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TGC Clinical Negligence

The Newsletter of the TGC Clinical Negligence Team

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A NOTE FROM THE EDITOR

By Lionel Stride

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

The last six months have lacked any single landmark decision on medical negligence, pending the Supreme Court's determination of the appeal from *Paul v The Royal Wolverhampton NHS Trust* [2022] EWCA Civ 12. They have nevertheless offered a rich diet of thoughtful judgments offering guidance and commentary on many issues practitioners face with regularity.

The recent cerebral palsy case of *CNZ (a minor) v Royal Bath Hospitals NHS Foundation Trust and Another* [2023] EWHC 19 (KB) before Mr Justice Ritchie, for which I delayed publication to ensure that it could be included in this edition, is probably the most significant judgment in the High Court in the last twelve months; it is required reading for all practitioners involved in birth injury cases, or where material contribution arguments are being run on causation of injury.

Among the bread-and-butter issues of breach and causation addressed by the cases summarised in this issue are the significance of national versus local guidelines in establishing *Bolam* compliance; the use of contemporaneous notes; the extent of a surgeon's discretion in deviating from a management plan; and the well-established difficulty of proving causation where the relevant breach of duty is a failure to obtain informed consent. On evidence, the last six months have seen helpful judicial guidance on the correct approach to causation when directly relevant medical literature is sparse, the continued importance of basic concepts of burden of proof, the credibility of expert witnesses, and the role of the '*Keefe* benevolence principle'.

On the procedural front, a series of niche but significant developments have emerged from the courts. *Martin* saw a defendant make the successful case for a variable PPO on the basis of the claimant's possible future deterioration (such deterioration rendering her care less expensive, since it would lead to a transfer from home into institutional care). As Richard Wilkinson points out, claimants ought to be aware of such a possibility when being advised on whether to seek a PPO. The decision also deals a further judicial knock-back to the use of Personal Injury Trusts to protect vulnerable claimants. On costs, *Dance* has confirmed, despite 'ingenious' arguments to the contrary, that where an ATE premium is recoverable, the relevant costs order need not make express provision to that effect. Meanwhile, as *EXN* has emphasised, where a claimant's solicitors seek to recoup a shortfall in costs from the claimant's damages under a CFA, the client's consent must be fully informed; James Arney KC sets out the implications for claimants and their solicitors.

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 open the new issue, Anthony Lenanton examines the Court's analysis of local and national clinical guidelines and their significance for compliance with the *Bolam* test in *O'Brien v Guy's & St Thomas' NHS Trust* [2022] EWHC 2735 (KB).

- Helen Nugent analyses *McCaul v Lancashire Teaching Hospitals NHS Foundation Trust* [2022] EWHC 1963 (QB) in which the High Court emphasised the primacy of a surgeon's discretion in deviating from a pre-surgical management plan.

- Ellen Robertson sets out the formidable challenges facing claimants seeking to establish causation after a clinician's failure to obtain informed consent in her analysis of *Watts v North Bristol NHS Trust* [2022] EWHC 2048 (QB).

- Anthony Johnson considers *CDE v Surrey and Sussex Healthcare NHS Trust* [2022] EWHC 2590 (KB), a tragic case which contains important observations on the appropriate use of medical notes when the witness evidence of clinicians is rejected as unreliable.

- I consider the case of *CNZ (a minor) v Royal Bath Hospitals NHS Foundation Trust and Another* [2023] EWHC 19 (KB), an important cerebral palsy case which addressed the correct approach to causation and apportionment where brain injury is sustained following negligent delivery.

Evidence

- Turning to evidential issues, I explore *Pickering v Cambridge University Hospitals NHS Foundation Trust* [2022] EWHC 1171 (QB), which offers a detailed account of the Court's approach to causation where the relevant medical literature is unhelpfully sparse.

- Marcus Grant considers the interplay between '*Keefe* benevolence', medical records, and evidential reliability in his analysis of *Richins v Birmingham Women's and Children's NHS Foundation Trust* [2022] EWHC 847 (QB), a liability-only trial dealing with alleged negligence 14 years previously.

- James Yapp analyses *Johnson v Williams* [2022] EWHC 1585 (QB), a reminder of the continued importance of burden of proof in clinical negligence claims and, correspondingly, the existence of cases in which the Court is unable to 'solve the puzzle'.

Procedure

- Turning to procedure, I examine the unusual case of *Pal v Damen and Belgo International Research Applications and Development NV* [2022] EWHC 4697 (QB), which concerned the Court's jurisdiction over a Belgian surgeon and clinic in respect of treatment prior to Brexit.

- Richard Wilkinson presents an analysis of *Martin v Salford Royal NHS Foundation Trust* [2022] EWHC 532 (QB), in which the Defendant sought, counterintuitively, a variable PPO on the basis of future deterioration.

- James Arney KC examines *EVX (a minor by her mother and litigation friend XYZ) v Smith* [2022] EWHC 1607 (SCCO), which provides important guidance to solicitors on what must be explained to a client in order to maximise the prospect of costs recovery under a shortfall provision in a CFA.

- Robert Riddell analyses the Court's rejection of the Defendant's 'ingenious' challenge to the recoverability of an ATE premium in *Dance v East Kent University Hospitals NHS Foundation Trust and Others* [2022] EWHC 2198 (SCCO).

- Oliver Brewis summarises three procedural decisions arising in a clinical negligence context: *Macaulay v Karim and Croydon Health Services NHS Trust* [2022] EWHC 1270 (SCCO), which confirms that legally aided claimants are not excluded from QOCS protection; *Aderounmu v Colvin* [2022] EWHC 637 (QB), which looks at the interplay between costs and disputes over limitation; and *EXN v East Lancashire Hospitals NHS Trust* [2022] EWHC 872 (QB), in which relief from sanctions was successfully sought after a failure to comply with the rules on giving notice of a CFA with success fee.

Case Summaries

- To conclude this issue, James Arney KC and I report on some notable cases in which we have (separately) been successful in court or at JSMs.

- In *Preater v Betsi Cadwaladr University Health Board* (unreported, August 2022), the Court rejected the Defendant's contention that a claim was fundamentally dishonest on the basis the Claimant had failed to disclose small amounts of paid work she had undertaken and exaggerated her symptoms to experts.

- In *T v Guy's & St Thomas' NHS Foundation Trust* the Claimant sustained a catastrophic second hypoglossal injury during carotid endarterectomy surgery after a failure to offer him a suitable alternative treatment in the form of carotid stenting that carried no risk of such an injury (but higher stroke risk). Settlement of £800,000 was achieved a month before trial.

- In *JXD v University Hospitals Bristol & Weston NHS Foundation Trust*, the Claimant sustained injury attributable to failure to diagnose and treat his retinopathy of prematurity alongside significant non-negligent disabilities. Settlement of £800,000 was achieved despite difficult issues relating to breach of duty, causation and quantum.

(Non)-adherence to national clinical guidelines: O'Brien v Guy's & St Thomas' NHS Trust [2022] EWHC 2735 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY – NICE CLINICAL GUIDELINES – LOCAL GUIDELINES – BOLAM COMPLIANCE

By Anthony Lenanton
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*O'Brien r*aises an interesting legal question that has received comparatively limited attention in the authorities: what is the relevance of (non)-compliance with clinical guidelines, both national and 'in-house', to *Bolam* negligence? The Defendant Trust's in-house ICU guidelines on the use of Gentamicin conflicted with both NICE guidelines and those used by the Trust outside ICU. Anthony Lenanton examines the Court's approach to this discrepancy and sets out its conclusions.

Facts

The patient ('P') was admitted to St Thomas' Hospital in February 2017 following a heart attack. He was 70 years old and had several health problems, the most relevant of which was that he had end stage renal failure and was on dialysis.

By 3 March, P had developed a significant chest/lower respiratory tract infection. He was at risk of sepsis, which would have been life threatening given his other vulnerabilities. He required urgent treatment with antibiotics and was given Vancomycin and Gentamicin. The prescribed dose of Gentamicin (80mg) was significantly lower than was recommended in the guidelines (albeit it was not alleged to be negligent). P was then transferred to ICU.

By the following morning, 4 March, P's clinical presentation had improved, but his blood tests indicated that he had a worsening systemic infection. At midday, an ICU consultant prescribed a 400mg dose of Gentamicin, which was administered at 8:30pm; some, but not all, of this eight-hour delay was deliberate and intended to allow the circulating level of Gentamicin to fall to a level where it was safe to re-dose. P's infection improved and he was discharged on 16 March.

The known side effects of Gentamicin include a risk of ototoxicity, which is when a medicine damages the inner ear causing balance or hearing problems. This risk materialised for P. Following discharge, he suffered dizziness, bilateral hearing loss and tinnitus. In May 2017, he was diagnosed with Gentamicin-associated vestibular ototoxicity. His sister (the Claimant; P died in 2019 of causes unrelated to the Defendant's treatment) spent considerable time caring for him.

aaNICE had issued a guideline for Gentamicin (set out in the BNF) which provided that the dose should be reduced in patients with severe renal impairment. A similar approach was taken by the Defendant's 'in-house' guideline that applied to areas of the hospital outside of ICU. The Defendant's ICU had produced its own Gentamicin guideline, which differed from the NICE/BNF guideline and the guideline in use in the rest of the hospital by leaving more room for individual clinical judgement on dosage.

Negligence

The Claimant argued that the ICU guideline was itself *Bolam* negligent in failing adequately to take account of both the extent of a patient's renal impairment and the association between high Gentamicin dosage and ototoxicity, and in departing from other national and in-house guidelines for no good reason. The Judge accepted that the ICU guidance was flawed ("***surprisingly sloppily-drafted***", "***internally inconsistent***", "***likely to lead to misunderstandings on dosing***"). Nevertheless, he found that it was not intrinsically negligent but simply left a great deal to clinical judgment. He accepted the Defendant's analysis that "***ICU is different***" and that in cases of seriously ill ICU patients it was logical for the ICU guideline to depart from the NICE guideline.

The issue thereafter was whether the 400mg Gentamicin dose was negligently excessive in all the circumstances (a more typical *Bolam/Bolitho* challenge). The Judge found the ICU consultant chose a high dose of Gentamicin (and thus departed from the NICE guideline) for deliberate and considered reasons and "***independently exercised his clinical judgment which was logical and […] reasonable***". The claim therefore failed.

Comment

National guidance from authoritative bodies (NICE, the Royal Colleges, the BMA, etc) is issued regularly across a range of clinical conditions. Its purpose is to assist clinicians in making decisions about treatment for specific conditions and to promote 'best practice'. As occurred in this case, many trusts, hospitals, ICBs, GP practices, etc, will also produce their own 'local' clinical guidance.

Practitioners will note the Judge's discussion about the relative status of national versus local guidance. Plainly, an 'in-house' guideline is not of the same status as a national guideline. Compliance with a national guideline is likely to be inconsistent with negligence ***if*** the guideline constitutes a *Bolam*-compliant body of opinion. The same point does not apply equally to local or 'in-house' guidance: local guidance cannot by itself constitute a *Bolam* compliant body of opinion (although it may reflect such a body of opinion). This is because the standard of care is objective and if it were otherwise then a defendant hospital could effectively determine their own standard of care.

Inevitably, no guideline can ever be a substitute for clinical judgment in the particular circumstances of the particular patient at the particular time. Clinical negligence practitioners will encounter cases where the relevant NICE/BNF guidelines may be less than comprehensive. In such cases, compliance with the guideline (assuming it is otherwise satisfactory) may militate against negligence, but the Court will assess the clinicians' conduct against the other surrounding circumstances.

There will be other cases (as here) where there has been a departure from the guideline. Take, for example, administration of drugs to induce labour. The relevant NICE guideline might advocate one approach but the risk/benefit analysis for that patient may justify a different approach. Any departure from a national guideline will call for explanation. The nature and degree of detail required will depend on all the circumstances. If the departure is significant then the decision will need to be well reasoned (and ideally documented near contemporaneously) to ensure that the decision can withstand logical analysis.

