004 with Dr Salman. The Claimant was born 4 days later by emergency caesarean section having suffered permanent brain damage from chronic partial hypoxia which resulted in asymmetric quadriplegic cerebral palsy.

It was agreed that if LJR had raised a concern about reduced foetal movements on 6th October, then Dr Salman was negligent in failing to act upon it.

The key note from the day stated: *"Well. Worried if baby breech. Confirmed cephalic by USS. Declines having FBC. See @ 41/40. Active FMs [foetal movements]."*

The Parties' Cases

LJR's said she reported reduced foetal movements to Dr Salman; that Dr Salman performed an ultrasound on 6th October; and that Dr Salman had reassured her regarding the reduced movements.

Dr Salman had no independent recollection of the consultation. The claim was not intimated until 8 years after the incident. She said that if reduced foetal movements had been reported, then she would have recorded this in the notes. Dr Salman said she did not perform the ultrasound.

The Defendant also prayed in aid notes following LJR's admission on 10th October. These did not refer to concerns on 6th October, but only on subsequent days.

The Defendant invited the Court to rely upon the contemporaneous notes rather than LJR's recollection.

The Ultrasound Issue

Whether Dr Salman performed the ultrasound scan on 6th October became an important issue at trial. LJR and her mother were adamant that Dr Salman had performed the scan. Dr Salman said in a witness statement that: *"... to be absolutely clear, whatever the state of my training in October 2004, I was never trained to perform ultrasound scans, I never scanned, I still don't scan".*

Dr Salman accepted in cross-examination that she in fact received 'hands on' training in December 2004. She had then carried out scans infrequently over two to three years. Cotter J was unimpressed:

"It is very difficult to understand how Dr Salman came to prepare and verify a statement, the sole purpose of which was to address one issue... which was so fundamentally incorrect a fortiori when expressly setting out that she was making matters "absolutely clear"... I received no satisfactory explanation for this very seriously misleading assertion... It resulted in the balance of her evidence, when not corroborated by records or other witnesses, having to be treated with considerable caution..."

The Judge found that Dr Salman was mistaken about the date of her 'hands on' training. He accepted Dr Salman had performed the scan on 6th October.

The Relevant Principles

Paragraphs 73–83 of the judgment are worth reading in full for a summary of the relevant principles when considering the reliability of witness evidence and of medical records. A few of the relevant points are summarised below.

On medical records: -

i. Some documents are by their nature likely to be reliable; medical records ordinarily fall into that category.

ii. Medical records are obviously worthy of careful consideration but must be judged alongside the other evidence. Other evidence may establish that a record is inaccurate.

iii. The reliability of clinical notes may be diminished where there is uncertainty about the circumstances in which they are made.

iv. A court will often take as a starting point, but no more than a starting point, that a contemporaneous medical record is likely to be a correct and accurate record of what was said and done at a consultation.

On evaluating the evidence of a witness: -

i. A witness' evidence should be broken down into component parts. The fact that one part is incorrect may, but does not necessarily, mean the rest is unreliable.

ii. There may many reasons why an incorrect element creeps in. These include the passage of time, conscious or subconscious reconstruction, or corruption of memory following exposure to the recollection of another.

iii. There can be conscious or subconscious bias in the recollection process. People often adopt the stance that they were not at fault when asked to recall an event in the context of criticism.

iv. There is a tendency to fall back on one's usual practice.

v. In a complex case with conflicting evidence it can be impossible to piece together the entirety of the 'jigsaw'. Individual pieces may be wrong, distorted or missing. However, often enough they will fit together to allow the full picture to be seen.

Records as One Piece in the Puzzle

The Judge stated the general rule that medical records are ***"usually of very considerable importance in clinical negligence cases".*** He went on to find that they provided *"only some assistance"* on the central issue of fact in this case; it was made clear that his finding must turn mainly upon his assessment of the reliability of LJR's recollection.

He took into account the fact that an earlier statement given by the Claimant had been proved right about certain issues. This statement was compiled in 2012 and was thus reliant upon her recollection rather than medical records.

The Judge was satisfied to a very high degree of probability that LJR had reported reduced movement to Dr Salman. Importantly, there was nothing in the key record which directly contradicted JLR's account.

"The critical medical note records active foetal movement (Active FMs). However, such an entry... does not preclude concern having been expressed by LJR that there had been reduced (as opposed to no) movement recently. Dr Salman's evidence was that if such concern has been expressed she would have recorded it, and as she had not made a record of such a concern it cannot have been raised. However, as I have already stated, I believe that her recollection has been affected by the intervening years of practice and the greater emphasis on reduced foetal movement since 2011."

The Judge accepted LJR's account that Dr Salman had reassured her on 6th October. It was therefore possible to understand why subsequent records did not mention reduced movements on that date. LJR said she would have excluded that day when explaining the period of reduced movements to subsequent clinicians because of the reassurance she had received.

Inaccuracies and Credibility

This case again illustrates the importance of accurate witness evidence. Dr Salman's credibility was damaged by stating ***"I was never trained to perform ultrasound scans, I never scanned, I still don't scan"***. Inaccurate evidence, even on seemingly minor issues, can harm a witness' credibility generally. That sentence appeared in a witness statement filed in response to a Part 18 question from the Claimant. Looked at another way, this case is also an example of how a well-drafted Part 18 request can affect the outcome of a case.

