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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 fifth issue of the TGC Clinical Negligence Newsletter.

Preparation for this issue has, unsurprisingly, involved a careful wait for the Supreme Court's decision in *Paul and anor v Royal Wolverhampton NHS Trust* [2024] UKSC 1. After an anxious eight-month delay between the appeal hearing and the judgment hand-down, the Court has produced a definitive response to the appellants' request to clarify the circumstances in which recovery is possible after a claimant suffers psychiatric injury after witnessing the consequences of clinical negligence in a close relative. In a decision which will bitterly disappoint claimants but be welcomed by hospital trusts, the Court has precluded recovery in almost every case, leaving open the possibility of success in only the narrowest of circumstances. It has also provided helpful clarification of the test to be applied in non-clinical cases.

As well as the landmark decision in Paul, the past months have brought further analysis of issues relating to informed consent and, in particular, the proper determination of what constitutes a reasonable alternative treatment. As Helen Nugent explains in the article which opens this issue, in *McCulloch and ors v Forth Valley Health Board* [2023] UKSC 26 the Supreme Court has confirmed the supremacy of the Bolam 'professional practice' test in determining what constitutes a reasonable alternative treatment. The three articles that follow expand on further aspects of the recent judicial treatment of the issue of informed consent, including the importance of pleading the relevant breach of duty, the information to be provided to patients facing alternative options for surgery, and the difficulty of proving factual causation where a claimant's oral evidence on preferred treatment if properly consented is equivocal.

Among the broader issues on breach of duty and causation addressed in this issue are the circumstances in which medical notes might be found to have been falsified; the need to ensure experts do not avoid key issues raised by their opposite numbers; the (inevitable) difficulty of assessing witness evidence relating to events which occurred over a decade ago; and the circumstances in which the Court will accept that a claimant's surgery should have been undertaken in preference to that of another patient. Two important cases addressing psychiatric and psychological negligence, *Zgonec-Rozej (on her own behalf and as executor of the estate of Jones) and ors v Pereira and ors* [2023] EWHC 1770 (KB) and *GKE v Gunning* [2023] EWHC 332 (KB), are also summarised and the key implications for practitioners drawn out.

In the final section of the newsletter, James Arney KC provides articles on two recent judgments in *CCC v Sheffield Teaching Hospitals NHS Foundation Trust* [2023] EWHC 1770 (KB) and [2023] EWHC 1905 (KB), which address issues including the need for waking versus sleeping night carers, the shortcomings of expert care

evidence, the test for proportionality in relation to hydrotherapy provision, and the treatment of a carer's 'but for' accommodation.

Turning to procedural matters, I summarise *Bayless and ors v Norfolk and Norwich University Hospitals NHS Foundation Trust* [2023] EWHC 2986 (KB), a costs judgment arising from a failed application to strike out a second claim after a failure to secure approval for an intended settlement involving two minors.

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: -

Secondary Victim Claims

- I open the issue with a detailed review of the Supreme Court's reasoning in dismissing the conjoined appeals in *Paul and anor v Royal Wolverhampton NHS Trust* [2024] UKSC 1.

Informed Consent

- To open the issue, *Helen Nugent summarises McCulloch and ors v Forth Valley Health Board (Scotland)* [2023] UKSC 26, an important Supreme Court decision that clarifies the role of professional judgement in identifying appropriate alternative treatments.

- In his account of *Bilal and anor v St George's University Hospital NHS Foundation Trust* [2023] EWCA Civ 605, Anthony Johnson looks at the key importance of the requirement to ensure all particulars of negligence relied upon are fully pleaded.

- In his exploration of *Snow v Royal United Hospitals Bath NHS Foundation Trust* [2023] EWHC 42 (KB), Marcus Grant sets out some of the key implications of the judgment where it is alleged that there has been a failure to alert a claimant to an alternative procedure and to obtain appropriate consent.

Breach of Duty and Causation

- Turning to more general issues of liability, summarising *Graham (a child) v Altaf* [2023] EWHC 156 (KB), Anthony Johnson considers the difficulty faced by a judge in finding facts based on witness evidence of events from over a decade ago.\

- In my account of *Astley (a minor) v Lancashire Teaching Hospitals NHS Foundation Trust* [2023] EWHC 1921 (KB), I examine the circumstances in which Martin Spencer J concluded that the foetal heart rate record from a key section of the Claimant's negligent delivery was falsified by the midwife responsible for the birth.

- Emma-Jane Hobbs then examines the Judge's careful treatment of the mechanism of surgical injury in *OXR (a child) v Mid and South Essex Hospital NHS Foundation Trust* [2023] EWHC 2006 (KB), in which a child sustained permanent conductive hearing loss as a result of a substandard attempt to extract a glass bead from the ear canal.

- Concluding the section, Rochelle Powell looks at *Middleton (personal representative of Middleton) v Frimley Health NHS Foundation Trust* [2022] EWHC 2981 (KB), in which the key issue for the Court was whether a decision to delay the revascularisation of the Deceased's leg had amounted to a breach of duty in circumstances where individual clinical judgment was key.

Psychiatric Negligence

- In my summary of *Zgonec-Rozej (on her own behalf and as executor of the estate of Jones) and ors v Pereira and ors* [2023] EWHC 1770 (KB), I examine some of the key difficulties of establishing a causative breach of duty in a psychiatric context (especially where, as here, a patient has tragically taken his own life).

- In her account of *GKE v Gunning* [2023] EWHC 332 (KB), Rochelle Powell examines a successful recent claim against a treating psychologist for negligent abuse of trust based on inappropriately sexualised comments made within the therapeutic relationship.