Finally, as a practice point, *O'Brien* makes clear that national clinical guidelines are no substitute for expert evidence about clinical judgement.

By Anthony Lenanton
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Discretion on the surgeon's table: McCaul v Lancashire Teaching Hospitals NHS Foundation Trust [2022] EWHC 1963 (QB)

CLINICAL NEGLIGENCE – BREACH OF DUTY & CAUSATION – PRE-OPERATIVE MANAGEMENT PLAN – WITNESS EVIDENCE – SURGICAL DISCRETION – STANDARD CLINICAL PRACTICE

By Helen Nugent
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In a first-instance decision from Turner J in favour of the Defendant ('D'), the Claimant ('C') alleged that the operating surgeon was negligent for failing to follow the pre-operative management plan. As Helen Nugent explains, the judgment contains important observations on the recollections of treating clinicians, the significance of the surgeon's discretion, and the circumstances in which departure from a pre-operative plan will be justified.

Background

On 12th May 2017 C was admitted to D's Hospital with a two-week history of blackening of the 4th toe on her right foot. She was diagnosed with stenosis of the right common iliac artery, following CT angiogram investigation. That diagnosis was made against a relevant and significant history of smoking, peripheral vascular disease, stroke and TIA; these factors placed C at risk of arterial disease.

Initial treatment comprised an angioplasty on 8th June 2017, with the insertion of a balloon to widen the affected artery and improve blood flow. Notwithstanding that early intervention, the condition of C's right leg deteriorated. She was re-admitted on 26th June 2017 with necrosis of the right foot. The cause of the necrosis, confirmed by a further CT angiogram, was likely to have been a thrombosis, arising from occlusion at the site of previous surgery. Further surgical intervention was indicated.

The results of the further clinical imaging were the subject of dispute between the Parties' CPR Part 35 experts. The central issue related to the extent of stenosis which would typically be expected to affect the flow of blood through the diseased artery. The degree of stenosis that had been recorded on the CT angiogram was 50%. D's consultant vascular radiologist formed the view, from his own precise measurements of the scan, that the degree of narrowing fell below 40%. It did not necessarily follow from that finding that there was good arterial blood flow, but it made the finding of stenosis less haemodynamically significant.

The plan for managing C's condition was for a right iliac angiogram +/– right common iliac artery angioplasty/stent and right common femoral artery thrombo-endarterectomy with patch. It was, however, common ground between the Parties that the surgeon responsible for operating on C had limited the procedure to an endarterectomy and patch. That represented, on C's case, a departure from the pre-operative plan and a breach of duty on D's part.

In respect of causation, C contended that had the pre-operative plan been followed there would have been a better prognostic outcome.

D contended that the results of the CT angiogram did not mandate an angioplasty; and further, that the procedure was one that carried its own inherent risk of injury. It emphasised the importance of intra-operative findings in the treating surgeon's decision making. If there had been good flow through the affected blood vessels (such that the purpose of the further surgery had been achieved) then the angioplasty was probably unnecessary.

The Evidence of the Treating Surgeon

Mr Spachos had no direct recollection of the Claimant. As is often the case many years after an operation, he relied instead on the contemporaneous notes and his general practice. Although there was no record of any check of C's femoral pulse being made, Mr Spachos purported in cross-examination to have some recall on the point. He was described as defensive in his presentation, but not deliberately trying to mislead. The Court considered it possible that Mr Spachos' evidence on the discrete issue had been tainted by hindsight, but that did not render the totality of his evidence unreliable.

The Court found that Mr Spachos probably did check C's femoral pulse as a matter of routine practice. That, it observed, probably justified the provisional view that an angioplasty was not necessary.

Post-operative Complications

C did not achieve a good outcome from surgery and the condition of the right leg continued to deteriorate. She underwent a below-knee amputation on 4th July 2017. An above-knee amputation was carried out approximately one week later.

It was C's case that D's negligence contributed to that poor outcome. She conceded that a transtibial amputation would have been indicated in any event, but the above-knee amputation could have been avoided.

She relied on the fact of amputation as an indicator of poor inflow at the time of Mr S' surgery. The Court did not agree.

C had a complex and significant past medical history, she was prothrombotic consequent on recent major surgery and her medication was associated with poor healing. Those were plainly complicating factors relevant to the prospect of surgical success.

The Decision

The decision not to proceed with the angioplasty was a reasonable one, on a risk-benefit analysis. D had not been negligent in departing from the pre-operative plan: there had been good reason for Mr S to conclude that the procedure was not necessary. The operating surgeon had the benefit of his intra-operative findings; and those findings formed an important part of his decision as to how best to manage C's condition. A pre-surgical management plan should not dictate a surgical course that was contra-indicated.

Analysis

This decision emphasises the primacy of surgeon discretion, where the treating surgeon has the advantage of intra-operative findings. For obvious reasons it would be wrong to expect a doctor blithely to follow a management plan where those findings suggested a particular procedure may be unnecessary; but a departure from it must be supported with good reason.

It is also a useful reminder of how the Court treats the evidence of medical professionals where they have little or no memory of any particular claimant, but instead rely on standard practice.

By Helen Nugent
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Informed consent and counterfactual intentions: Watts v North Bristol NHS Trust [2022] EWHC 2048 (QB)

CLINICAL NEGLIGENCE – BREACH OF DUTY & CAUSATION – INFORMED CONSENT – ALTERNATIVE TREATMENT – JOINT STATEMENTS

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As Ellen Robertson explains, this appeal from the County Court demonstrates the myriad challenges facing claimants in establishing causation in claims arising out of a clinician's failure to obtain informed consent. Practitioners should take note of the importance of pleadings and statements adequately addressing the question of why they would have chosen alternative treatment, and the need for expert evidence to address the likely outcome of the alternative treatment.

The Appellant alleged that the Respondent NHS Trust was liable for the acts and omissions of a consultant orthopaedic and spinal surgeon ('the Surgeon') who had advised and treated him for back and leg pain. The Surgeon had conducted a pre-operative consultation with the Appellant in which he proposed spinal fusion to the Appellant. The Surgeon then performed that spinal fusion surgery on the Appellant a few weeks after the pre-operative consultation. The fusion surgery was unsuccessful, leaving the Appellant with increased pain and mobility problems. By the time of the appeal it was agreed that the fusion surgery had been conducted competently.

At first instance, the Appellant succeeded in proving that the Surgeon had failed to obtain his informed consent. The Surgeon had failed to provide sufficient information about alternative procedures, specifically by only mentioning the alternative option of microdiscectomy, which was less invasive, without sufficiently advising on its advantages and disadvantages.

However, the Appellant had failed at first instance in establishing that, had such information been provided, he would have elected to undergo microdiscectomy rather than spinal fusion. He also failed at first instance in establishing that undergoing spinal fusion had led to him sustaining pain, suffering and losses which would not have been incurred had he opted for the less invasive option. His claim therefore failed.

The matter highlights the importance of expressly pleading and evidencing why a claimant would have chosen an alternative option if properly advised. The Appellant's Particulars of Claim had asserted that he would have chosen microdiscectomy but gave no further details. His first witness statement was silent on the issue. In a second witness statement served shortly before trial, he claimed he would have preferred microdiscectomy, giving the reason that it was a less invasive option and would have allowed for the possibility of spinal fusion in the future had it failed. In cross-

examination, he said that he would have taken the less risky and less invasive procedure, asking why anyone would chose the riskier option to achieve the same outcome.

The Appellant's explanation had been rejected by the trial judge, who noted that the two procedures were not designed to achieve the same outcomes. He considered that the choice between the procedures would have been objectively difficult, and noted the difficulty for any claimant of giving a reliable answer to the question of what he would have done, once the outcome of the spinal fusion was known. He found that the Appellant had failed to prove on the balance of probabilities that he would have chosen microdiscectomy.

On appeal, Bourne J noted that the hypothetical situation being considered to determine what the Appellant would have done needed to be defined with precision. He determined, based upon the facts found by the trial judge, that the Surgeon would have set out the same advice about fusion, identifying it as the appropriate treatment, and would also have advised that microdiscectomy remained possible but he did not recommend it and was not willing to undertake it himself.

The Court then considered the case put forward by the Appellant. His Particulars of Claim averred that he would have undergone the microdiscectomy. His initial witness statement, however, failed to state in terms that he would have chosen that alternative option. The Court noted that the Defence had failed to take issue with the case on choosing an alternative option, which might have explained the failure to address it initially, but noted that the Appellant had given an explanation in his second statement. That explanation, or the explanations given in cross-examination, did not adequately engage with the fact that the Surgeon was strongly recommending fusion, or that the fusion was likely to relieve back and leg pain. In those circumstances, the Appellant had failed to explain why those facts would have outweighed the potential benefits of the alternative microdiscectomy.

The Court noted that the "***objective assessment***" of the options facing claimants, as set out in *Smith v Barking, Havering and Brentwood Health Authority* [1994] 5 Med LR 285, acts as a reminder of the logical need for some caution in accepting a claimant's assertion about alternative treatment.

The Appellant therefore failed on the first ground of appeal, with the Court upholding the conclusion of the trial judge that the Appellant had not proved he would have selected the alternative option.

The Court also considered the second ground of appeal: that the trial judge had erred in finding the Appellant would not have been better off had he undergone microdiscectomy instead of fusion. The crucial question was whether, on the balance of probabilities, there would have been a better outcome if the Appellant had undergone the microdiscectomy. The Court was critical of the large number of questions asked of the experts in the joint statement, noting that the lack of identification of key issues meant that neither of the parties' experts had adequately addressed the outcome had the Appellant undergone microdiscectomy.

The Court was critical of the reasons given by the trial judge to explain the evidential basis for his findings on this matter and did not uphold his conclusion on causation. However, given the failure on the first ground, the appeal was dismissed.

By Ellen Robertson
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Narrow 'windows' of causation and the importance of contemporaneous notes: CDE v Surrey and Sussex Healthcare NHS Trust [2022] EWHC 2590 (KB)

CLINICAL NEGLIGENCE – CAUSATION – CEREBRAL PALSY – MEDICAL NOTES – UNRELIABLE WITNESS EVIDENCE

By Anthony Johnson
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The decision of Ritchie J in *CDE* will be of interest to practitioners because of the useful guidance it provides about the importance of contemporaneous medical notes and its treatment of the thorny issue of causation. It is of special relevance to cases arising from allegedly negligent delivery where the window for successful delivery is narrow. Anthony Johnson sets out the factual background to the case and examines some of its key implications.

The case arose from a tragic medical event where the Claimant, who was born by emergency caesarean section, suffered acute profound hypoxic ischemia before, during and after her birth. The Claimant suffered from quadriplegic cerebral palsy with severe global developmental delay; she suffered seizures, was unable to self-feed and had to be fed by tube and was categorised at the most severe level on the Gross Motor Function Classification System.

The pleaded issues between the parties were broad and varied, but by the conclusion of the trial they had been narrowed significantly. At the outset of his judgment, the Judge identified that, by the time of closing submissions, the issues between the parties were as follows:

i. Did the Defendant fail to provide a reasonable standard of care to the Claimant by failing to transfer her mother to the labour ward or delivery suite 40-50 minutes earlier than in fact occurred?

ii. Did that failure lead to delay in the performance of the emergency C-section that was eventually carried out to deliver the Claimant? The Claimant asserted that it should have been carried out 4-7 minutes earlier than it actually was.

iii. Did any such delay increase the acute profound hypoxic ischemia suffered by the Claimant and so cause or materially contribute to her cerebral palsy?

Whilst the Defendant admitted some of the breaches alleged by the Claimant by the end of the trial, it argued that the claim had to fail due to the lack of factual causation, and that the breaches (admitted and alleged) did not cause any, or any additional, damage.

Legal causation was ultimately not in dispute in that the Defendant admitted in the course of the trial that if the Claimant proved over five minutes of saved hypoxic ischemia then a material contribution would have occurred (pursuant to cases such as *Bailey v Ministry of Defence* [2008] EWCA Civ 883) and the Claimant would be entitled to recover 100% of her damages.