James Yapp JamesYapp@TGchambers.com

The 'scope of duty' of expert witnesses: *Radia v. Marks* [2022] EWHC 145 (QB)

Clinical Negligence – Expert Evidence – Professional Liability – Scope Of Duty

Marcus Grant explores the case of *Radia*, which addresses the potential liability of expert witnesses for factual inaccuracies in their reports. He emphasises that experts should not be commenting on matters of credibility. Accordingly, an error of fact in an expert report resulting in an adverse credibility finding against the client who commissioned that report, cannot give rise to an action in contract or tort. The constituent elements of negligence or breach of contract require a loss within the scope of a duty of care. Any loss falling outside that scope nullifies any breach that might otherwise be actionable.

Background

In this case, Christina Lambert J was asked to consider the scope of a contractual and common-law duty of care owed by a jointly instructed expert to a party when preparing a medical report.

R brought a claim for professional negligence against M for failing to record accurately his weight at the conclusion of a course of chemotherapy treatment for acute myeloid leukaemia ("AML"). In his report, M recorded that he weighed ***"slightly less than 50 kg, i.e., he had lost nearly 50% of his total body weight"*** at the end of treatment, having weighed 95 kg at the start of treatment.

That weight loss was a significant factor which R relied on in corroborating his case against his former employer that he was suffering significant post-chemotherapy fatigue that amounted to a disability forming the basis of his disability discrimination claim for damages.

In the course of employment tribunal proceedings, a contemporaneous treatment record was relied upon by the employer which recorded R's weight as being 81.5 kg at the conclusion of his chemotherapy treatment. In evidence, M agreed that he had missed that reference and arrived at his estimate of ***"slightly less than 50 kg"*** from R's oral history at the examination, which was confirmed in his handwritten clinic note.

The Tribunal went on to find that R's evidence that his post-treatment weight was around 50 kg was unreliable and contributed not only to the dismissal of his claim for disability discrimination, but also for the costs' orders made against him; these were made on the basis that he had acted unreasonably ***"by telling lies which were deliberate, serious and central to the case"***. R was ordered to pay his former employer's costs of defending the tribunal proceedings and subsequent cost proceedings that mounted to a sum in excess of £600,000.

R claimed damages in this sum against M, alleging that his failure to review the contemporaneous treatment records carefully amounted to a breach of his duty of care that ***"caused the employment tribunal to find that the claimant had been dishonest"***, which in turn paved the way to the substantial costs' orders made against him.

M accepted that he had made a mistake in missing the entry recording his post-treatment weight at 81.5 kg. However, he did not accept that the mistake was actionable. He contended that he was entitled to accept R's own oral evidence as to his post-treatment weight. He contended that he was under no duty to cross reference that account with the contemporaneous clinical records. He observed that the clinical records had been provided to him late in the day before completing his report in a disorganised and unpaginated state, and that it was not unreasonable that he had missed that single reference to R's post-treatment weight.

Judgment and Reasoning

The Court agreed and dismissed R's claim. Importantly, the Court found that it did not fall within the scope of an expert's duty of care to an instructing party to protect that party from the risk of an adverse credibility finding or finding of dishonesty.

The medical expert had been instructed to address three medical matters, one of which included the effect of the cancer upon R's condition during two time periods. At no point was a part of his retainer to advise or assist on issues concerning the credibility or reliability of R's evidence.

The Court reiterated that matters of credibility lie solely with the Court (or the tribunal on the facts of this case) and not with the expert. Lambert J observed ***"the scope of the defendant's duty of care this case cannot extend to the protection of a party from a risk upon which the defendant was not competent to give an opinion".***

The Court acknowledged that:

"One of the effects of a medicolegal expert's evidence may be to highlight an oddity or inconsistency or discrepancy in the evidence which may then inform a tribunal's judgement on matters of credibility and reliability of parties and witnesses. That happens frequently. But the fact that this is, or maybe, a side-effect of the expert evidence does not extend the scope of the duty of such an expert to protect the party or witness from the risk of adverse credibility findings, just as it is no part of the role of the expert to seek to support the credibility of a witness or party".

In reaching these findings, the Court cited Lord Oliver's ratio in Caparo Industries ***Plc v. Dickman*** **[1990] 2AC 605 at 651** where he addressed the scope of a duty of care in the following terms: -

"The duty of care is inseparable from the damage which the plaintiff claims to have suffered from its breach: it is not a duty of care in the abstract but a duty to avoid causing to the particular plaintive damage of the particular kind which he has in fact sustained".

Applying that *ratio* to the facts of this case, M could not be said to have breached any duty that caused a tribunal to find that R had been dishonest, because he owed no such duty. That was the end of the case.

However, for completeness, on the specific facts of this case, the Court found that whilst M had made a mistake in failing to pick up the reference in the medical records to R's post-treatment weight, that mistake was not actionable given that he had been provided with the records late in the day in a disorganised state and placed under significant time pressure to produce his report.

Comment

The takeaway points from this unusual decision are: -

i. It is not an expert's duty to express opinions on matters of credibility. That is the sole province of the Court as the finder of fact.

ii. It is good practice for instructing solicitors to provide medical records in a paginated an orderly fashion if they wish experts to review them correctly and provide clear instructions on issues arising from those records which the expert should consider.

iii. An expert's duty of care does not extend to cross-referencing instructions from the patient with contemporaneous clinical records, to test the credibility of one against the other.

Marcus Grant MarcusGrant@TGchambers.com

Update to Clinical Negligence Standard Directions

Clinical Negligence – Procedure – Practice Guidance - Standard Directions

Official Practice Guidance

Philip Matthews highlights that, on 11 February 2022, the standard direction order templates to use in multi-track clinical negligence cases being heard in the county courts and district registries or Royal Courts of Justice were updated.