Quantum

- James Arney KC examines *CCC v Sheffield Teaching Hospitals NHS Foundation Trust* [2023] EWHC 1770 (KB) and [2023] EWHC 1905 (KB), two significant recent judgments addressing key issues relating to quantum in high-value cerebral palsy cases. His first article summarises the quantum judgment, whilst his second addresses consequential matters including a leapfrog appeal to the Supreme Court.

Procedure

- Turning to a brief but interesting procedural decision, I analyse *Bayless and ors v Norfolk and Norwich University Hospitals NHS Foundation Trust* [2023] EWHC 2986 (KB), in which the defendant Trust unsuccessfully contended no order for costs should be made after it withdrew a strike-out application.

Committal for Contempt

- Oliver Brewis summarises *Nottingham University Hospitals NHS Trust v Bogmer* [2023] EWHC 1724 (KB), in which the Claimant in prior clinical negligence proceedings was found guilty of contempt of court on the basis of statements made on the nature of his alleged restrictions that were contradicted by agreed expert evidence.

Fixed Recoverable Costs

- To conclude this issue, Oliver Brewis addresses the Government's forthcoming introduction of a Fixed Recoverable Costs regime for clinical negligence claims with a damages value between £1,501 and £25,000, which it is intended will apply to all such claims notified from 4 April 2024 onwards.

The end of the road for secondary victim claims following medical negligence: *Paul and anor v Royal Wolverhampton NHS Trust, Polmear and anor v Royal Cornwall Hospitals NHS Trust and Purchase v Ahmed* [2022] EWHC 260 (QB)

CLINICAL NEGLIGENCE – BREACH OF DUTY & CAUSATION – CLINICIANS' DUTY OF CARE – PSYCHIATRIC INJURY – SECONDARY VICTIMS – ALCOCK REQUIREMENTS – LEGAL SIGNIFICANCE OF ACCIDENT – PROXIMITY

By Lionel Stride
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After an anxious wait, the Supreme Court has handed down its long-awaited decision in the three conjoined appeals in Paul, Polmear and Purchase.[1] In doing so, it has brought to an end decades of uncertainty by decisively precluding recovery for almost all claimants who have suffered psychiatric injury after witnessing the consequences of substandard care in their close relatives. Lionel Stride examines the Court's reasoning and looks at the practical implications of this landmark judgment.

The Facts

Each of the cases arose from the tragic death of a close family member which had been witnessed by the claimants. Thereafter, each suffered psychiatric injury and sought to recover as a secondary victim under the principles set out by the House of Lords in *Alcock v Chief Constable of South Yorkshire Police*.[2]

In *Paul*, the deceased had suffered a cardiac arrest and collapsed whilst out shopping with his young daughters. It was alleged that the defendant had been negligent in failing to arrange coronary angiography during his admission to hospital 14 months previously.

In *Polmear*, the deceased was a 6-year-old girl who was suffering from undiagnosed pulmonary veno-occlusive disease. As a result of the disease, in July 2015 she died in the presence of her father; her mother witnessed the unsuccessful attempt to resuscitate her. The defendant admitted that failure to diagnose the disease by mid-January 2015 had been a breach of duty.

Ms Purchase was a 20-year-old who died from severe pneumonia after attending an out-of-hours clinic 3 days prior. Her condition was not diagnosed and the final stages of her decline and death were witnessed by her mother and younger daughter.

1. [2022] EWCA Civ 12.
2. [1992] 1 AC 310.

The Decision Below

The key issue for the Court of Appeal was whether a claimant who has witnessed the wrongful death or injury of a loved one is entitled to recover from a negligent clinician responsible for this outcome. In all three cases under appeal, the defendant had applied to strike out the claim on the basis that it could not succeed as a matter of law. The Court of Appeal unanimously concluded that recovery was precluded on the basis that there had been a delay between the negligent act or omission and a horrifying event caused by it. In this regard, the Court held itself bound by *Taylor v A Novo,*[3] itself granting permission to appeal to the Supreme Court.

The Supreme Court's Reasoning

In a judgment with which six of a seven-justice panel agreed [4], Lord Leggatt and Lady Rose began by situating recovery as a secondary victim within the taxonomy of exceptions to the common law rule that a claimant has no legally compensable interest in the physical well-being of another. Thereafter, the Justices characterised the 'critical question' at issue in the appeal as:

> ***'…whether a doctor, in providing medical services to a patient, not only owes a duty to the patient to protect the patient from harm but also owes a duty to close members of the patient's family to take care to protect them against the risk of injury that they might suffer from the experience of witnessing the death or injury of their relative from an illness caused by the doctor's negligence': [22].***

There were, the Court emphasised, 'two ways' of approaching this question, only the second of which had formed the focus of the claimants' submissions: firstly, by considering the *'basic legal principles which determine the scope of the duty of care owed by a doctor and the persons to whom this duty is owed'*; and, secondly, by examining cases in which the courts have previously permitted recovery by claimants who have suffered injury in connection with the death or injury of another person: [23]. The key question with the latter approach was whether the rules developed in those cases applied, or could by permissible incremental development be extended to apply, in a medical context.

The Accident Cases: *McLoughlin, Alcock and Frost*

Following a detailed review of the House of Lords' decisions in *McLouglin v O'Brian*,[5] *Alcock and Frost v Chief Constable of South Yorkshire*, [6] the Court emphasised their limited applicability in a clinical context. Each fact-pattern had involved an 'accident', defined as an unexpected and unintended event causing injury (or its risk) by violent external means to one or more primary victims: [53]. This was to be distinguished from a 'medical crisis', which was properly characterised as *'the suffering or death of [a] relative from illness'*.