The Judge summarised his conclusion in the following terms:

> ***"The Defendant, through a midwife and a senior house officer who was the acting registrar at the time, breached its duty of care to the Claimant by failing to make proper clinical notes and failing for two hours to assess her mother's and her condition whilst she was left on the ante natal ward. Those breaches were combined with a further breach caused by a delay of around 40-50 minutes in transferring the Claimant's mother to the labour ward.***
>
> ***"However the delayed transfer to the labour ward and the breaches I have found above did not make any difference to the tragic outcome on 4th June 2018. It would have been the same in any event due to the sequence of events which emerged on the day which were both extremely rare, sudden and unpredictable. In the event Miss Helen Nicks and her staff on the labour ward at East Surrey Hospital saved the lives of both the Claimant and her mother due to their prompt and professional action in the face of a very rare, life-threatening emergency."***

In the course of a very detailed judgment on the facts, the Judge rejected the evidence of the Defendant's registrar on the basis that it ***"lacked credibility, consistency, logicality and insight",*** concluding that he was not a witness upon whose evidence the Court could safely rely. He decided that the safest course was to rely upon the contemporaneous clinical notes rather than the witness evidence, making the following useful comments about the medical notes:

> ***"The starting point for my decision making on what occurred before and after the Claimant's birth is the medical notes. These medical notes were made by trained professionals who realised or should have realised that their medical notes represent the primary contemporaneous record of the events and that each separate note should be timed and signed so that other clinicians can understand what has occurred and when it occurred and who was involved in the treatment of M and the baby and the details thereof."***

This case also provides a useful reminder of the difficulty in proving causation in this type of case where the window for a successful delivery would have been a matter of minutes. Whilst by no means being an impossibly high burden for a claimant to satisfy, there is evidently a need for clear and unequivocal medical evidence on the particular point if such a claim is to be successful. In addition, the Claimant in *CDE* faced a particularly difficult task given the extent of the disputed facts that are addressed at length in the judgment.

By Anthony Johnson
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Material contribution, divisibility and apportionment following negligent delivery: CNZ (a minor) v Royal Bath Hospitals NHS Foundation Trust and Another [2023] EWHC 19 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY & CAUSATION – MATERIAL CONTRIBUTION – DIVISIBILITY OF INJURY – FUNCTIONAL DISABILITY – CEREBRAL PALSY

By Lionel Stride
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In *CNZ,* the Court examined whether an allegedly negligent delivery had caused the Claimant to sustain quadriplegic cerebral palsy; and, if so, the appropriate apportionment of damages. In approaching the task, Ritchie J conducted a thorough review of the law relating to material *contribution* as opposed to *but for* causation, drawing a distinction between causation of injury and functional disability. The judgment is notable for its careful analysis of the issue of divisibility of injury and its crucial observations on quantification and timing in cerebral palsy cases. It also indicates that the Montgomery approach to consent may be applicable to cases from as early as 1993, although that part of judgment is beyond the scope of this article. As Lionel Stride explains, *CNZ* is required reading for all practitioners involved in birth injury cases.

Outline

The Claimant had been born at around 01.03 hours on 3 February 1996. As a result of suffering acute profound hypoxic ischaemia ('PHI') both before and for three minutes after birth, she sustained quadriplegic cerebral palsy.

The Claimant contended that her mother requested caesarean section ('CS'), but her requests were delayed or refused; that she was never offered elective caesarean section ('ECS'), despite her contention that this was a reasonable treatment; and that when the hospital decided to deliver by CS, the operation was carried out negligently late. In consequence, the acute PHI she suffered was not avoided or ameliorated as it should have been.

The Defendants asserted that ECS was not offered because, in 1996, it was not a reasonable treatment option in the antenatal period. They contended that offering and advising normal vaginal delivery was the correct practice and that, in any event, the Claimant's mother did not request CS antenatally. They denied any negligence during labour and asserted that the parents' request for CS were granted timeously.

The Arguments on Causation

The Claimant pleaded in the Particulars of Claim that delivery should have taken place by 00.46, and that this would have avoided all injury. In the alternative, it was contended that delivery by any time before 01.03 (the actual time of birth) would have made a material contribution to reduction in injury. The Re-Amended Particulars averred that even a short delay would have made a material contribution justifying 100% recovery on the basis that the "***functional result of a few minutes of negligently caused acute PHI is indivisible from the total injury suffered***".

In their Amended Defence, the Defendants admitted that if the Claimant had been born by 00.55 hours, all injury would have been avoided. Significantly, however, they asserted that birth between 00.56 and 01.01 would have led to a reduction in the Claimant's injuries which is "***assessable and apportionable in law***". On this basis, they averred that damages should be apportioned between non-negligent brain damage and negligently caused brain damage.

In a Re-Amended Defence, the Defendants further particularised these contentions, asserting that, if the Claimant had been delivered between 00.56 and 01.01, she would have sustained up to around only 5 minutes of acute PHI. She would therefore probably have been less functionally injured, leading to well-preserved communication, cognition, and ability to manage self-care, and mobility at GMFCS 2.

Findings on Causation

In the event, the Judge concluded that causation with respect to the whole of the injury and the whole of the Claimant's functional disability was established on a 'but for' basis. The Judge concluded that the First Defendant was negligent in delaying birth by 6.5 minutes, in part because the Claimant's mother was kept in the delivery suite too long and sent to theatre too slowly. But for this negligence, the Claimant would have avoided 6 'damaging' minutes of PHI (which followed 10 'non-damaging' minutes), with a range between 4-8 minutes. But for the 6.5 minutes of negligent delay (the range being 5-8 minutes), the Claimant would have avoided all injury.

However, given his finding that a range of timings was possible, the Judge made a secondary ruling on causation applying the 'material contribution to injury' test to the Claimant's functional disability. Taking this approach, causation was established even on the timings most generous to the Defendant. Were the negligent delay only 5 minutes (the lower end of the identified range), and the duration of PHI at the higher end (18 minutes, of which 8 were 'damaging'), causation would still be satisfied and all damage suffered by the Claimant recoverable: "***the delay made a material contribution to the Claimant's disabled functional outcome and […] it is impossible on the evidence before me to determine the outcome 'but for the negligence'***" (see [406]). The Judge therefore concluded that the Claimant was entitled to recover "***100% of the damage caused by the PHI she suffered using the material contribution test***" (ibid.)

Reasoning

In reaching these conclusions, Ritchie J undertook an extensive review of the jurisprudence on the material contribution test. In summary, his reasoning was as follows: -

i. Where the state of medical knowledge is insufficient to discern "***what the breach caused by way of functional disability***", 'but for' causation may be impossible to prove (see [341]). If the but for test cannot be satisfied due to "***scientific gap impossibility***", then the law will apply the material contribution to injury test (see [350]). Pursuant to this approach, if the Claimant can prove the breach made a "***material contribution to the Claimant's injury which was more than de minimis***", damages are to be awarded against the Defendant.

ii. The word '**indivisible**' is commonly adopted in scientific gap cases (see [357]). Injuries said to be indivisible fall into two categories:

    1. Injuries in which the injury is not 'dose-related'. In such an injury, "***once the trigger is pulled the disease progresses unaffected by any further dose***" (see [358]). An example of such an injury, as cited by Lord Phillips in *Sienkiewicz v Greif (UK) Ltd*, is malaria: although an increase in quantity of malarial mosquitoes may increase the risk of contracting malaria, it does not affect the manner in which the disease is contracted or its severity.[1]

2. Injuries in which the injury is triggered by a 'dose build-up', for instance, where disease emerges only when "***the weight of the noxious substance inhaled builds up sufficiently***": see [359]. The example cited by Lord Phillips in *Sienkiewicz* is lung cancer caused by smoking.[2] Ritchie J noted that the Claimant's PHI did not fall into this category, despite any superficial resemblance, because Lord Phillips used the category only in relation to 'indivisible' or 'trigger' diseases such as cancer.

iii. By contrast, a '**divisible**' injury is 'purely dose-related'; it is started, and subsequently worsened, by exposure to a noxious substance or similar (see [360]). As Lord Phillips explained in *Sienkiewicz*, "***the severity of the disease is related to the quantity of the agent that is ingested***".[3] Lord Phillips cited asbestosis and silicosis as examples of such divisible injury.

iv. Applying this system of categorisation, the Judge concluded that the brain injury suffered by the Claimant was not, properly understood, an indivisible injury: see [361]. An indivisible disease is one that starts when triggered and takes its course whatever the exposure to the noxious substance after the triggering event. By contrast, brain damage caused by PHI is "***wholly dose dependent***": "***The more PHI the fetus suffers the greater the outcome***" (see [362]). However, the concept of indivisibility *was* relevant to the "***functional outcome***" caused by one or more minutes of acute PHI: see [362].

v. In the present case, the relevant test for determining whether breach caused brain injury itself was the 'but for' test (see [389]). This was because there was a consensus among experts that, on balance of probabilities, every minute of acute PHI after the tenth minute caused damage.

vi. In cases involving brain damage and acute PHI during delivery, the relevant "***scientific gap***" is how to attribute the "***breach PHI***" (i.e., each minute of brain damage sustained as a result of breach) to the Claimant's functional deficit: see [383]. On the expert evidence, it was impossible to predict the Claimant's condition had she suffered (for instance) 1 to 3 minutes' less acute PHI: see [390].

vii. In the present case, the 'scientific gap' wholly precluded both proof of causation of functional outcome, and quantification of functional outcome: see [391]. Crucially, these were "***impossible***", not "***merely difficult***". It followed that the Claimant was entitled to recover 100% of the damage she had suffered provided she could prove the breach made a more than *de minimis* material contribution to her reduced functional outcome. That being established, all damage was recoverable.

Timing

In addition to the judgment's detailed analysis of causation, its findings on the relationship between duration of acute PHI and the nature and extent of injury are of particular relevance to cerebral palsy cases.

The Defendants' expert paediatric neurologist, Dr Rosenbloom, addressed the relationship between the Claimant's brain damage and the period of negligent acute PHI she suffered using the 'Aliquot' theory. Under this approach, five-minute tranches of delay are said to correspond to varying degrees of sustained disability. Dr Rosenbloom divided the periods as follows: -

i. The first 10 minutes of PHI are non-damaging.

ii. In the period between minute 10 and minute 15, mild to moderate disabilities arise, including bilateral dystonic cerebral palsy with independent mobility at GMFCS level 2. However, cognition, the ability to walk, undertake self-care and write (albeit with some limitations to fine motor function) are preserved. Social and economic independence is possible.

iii. Between minute 15 and minute 20, moderate to severe disabilities arise, with severe movement limitation at GMFCS level 4. There is a need for body support and effective wheelchair dependency; impaired hand functioning, oral feeding, severe dysarthria and some cognitive impairment will arise. Social and economic independence are precluded.

iv. Between minute 20 and minute 25, patients will sustain severe profound disabilities, with significant cognitive impairment. They are immobile and wheelchair-dependent, and wholly dependent on others for care.

v. Thereafter, very profound brain damage or death occurs.

On the basis of such an approach, Dr Rosenbloom concluded that, had the Claimant suffered 5 minutes less PHI, she would have suffered only the mild to moderate disabilities listed at (ii) above.

Dr Newton, the Claimant's expert paediatric neurologist, rejected the 'Aliquot' theory in its entirety. In his opinion, the true variability was too wide and the neatness of such an approach was undermined by the fact that, within each bracket, there were individuals who were substantially more or less disabled than would be predicted by the approach. He confirmed his view that the Aliquot approach was '***not scientifically appropriate***' and asserted that it lacked '***any proper database***' bearing out its conclusions (see [238]-[239]).