Of particular note is the emphasis on reducing 'door of the court' settlements. These are considered wasteful of costs, resources and judicial time. The updated directions now include the standard provision (that most directions orders were seeking in any event) that "Any party not engaging in any means of Alternative Dispute Resolution proposed by another party is to serve a witness statement giving reasons within **21 days** of receipt of that proposal."

It is notable that Under CPR 3.1(2)(m), the Court now also has the power to order Early Neutral Evaluation. It remains to be seen whether this will become a standard direction in due course.

Knowledge, Extensions and Agendas: *Aderounmu v Colvin* [2021] EWHC 2293 (QB)

Clinical Negligence – Procedure – Limitation – Capacity – S.14 Limitation Act 1980

Richard Boyle considers the case of Aderounmu, which concerns limitation. In relation to s.14 of the Limitation Act 1980 ("LA"), Brooke LJ complained that the law was *"grossly overloaded"* with authority and, 15 years later, Lord Walker remarked that *"the overload has increased"*. This article will attempt to avoid further overload by exploring the impact of capacity on limitation and a practice point concerning joint reports.

Background

On 19th November 2009, the Claimant had a consultation with his GP, the Defendant. The Claimant was not speaking clearly and this was noted in the medical records. Four days later, the Claimant suffered a stroke causing a serious neurological injury, including dysphasia which affected his written and spoken language. The Claimant claimed that the Defendant should have referred him for urgent investigations to exclude a stroke.

The claim was issued on 10th October 2017, almost eight years from the date of the injury. The Claimant claimed that he lacked capacity to litigate and so was disabled for the purposes of s.38(2) LA. Alternatively, he did not have knowledge under s.14 LA or sought an extension of time under s.33 LA. Limitation was tried as a preliminary issue by Master Cook.

Capacity

The Master summarised the law of limitation, citing many of the familiar authorities (see §16–23). He then summarised the law in relation to capacity: -

i. Capacity is defined by ss.1–3 Mental Capacity Act 2005 ("MCA");

ii. Capacity is issue specific (***Masterman- Lister Brutton & Co* [2002] EWCA Civ 1889** at §27). An individual may not have capacity to understand some of the subject matter of litigation but still have capacity to litigate (***Sheffield City Council v E(1) & S(2)* [2004] EWHC 2808** at §49);

iii. The court is not bound by expert evidence and may take account of all available evidence e.g. medical records, background facts, evidence from other witnesses (***Saulle v Nouvet* [2007] EWHC 2902**); and

iv. The core issue was whether, notwithstanding the Claimant's impairment, he could retain information in order to make appropriate decisions in the litigation.

The Master then considered the Claimant's capacity on the facts: -

i. No concerns were raised with the Claimant's mental capacity following the stroke;

ii. The Claimant had made decisions relating to: immigration claims from 2011 to 2017; other health conditions; difficulties with housing and accommodation; difficulties with debts at his university and hospital; marriage and childbirth;

iii. The Master preferred the Defendant's expert neuropsychiatrist, who considered the discrepancies between the medical records and the Claimant's account; and

iv. The neuropsychologists did not provide great assistance. He was not convinced the Claimant properly engaged with their tests and placed little weight on them.

The Master concluded that the Claimant could make decisions in the litigation; was able to give instructions concerning damages; and was able to understand offers of settlement. The Claimant did not need to understand every element of his case or the expert reports. This would be beyond most average litigants in clinical negligence claims.

Date of Knowledge

Medical records from December 2010 noted the Claimant's symptoms and his anger with his GP. The Master concluded that the Claimant knew the injury was significant, that it was attributable to an omission by his GP and that it was probably a breach of duty. He had actual or constructive knowledge meaning that the claim was out of time by almost four years.

Section 33 LA

The Master noted that, while the Claimant had capacity, he required help and support to make decisions. It did not appear that the Claimant had received much support until 2013. The Claimant was only prompted by others to contact solicitors in January 2017. Until October 2017, the Claimant was primarily preoccupied with his immigration litigation. In relation to the cogency of the evidence, the medical records were available and would be of central importance. The Defendant had some independent recollection of the consultation and did not appear handicapped by the passage of time. The impact of the delay was less than it might have been. The Claimant had undoubtedly exaggerated his symptoms but did suffer significant cognitive impairments. He may have been influenced by the Litigation Friend, whose evidence the Master found to be "***most unsatisfactory***". It was possible to have a fair trial and the action should proceed.

Practice Point: Joint Statements

The Master also commented on the joint statements. He called the joint psychiatric report "***an overly lawyered document***". He criticised the number of questions (34), presumably arising from the agenda. The joint neuropsychological report suffered from the same vice: of 41 questions posed, only about two were of assistance. The questions descended into cross examination in places which was unhelpful. A joint report should aid the understanding of key issues and each expert's position on those issues. A joint statement is for the benefit of the Court and should not be a proving ground for the parties' respective cases. Parties often struggle to agree an agenda for joint statements. These dicta provide support for a party that seeks to simplify and shorten an agenda or to remove cross-examination type questions.

Richard Boyle RichardBoyle@TGchambers.com

Don't pay too quickly: *Gibbs v King's College NHS Foundation Trust* [2021] EWHC B24 (Costs)

Clinical Negligence – Procedure – Costs – Remission Of Court Fees – Failure To Mitigate

Anthony Johnson considers the case of *Gibbs*, where it was held that a party who had not considered whether they were entitled to a remission of Court fees before paying them risked being unable to recover those fees in a costs' assessment undertaken on the standard basis. If the paying party could demonstrate that the receiving party fell within the remission scheme, it was beholden on the receiving party to justify why the fee had been incurred. In the absence of such justification, the fee should be disallowed.