Rejecting the claimants' contention that the language used in *Alcock* was wide enough to encompass such a crisis, the Court noted the repeated use of the term 'accident' within both *Alcock and Frost*. It was, the Justices held, 'fallacious' to 'fasten selectively' on particular forms of words used within speeches and to deploy those quotations out of context in support of an argument which had not been in the contemplation of the court: [54].

The Medical Negligence Cases: *Taylor v Somerset,*[7] *Sion,*[8] *Walters,*[9] *Shorter* [10] and *Ronayne* [11]

The Court then summarised and addressed the small body of case law in which secondary victim claims have been brought in a clinical context. The Justices emphasised that, in all cases except *Taylor*, the court had not been required to determine whether in principle the rules developed in accident cases ought to be applied in a medical context; in *Walters, Shorter* and *Ronayne* it was simply assumed that they did. Rather, the judgments in all these cases focused on the 'sudden shock' and *'sudden appreciation of a horrifying event'* elements alluded to in *Alcock*.

Significantly for practitioners dealing with 'accident' claims, the Justices held that neither element is in reality required to found a valid claim. Rather, the Court emphasised at [74] that *'it is sufficient for a claimant who was present at the scene of the accident […] to show that there is a causal connection between witnessing [the event of injury] and the illness suffered'*. There is no additional requirement to demonstrate the mechanism by which the illness was induced. Despite intimations to the contrary in subsequent case law, *Alcock and Frost* do not establish a requirement for a *'sudden shock to*

3. [2013] EWCA Civ 194.
4. Lord Burrows' dissenting judgment is not addressed in this article but itself repays careful attention.
5. [1983] 1 AC 410.
6. [1999] 2 AC 455.

the nervous system'. [78].

Novo and the Reasoning of the Courts Below

Having clarified the significance of Alcock itself, the Court then turned to address the significance of Novo, the case by which the Court of Appeal had held it was precluded from permitting recovery in the present case.

In Novo, the claimant's mother had sustained injury in a workplace accident which was the result of admitted negligence. During a period of apparent recovery, she collapsed and died due to a pulmonary embolism attributable to the accident; this was witnessed by the claimant, who then developed PTSD. Whilst the claimant had been permitted to recover at first instance, the Court of Appeal allowed the defendant employer's appeal on the basis that there had been insufficient proximity between the claimant and her mother at the time of the accident. It emphasised that the contrary stance would mean the claimant could have recovered months or years after the accident.

Whilst the Supreme Court agreed with the Court of Appeal in *Paul* that the appeals could not succeed unless *Novo* was wrongly decided, the Justices disagreed with the lower court as to *what* was decided in *Novo*. Properly understood, the Supreme Court held, *Novo* does not indicate that the length of time between the defendant's negligent act or omission and the horrific event witnessed by the claimant is a material factor. Nor does it support the need for the horrifying event to involve the *'first manifestation of the damage'* which it was the defendant's duty to prevent, as was contended by counsel for the *Paul* [12] claimants. Crucially, the basis of the decision in *Novo* was instead that the claim could not succeed because *'the claimant was not present at the scene of the accident or its immediate aftermath and the event which she witnessed was not an accident'*: [104].

The Legal Significance of an Accident

The Court's analysis of Novo forms the prelude to the most crucial section of the judgment: that in which it articulates the distinct legal signifcance of witnessing an accident as opposed to a medical crisis. The Court highlighted three ways in which witnessing an accident is legally significant and justifies a discrete category of claims by secondary victims.

First, an accident is (by definition) a discrete event which happens *'at a particular time, at a particular place, in a particular way'*: [108]. Second, witnessing an accident involving a close family member is likely to be a disturbing and upsetting event even if that person escapes unharmed and all the more so if he or she is injured or killed. Third, in such cases it is often *'difficult or arbitrary'* to distinguish between primary and secondary victims.

By contrast, in 'non-accident' cases, there is often no discrete event comparable to an accident: [112]. Second, in non-accident cases where the claimant has witnessed the injury or illness of a close family member, the extent to which the experience is traumatic is variable. Third, where the claimant was not present at the scene of any accident, *'no question can arise of the claimant suffering psychiatric harm through fear for her own safety or bodily integrity'*: [114].

For these reasons, the majority held that no analogy can reasonably be drawn between the situation addressed in the *McLoughlin, Alcock* and *Frost* triad of cases and that involved in a medical crisis. Further, the extension of allowable claims by secondary victims beyond accidents would give rise to unacceptable differences in treatment between different categories of claimant (for instance, the denial of compensation to a mother whose daughter had been killed on the road but not to a daughter who witnessed her parent die from an avoidable heart attack). Finally, it was undesirable for decisions on end-of-life care to be complicated by an increased risk of liability as a result of family members seeing and remaining with a patient.

It follows that *Walters*, the only reported case in which a secondary victim claimant has succeeded in recovering in a clinical context, was wrongly decided and should not be followed.

7. Taylor v Somerset Health Authority [1993] PIQR P262.
8. Sion v Hampstead Health Authority [1994] 5 Med LR 170.
9. North Glamorgan NHS Trust v Walters [2002] EWCA Civ 1792.
10. Shorter v Surrey and Sussex Healthcare NHS Trust [2015] EWHC 614 (QB).
11. Liverpool Women's Hospital NHS Foundation Trust v Ronayne [2015] EWCA Civ 588
12. The claimants in the Polmear and Purchase cases did not support such an argument and in both cases the deceased had exhibited significant signs of illness prior to death.