After a review of expert evidence on both sides, Ritchie J concluded that "***medical science is unable to identify with generality, accuracy or detail the functional effect of each minute of brain cell deaths***" (see [327]). He decisively rejected the validity of the Aliquot theory (see [384]-[388]). He emphasised that, even if he had accepted the theory, it would not have justified a percentage-based approach to apportionment. This was because even the Aliquot theory was unable to correlate duration of PHI with functional outcome in anything less than five minute blocks: for smaller aliquots, "***the functional outcome was too uncertain for medical science to be able to advise upon***" (see [329]). In addition, there was a consensus that damage was non-linear, with each organ of the brain "***fall[ing] off a cliff at certain unknown times***" (see [328]).

Conclusion

CNZ is probably the most important clinical negligence judgment of the last 12 months. Its detailed analysis of the authorities supporting the use of the material contribution to injury test is of relevance for all practitioners acting in cases where material contribution arguments are being run. In relation to cerebral palsy, the judgment suggests that any percentage-based apportionment is likely to be precluded by the state of current medical science for the foreseeable future. Despite the Judge's attraction to percentage apportionment as a means of achieving a fair outcome (see [374]), he concluded it was not warranted by the expert evidence. Significantly for future attempts to revisit the percentage apportionment issue, the Judge emphasised that this would have remained the case even had he accepted the 'Aliquot' theory endorsed by the Defendant's neurologist.

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1 *Sienkiewicz v Greif (UK) Ltd* [2011] UKSC 10 at [12].

2 *Sienkiewicz v Greif (UK) Ltd* [2011] UKSC 10 at [13].

3 *Sienkiewicz v Greif (UK) Ltd* [2011] UKSC 10 at [14].

Causation, knowledge and the Hippocratic oath: Pickering v Cambridge University Hospitals NHS Foundation Trust [2022] EWHC 1171 (QB)

CLINICAL NEGLIGENCE – CAUSATION – STROKE RISK – EXPERT EVIDENCE – MEDICAL LITERATURE

What is the proper approach to causation where ethical considerations prevent the development of a medical literature that directly addresses the issue on which causation turns? As Lionel Stride explains, this was the problem faced by the High Court in *Pickering.* In a thorough and robustly reasoned decision, Ritchie J offered a useful survey of the factors relevant to the credibility of medico-legal evidence where relevant literature is scarce.

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The Facts

The Claimant, who had longstanding atrial fibrillation, suffered symptoms including her right leg turning white and feeling cold, then returning to pink again, with intermittent repetition. She also experienced pain and the sensation of pins and needles in the foot. After calling 999 on the evening of 24 September 2015, she attended A&E having refused an ambulance. Whilst there, she was triaged and sent to the adjacent Out of Hours GP centre, who recorded a possible diagnosis of intermittent claudication and queried the cause. The Claimant was then sent back to A&E and seen by a specialist registrar, who recorded a "? Resolved ischaemic event of Rt leg" and discharged her home. She was advised to attend her GP for a follow-up in 5 to 7 days, and to return to A&E if she experienced further pallor, coldness, pain or paraesthesia.

On the evening of 27 September, the Claimant suffered a stroke with right facial droop and slurred speech. CT brain imaging disclosed a short segment of hyperattenuating thrombus in the distal M1 segment of the left middle cerebral artery; there was occlusion of the left internal carotid artery from at least the level of the skull base. Despite treatment with thrombolytic drugs, the damage worsened over the following two days and the Claimant was left profoundly impaired.

The Issue

Although the Defendant averred in its Amended Defence that omission to administer Heparin was not a breach of duty, it conceded the issue following the conclusion of evidence on breach. By the end of the trial only a single issue fell to be determined: but for the Defendant's admitted negligence, would the Claimant have avoided suffering a stroke because of the beneficial effects of Heparin treatment? The Defendant accepted

it should have commenced this treatment by 1:44 on 25 September 2015 and continued it until the Claimant was provided with therapeutic anti-coagulation using Warfarin or a suitable alternative.

The Risk

It was admitted that the Claimant was at high risk of an embolus (a portion of the blood clot) breaking free from the blood clot that was likely to be present in her left atrial appendage ('LAA'). This risk could lead to a stroke, whether in the form of a blockage of the arteries in the brain or the arteries to the gut or limb. Which of the two is a matter of pure chance: on breaking off, the embolus travels into the left ventricle, is pumped up the arch of the aorta and turns either left to the brain or right to the body. All four causation experts who gave live evidence agreed that, on balance of probabilities, this risk had eventuated on 27 September.

Causation

In determining causation, Ritchie J relied on the written and oral evidence of the four relevant experts (a neurologist, a consultant in general medicine, geriatrics and stroke medicine, and two haematologists), on the medical literature, and on the credibility of the experts under cross-examination by experienced counsel.

Taking these factors into account, and placing especial reliance on the conclusions of the Claimant's haematologist, the Judge made the following findings of fact:

1. In the lead-up to 24 September 2015 the Claimant developed an unstable blood clot in her LAA. This was a result of pre-existing atrial fibrillation and her failure to take Aspirin for several days.

2. The unstable clot fired off an embolus which travelled through the left ventricle, round her aortic arch and down into her leg, causing the ischaemia of the leg that prompted her hospital attendance. She was at high risk of the unstable clot firing off another embolus.

3. Had Heparin been administered as it should have been, it would have started working within 1 to 3 hours, starting the body's natural processes of dissolving the unstable clot, stabilising, organising it, walling it off or adhering it to the atrial wall. Had the Heparin been administered, followed by an appropriate anticoagulant such as Warfarin, then the clot would have dissolved in about 25 days.

a4. In the 67 hours (2.79 days) between the point at which Heparin should have been administered and the Claimant's stroke, the clot would have reduced in size by over 50%.

5. On balance of probability, Heparin would have prevented an embolus from being 'fired off', because it would have averted new clot formation, prevented propagation of the existing clot, and enabled the Claimant to reduce the size of the original clot and make it less friable, more stable and more organised. The Judge rejected the opinion of the Defendant's haematology expert to the effect that Heparin does not enable the body to reduce the embolic danger created by a blood clot and merely allows the body to dissolve the existing clot.

Discussion: Points to Note

Beyond the narrow issue it addresses, the judgment is notable for its painstaking, strongly reasoned and clearly worked analysis of the causation evidence; and for its determination of a timeline of events but for breach where the relevant medical literature is lacking in important respects. As the Judge noted at [135]:

> ***"At the root of the issue in this case is the lack of clinical trials to show whether Heparin has a front loaded or constant effect in acute cases involving atrial fibrillation with a clot in the left atrium or LAA which has already fired off an embolus. Or whether the beneficial effect only kicks in after 30 days as Dr. Patel advises. […] If a researcher suggested carrying out a study in which half the patients in acute danger of death or serious stroke were given the recommended treatment, namely Heparin, and the other half were not, that would be a breach of the Hippocratic oath for the placebo patients. In any event no patient with capacity who was facing an acute and significant risk of death or serious stroke by thromboembolism would consent to enter such a study and accept the placebo."***

In such a scenario, factors such as witness credibility and the logical cogency of the experts' respective positions are likely to take on a renewed salience.

In the instant case, the Judge singled out the "***fixed thinking and questionable logic***" of the Defendant's haematologist as a factor that damaged the credibility of his evidence. His credibility was further undermined by his reluctance, in cross-examination, directly to address the anatomy of the blood clot over the period of its dissolution, and by his tendency to produce what the Judge termed "***rather extreme opinions***".

By contrast, the credibility of the Claimant's haematologist was underlined by his extensive clinical experience, his knowledge of clinical guidelines and practice, his research on thrombosis and atrial fibrillation, and his involvement in writing guidelines on the use of Warfarin. The Judge also noted his correct definition of the 'but for' test when challenged in cross-examination.

Finally, the decision demonstrates the Court's willingness, in an appropriate case, to conduct its own analysis of the medical literature and draw conclusions that contradict those of the expert who relies on it.

In asserting that Heparin would not have averted embolisation, the Defendant's haematologist cited a body of papers in which Heparin had been used to 'bridge' discrete courses of Warfarin around elective surgery. These appeared to show no positive effect on the incidence of embolism. However, the Judge concluded that it was illegitimate to extrapolate from the discrete 'bridging' scenario addressed by the papers because, in the examples cited, there were many potential clotting mechanisms unrelated to Heparin, such as intraoperative haemodynamic changes, IV fluids and blood transfusions. These factors did not apply to the Claimant. **The judgment therefore reinforces the need fully to consider any literature that is cited by the experts. There may be multiple ways in which to distinguish any studies on which they rely.**

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Benevolence, record-keeping and reliability: Richins v Birmingham Women's and Children's NHS Foundation Trust [2022] EWHC 847 (QB)

CLINICAL NEGLIGENCE – EVIDENCE – WITNESS RELIABILITY – GESTMIN APPROACH – KEEFE BENEVOLENCE PRINCIPLE – CONTEMPORANEOUS EVIDENCE

Richins was a liability-only trial arising out of alleged negligence 14 years earlier against the Defendant's ('D') midwifery team for failure to summon obstetric intervention in time to prevent the death of the Claimant's ('C') unborn child. The Judge presented a careful analysis of the legal principles underpinning the assessment of witness reliability, as well as the '*Keefe* benevolence principle'. As Marcus Grant explains, the decision is required reading for anyone seeking a masterclass in the complexities and nuances of clinical negligence litigation.

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The judgment sets out over 39 pages an impeccable analysis of the facts, the law, and the applications of the two with regard to the issues of breach and causation. One of the challenges facing the Judge is that she heard live oral evidence from witnesses attempting to recall the precise chronology of events 14 years earlier. Part of the allegations of breach of duty concerned deficiencies in the Defendant's contemporaneous midwifery medical notes.

The Judge bore in mind the seminal guidance of Leggatt J (as he then was) as to the assessment of witness reliability in the commercial case of *Gestmin SGPS SA v Credit Suisse (UK) Ltd* [2013] EWHC 3560 at [16]–[22]. This suggested that courts must avoid the error of assuming that stronger and more vivid feelings and/or confidence in recollections make it any more likely that those recollections are accurate. It established the principle that factual findings based on inferences drawn from documentary evidence and known or probable facts is likely to be more reliable. These principles have been described as '***the Gestmin approach***' by other judges.

The judgment considered other cases where the *Gestmin* approach had undergone judicial scrutiny, including Tomlinson LJ's words in *Synclair v East Lancashire Hospitals NHS Trust* [2015] EWCA Civ 1283 at [12], when he stated:

> ***"Simply because a document is apparently contemporary does not absolve the court of deciding whether it is a reliable record and what weight can be given to it. Some documents are by their nature likely to be reliable, and medical records ordinarily fall into that category. Other documents may be less obviously reliable, as when written by a person with imperfect understanding of the issues under discussion, or with an axe to grind."***

The Judge referred also to *HXC v Hind & Craze* [2020] EWHC (QB) (5 October 2020) at [137], in which she stated:

> ***"A court can and often will taking a starting point, but no more than a starting point, that a contemporaneous entry made by a medical professional is likely to be a correct and accurate record of what was said and done at a consultation/examination."***

Finally, on the issue of weight to attach to oral evidence based on recollection, the Judge referred to another of her cases, *Pomphrey v Secretary of State for Health & North Bristol NHS Trust* [2019] EWHC (QB) (26 April 2019), [2019] Med LR 424 at [31]–[32], where she said:

> ***"If one element is incorrect, it may, but does not necessarily mean, that the rest of the evidence is unreliable. There are a number of reasons why an incorrect element has crept in. Apart from the obvious loss of recollection due to the passage of time, there may be a process of conscious or subconscious reconstruction, or exposure to the recollection of another, which has corrupted or created of the recollection of event or part of an event. The Court must also have regard to the fact that there can be bias, conscious or subconscious within the recollection process."***

The judgment made reference to '**the *Keefe* benevolence principle**', which derived from a judgment of Longmore LJ in *Keefe v Isle of Man Steam Packet Company* [2010] EWCA Civ 683 at [19], when he stated:

> ***"If it is a defendant's duty to measure noise levels in places where his employees work and he does not do so, it hardly lies in his mouth to assert that the noise levels were not, in fact, excessive. In such circumstances the court should judge a claimant's evidence benevolently and the defendant's evidence critically. … Similarly a defendant who has, in breach of duty, made it difficult or impossible for a claimant to adduce relevant evidence must run the risk of adverse factual findings."***

In *Richins*, the Court applied these principles to the evidence it heard. A critical issue in the case was whether D's midwives ought to have tested C's urine between the hours of 6 pm and 3 am, and whether they ought to have transferred her to a delivery suite in sufficient time to prevent the death of her unborn child at 6:45 am, when abruption occurred.