The discrete issue that was before Costs Judge Rowley in the Detailed Assessment in Gibbs concerned the Court's issue fee, which had been incurred by the Claimant at the maximum level of £10,000 in a clinical negligence claim. There were two entries in the electronic bill which referred to fee remission having been contemplated. The Defendant's Points of Dispute stated: -

"The Claimant was self-employed, and was in receipt of Employment and Support Allowance (ESA), as well as the enhanced Living Component of Personal Independence Payment (PIPL), and the enhanced rate of the Mobility Component of Personal Independent Payment (PIPM). The Claimant would be eligible for an issue fee remission and incurring the fee is an unreasonable cost. The Claimant is put to proof that an application for issue fee remission was considered, prepared, and the outcome of the same."

As it was a standard basis assessment, the burden of proof was on the receiving party to demonstrate that the fee was reasonable and proportionate.

The Claimant's response had been that there was no requirement for any claimant to mitigate their loss by relying upon the public purse; the authority of *Peters v. East Midlands Strategic Health Authority* [2010] QB 48 was relied upon in support of this proposition. It was suggested that incurring the Court fee was not a failure to mitigate loss because the real issue was who should bear the burden of the fee – the tortfeasor on the one hand or the State on the other? It was averred that the fact that the fee earners had been thinking about fee remission after the event did not carry any weight regarding the decision not to seek it in the first place.

In response, the Defendant referred to the judgment of HHJ Lethem in the case of ***Ivanov v. Lubbe*** (unreported, Central London CC, 17.01.20). It was pointed out that there was a three-month period in which a claim could be made for a refund where a party had paid the fee but was held to be entitled to a remission. It was submitted that a consideration of whether a fee had been reasonably incurred should depend upon the facts of the individual case.

The practical considerations underpinning the decision were summarised in paragraphs 19–20 as follows: -

"It clearly would not have been too difficult for the claimant and her solicitors to make an application for fee remission. If the application had been turned down then that would be the end of the defendant's challenge. In my view, the costs of making an application where the claimant may potentially be entitled to fee remission are recoverable between the parties. The paying party may well take the point when it comes to a detailed assessment and time spent to establish the position, in my view, generates costs which are reasonably incurred in principle. ... Consequently, if, as appears to be the case here, it was simply overlooked, should the court allow the fee as being reasonably incurred in any event? In my judgment the answer is, no."

In addressing the Claimant's argument that the Defendant's position would inevitably lead to a reduced income to the Court Service and that this would have a detrimental effect upon the administration of justice, Costs Judge Rowley emphasised that it is plausible that by implementing a fee remission scheme in the first place, Parliament would expect all eligible people to use it. The number of people who would be entitled to use the scheme would inevitably have been factored into Parliament's calculations. It is just as likely that such claimants are 'precisely following a model designed by the State' as causing it a loss.

After discussing the role that mitigation plays in costs assessments, as compared to claims for damages, the Judge set out the following conclusion in the final paragraph of his judgment:

"In my judgment, a party who does not consider whether they are entitled to a fee remission and, thereafter make an application if there is any doubt, risks being unable to recover that fee from their opponent. If the opponent can demonstrate that the receiving party appeared to fall within the remission scheme, the onus will be on the receiving party to justify why the court fees were incurred. If as here, there is no such justification put forward, the fee should be disallowed under CPR 44.3. Such a party has not incurred the lowest amount it could reasonably be expected to spend. At the very least there has to be a doubt which is to be exercised in favour of the paying party."

It follows from the above that ***Gibbs*** is a decision that all clinical negligence practitioners should have at the forefront of their minds whenever a decision is taken to go ahead and issue proceedings. A failure to apply for a fee remission that the claimant would have been entitled to could lead to a shortfall of up to £10,000 on assessment.

If there is any doubt about whether a particular claimant is entitled to such fee remission, it is suggested that it would be sensible to make an application to ensure that a determination is made one way or the other on the point. The decision of Costs Judge Rowley gives a clear indication that he would have looked favourably upon the costs of even a failed application for fee remission. It seems to be implicit in this, however, that such an application would have had to have been reasonably made, i.e., that the claimant's solicitors would have to be able to explain why it was considered that remission may have been granted.

Anthony Johnson
AnthonyJohnson@TGchambers.com

Practice Note by the Senior Costs Judge: Children / Protected Parties and Deductions from Damages

Clinical Negligence – Procedure – Costs – Children – Protected Parties – Deductions From Damages

Philip Matthews considers the new guidance from the Senior Costs Judge, published on 2 December 2021, on the approval of costs settlements, assessments under CPR 46.4(2) and deductions from damages, as it relates to children and protected parties ('P').

The Relevant CPR Provisions

CPR 21.10 requires any settlement on behalf of P to be approved.

CPR 46.4(2)(a) provides that where money is ordered or agreed to be paid to P, there must be a detailed assessment of the costs payable by or out of P's money. The costs payable from P's award must be limited to that amount (CPR 46.4(4)). On assessing those costs, the court must also assess in detail the costs payable to P, unless there is a default cost certificate or fixed costs apply (CPR 46.4(2)(b)).