General Principles

In the final section of their judgment, Lord Leggatt and Lady Rose turned back to the general principles governing the existence and scope of a clinician's duty of care in order to test these conclusions. First, they emphasised the essential need for proximity in the relationship between the parties (in addition to foreseeability of harm) in order to justify the imposition of a duty of care. In the present context, the key question was whether a doctor who owes a duty of care to a patient also owes a duty to members of the patient's close family to take care to protect them against the risk of illness from the experience of witnessing a medical crisis arising from the doctor's negligence. In this regard, they concluded at [138]: -

'We are not able to accept that the responsibilities of a medical practitioner, and the purposes for which care is provided, extend to protecting members of the patient's close family from exposure to the traumatic experience of witnessing the death or manifestation of disease or injury in their relative. To impose such a responsibility on hospitals and doctors would go beyond what, in the current state of our society, is reasonably regarded as the nature and scope of their role.'

Whilst the experience of seeing a person die was rarer than it once was, society had not yet reached a point at which individuals could reasonably be expected to be shielded by the medical profession from the experience of witnessing a close family member die from disease. It could not be said that the necessary relationship of proximity was present to justify a duty of care to close relatives, with fatal consequences for secondary victim claims in a clinical context.

Conclusion

Despite the Court of Appeal's tentative suggestion that the law in this area might be revisited, a seven-Justice panel of the Supreme Court has decisively precluded recovery as a secondary victim in almost every case in which a loved one suffers injury as a result of medical negligence. The decision will be a bitter disappointment to claimants, who will be unable to recover as secondary victims save (potentially) in the most unusual of circumstances.

Whilst various stances can be taken on the cogency of the Court's reasoning and the desirability of the outcome reached, the law in this area is now settled. Outside a clinical context, the decision brings further clarity to the test to be applied in accident cases, making plain that sudden shock to the nervous system and sudden appreciation of a horrifying event form no part of the test for recovery.

By Lionel Stride
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The range of reasonable treatment options is an exercise for professional judgement: *McCulloch and ors v Forth Valley Health Board (Scotland)*[2023] UKSC 26

CLINICAL NEGLIGENCE – BREACH OF DUTY – CONSENT – BOLAM COMPLIANCE – ALTERNATIVE TREATMENTS

In McCulloch, the Supreme Court set out conclusive guidance on the interaction between the advisory duty in Montgomery and the 'professional practice' test contained in Bolam. As Helen Nugent explains, the Court confirmed that the assessment of whether an alternative treatment is reasonable and ought to be discussed with the patient is a matter of professional judgement. Affirming the earlier decisions of the Inner House and the Lord Ordinary, the Court held that it is the latter test which applies to determining what constitutes a reasonable treatment.

By Helen Nugent
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Factual Background

The matter arose from alleged mismanagement of Mr McCulloch (the Deceased)'s cardiac condition, pericarditis. It was principally (but not exclusively) alleged by his widow (P)[14] that there had been a failure on the part of the Defendant (D)'s consultant cardiologist, Dr Labinjoh (Dr L), to provide advice about treatment; specifically, the use of non-steroidal anti-inflammatory drugs ('NSAIDs').

The Deceased suffered cardiac tamponade, a condition that occurs when abnormal amounts of fluid accumulate in the pericardial sac; this causes compression of the heart and decreased cardiac output. Idiopathic pericarditis[15] and pericardial effusion were recorded as the causes of his death.

A claim for damages was pursued on the basis that:

i. Dr L ought to have advised the Deceased about the option of treatment with NSAIDs for pericarditis. It was standard practice to prescribe non-steroidal anti-inflammatory medication to treat the condition, and clinical experience demonstrated that it was usually effective in reducing pain and pericardial effusion. C alleged that the use of NSAIDs constituted a reasonable alternative treatment.

ii. Had such advice been given, the Deceased would likely have followed it.

iii. On the balance of probabilities, NSAIDs would have been effective treatment and the fatal cardiac arrest avoided.

14. Pursuer in the Scottish Courts.
15. Inflammation of the lining around the heart.

The Deceased was first admitted to hospital on 23 March 2012 with severe pleuritic chest pains, worsening nausea and vomiting. A working diagnosis of pericarditis was made and initial treatment comprised IV fluids and antibiotics for sepsis. There was a marked deterioration in the Deceased's condition on 24 March 2012, resulting in him being intubated and ventilated on the ICU.

Dr L was first involved in the Deceased's care on 26 March 2012. She was responsible for reviewing the results of the echocardiogram. The Deceased's condition had, by then, improved and his presentation was considered not to be consistent with the earlier diagnosis of pericarditis. He was discharged on 30 March 2012.

She was later involved in the Deceased's care following a re-admission on 1 April 2022. The Deceased presented (again) with pleuritic chest pain. That further involvement comprised a review of the updated echocardiogram and a ward visit. The Deceased denied chest pain. Dr L formed the view that NSAID treatment was not indicated in his case, because of the absence of pain and the fact that there was no clear diagnosis of pericarditis. Having made the decision that NSAIDs did not constitute a reasonable treatment option, she did not discuss the possibility of taking Ibuprofen (or similar medication) with the Deceased. He was discharged on 6 April 2012 without any further cardiology input.

The Deceased suffered a fatal cardiac arrest on the following day.