In a meticulous judgment set out over 155 paragraphs, the Court found that there were several breaches of duty, some of which depended on application of the '*Keefe* benevolence principle'. However, the claim failed on the final hurdle of causation: even if C had been transferred to the delivery suite shortly after 3 am, as the Court found she should have been, on a balance of probabilities, a proper and responsible body of obstetric experts would have decided to delay the delivery until after 6:45 am and when senior staff were on duty to assist with the delivery.

The judgment is required reading for anyone wanting to read a masterclass in explaining the complexities and nuances of clinical negligence litigation.

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The Sherlock Holmes fallacy and the case of the dogmatic expert: Johnson v Williams [2022] EWHC 1585 (QB)

CLINICAL NEGLIGENCE – EVIDENCE – BURDEN OF PROOF – UNUSUAL COMPLICATIONS – EXPERT EVIDENCE

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As James Yapp explains, the decision in *Johnson* is a reminder of the importance of the burden of proof. It can be difficult for a claimant to prove a claim arising from a very unlikely complication. The defendant need not prove an alternative cause for a claim to be dismissed. The judgment also contains important observations on expert evidence. Both parties' experts were criticised, albeit for different reasons.

The Evidence of the Treating Surgeon

The Claimant was a professional footballer. In January 2017 he suffered a knee meniscus tear. He was operated on by the Defendant. The operation appeared to go well. The knee subsequently showed signs of infection. In March 2017 the Defendant performed a synovectomy to remove the infective material.

Scans 25 days post-surgery showed a large tear (approximately the size of a 50p coin) to the medial retinaculum. The cause of the tear was unclear. The experts agreed that causing a large rupture to the retinaculum would constitute ***"an extremely rare and unusual complication following synovectomy".***

The Defendant's evidence was that he could not have caused the defect during surgery. Even if he had, he could not have failed to spot it. During the surgery and washout he had good visualisation. Fluid applied under pressure would have made the defect obvious.

The Parties' Cases

The Claimant argued the only possible and likely cause of the tear was surgical error; the alternative causes suggested by the Defendant were so unlikely that they could be rejected.

The Defendant put forward two alternative causes: infection or the Claimant's failure to follow post-operative instructions. It argued that, in any event, the Claimant could not discharge the burden of proof.

The Sherlock Holmes Fallacy

Jeremy Hyam QC (sitting as a High Court Judge) reminded himself of the well-known case of *Rhesa Shipping Co. SA v Edmunds* [1985] 1 WLR 948, *'The Popi M'*. As Lord Brandon explained in that case:

> ***"…it is important that two matters should be borne constantly in mind. The first matter is that the burden of proving, on a balance of probabilities, that the ship was lost by perils of the seas is and remains throughout on the shipowners. Although it is open to the underwriters to suggest and seek to prove some other cause of loss… there is no obligation on them to do so. Moreover, if they chose to do so, there is no obligation on them to prove, even on a balance of probabilities, the truth of their alternative case."***

Lord Brandon explained why the Court should reject the 'Sherlock Holmes fallacy' that "***once you have eliminated the impossible, whatever remains, however improbable, is the truth***". First, the judge is not always obliged to make a finding but can fall back upon the burden of proof. Second, this reasoning can only be used where all facts are known so every possible explanation can be ruled out. Third, if a judge finds that an event is extremely unlikely to have occurred, it does not accord with common sense to find that it was more likely than not to have occurred.

The Decision in Johnson

The Judge found that the Defendant causing the hole with a surgical shaver and then failing to spot it was possible, but very unlikely. This would have required the repeated use of excessive force. The Defendant was an experienced surgeon and this would have required a high degree of inadvertence. Moreover, the hole should have been immediately apparent, and should have been apparent again at washout.

Ultimately, the Judge was left in very considerable doubt. He could not rule out other possible causes, even though these were also unlikely. The Claimant failed to prove his case.

While judges are reluctant to fall back upon the burden of proof, there will be cases – like *Johnson* – in which the Court won't be able to 'solve the puzzle'. It remains for claimants to prove the negligence alleged, not for the defendant to disprove it by proving an alternative. Practitioners must bear this in mind, particularly when dealing with very unusual complications.

It Can Happen … Because It Did

The Judge was critical of both experts. Much of the criticism was directed at the Claimant's orthopaedic surgeon.

In cross-examination the expert had said that the complication in question "***happened in some cases***". When this was explored further, it transpired that the expert was not aware of previous cases, but was saying it had happened in this case so "***it can happen***". The Judge considered this too extreme and inflexible a position for such an unusual complication.

The expert had also perhaps over-egged the pudding in his CV, describing himself as "***the Manchester United Orthopaedic Surgeon for 20 years***". In fact, he had done some work for the club, but was never employed by them. Other surgeons had worked for the club as well. These concessions took some time to extract. The Judge found this highlighted a theme of his evidence which was a degree of overstatement and inflexibility.

The criticisms of the Claimant's expert provide guidance for experts and those who instruct them. Overstating matters – including one's skills and experience – is usually exposed and never impressive. Perhaps more fundamentally, concluding that an extremely rare event 'can happen … because it did' will rarely be persuasive.

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PROCEDURE:

Foreign law and the dangers of expert advocacy: Pal v Damen and Belgo International Research Applications and Development NV [2022] EWHC 4697 (QB)

CLINICAL NEGLIGENCE – JURISDICTION – BRUSSELS RECAST REGULATION – CONTRACT – EXPERT EVIDENCE ON FOREIGN LAW

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The question addressed in *Pal* was whether the Court had jurisdiction to try a claim against a Belgian surgeon and clinic. Proceedings having been issued before the end of the Brexit implementation period, questions of jurisdiction were governed by the Brussels Recast Regulation (Regulation EU No 1215/2012). As Lionel Stride explains, the decision is an important reminder that, where an issue turns on the interpretation of foreign law, the credibility of the relevant experts is fundamental.

The Facts

The First Defendant ('the Surgeon') was a consultant plastic surgeon domiciled in Belgium. The Second Defendant ran a clinic ('the Clinic') located in Genk, Belgium. In 2016, the Claimant, who had been researching breast enlargement procedures, discovered the Clinic's website. Favourably impressed by the price and testimonials, she followed a link from the site to complete an online reservation form and was required to pay a €500 deposit.

Shortly afterwards, the Clinic sent an email confirming receipt of the deposit, and that an appointment for a consultation with the Surgeon had been made for 25 May 2016. Surgery was to take place the following day. The Claimant duly attended the Clinic and paid, first for the consultation and then the balance of the cost of the surgery, by bank card.

The Clinic's evidence was that the Clinic was a facilitator of supporting services to physicians; was not involved in the practice of medicine; and did not employ physicians. Rather, it provided premises containing waiting rooms, operating theatres and a recovery room, together with a website. The Claimant did not contest its assertion that the appointment Terms and Conditions stated that "***Physicians are liable for any damages suffered by a patient as a result of the physician's failure to respect his/her obligations stated in the treatment agreement***". The Terms purported to exempt the Clinic from liability for "***medical accident***"; and stated that the Clinic was "***the company that provides the infrastructure where physicians can practice their profession***" and was not a party to the treatment agreement between patient and clinician.

The Legal Background

By the hearing, it was accepted that the Claimant was unable to rely on Article 7(2) of the Brussels Recast Regulation because the place where both the events giving rise to the damage and where the direct and immediate damage occurred was Belgium. It was also accepted that the Claimant had entered into a consumer contract. The key provision was therefore Article 18(1), which gave a consumer in the Claimant's position the right to "***bring proceedings against the other party to a contract either in the courts of the Member State in which that party is domiciled or, regardless of the domicile of the other party, in the courts for the place where the consumer is domiciled***". Whether jurisdiction was established against the Surgeon and/or Clinic therefore depended on the existence of a contract with either one under Belgian law.

As Master Cook emphasised, an application under CPR Part 11 is not a trial and should usually proceed on the basis of written evidence and submissions only; any concluded view of the merits of the case should be avoided. The burden of proof is on the Claimant to establish a jurisdictional gateway. The question the Court must ask itself, following *Four Seasons Holdings Inc v Brownlie* [2017] UKSC 80, is whether the claimant has "***the better of the argument***". These requirements were affirmed and reformulated in *Goldman Sachs International v Novo Banco SA* [2018] UKSC 34 as follows:

1. The claimant must supply a plausible evidential basis for the application of the gateway.

2. If there is an issue of fact about it (or some other reason for doubting whether it applies), the Court must take a view on the material available if it can reliably do so.

3. Should the nature of the issue and limitations of the material available at the interlocutory stage prevent a reliable assessment being made, then there is a good arguable case for the application of the gateway if there is a plausible evidential basis for it.

Conclusion

Master Cook accepted without hesitation that there was a good arguable case that the Claimant entered into a contract with the Surgeon. In reaching this conclusion, he placed significant weight on the cogency of the evidence of Mr Beer, Belgian law expert for the Clinic. His was the only expert evidence, asserted the Master, that "***properly considered the factual background and contractual background in a balanced and logical manner***". Master Cook therefore endorsed his conclusion that this was not an 'all in' agreement under which the clinic provided the medical services of the surgeon, but a 'doctor out' agreement in which there was a separate contract between the Claimant and the Surgeon for medical services.

By contrast, no weight could be placed on the evidence of Mr Steyvers, the expert instructed by the Surgeon. Not only did his report fail to comply with the formal requirements of CPR 35.3(2); it was also partial in both senses, failing to address factual evidence concerning the contract that was adverse to the Surgeon. In line with Mr Steyvers' role as the Surgeon's Belgian advocate, the report carried out advocacy on his behalf and contained the "***abrupt***" observation that Mr Beer's report "***contains a lot of mistakes and incorrect information***". Mr Steyvers' conclusion that the contract was with the Clinic alone was therefore rejected.

Whilst the report of the Claimant's expert, Mr Delvaux, was CPR-compliant, parts of its reasoning did not withstand logical analysis; in particular, its analysis of a particular case from the Court of Appeal of Liège was found lacking. It followed that Mr Delvaux's opinion that there was an 'all in' agreement did nothing to disturb the Master's conclusions that the contract was with the Surgeon alone.

Discussion

As practitioners will be aware, the Brussels Recast Regulation has no application to proceedings issued after the conclusion of the Brexit implementation period on 31 December 2020. However, the judgment has significance for decisions that turn on the interpretation of foreign law. In such cases, it is crucial that experts approach their task in line with the letter and spirit of CPR Part 35, addressing all relevant matters comprehensively, logically and in a balanced manner. As with medico-legal evidence, partiality, illogic, failure to consider all available factual evidence and overt advocacy for the instructing party is unlikely to be persuasive and may well damage the interests of the instructing party.

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Variable PPOs: a second bite of the cherry? And no joy on PI trust costs: Martin v Salford Royal NHS Foundation Trust [2022] EWHC 532 (QB)

CLINICAL NEGLIGENCE – QUANTUM – DAMAGES – VARIABLE PPOS – FINANCIAL VULNERABILITY – PERSONAL INJURY TRUSTS – ECHR ARTICLE 2

By Richard Wilkinson
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When a case reaches trial not once, but three times, it is fair to expect it to contain something of interest. As Richard Wilkinson explains, the *Martin* case does not disappoint. Here, he reviews the implications of a novel application by a *defendant* successfully seeking an order for a variable PPO in respect of future deterioration in the Claimant's condition; and looks at the difficulties still facing vulnerable claimants seeking to recover the costs of running a Personal Injury Trust ('PIT') to protect their damages.