If the costs payable by P comprise only a CFA success fee or the balance under a DBA, the court may direct a summary assessment (COR 46.4(5)). However, it is important to note that only in circumstances where such costs are incurred by a child (and not a protected adult) in a PI claim and where damages do not exceed £25,000 should those costs be summarily assessed (CPR 21.12(1A)).

CPR 21.12(1A) provides that the only recoverable costs in respect of a child are: -

- Costs flowing from a detailed assessment under CPR 46.2(2);
- Those summarily assessed costs under CPR 21.12(1A); and
- Those costs incurred where a detailed assessment has been dispensed with under CPR 46.4(3), as provided by the exceptions listed at CPR PD 46, paragraph 2.1.

Those exceptions to the general rule that costs are to be assessed in detail contained in PD 46 are as follows: -

- Where there is no need to do so to protect the interests of the child or the protected party or their estate;
- Where another party has agreed to pay a specified sum in respect of the costs of the child or protect party and the legal representatives acting for the child or protected party has waived the right to claim further costs;
- Where the court has decided the costs payable to the child or protected party by way of summary assessment and the legal representative acting for the child or protected party has waived the right to claim further costs;
- Where an insurer or other person is liable to discharge the costs which the child or protected party would otherwise be liable to pay to the legal representative and the court is satisfied that the insurer or other person is financially able to discharge those costs; and
- Where the court has given a direction for summary assessment pursuant to CPR 46.4(5).

The Practice Note sets out some scenarios and relevant proposed precedent orders. These should be the starting point for practitioners in the area.

Scenario 1

In normal circumstances, the court approving the settlement of the claim will have a costs provision that any costs will be subject to detailed assessment or that detailed assessment is to be dispensed with following one of the exceptions contained in PD46.

Scenario 2

Where a detailed assessment has been ordered, but those costs have been agreed or waived by P's legal representative, the costs settlement can be approved under CPR 21.10 and an application to the SCCO should be made under CPR 23.

Scenario 3

Where there is no PD 46 exception and only a CFA success fee or DBA is sought (and summary assessment is not precluded by CPR 21.12(1A)) an application to the SCCO may be made under CPR 23 for summary assessment under CPR 46.4(5).

Scenario 4

On occasion, parties had sought to 'approve' or 'certify' payment of costs by P to their legal representatives in a proposed order. This is no longer likely to be deemed appropriate. Either detailed assessment is dispensed with, or a request for detailed assessment must be filed in the form N258 with the appropriate fee.

In such circumstances where inter-party costs are agreed and therefore (usually) assessed in that agreed sum, the paying party does not need to attend the detailed assessment hearing. The N258 form should clearly state that costs have been agreed and the purpose of the hearing is to assess the costs/ disbursements sought by P's legal representatives.

An important feature of the proposed order in this scenario is the inclusion of a direction in relation to ATE insurance; it is no longer appropriate, as referred above, to simply certify that such costs are payable by P in the context of the wider agreed inter-party costs.

The new guidance notes that the costs of such a hearing are unlikely to fall at the feet of P, the hearing being primarily for the benefit of the legal representatives. The guidance goes on to state that "for that reason, unless the child or protected party's litigation friend or Court of Protection deputy takes issue with the costs sought by the legal representatives and participated in the detailed assessment of the costs, the court is likely to make no order as to the costs of the detailed assessment proceedings beyond any figure agreed with the paying party."

Philip Matthews

Pyrrhic victories and the right to set off: *Ho v Adelekun* [2021] UKSC 43

The central question before the Supreme Court in *Ho v Adelekun* [2021] UKSC 43 was whether, in claims to which Qualified One Way Cost Shifting ('QOCS') applies, it is permissible to order set-off of a defendant's costs against those of a claimant. The short answer is 'no': the ability of defendants to recover costs awarded in their favour by off-setting them against costs awarded to the claimant in certain situations has gone. This overturns the earlier Court of Appeal decision, along with the decision in *Howe v MIB (No.2)* [2017] EWCA Civ 932. Lionel Stride considers the implications of this landmark judgment.

The Facts

The Claimant was the victim of a road traffic accident, and brought proceedings against the responsible driver. In due course, that claim settled for £30,000 by way of acceptance of a Part 36 offer, entitling the Claimant to a payment of damages and costs from the Defendant.

There was subsequently a dispute about the basis of assessment of those costs. The Defendant contended that the Claimant was entitled to no more than "Fixed Recoverable Costs" rather than assessed costs on the standard basis. The point was argued to the Court of Appeal, where the Claimant lost and was held to be entitled to fixed costs of around only £16,700. The Defendant was also awarded its costs of the appeal, which amounted to £48,600.

The Claimant argued that she was protected from paying any of the Defendant's costs by the QOCS regime, which precluded enforcement of the Defendant's costs beyond the level of 'damages and interest' payable pursuant to a court order (see CPR 44.14(1)). In ***Cartwright v Venduct Engineering*** **[2018] 1 WLR 6137**, the Court of Appeal had already determined that damages payable pursuant to a Tomlin Order or a Part 36 settlement could not be considered equivalent to a court order for 'damages and interest', such as to trigger a successful defendant's right to enforce an order for costs under CPR 44.14. Accordingly, if the Claimant was right, the Defendant would have nothing to enforce her costs against other than her costs award.

The Defendant therefore argued that it was possible to set off the two costs orders against each other, with the net effect that the costs payable to the Claimant would be wiped out by those payable to the Defendant. The case returned to the Court of Appeal to resolve this thorny issue, which in turn held itself bound by the earlier decision of ***Howe v MIB*** **[2020] Costs LR 297** to agree that the Defendant's interpretation of the rules was correct.