The Legal Tests

The Supreme Court considered the two key tests for liability in medical negligence claims.

First, the Professional Practice Test: the now well-established test for assessing whether a doctor has been negligent in diagnosing and treating a patient was laid down in Bolam Friern Hospital Management Committee [1957] 1 WLR 582 (qualified by Bolitho v City and Hackney Health Authority [1998] AC 232). The question is whether the doctor acted in accordance with a practice accepted as proper by a responsible body of relevant medical opinion.

Second, the advisory duty: In Montgomery v Lanarkshire Health Board [2015] UKSC 11 the Court concluded that the Professional Practice Test did not apply to the doctor-patient discussion about recommended treatment, possible alternatives and risks of injury. Those were not matters which should be confined to professional opinion, but ought also to involve recognition of and respect for patient autonomy and the patient's right to determine which risks they were prepared to take. A doctor was under a duty to take reasonable steps to ensure that a patient was aware of any material risks involved with recommended treatment, and any reasonable alternative or variant treatments. Emphasis was placed on the need to ensure that the information provided was comprehensible.

The Decisions of the Lower Courts

The Lord Ordinary concluded that the Professional Practice Test applied, drawing a distinction between the role of a doctor to consider treatment options and the duty imposed on a doctor to discuss with the patient the risks of injury associated with recommended treatments. He was conscious not to extend the decision in Montgomery beyond the scope envisaged by the Supreme Court. The decision was, in effect, an endorsement of the earlier ruling in AH v Greater Glasgow Health Board [2018] CSOH 57 – where comparable arguments were advanced by the pursuer.

The Inner Court agreed with the analysis in AH and the conclusions of the Lord Ordinary.

The Reasoning of the Supreme Court

The Supreme Court rejected P's argument. It concluded that the identification of treatments as reasonable alternatives was a matter for medical expertise and professional judgement. It arrived at that conclusion, having regard to:

i. The distinction made in Montgomery between the exercise of professional skill/clinical judgment and the duty to inform.

ii. The two-stage test in Duce v Worcestershire Acute Hospitals NHS Trust [2018] EWCA Civ 1307. [16]

iii. The importance of clinical judgment.

16. The two-stage test being: (i) what risks associated with an operation were or should have been known (a question of expert/professional assessment); and (ii) whether the patient should have been told about those risks by reference to whether they were material. Materiality and the need to inform are matters to be determined by the Court.

iv. The risk of doctor/patient conflict which may arise if a doctor were required to inform the patient about treatment that they did not endorse.

v. The risk of bombarding a patient with information/ defensive medicine, where doctors advise on all possible treatment options, irrespective of number or clinical suitability.

vi. The potential for uncertainty, if the Montgomery duty were extended.

Comment

The decision is a useful reminder of the central liability issues to consider in medical negligence claims and it provides useful clarification on the scope and application of the principles set out in Montgomery. It will no doubt be welcomed by defendants.

In terms of practical points:

i. First, there must be an assessment of the range of reasonable treatment options. That is an exercise for professional judgement.

ii. It remains the case that a doctor cannot confine their advice to treatment modalities that they prefer.

iii. The duty does not extend to informing a patient about treatment options which the doctor does not consider to be reasonable, even if another responsible body of professional opinion may take a different view. Although that excludes the patient from part of the decision-making process, it avoids the task becoming complex and confusing.

By Helen Nugent
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The importance of the particulars of negligence: *Bilal and anor v St George's University Hospital NHS Foundation Trust* [2023] EWCA Civ 605

CLINICAL NEGLIGENCE – BREACH OF DUTY & CAUSATION – INFORMED CONSENT – ALTERNATIVE TREATMENTS – PLEADINGS

By Anthony Johnson
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As Anthony Johnson explains, the Court of Appeal's decision in Bilal emphasises the crucial importance of a claimant fully pleading the relevant Particulars of Negligence. Like McCulloch (above), the judgment also contains a useful analysis of the meaning of 'Montgomery informed consent' in situations where it is alleged that alternative treatments should have been considered.

Background

The personal representatives of the (deceased) Claimant brought a claim alleging that he had suffered spinal cord injury as a consequence of the negligence of the defendant neurosurgeon during elective decompression surgery that had taken place after neurological damage had been suffered during previous emergency surgery. It was alleged that the neurosurgeon had failed to recognise that the pain was of neuropathic origin rather than radicular, failed to differentiate between the causes of pain, failed to recommend alternative treatments, failed to advise properly of the risks of surgery and failed to obtain informed consent.

The trial Judge found for the Defendant on the basis that it had been reasonable to offer the surgery, appropriate advice had been given to the Claimant as to the potential risks of the surgery and the consenting process had been adequate. In rejecting the allegation that it was negligent not to have discussed pain treatment as an alternative, it was noted that the Claimant had expressed reluctance to increase his pain relief medication.