Background

The complex factual background is summarised only very briefly within this article. Prior to the Defendant's negligence, the Claimant had an extensive psychiatric history including an Emotionally Unstable Personality Disorder ('EUPD') and paranoid schizophrenia. She had a history of substance abuse, had attempted suicide and had been detained at mental health facilities for long periods.

The first trial, in 2018, resolved liability in the Claimant's favour4 in circumstances where in 2010, she suffered a fall; at the time, she had been a psychiatric inpatient pursuant to a hospital order under s.37 of the Mental Health Act 1983 following a conviction for arson. She suffered an undisplaced and incomplete right sub-trochanteric fracture. Surgery was negligently delayed for a number of months by those responsible for her care and the opportunity to perform minimally invasive surgery lost. She eventually required open surgery following which she developed infection resulting in septic shock, septicaemia, multiple organ failure and a brain injury, as well as malunion of the femur. The Judge found that timely surgery would have avoided these outcomes.

At a second trial three years later the main quantum issues were resolved.5 As a result of the Defendant's negligence, the Claimant was left dependent on others for all aspects of her daily life, reliant on the use of an electric wheelchair and on carers, needing to be hoisted to move from her chair. She was left with a shortened leg and footdrop, with restricted movement in all limbs and very poor sitting balance. Until the quantum trial the Claimant had received a package of care providing both mental health support and physical care pursuant to statutory duties under s.117

of the Mental Health Act. Notwithstanding this regime of care, at trial the Judge accepted that damages should be awarded for the remainder of the Claimant's life to provide a privately funded care regime consisting of 2 day-time carers/support workers, a personal assistant and one night-time sleeping carer. As is common, the issue of whether to make a PPO order was left over until after delivery of the main quantum judgment.

The Claimant also suffered a brain injury resulting in neurological impairment. Importantly for present purposes however, the Judge concluded the Claimant retained capacity to manage and control her damages award. However, he permitted the Claimant to amend her Schedule at trial to include a claim in the alternative for the costs of a PIT which had hitherto been overlooked.

The matter then proceeded to a third contested hearing. By this stage there was no dispute that a PPO should be made in respect of the Claimant's future care costs but the Judge was invited to determine (1) an application by the Defendant for a variable PPO order; and (2) the Claimant's claim for damages in respect of the costs of a PIT (quantified in her Schedule at £385,000).

Variable PPO

The evidence at the quantum trial had identified a risk that the Claimant's condition might deteriorate in her sixties to the extent that she would need to transfer to institutional care (and in consequence no longer need the more expensive regime of home care upon which the Judge had based his assessment of damages). In his main quantum judgment, the Judge declined to reduce the award to reflect this risk, accepting that the period of any such revised regime was likely to be short (given the Claimant's reduced life expectancy) and balancing against the possibility that she might still be able to be cared for at home despite a subsequent increase in her physical care needs. Thus the Defendant's subsequent application for a variable PPO effectively gave them a second bite at reducing the claim for future care costs.

The power to make an order for a variable PPO is contained in Article 2 of the Damages (Variation of Periodical Payments) Order 2005 and arises

> ***"If there is proved or admitted to be a chance that at some definite or indefinite time in the future the claimant will (a) as a result of the act or omissions which gave rise to the cause of action, develop some serious disease or suffer some serious deterioration, or (b) enjoy some significant improvement, in his physical or mental condition, where that condition had been adversely affected as a result of that act or omission."***

Two obvious points stand out. First, the similarities (accepted by the Judge) with the terms (and thus the law) relating to awards for Provisional Damages. Second, an expectation that defendants might more naturally be interested in those cases where there was the prospect of significant *improvement*, rather than deterioration, in a claimant's condition.

On the facts, the Judge accepted there was a sufficient (more than fanciful) chance that the Claimant would suffer a serious deterioration in her condition and that he should exercise his discretion in favour of making an order for a variable PPO despite (1) the Claimant's opposition to the same and (2) accepting that such orders should not be the norm. He also rejected the Claimant's attempt to prevent any such application being made prior to her 60th birthday.

Comment

Given the 'full' award of damages for future care on a lifetime multiplier basis made at trial, it is unclear whether the Claimant would have still pursued (or been advised to pursue) a PPO award had she known the Judge would accede to the Defendant's request for a variable PPO. This decision, if adopted more widely, may act as a further disincentive to claimants seeking PPOs and is certainly an issue those advising claimants should be alive to when advising clients on the merits of a PPO.

4 [2018] EWHC 1824 (QB)

5 [2021] EWHC 3058 (QB) ('the quantum judgment')

Personal Injury Trusts

For many years, claimant advisers have had to grapple with those difficult cases where the claimant's capacity to manage their finances is borderline. Under the Mental Capacity Act 2005 a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success, so such borderline cases are often termed 'dependent capacity': capacity is retained, but only because of the support provided. But what if that support incurs significant financial cost? One mechanism frequently deployed by those advising claimants to protect vulnerable claimants is the use of a Personal Injury Trust. Their use has persisted despite judicial knock-backs in cases such as *Owen v Brown*[6] and *AB v Royal Devon & Exeter NHS Foundation Trust*[7]. In both cases the claims for the cost of a PIT were rejected on the grounds that such trusts could be wound up by the claimant at any time.

Despite this unpromising background, the Claimant may have approached the hearing with some optimism in circumstances where: -

i. The Judge had permitted the late amendment to her Schedule; and

ii. The Deputyship experts had agreed in their Joint Statement that (1) the PIT gave "some protection against vulnerability" because it gave the trustee the opportunity to discuss a decision with the beneficiary and (2) the level of costs proposed was "reasonably necessary" to manage the Claimant's award.

Perhaps in an attempt to circumvent previous unhelpful rulings, the Claimant also made an innovative attempt to invoke the Court's protective jurisdiction said to arise from the operational duty arising under Article 2 in circumstances where the Claimant presented with a risk of suicide (albeit such risk pre-dated the Defendant's negligence).[8]

Any such optimism was dashed by the Judge's emphatic rejection of the claim. In a comprehensive judgment he concluded that (1) no operational duty arose on the facts of this case; (2) if it did, the duty had been discharged; and (3) in any event there were no reasonable or proportionate steps the Court or Defendant should be required to take to deal with the risk, noting that requiring the Defendant to fund a PIT would not "***address the risk faced by the claimant in any meaningful way***" (at [74(b)]).

In considering the claim as more conventionally presented, the Judge regarded the absence of reported decisions allowing recovery of PIT costs as instructive. He noted the Deputyship experts had agreed that a bare trust was the usual and most suitable form of trust in such circumstances and the Judge accepted that such a trust could be unravelled at any time by the Claimant. He also considered that some protection was afforded to the Claimant by the making of a PPO.

Comment

The case serves as a stark reminder of the difficulties of recovering the costs of a PIT under the current law. The Judge began by reminding himself that even if the Claimant could establish a reasonable need to receive damages to cover the cost of a PIT, that did not establish a right to recovery: see [63]. The mere availability of a PPO (even if not pursued by the Claimant) could on this analysis also be regarded as a factor pointing against recoverability.

His judgment further highlights the need for claimants to present careful evidence as to the form and wording to be proposed in any Trust:

> ***"It may be that other mechanism could be worked into the trust to introduce a cooling off period or other protections, but such mechanisms were not explained to me and could not interfere with the overriding purpose and principle of a bare trust. … A bare trust offers little (if any) protection against the claimant's vulnerability"*** *(at [81(b)]).*

Consideration needs to be given to any alternative mechanisms that may exist to provide financial protection to vulnerable claimants.

One final thought: if a PIT is not used, can a claim be made for time reasonably spent by others in providing financial support, guidance or advice to a vulnerable claimant who has indicated a willingness to accept such assistance? And if no family member is able or willing to take on this role, who is best placed to perform the role?

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6 [2002] EWHC 1135 (QB)
7 [2016] EWHC 1024 (QB)
9 See Rabone v Pennine Care NHS Foundation Trust [2012] UKSC 2.

Shortfall provisions, informed consent and the presumption of reasonableness: EVX (a minor by her mother and litigation friend XYZ) v Smith [2022] EWHC 1607 (SCCO)

CLINICAL NEGLIGENCE – COSTS – ASSESSMENT – CFAS – SHORTFALL PROVISIONS – INFORMED CONSENT

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Shortfall provisions within CFA retainers are becoming increasingly common. As James Arney KC explains, the decision in EVX provides important protection for claimants against the excessive costs which might otherwise arise under such agreements. It also gives solicitors crucial guidance on what must be explained to the client in order to maximise the prospects of costs recovery under the shortfall provision.

Factual Background

The minor Claimant brought a clinical negligence claim for failure to diagnose and appropriately treat her dysplasia in her left hip. Following settlement of the claim (without admission of liability) for £225,000, the Claimant's solicitors sought to recoup from the Claimant's damages the sum of £28,113, being the shortfall in base costs over and above the £130,000 agreed *inter partes* costs liability.

The Litigation Friend ('LF') did not object to the deductions. At the approval hearing the court approved the damages settlement figure, allowed the claimed success fee and ATE insurance premium, but ordered that there be a detailed assessment ('DA') on the indemnity basis in respect of the shortfall.

The Solicitors' Contention

The solicitors argued that the LF had approved the hourly rate by entering into a CFA which provided for the rates claimed, after being given an oral explanation of its terms. They contended that such agreement to the hourly rates prevented the court from assessing the sums payable by reference to reasonableness. They pointed to the LF's express agreement as to the sums payable by the Defendant, and the fact that she had been told that the shortfall would be recovered. This, they argued, created an irrebuttable presumption that the rates claimed were reasonable. Their fallback position was that the rates were in any event reasonable.

Relevant Legal Principles

CPR 46.4(2) provides that where money is payable by or to a child or protected party, the general rule is that the court must order a detailed assessment of the costs payable by or out of the money belonging to the protected party.

CPR 21.12 provides (in respect of expenses incurred by a LF) that: -

(1A)(a): Costs recoverable in respect of a child are limited to costs which have been assessed by way of DA pursuant to rule 46.4(2).

(4): In deciding whether the costs or expenses were reasonably incurred and reasonable in amount, the court **will have regard** to all the circumstances including the factors set out in rule 44.4(3) and 46.9.

(5): When the court is considering the factors to be taken into account in assessing the reasonableness of the costs or expenses, it will have regard to the facts and circumstances as they reasonably appeared to the LF or to the child's or protected party's legal representative when the cost or expense was incurred.

By CPR 46.9, DA of solicitor client costs will be presumed to have been: -

- Reasonably incurred if incurred with the express or implied approval of the client, and
- Reasonable in amount if their amount was expressly or impliedly approved by the client; but
- Unreasonably incurred if: -
  - They are of an unusual nature or amount; and
  - The solicitor did not tell the client that as a result, the costs might not be recovered from the other party.

By CPR 44.3, even on the indemnity basis, the court will not allow costs which have been unreasonably incurred or are unreasonable in amount.

To benefit from the presumption under CPR 46.9, it is for the solicitors to establish informed consent to the incurring of the costs by the LF (see *Macdougall v Boote Edgar Esterkin (a Firm)* [2001] 1 Costs LR 118). This requirement cannot be satisfied by the mere fact of the LF's consent, otherwise the word 'informed' would be redundant.

'Unusual' in CPR 46.9 must be read in the context of a between the parties assessment (*ST v ZY* [2022] EWHC B5 (Costs)).

Written agreement as to costs is not a determination of the sums due by way of costs. A 'Solicitor Act' assessment proceeds not by way of a determination of what is due on an agreement as to costs, but upon an assessment of the reasonableness of the charges set out in a bill.

An agreement or approval by a client merely creates a presumption in a 'Solicitor Act' assessment, and the consent/approval must be informed. It is difficult to see how a child or protected party can be worse off than they would be under a 'Solicitor Act' assessment.