Judgment

Overturning ***Howe***, the Supreme Court unanimously held that, as a matter of construction, set off in the context of CPR r.44.14(1) was a species of enforcement and therefore precluded where it exceeded the total of any orders for damages and interest made in favour of the claimant.

Analysis

It follows that, in circumstances where there is no court order for damages (e.g. because the claim concluded by settlement), a defendant cannot recover any of its costs absent some other discrete exception applying (e.g. under CPR 44.15). Further, any costs order in favour of a claimant is protected from set off, even where the balance of costs would be heavily in the defendant's favour. Likewise, a defendant who, for example, betters its Part 36 offer at trial, with an order for costs in its favour from expiry of the offer, cannot now setoff any shortfall in costs beyond the level of damages awarded;

payment of the claimant's full assessed costs would still be required.

Given that it is not unusual for cases to settle with outstanding costs awards in favour of defendants on discrete issues (such as interlocutory applications), this decision has wide ranging and significant ramifications. Unless the parties agree to set off of those costs as a condition or specific term of settlement, they would not be recoverable at all.

A question for the Civil Procedure Rules Committee?

Interestingly, the Supreme Court was prepared to recognise that their conclusion "***may lead to results that at first blush look counterintuitive and unfair" and could not help but observe that "no one has claimed the QOCS scheme is perfect. It is, however, the best solution so far that the opposing sides in the ongoing debate between claimant solicitors and defendant insurers have been able to devise...***" [44]

Further, the Supreme Court doubted whether it had been appropriate for a procedural question of this kind to be referred to them at all, suggesting that the Civil Procedure Rules Committee (CPRC) would be better constituted to put right any ambiguities in the rules. They commented that they would leave it to the CPRC to amend the relevant rules if the Court's interpretation did not best reflect the purpose of QOCS and the Overriding Objective.

Lionel Stride LionelStride@TGchambers.com

"A change gonna come" – The Ockenden Report and Fixed Costs Regime for Clinical Negligence

Clinical Negligence – Alternative Dispute Resolution – Early Neutral Evaluation Ockenden Report – Fixed Costs Regime

Peter Freeman considers recent developments away from the Courtroom, which will affect the way claims are resolved in future.

The Ockenden Report into Shrewsbury & Telford NHS's maternity services makes for truly shocking reading. The executive summary gives an indication of scale: of 498 cases of stillbirth, one in four cases were found to have significant or major concerns in maternity care which, if handled appropriately, might or would have resulted in a different outcome. In fact, the review considered 1,500 families' experiences, predominantly between 2000 and 2019, and revealed maternity services that failed to investigate, failed to learn and failed to improve and, therefore, failed to safeguard mothers and their babies. Equally shocking is the fact that these findings only came about because of the parents' "***unrelenting commitment***". Jeremy Hunt MP praised the ***"really extraordinary role***" played by the families in investigating and campaigning, but asks why it took their efforts "***rather than the NHS itself to be really hungry to learn from mistakes.***"

Changes to maternity services are promised. Everyone hopes that "***a change gonna come.***" Regrettably, as Sam Cooke's lyrics point out, *"it's been a long, a long time coming*" and it is too late for the Shrewsbury families.

Unsurprisingly, MPs are quick to say that the affected families will receive justice "***now***". However, there is little hope for rapid "***justice***" unless there is rapid change in the NHSR and Court Service.

Sometimes one has to point out the absolutely commonplace simply because it has ceased to attract attention. This is not news, but the first two trials I fought in 2022 concerned events that had occurred more than a decade beforehand.

One often hears that the NHS's response to claims against it is too often simply "***to deny, to delay and defend***".[1] However, in my cases, the problem was not the Defendants' attitude or tactics, but rather the extraordinary delays in getting Costs & Case Management hearings, the massive delays in listing interlocutory hearings and, despite listing appointments and Pre-trial reviews, very late vacating of trials on multiple occasions spanning many years. Regrettably, the Court Service is now very substantially under-funded and under-staffed, and consequently seriously sub-optimal for disputants.

Human beings – families, bereaved parents and doctors – are at the heart of the cases we deal with. Delays, late adjournments of trials and re-listing more than a year into the future are devastating for all involved. I cannot recall any litigants getting to the end of a trial or pre-trial settlement meeting and saying "***that was dealt with quickly***". And yet, at the end of trials, I routinely hear litigants speak of the importance of feeling listened to, of how impressed they have been with the Judge. In short, it is the trial, with forensic analysis of evidence overseen by a learned and manifestly neutral judicial figure, that is the reason why an English Civil trial is the gold standard of dispute resolution. The best part of the legal system is the part that people simply cannot afford access to, or cannot access easily and within a reasonable timeframe.

Everyone hopes that that lives already blighted for years by the medical system will not be further blighted by the legal system, and that a different attitude will prevail for the Shrewsbury families following this independent review

We are approaching the 25th anniversary of the Woolf reforms, which promised change. It is nearly 20 years since ***Halsey v Milton Keynes NHS Trust***[2] when Dyson

LJ (as he then was), recognising the attritional warfare and delay in the Court service, reminded members of the legal profession that "***acting in a client's best interests includes advice on resolving disputes by all appropriate means of ADR***." It is more than five years since the Ministry of Justice acknowledged that years after the Woolf reforms, cases were "***still resolved too late, too expensively, with complex procedures and an adversarial climate, imposing costs that sometimes dwarf the value of the contested claim***." On 9th March 2016,[3] without knowledge of the Shrewsbury NHS scandal, Lord Garnier stated with remarkable prescience:

"Most complainants just want someone to take responsibility and say sorry, and are not after money or revenge. That applies to the bereaved parents of stillborn babies as much as it does to the adult children of an elderly patient who died after a fall from a hospital bed, or who lay for days in agony because of untreated bed sores. The defensive failure to apologise often causes more heartache than the negligence itself and causes claimants to believe they have to sue to get justice. In addition, the NHSLA too often engages in unproductive trench warfare: it must not be seen to be giving ground, so the order goes out: "Deny, defend, delay!"