The Court of Appeal's Decision

In dismissing the Claimant's appeal, the Court noted that the primary focus on the appeal had been on the neurosurgeon's failure to ask the deceased how long he had suffered from intercostalgic pain. The judgment of Davies LJ states (at [43]):

> ***"The difficulty for the appellants is that the failure of [the neurosurgeon] to ask this question was not a pleaded Particular of Negligence. It was not an issue raised with the neurosurgical experts prior to trial, as a result neither addressed the absence of the question, nor any consequence of the omission, in their reports nor in their joint statement. It was an allegation that was not put to [the neurosurgeon] in cross-examination, as a result he was given no opportunity to address the issue which the appellants now elevate to the core of this appeal."***

Reference was made to [75] of the judgment of Rimer LJ in Lombard North Central PLC v Automobile World (UK) Ltd [2010] EWCA Civ 20 where he stated:

> ***"It remains a basic principle of our system of civil procedure that the factual case the parties wish to assert at trial must ordinarily be set out in their statements of case ("pleadings"). That is not a principle based on mere formalism. It is essential to the conduct of a fair trial that each side should know in advance what case the other is making, and thus what case it has to meet and prepare for. It is the function of the pleadings to provide that information."***

Considering this in the context of clinical negligence claims, Davies LJ emphasised the following (at [45]):

> ***"The importance of pleadings carries particular weight in clinical negligence claims which can be complex and are dependent on expert evidence. The pleaded allegations of negligence will form the basis of the instructions to the relevant expert, who will then prepare a report. This will be followed by a meeting(s) of experts, the agenda for which will reflect the pleaded particulars."***

Commentary

Whilst none of Davies LJ's guidance will come as a surprise to experienced practitioners in the field, the decision in *Bilal* is a salutary reminder of the potential consequence in a situation where developments in a claim mean that the case that is pursued by the claimant at trial has evolved since it was initially pleaded. Whereas in personal injury cases, many judges are often sceptical of technical 'pleading points' being taken by defendants where both sides are fully aware of the case advanced by the other, it is unlikely that such latitude will be extended in clinical negligence where the pleaded allegations are fundamental to the progression of the case.

Moreover, it logically follows from [45] (which is reproduced above) that, if a claimant finds themselves in a position where their case has evolved beyond that which was pleaded, a prompt application to amend the Particulars of Claim should be made. Depending upon the content of the expert evidence on breach and causation, it may well be necessary for a further round of expert evidence and/or a supplementary witness statement from the claimant or other witnesses.

Insofar as some case managing judges may have difficulty with the cost and delay associated with additional procedural steps having to be taken, claimants would be astute to take the judge to the judgment in *Bilal* to emphasise the importance of such steps. It is arguably far better that the claimant brings the judgment to the Court's attention at an application hearing than that the defendant is able to rely upon it to defeat the case at trial.

The other most notable aspect of the judgment is the analysis of informed consent pursuant to *Montgomery v Lanarkshire Health Boar*d [2015] UKSC 11. The Judges analysed the interaction between *Montgomery and Bolam v Friern Hospital Management Committee* [1957] 1 WLR 482 in a manner that is entirely consistent with the Supreme Court's recent decision in *McCulloch v Forth Valley Health Board* [2023] UKSC 26 (discussed elsewhere earlier in this edition by Helen Nugent).

The Court emphasised that *Mongomery* draws a distinction between two aspects of a clinician's role, i.e. an assessment of treatment options *(Bolam)*; and an assessment of what risks and treatment should be explained to the patient because they are material *(Montgomery)*. At [66] of the judgment, Nicola Davies LJ goes on to state:

> ***"The distinction between the two roles of the clinician is contained within the judgment of Montgomery at para 87 where it is stated that: "the doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments." I accept that "reasonable" in respect of the assessment of alternative or variant treatments encapsulates the Bolam approach. As to material risks, that is the element of materiality which is to be judged from the perspective of the patient i.e. Montgomery. In my judgment it is for the doctor to assess what the reasonable alternatives are; it is for the Court to judge the materiality of the risk inherent in any proposed treatment, applying the test of whether a reasonable person in the patient's position would be likely to attach significance to the risk. Thus the Judge at [93] was correct to apply Bolam and to conclude that his assessment reflected the guidance set out in para 87 of Montgomery."***

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Surgical candour, experience, and informed consent: *Snow v Royal United Hospitals Bath NHS Foundation Trust* [2023] EWHC 42 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY & CAUSATION – INFORMED CONSENT – ALTERNATIVE TREATMENT – PROVISION OF INFORMATION – SURGICAL TRAINING – CANDOUR

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In Snow, the High Court considered in detail the requirements relating to informed consent where two competing surgical procedures are, or should be, offered. As Marcus Grant explains, the judgment will be of interest to all practitioners and clinicians who deal with such issues.

The Claimant ('C') claimed damages for clinical negligence against the Defendant ('D') health authority for failing to obtain his fully informed consent for a laparoscopic low anterior resection of rectal cancer with a 'trans-anal (Ta) total mesorectal excision' ('TaTME') and for negligent intra-operative care. He contended that if adequately consented, he would have chosen to undergo a TME, not a TaTME, and would therefore have avoided the complications that befell him following the latter procedure, namely: impotence, urinary urgency and incontinence, faecal urgency and incontinence, exacerbation of 'lower anterior resection syndrome' and psychological sequelae.

D admitted it failed to consent C adequately but denied that the narrow failings had any causal impact on the outcome.

The 135-page judgment from HHJ Richard Roberts, sitting as a Judge of the High Court, is a model of forensic analysis of the factual considerations underpinning the courts' approach to the evolving law on consent. It is a must read for all clinicians and has several useful takeaways for legal practitioners that are applicable to consent jurisprudence.

Some of these are highlighted below with paragraphs in the judgment identified.

Whilst failure to follow NICE guidance is not prima facie evidence of negligence, failure by a defendant to justify that failure with a cogent explanation would give rise to such an inference (see also *Price v Cwm Taf University Health Board* [2019] PIQR P14, at P22: [69]).

D's failure to provide the following documents on disclosure was prima facie a breach of its duty of care to C:

1. A policy on information to be given to patients undergoing a TaTME, including the provision of written information, for which NICE had already provided a clear working model.