The Decision

The rates claimed for the lower fee earners (£235-£240 ph for Grade C) were 'unusual' in their amount, in the context of Guideline Hourly Rates ('GHR') (£161 in 2020, £178 in 2021).

Although GHR are a mere guide/starting point for summary assessment, they are intended to be reflective of rates actually charged, and serve as a starting point for DA.

There is no basis for saying that hourly rates cannot be assessed, and if appropriate reduced, even if they are agreed.

It was not enough for the LF to have been informed of the prospect of there being a shortfall, or to be informed of the amount of that shortfall, or even that the LF agreed to the costs settlement with the Defendant knowing that a shortfall was thereby produced. The solicitor's explanation must be directed to the unusual nature of the costs (in this instance the hourly rates). To provide greater protection against a contention that the costs are unreasonable, a solicitor's explanation would need to set out that their hourly rates were unusual, **and that as a result** the costs might not be recovered from the other party. No such explanation had been given here.

Accordingly there was no informed consent to the hourly rates claimed, and therefore no presumption of reasonableness. Any such presumption would not, in any event, have been irrebuttable.

In any event, having regard to the relevant factors, the Costs Judge concluded that the rates were clearly unreasonably high.

Even if the rates had been found to be reasonable, the sums claimed would have needed adjusting to account for the efficiency and experience ordinarily implicit in such rates.

As to the hourly rates awarded, the Costs Judge gave the solicitors a further opportunity to provide relevant information and clarification in respect of the individual fee earners who had conducted the work, but allowed £210 ph in respect of two grade C fee earners once qualified.

Comment

As shortfall provisions within CFA retainers become more common, this decision provides important protection for claimants against excessive costs, and equally important guidance to solicitors as to what must be explained to the client in order to maximise their prospects of costs recovery under the shortfall provision. It is insufficient to rely on the client's agreement to the CFA provisions, nor even to rely on their after-the-event agreement to the shortfall recovery being claimed.

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Dancing on the head of a pin – a defendant's 'ingenious' challenge to an ATE premium is dismissed: Dance v East Kent University Hospitals NHS Foundation Trust and Others [2022] EWHC B9 (Costs)

CLINICAL NEGLIGENCE – COSTS – RECOVERABILITY OF ATE PREMIUM – RECOVERY OF COSTS INSURANCE PREMIUMS IN CLINICAL NEGLIGENCE PROCEEDINGS (NO 2) REGULATIONS 2013 – PART 36 OFFERS

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Arguments about whether a claimant is entitled to recover their ATE premium in civil litigation have largely been resolved by the 2013 Jackson reforms, which in general removed defendants' liability to pay for them. However, the exception from this general rule for certain clinical negligence claims has led to increasingly ingenious attempts on the part of defendants to avoid reimbursing claimants for the cost of funding their claims, whether on assessment (as clarified by the Court of Appeal in *West v Stockport NHS Foundation Trust* [2019] EWCA Civ 1220), or by way of challenge to the recoverability of such costs. Robert Riddell considers an example of the latter approach in the recent judgment of Master Leonard.

The Facts

In *Dance* the Claimant had accepted a Part 36 offer to settle his clinical negligence claim. Subsequently, he sought to recover from the Defendants the sum of £5,266.01, being the cost of his ATE premium. It was not disputed that this sum was in principle recoverable under the Recovery of Costs Insurance Premiums in Clinical Negligence Proceedings (No 2) Regulations 2013 ('the No 2 Regulations'). These regulations permit the recovery of ATE premiums in prescribed circumstances, specifically: (a) where the financial value of the claim for damages exceeds £1,000; and (b) only to the extent that the premium relates to the risk of incurring the costs of expert reports determining liability and causation. Nonetheless, the First Defendant contended that the premium was irrecoverable.

The Challenges

The first challenge was that, pursuant to the Court of Appeal's decision in *Cartwright v Venduct Engineering Limited* [2018] EWCA Civ 1654, the Claimant's acceptance of a Part 36 offer left him without the benefit of an 'order for costs' by which he could recover the costs of the premium. This point, not apparently pressed by counsel, was shortly dismissed: as the Master observed, the Claimant's right to recovery of costs arises under CPR 36.13(1), and under CPR 44.9(1)(b) is deemed to have been ordered on the standard basis. Nothing in *Cartwright* disturbed that assumption.

The second challenge was more involved. The essence of the First Defendant's submission was that even where there is an order for costs, the ATE premium will only be recoverable if the costs order makes specific provision to that effect. This rested on a close reading of the relevant part of the No 2 Regulations, which provides that "***a costs order made in favour of a party to clinical negligence proceedings who has taken out a costs insurance policy may include provision requiring the payment of an amount in respect of all or part of the premium of that policy***".

As noted by the First Defendant, the editorial commentary to the *White Book* (at 48.0.4) stated that

> ***"[i]t is therefore incumbent on the party seeking costs to request the judge to include the necessary provision when making the order. If no such provision is included in that order, the cost of the premium will not be recoverable."***

In support of its contentions, the First Defendant raised a number of arguments including the following:

1. The No 2 Regulations afforded a facility to the Court to make an order to include provision for the payment of a recoverable ATE premium; it did not assume that a claimant would be entitled to recover a premium as a default (subject to prescribed fetters). That was made clear by both the language and the legislative context. As a matter of policy, it was logical that Parliament would have wished to impose some constraint on a defendant's potential liability for an ATE premium given they are subject to assessment only on macroeconomic grounds and exempt from the standard proportionality test.

2. The claimant's right to recover costs under the CPR expressly does not include recoverable ATE premiums, which are omitted from the definition of 'costs' in CPR 44.1(1). Recoverable ATE premiums are therefore not costs by default, but only become costs if the Court makes an order that they are recoverable.

3. Even on a purposive interpretation of the relevant Regulations, the purpose of the legislation was to strike a balance between the needs of claimants (access to justice) and the needs of defendants (protection from excessive liability), and that any interpretation which favoured the former without regard to the latter would be impermissible. In any event, a purposive interpretation would be required of the CPR rather than the No 2 Regulations, which would cut across the well-established principle that Part 36 is a self-contained code and that CPR Part 44 does not include any reference to 'additional liabilities'.

4. Acceptance of a Part 36 offer would not preclude a claimant from recovering an ATE premium because they could make an application either under CPR Part 8 or CPR Part 23 for such an order.

The Decision

Despite admiring the First Defendant's 'ingenuity', the Master rejected the basis of the submissions because (a) he did not accept that the No 2 Regulations create an exception to the general rule that costs, as defined under CPR 44.1(1), are recoverable under an order for costs without the need for specific provision for any particular element of those costs; and (b) that recoverable ATE premiums do in any event fall within the definition of costs at CPR 44.1(1).

The Master considered that the indisputable purpose of the 2013 reforms was to establish a general rule that ATE premiums are not recoverable under any order for costs, except in limited and specific circumstances. On close reading of the relevant legislation, the Master's interpretation did not allow that a costs order must make express provision to a recoverable ATE premium in order for that sum to be recovered; indeed, the exact opposite was true. In other words, the Master's conclusion on the Regulations was that they provided that a costs order in such cases will permit a claimant to recover the premium *unless* the order makes express provision to the contrary.

In any event, the Master found no basis for concluding that the No 2 Regulations intended to establish some form of additional requirement for claimants to overcome. There was no need for a new phase of judicial oversight beyond what could already be imposed on assessment (for instance, in circumstances in which a premium had been unreasonably incurred). Further and an in any event, there would be no opportunity for judges to scrutinise the recoverability of ATE premiums in the majority of clinical negligence cases that settle before trial.

What clinched the matter was the Court of Appeal's judgment in *McMenemy v Peterborough and Stamford Hospitals NHS Trust* [2017] EWCA Civ 1941 (a claim which, on its facts, had also settled following acceptance of a Part 36 offer). That decision "***could not be clearer***" in determining that in the context of a claim to which the No 2 Regulations apply, 'costs' includes an ATE premium, and an order for costs is an order for payment of an ATE premium. As the Claimant had argued, any other conclusion would give rise to consequences wholly at odds with the intention of allowing ATE premiums to be recovered in prescribed circumstances.

Master Leonard expressly disagreed with the conclusions reached by the author of the commentary at 48.0.4 in the *White Book*. Given Lewison LJ registered his disappointment with the absence of a practice direction dealing with the recovery of ATE premiums in clinical negligence cases, perhaps this latest case might motivate the Rules Committee to think again.

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Legally aided claimants not excluded from QOCS protection: Macaulay v Karim and Croydon Health Services NHS Trust [2022] EWHC 1270 (SCCO)

CLINICAL NEGLIGENCE – PROCEDURE – COSTS – LEGAL AID – QOCS – INTERIM PAYMENTS

By Oliver Brewis

Where a claimant is legally aided in proceedings for clinical negligence, can he or she also receive the further protection of qualified one-way costs shifting? Senior Costs Judge Gordon-Saker answered in the affirmative.

Following a split trial on liability, the Claimant, who was legally aided throughout, obtained judgment against the Second Defendant. However, he failed against the First Defendant. In a ruling on consequential matters, Foskett J ordered the Claimant to pay the First Defendant's costs limited to the issue of breach of duty alone, "***to be payable from any damages awarded to the Claimant at the conclusion of his action against the Second Defendant but […] not to be enforced without permission of the Court***".

The Costs Judge firmly rejected the First Defendant's argument that QOCS did not apply to legally aided claimants. He emphasised that nothing in the rules by which QOCS was introduced suggests it does not apply in these circumstances. By contrast, CPR 44.17 operates expressly to exclude claimants with a pre-commencement funding arrangement; had it been intended to exclude legally aided claimants, it would be logical to anticipate an analogous provision. Moreover, such an outcome did not produce any conceptual difficulty: legal aid costs protection relates to the amount to be paid, whereas QOCS relates to enforcement. No order for damages or interest had been made against which the First Defendant could enforce its costs order under the QOCS regime, since an order for interim payment was not an order for damages for the purposes of CPR 44.14.

Indemnity costs and relief under s.33 of the Limitation Act 1980: Aderounmu v Colvin [2022] EWHC 637 (QB)

CLINICAL NEGLIGENCE – PROCEDURE – COSTS – LIMITATION – CAPACITY TO LITIGATE – DATE OF KNOWLEDGE – S.33 LIMITATION ACT 1980 – INDEMNITY COSTS

By Oliver Brewis

A preliminary issue trial had been required to determine whether the Claimant had capacity to litigate, his date of knowledge under s.14 of the Limitation Act 1980, and (if primary limitation had expired) whether the Court should nevertheless exercise its discretion to allow the claim to proceed pursuant to s.33. The Claimant lost on the first two issues but succeeded on the third.

In this subsequent costs judgment, the Court endorsed the Claimant's contention that he should be awarded 70% of the costs of the preliminary issue trial to reflect the fact he won overall. However, it declined to award costs on the indemnity basis; there had been nothing out of the ordinary or unreasonable about the Defendant's conduct in resisting the relief sought by the Claimant under s.33 of the Act. The Claimant's failure to provide his experts with full medical and immigration records, which increased the costs of the preliminary issue, meant the remaining 30% should not be costs in the case.

Applying *Eastman v London Country Bus Services Ltd* [1985] 1 WLUK 157, the Court further rejected the Defendant's contention that the Court should make an issue-based costs order, awarding the Claimant the costs of the s.33 issue alone: the single statutory regime governing limitation in claims for personal injury and death meant that capacity, date of knowledge and s.33 could not reasonably be regarded as discrete issues; and, in any event, in the instant case the issue of capacity was inextricably linked to the remaining issues.