Cases that could have been resolved months and sometimes years earlier end up being settled at the door of the court, or lost after a trial, by which time advocates' brief fees have to be added to all the other costs that have piled up unnecessarily since the complaint was first raised. If ever there was a need for a patient to heal himself, it is the NHSLA in its refusal to free itself from the indefensible, or to see the wood for the trees. Rather than too often denying, defending and delaying in the wrong cases, it should assess, admit and apologise in the right cases.

The Courts have issued ever-sterner warnings that parties should utilise ADR, and maybe at risk of costs sanctions for failing to engage. The NHSR has changed to some extent: it demonstrated a drive towards mediation and undoubtedly the NHSR's preferred mediation providers have successfully mediated settlements, but overall take up is tiny. One questions whether the bereaved families of Shrewsbury would have found satisfaction with a 'no fault / no admission', mediated settlement. The same can certainly be said for clinicians who genuinely believe that they have acted appropriately at all times, and there must be better options for meeting the DHSC's stated aims of "***addressing the causes of harm and improving the quality of the NHS***".

At the same time as the Ockenden Report was being written, the NHSR, the Civil Justice Council and DHSC were working on their proposals for a Fixed Recoverable Costs ('FRC') regime that would surely cover many of those maternity death cases. The DHSC Consultation also makes for pretty shocking reading. I urge all practitioners to read it and make their own minds up as to whether the "***proposal to introduce FRC***" really can be intended for "***ensuring greater consistency and fairness for claimants and defendants when people have been harmed***", or whether it risks further eroding access to justice. As ever, the Consultation period is short and responses had to be submitted by 24 April, but "***a change is gonna come***."

I will put aside the proposed Fixed Costs, which are an article in their own right, and focus on the proposed resolution. The NHSR have seemingly recognised mediation's shortcomings and concluded that the solution is "***mandatory neutral evaluation***."

Early neutral evaluation ('ENE') came into existence in California in the 1980s. It did not catch on like wildfire in its original form, but rather proved that change is a long time coming. However, by July 2015 it had taken root sufficiently to gain an entry into the CPR[4] and was being widely used in other areas of law. As Norris J pointed out: "***The advantage of an early neutral evaluation process over mediation is that a person with subject matter expertise evaluates the parties' cases in a direct way, and provides an authoritative view of the legal issues of the case and an experienced evaluation of the strength of the evidence.***"[5]

ENE took off in personal injury actions; it has been remarkably successful in resolving liability, causation, quantum and even 'fundamental dishonesty' disputes and, very often, cases where all those issues are in dispute and the parties are, or risk becoming, entrenched in diametrically opposed positions. There is good evidence that parties find the process very much more satisfactory than mediation, and no reason whatsoever that it could not do likewise in clinical negligence claims.

The Court Service is struggling to resolve disputes efficiently and this undoubtedly pains fair-minded, decent Judges whose judgments now frequently

include comments such as this by HHJ Stephen Davies: "***I am acutely aware that, as so often occurs, the outcome will be a disaster for one of the parties and, even if not, likely an expensive and ultimately unrewarding result for both.***"[6] Having chivvied and warned practitioners to use ADR and avoid litigation, there is now a change to compulsion. HHJ Stephen Davies has now set out a standardised approach for the first CCMCs in cases, whereby there will be an Order for compulsory ENE. The RCJ Masters have also embraced ENE since 2020[7] and the direction of travel can be seen clearly from recent speeches by the Master of the Rolls.

The questions are really whether ENE should be done within the Court system or outside of it, whether it should be voluntary or compulsory. I have had experience of both 'Judicial' and 'Independent' Evaluation, but always on a voluntary basis.

Unfortunately, 'Judicial' ENE is plagued with the same problems afflicting the Court Service. The Judiciary are running at c. 66% of full complement. There were delays in getting the appointment for the ENE; unfortunately, at the outset, the Judge declared that the 'reading day' he had required had been filled with other cases and the papers had only just reached him. The case was not resolved. Unfortunately, the future for claims within the Court Service is likely to be one of ever-lengthening delays before resolution, whether that be judicial ENE or trial.

Whether because of the lack of resources or the state of the Court backlog, recent pronouncements indicate a determination to shift the battleground to 'pre-issue', thereby avoiding litigation completely. Thus, pre-issue, independent evaluative solutions are likely to become the norm in future.

Practitioners' experiences of Independent Evaluation are a world away from those of the Court Service. At its core is the appointment of a Deputy High Court Judge with subject matter expertise that is respected by both parties. Once appointed, that Evaluator guides the parties through a 'Directions' phase and onwards towards an Evaluation of the likely outcome at trial. The Evaluator, who is already familiar with the papers, has the Evaluation bundle at least a week in advance of the Evaluation. Delays and adjournments are unheard of. The parties benefit from all the finest qualities of a civil trial, without any of the worst qualities of the system. The time taken from start to finish can be reduced from years of litigation to weeks or months. To quote one lawyer who routinely has his clients' disputes evaluated: "***it is the legal equivalent of private health; no waiting lists, best Consultants, best chance of a cure***".Deputy High Court Judges, such as David Pittaway QC and Andrew Lewis QC, have deserved reputations for excellence in Independent Evaluation of the most difficult cases. There is something very striking when witnessing claimants and defendants mingling after their Evaluations: they feel listened to; they feel as if they have had an equivalent to their day in Court; they feel that lessons have been learned and, vitally, they feel that justice has been done.