2. A pro forma to record patient selection, which should be copied to the patient's records.

3. A policy to keep records of patients undergoing a TaTME and for regular reviews.

4. A training policy to include supervision and mentoring or proctoring (at [73]).

The Court reviewed carefully the academic and practical experience of the surgeons performing the complex procedure when assessing the issue of consent (see [80]).

The Court found that the need for training, mentoring and supervision before introducing new surgical operations and procedures was an integral part of the NICE Guidelines in place prior to the operation, and should not have been overlooked by D ([83]).

The Court found that D's colorectal medico-legal expert damaged his credibility by attempting to assert that because training, supervision and mentoring were not referred to explicitly in NICE documents, that they were not requirements that needed to be adhered to. This assertion was described by the Court as '*flying a kite*' ([84]).

The Court found it was negligent of the D health authority to fail to provide the surgeons with a mentor and *'concerning'* that D suggested that a mentor was unnecessary ([86]).

It was common ground that D's surgeons were only carrying out their second TaTME, and that there was no supervision. That was negligent ([88]).

The Court was critical that there was no written record of patient selection for the TaTME operation. D's surgeon was negligent in characterising it as a mere *'extension to a laparoscopic TME'*. The Court rejected that assertion ([95]).

The Court was critical of the MDT meeting note. It did not record that a decision was made to carry out a TaTME operation. There was no record of the care plan. There was no record of alternative surgical procedures discussed (namely TME, carried out as a laparotomy or laparoscopy). There was no record of C having been carefully selected for the procedure and there were no names of the attendees of the MDT meeting. All were negligent failures ([99]).

D accepted that it was substandard to consent a patient on the day of the operation ([101]).

The Court found that the operation should have been cancelled to enable C to be properly consented, especially bearing in mind that NICE had stated that special governance should be in place for a TaTME, and extra care taken in the consenting process as a consequence of the lack of evidence as to the efficacy and safety of the procedure ([103]).

The Court made findings of wide-ranging negligence with regard to failure to consent; specifically:

1. C should have been advised that NICE considered the evidence on the safety and efficacy of the procedure was time-limited, both in quantity and quality.

2. C should have been provided with a copy of the patient guidance.

3. C should have been informed that the surgeon had only carried out one such procedure before.

4. C should have been informed of alternative operations he could have undergone, specifically A TME laparotomy, and

5. C should have been informed of all the risks identified by NICE in their 2015 Interventional Procedures guidance. ([111])

The Court was *'deeply concerned'* with the lack of candour in D's treating surgeon's statement about the nature and extent of his failure properly to consent the patient. That lack of candour aggravated the underlying failures (see [112]).

The Court was critical of the D's treating surgeon's operation note, which was *'inadequate for governance purposes, research or investigation'* ([116]).

The Court was unimpressed with D's counsel's submission that the paperwork inadequacies were *'a matter of form filling'.* The Court found it was *'inappropriate to trivialise it'* in that way ([121]).

D, its treating surgeon and its medico-legal expert sustained criticism in the judgment that was excoriating, and a useful teaching exercise to clinicians and hospital management in future clinical situations revolving around the issue of properly consenting patients advised to undergo complex and novel procedures.

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Establishing a causative breach of duty: *Graham (a child) v Altaf* [2023] EWHC 156 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY & CAUSATION – MEDICAL CAUSATION – WITNESS EVIDENCE – GESTMIN APPROACH

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The decision of Judge Sephton KC (sitting as a High Court Judge in the Manchester District Registry of the King's Bench Division) in Graham is a useful illustration of the potential difficulties of proving a causative breach of duty, especially in a case dealing with an infant claimant and events that took place over a decade before the matter came to trial. As Anthony Johnson notes, the judgment is of particular interest for its analysis of the disputed evidence of fact.

The Claimant sought damages for alleged negligence out of treatment that had taken place in June 2010 when he was aged three. Having fallen ill on 13.06.10, he was taken to see the defendant GP in her surgery on 14.06.10 where she diagnosed tonsilitis and prescribed antibiotics. A further telephone consultation with the Defendant took place two days later on 15.06.10. The following day, on 16.06.10, the Claimant's condition had significantly deteriorated and the Defendant referred him to hospital, where he was admitted and it was found that he had developed meningococcal meningitis, which caused neuropsychological sequelae.

The primary allegation of negligence relied upon by the Claimant was that the Defendant had been negligent on 15.06.10; he should have been seen in the clinic as a matter of urgency, which would have led to him being referred to hospital. It was pleaded that this negligence had been causative in that it caused a material delay in the suspicion, diagnosis and treatment of the Claimant's meningitis. It was also pleaded that the Defendant placed insufficient reliance upon the fact that the Claimant had not taken the antibiotics that he had been prescribed. It was alleged that the Defendant had also been negligent in relation to the consultations on 14.06.10 and 16.06.10, although it was accepted that such negligence was not causative of the alleged sequelae, it was suggested that it was probative of the likelihood of the Defendant also having been negligent on 15.06.10.

At [66] of his judgment, having already preferred the Defendant's expert evidence to the Claimant's, the Judge ultimately concluded that no causative breach of duty had taken place. Crucial to that conclusion was his finding that the Defendant had been told that there had been an improvement in the Claimant's condition – it was found that she had been told that he was 'slightly better, no worse' – rather than the significant deterioration that was relied upon at trial. Having regard to the previous diagnosis of tonsilitis and the absence of any evidence that the Claimant was worse or had some other pathology, it had not been negligent to fail to refer him for further assessment or investigation.