Relief from sanctions after failure to give notice of a CFA with success fee: EXN v East Lancashire Hospitals NHS Trust and Another [2022] EWHC 872 (QB)

CLINICAL NEGLIGENCE – PROCEDURE – RELIEF FROM SANCTIONS – SUCCESS FEES – CFA NOTICE REQUIREMENTS

By Oliver Brewis

The Claimant, who was born in 2011, suffered from severe cerebral palsy as the result of admitted negligence by the Defendants. On 6 March 2012, a CFA was entered into on her behalf. On 17 April 2012, the Claimant's solicitors informed the First Defendant she was "***funded by way of a Conditional Fee Agreement***"; no mention was made of a success fee.

According to the rules then in place, a party entering into CFA with success fee was required to "***inform the other parties about this arrangement as soon as possible and in any event […] within seven days of entering into the funding arrangement concerned***" (Practice Direction – Pre-Action Conduct, paragraph 9.3). CPR 44.3B(1) precluded recovery of any additional liability for a period during which a party failed to provide required information about a funding arrangement.

At first instance, the District Judge declined to grant relief from sanctions. On appeal, Turner J refused to disturb his conclusion that the breach had been serious and without good reason. However, it was appropriate to grant relief from sanctions under the third stage of *Denton v TH White Ltd* [2014] EWCA Civ 906: the Defendants "***well knew***" that the CFA referred to in April 2012 would have provided for a success fee, since it would have been "***wholly irrational***" for solicitors to take on such a case without such an arrangement in place. Contrary to the District Judge's conclusions, no prejudice could be attributed to the breach, and it was appropriate to exercise the discretion afresh.

FUNDAMENTAL DISHONESTY

Court rejects fundamental dishonesty allegations and awards Claimant over £970k: Preater v Betsi Cadwaladr University Health Board (unreported, August 2022)

CLINICAL NEGLIGENCE – FUNDAMENTAL DISHONESTY – EXPERT EVIDENCE – COSTS

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In *Preater*, the Court rejected the Defendant Health Board's contention that a claim was fundamentally dishonest on the basis that the Claimant had failed to disclose that she had carried out small amounts of paid work post-injury and exaggerated her symptoms to experts. James Arney KC acted for the Claimant, instructed by Russell-Cooke. Here, he sets out the judgement's implications for claimants' representatives, defendant insurers and experts.

Background

In a clinical negligence claim arising from vaginal mesh surgery in 2014, it was agreed that the 45-year-old claimant suffered a variety of serious symptoms including neuropathic pain, fibromyalgia and the need to self-catheterise. Liability was compromised 85/15 in the Claimant's favour, and the case proceeded to trial in respect of quantum.

18 months before trial the Defendant amended its defence to plead fundamental dishonesty ('FD'). The defendant's allegations focussed on: -

- The claimant's failure to disclose offering beauty treatments over a period of 6 years post-accident;
- Accusations that she had exaggerated symptoms to experts; and
- Alleged inconsistencies arising from social media material and surveillance footage.

The Outcome

The Judge found that the Claimant was not dishonest, accepting that she had made very little income (about £3,000 pa) from performing beauty treatments, and accepting that the Claimant had not considered this to be 'work' comparable to her successful pre-accident career in marketing (earning £40,000 pa or more).

The Court also found that the Claimant had a fluctuating pain condition which she presented to experts at its worst, and in respect of which she answered the questions that the experts put to her.

The Judge did not go on to consider in the alternative, whether any dishonesty would have been fundamental, or whether to deprive the Claimant of her award would have amounted to a substantial injustice.

The Court's award included over £½ million for future loss of earnings calculated by reference to the Ogden 8 methodology.

The award also included Part 36 penalties for the Claimant having beaten her own Part 36 offer made in February 2021. Penalties included additional damages of over £68,000, interest on damages at 7.5% above base rate amounting to over £40,000, an indemnity costs order and interest on costs (again at 7.5% above base).

Lessons to be Learned

The judgment offers valuable lessons in the need to 'drill down' to the detail beneath the superficial impression created by the material that the Defendant had obtained. In this instance, Defendant experts had not been asked to reconsider their opinions by reference to the Claimant's explanations, or the opinions of other experts.

The case also offers guidance, of particular value in chronic pain cases, as to the need to consider symptoms by reference to good, average and bad days. In this instance, the Claimant's range of functionality between good and bad days was substantial. Not distinguishing between these differing scenarios risks failing properly to understand a claimant's injuries and resultant needs. In FD cases, such a failing can be fatal to the allegations being relied upon.

In addition, the judgment serves as a warning to experts that if they choose to enter the arena of commenting on surveillance material and allegations of dishonesty, they must do so in a considered and balanced way. In dismissing the Defendant's allegations of dishonesty, the Court was critical of several Defendant experts on whose opinions the Defendant relied in advancing its FD case. Failings included reaching beyond their fields of expertise, inaccuracies, unbalanced opinion, being "***blinkered***" in their approach and "***potentially very misleading***". Paragraph 127 of the judgment provides a detailed summary of the experts involved and the court's assessment of their evidence.

This case also serves as a further reminder of the high stakes involved when FD is alleged. The Claimant faced the prospect of receiving no damages despite her conceded serious symptoms, with the spectre of committal proceedings that may have followed. Once the FD allegations had been made, the focus of the litigation shifted inevitably towards those allegations, which took up the vast majority of Court time at trial. High stakes come at a cost, with the Claimant's cost budget being increased by about £100,000 to reflect the seriousness of the allegations and the additional work required to meet them.

The case also illustrates the challenge in FD cases for claimants and defendants respectively is to retain sufficient attention on presenting/challenging the quantum issues, notwithstanding the distraction caused by the FD issues.

Whilst each of these cases turns on its own facts, the judgment offers valuable lessons for claimants' representatives (when their clients are faced with FD allegations), defendant insurers (considering alleging FD) and experts (when instructed to consider FD allegations) alike.

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Clinical negligence settlement following failure to offer suitable alternative treatment: T v Guy's & St Thomas' NHS Foundation Trust

CLINICAL NEGLIGENCE – SETTLEMENT – MONTGOMERY – REASONABLE ALTERNATIVE TREATMENT

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Lionel Stride (instructed by Emma Doughty at Slater & Gordon) represented the Claimant in a High Court *Montgomery* consent case arising out of the alleged failure to offer reasonable alternative treatment in the form of carotid stenting rather than a carotid endarterectomy in circumstances where he had already suffered a partial hypoglossal injury. Consequently, during the procedure, the Claimant suffered a second hypoglossal injury that caused complete tongue paralysis, loss of speech and inability to swallow, immediate cardiac arrest (caused by his paralysed tongue blocking his airways and leading to hypoxia), the need for a tracheostomy, laryngoscopy and the insertion of a PEG feeding tube. The injury left him unable to communicate verbally, permanently fatigued and with associated respiratory issues. He had retired prematurely and was living a far more isolated life due to his difficulty communicating.

Background

The Claimant suffered from bilateral carotid stenosis for which carotid endarterectomy ('CE') is the standard recommended procedure. As the stenosis was worse on the left, he initially underwent a left CE in June 2015, which was successful in reducing his stroke risk but caused a partial left hypoglossal nerve injury. This caused the Claimant some minor difficulty but he remained able to work, verbally communicate and otherwise live a full life. Months later, after presenting with symptoms on his right side, he was advised to undergo a right CE to further reduce the stroke risk.

Despite having suffered a previous hypoglossal nerve injury, the Claimant was not given any other option for surgery. In particular, he was not informed that a recognised alternative treatment would be carotid stenting ('CS'), which carried a slightly higher stroke risk but no risk of a second hypoglossal injury. The Claimant therefore went ahead with a right CE. After suffering a second, catastrophic hypoglossal injury that could have been avoided, he claimed that he had not been properly consented for the surgery because of the failure to inform him of the availability of a reasonable alternative treatment in the form of CS (i.e., applying the principles set down in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11).

The Defendant denied liability, contending that CS was not a reasonable alternative treatment because it carried a much higher stroke risk; was not offered by or available to practitioners at the treating hospital; and transferring the Claimant to another hospital would have caused life-threatening delay. In addition, the Claimant was required to prove that he would have undergone CS if offered (given the higher stroke risk). Quantum also remained heavily in dispute, with the Defendant challenging amongst other things his earning capacity and likely retirement age; whether he reasonably needed ongoing assistance, provision for private transport and adapted accommodation as a result of his respiratory issues and consequential fatigue.

The claim settled at a JSM for £800,000 a month before trial. Although no formal concessions were made, the settlement sum reflected the Claimant's evidence that he should have been treated as a non-standard case given his original hypoglossal injury; that he would have chosen CS if offered, thereby avoiding any risk of a second hypoglossal injury; and that his consequential injuries had caused permanent disability that would have resulted in him being awarded a high proportion of his pleaded case at the upcoming trial. It had been critical in this case that: -

a. The Claimant's vascular expert had addressed the pros and cons of both procedures in detail, explaining fully why, in his view, it was necessary to offer the alternative treatment (CS), and why the Claimant might have accepted such an alternative; and,

b. The Claimant himself had been consistent throughout in his evidence that he had been so terrified of a second hypoglossal injury that he would have accepted a much higher stroke risk from any substitute procedure that avoided that possibility.

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Clinical negligence settlement following retinopathy of prematurity ('ROP'): JXD v University Hospitals Bristol & Weston NHS Foundation Trust

CLINICAL NEGLIGENCE – SETTLEMENT – EXPERT EVIDENCE – RETINOPATHY OF PREMATURITY

By James Arney KC
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James Arney KC was instructed on behalf of the Claimant by Alison Hills at Slater & Gordon in this challenging clinical negligence claim. The Claimant was born prematurely at just 26 weeks, giving rise to significant non-negligent disabilities including cerebral palsy, epilepsy, and mobility and cognitive impairment. The Claimant alleged that due to the Defendant's negligence in failing to diagnose and treat his aggressive ROP sufficiently early, he had also been rendered totally blind. The Defendant made no admissions, disputing both breach of duty and causation.

Liability issues included: -

i. *The extent to which regard should have been had to ROP research which had not yet been integrated into national guidelines.* National guidelines in force at the material time in 2006 required screening of vulnerable babies "***at least every two weeks***". Whilst 2003 research indicated that more frequent examinations would be appropriate, changes reflecting this research were not introduced into the national guidelines until 2008. The Defendant maintained that a responsible and logical body of practitioners would have continued to follow the prevailing national guidelines, advocating a two-week period for review.

ii. *How quickly the Defendant should have treated once ROP had been detected.* After findings on screening which were suggestive of ROP, the Defendant recorded merely that the Claimant should be re-examined after a further 7 days. The Claimant alleged that this was too slow, with the screening findings dictating that urgent action was required. Insofar as anyone else needed to be consulted, this should have happened as a matter of extreme urgency. On the facts, breach of duty at this stage is likely to have been established.

iii. *Whether by then the ROP was so advanced that the Claimant's sight would not have been saved even if treated promptly.* By this contention the Defendant sought to negate any finding of breach in respect of (ii) above. The main thrust of the Claimant's response to it, supported by his expert evidence, was that ROP does not emerge and become untreatable within a period of 2 weeks. Thus if the ROP was genuinely untreatable by the time of the later screening, it would also have been detectable at the previous screening, indicating that evidence of ROP was missed on that earlier occasion.

Quantum issues included: -

i. Demonstrating the *extent* to which the Claimant's sight had been damaged by the Defendant's breach, the expert evidence having acknowledged that *some* damage ("***very severe compromise***") to the Claimant's sight was inevitable in any event.

ii. The challenge of valuing care, case management, treatment and therapies, accommodation, general damages and miscellaneous claims in circumstances where the Claimant's non-negligent disabilities in any event left him wholly dependent on others. On the expert and lay witness evidence, the Claimant's blindness impacted on his mobility and communication, exacerbated frustration and behaviour, and intensified some of his care needs. Many of the blindness-related issues were qualitative rather than quantitative in nature, reducing the Claimant's ability to assist carers with many tasks, reducing his access to visual stimulation and rendering his interaction with others less fulfilling.

Balancing both liability and quantum issues, and with a liability trial imminent, global settlement was secured at £800,000, which the Court subsequently approved.

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