Compulsory ADR does not sit easily with me, even though it has been described as "***both legal and potentially an extremely positive development.***"[8] There should be no need for compulsion: for practitioners on both sides, who know the state of the Court system and take seriously their duty to act in the best interests of their clients, the landscape of dispute resolution has already changed to ENE. The DHSC/ NHSR proposals are greatly concerning: there is something deeply unsettling about telling the bereaved parents of Shrewsbury that they are forced to take a certain course of action prescribed by their opponent, and at the same time capping the recoverable fees at very modest sums.

Just as the Ockenden Report's findings came too late for the Shrewsbury families, so the DHSC / NHSR's proposals for 'mandatory neutral evaluation' are unlikely to be implemented in time. However, whether the DHSC / NHSR are serious about affecting change for good can easily be tested: there is already an established system of Independent Evaluation with expert Deputy High Court Judges; so the question is whether the NHSR are willing to voluntarily engage in the already established system of Independent Evaluation in order to ensure that the Shrewsbury families do get justice "now".

As we have seen from the reforms of Woolf and Jackson, not all change imposed on parties in dispute is for the better. It is regrettable that the Court Service and NHSR feel it necessary to make ENE compulsory, but far more so that they appear determined to ensure that it is their system and their fee regime. I challenge the DHSC / NHSR to engage urgently in a meaningful pilot scheme with AvMA, so that changes made now will be optimised.

Peter Freeman Peter.Freeman@TGchambers.com
End notes overleaf →

1. Hansard. Debate on Clinical Negligence Claims per Lord Garnier.

2. [2004] EWCA Civ 267.

3. Hansard. Debate on Clinical Negligence Claims.

4. CPR 3.1(2)(m)

5. *Seals & Another v Williams* [2015] EWHC 1829

6. *The Sky's the Limit Transformations Ltd v Mirza* [2022] EWHC 29

7. *Telecom Centre (UK) Ltd v Thomas Sanderson Ltd* (February 2020), Master McCloud.

8. Civil Justice Council's Report: 'Compulsory ADR', June 2021.

New NICE Guidelines on Rehabilitation after Traumatic Injury

Clinical Negligence – Calculation Of Damages – Nice Guidelines – Rehabilitation – Traumatic Injury

Lionel Stride and Philip Matthews considers the new NICE guidelines on 'Rehabilitation After Traumatic Injury' published on 18 January 2022, highlighting best practice in this field.

Traumatic injury is defined for the purpose of the Guidelines as any injury that requires admission to hospital at the time of injury. This could include musculoskeletal injuries, visceral injuries, nerve injuries, soft tissue damage, spinal injury, limb reconstruction and limb loss.

A set of recommendations are set out within the Guidelines, which apply to all people with complex rehabilitation needs after a traumatic injury. These recommendations are then broken down into sub-categories. The initial recommendation topics cover:

- initial assessment and early interventions for people with complex rehabilitation needs
- multidisciplinary team rehabilitation needs assessment
- setting rehabilitation goals
- developing a rehabilitation plan and making referrals
- rehabilitation programmes of therapies and treatments
- principles for sharing information and involving family and carers
- coordination of rehabilitation care in hospital
- coordination of rehabilitation care at discharge
- supporting access and participation in education, work and community (adjustment and goal settings)
- commissioning and organisation of rehabilitation services

This is then followed by specific rehabilitation therapies and interventions:

- physical rehabilitation
- cognitive rehabilitation
- psychological rehabilitation

There are then further injury-specific sections:

- rehabilitation after limb reconstruction, limb loss or amputation
- rehabilitation after spinal cord injury
- rehabilitation after nerve injury
- rehabilitation after chest injury

Each of these recommendation sections sets out bullet point guidance and advice about how to approach rehabilitation in that specific area.

By way of example, recommendations for rehabilitation after limb reconstruction, limb loss or amputation include: -

- 'Manage the different types of pain that can develop, for example, phantom limb pain, neurogenic pain, psychogenic pain, myogenic pain and complex regional pain, and refer the person to a specialist pain team if needed.'
- 'Consider visualisation interventions such as graded motor imagery or mirror therapy to manage phantom limb pain in people who have had an amputation or limb loss after trauma.'
- 'Do not wait for prosthetics to be fitted before starting rehabilitation after limb loss or amputation.'

The Guidelines also deal with more specific categories of people, such as children with spinal injuries.

At this stage the Guidelines do not cover the management of traumatic brain injury, except in relation to early screening for onward referral and the coordination of services for people with multiple injuries, one of which may be traumatic brain injury. It is understood that the specialist assessment and delivery of rehabilitation services for traumatic brain injury will be covered in a new NICE guideline on rehabilitation for chronic neurological disorders, including traumatic brain injury.

These Guidelines are a positive development in the field of serious and catastrophic injury. They will provide practitioners with a useful point of reference when assessing rehabilitative needs and assist in streamlining discussions as to the appropriate rehabilitation approach and ongoing funding (as practitioners are required to do under the Rehabilitation Code 2015).

Lionel Stride LionelStride@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