It was found that the Defendant had been given sufficient information to realise that the Claimant may not have taken all or any of the antibiotics that had been prescribed for him, but that her actions following the provision of this information were consistent with the practice of a responsible body of general practitioners. The Judge also rejected a subsidiary allegation that the Claimant's capillary refill time should have given additional grounds for concern, notwithstanding a finding that the clinical note in relation to this had been misleading.

The Judge found as a fact that the Claimant's mother was an honest, careful and impressive witness who was doing her best to assist the Court. However, notwithstanding that, the overall preponderance of the evidence did not support her having informed the Defendant of a significant deterioration in the Claimant's condition: this was not supported by either the contemporaneous clinical notes or her behaviour at the time. The reference to the Claimant being slightly better in the clinical note of 15.06.10 was consistent with a further reference the following day to it having appeared that the Claimant was better before he had then deteriorated. The Judge found that if the Claimant's mother had been concerned then she would have insisted upon seeing a doctor, as the Defendant had previously advised her to do if she had concerns. He also noted that she had returned to work on 15.06.10 having stayed off on 14.06.10 due to her concern about the Claimant's condition.

It was accepted in the course of the trial that the Defendant had made a mistake in her clinical notes in that she had confused a 'greater than' sign with a 'less than' sign, but held that this mistake was not causative of any injury complained of. The Judge also rejected the submission that this mistake undermined the remainder of the clinical notes, finding that a failure to assess or record was very different to making a note that conveys the opposite of what a doctor had been told by a concerned patient.

Dealing with his general approach to disputed facts that formed the subject matter of the trial, the Judge set out the following (at [53]):

> ***"I turn to consider the factual disputes at the heart of this case. I bear in mind that the events in issue occurred about 12½ years ago. I remind myself of the remarks about evidence based on recollection made by Leggatt J in Gestmin SGPS SA v Credit Suisse (UK) [2013] EWHC 3560. Although Leggatt J identified his approach as being appropriate for a judge in a commercial case, I take the view that the principles he expounded are similarly applicable to a case such as this. In my view, I ought to base my factual findings on inferences drawn from the documentary evidence and known or probable facts."***

It is respectfully submitted that this approach would be likely to be followed in the vast majority of cases arising from factual disputes of this nature: it is important that practitioners are aware of the contents of paragraphs 15-22 of the judgment of Gestmin which, whilst warranting careful reading in their entirety, can be summarised as follows:

- Human memory is unreliable, but in everyday life people are not aware of the extent to which memories can be unreliable;
- It is an error to suppose that a stronger and more vivid feeling or experience of recollection means that such recollection is likely to be more accurate;
- The level of confidence that a person has in their recollection does not make it more or less likely to be accurate;
- Memories are fluid and malleable, being constantly rewritten whenever they are retrieved;
- There is not a clear distinction between recollection and reconstruction as all remembering of distant events involves reconstructive processes;
- Memories of past beliefs can be revised to make them more consistent with present beliefs;
- External information can intrude into a witness' memory, as can their own thoughts and beliefs;
- There can be 'failure of source' memories of events that did not happen at all;

- Studies have shown that memory is particularly vulnerable to interference and alteration when a person is presented with new information or suggestions about an event in circumstances with their memory is already weak due to the passage of time;

- The process of civil litigation itself subjects the memories of witnesses to powerful biases; and

- The process of preparing a witness statement and then much later giving evidence at trial itself causes considerable interference with memory.

It is imperative, therefore, that practitioners on both sides pay particular regard to the contents of the evidence of lay witnesses of fact and the likely quality of their oral testimony at trial (taking into account the natural delays in recollection pre- and post-witness statement that one would expect to see in a trial taking place so long after the events concerned). That evidence must be weighed up against the documentary evidence and any agreed facts or facts that cannot be gainsaid.

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What price autonomy? Powell v University Hospitals Sussex NHS Foundation Trust [2023] EWHC 736 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY & CAUSATION – INFORMED CONSENT – FACTUAL CAUSATION – MEDICAL CAUSATION – EXPERT EVIDENCE

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As James Yapp explains, the case of Powell examines the principle of informed consent. It also illustrates the potential difficulty of proving factual and medical causation and emphasises the need to ensure experts remain within the bounds of their expertise. Whilst breach of duty was established, the claimant failed to prove causation.

Background

The claimant had a long history of knee complaints and surgery. In November 2013, she underwent a revision of a left total knee replacement. She complained of pain following the surgery.

She underwent further treatment. A DAIR procedure was performed on 16 January 2014.[17] An infection was diagnosed around 19 January. A further DAIR was performed 28 January.

An exploratory surgery and knee washout was performed in June 2014. The first stage of revision surgery was performed in October 2014.

A Staphylococcus epidermidis infection ('the Relevant Infection') was diagnosed following the October 2014 surgery. This led to an above knee amputation.

The Issues

The claimant had to prove:

1. That she should have been offered a first stage procedure in January 2014 (breach);

2. That she would have chosen to go ahead with it (factual causation); and

3. That the Relevant Infection was present by 28th January 2014 (medical causation).

17. As the Court explains at [13], DAIR is '[a] way of treating an infected wound' and involved the following: 'Debridement: treating wound by cleaning out and removing non-viable (necrotic) tissue. Antibiotics: targeted at bacterial organisms. Irrigation: washing out wound. Retention: retaining the implant.'

Breach and Informed Consent

Breach of duty was ultimately admitted. The Defendant accepted it was mandatory as at 28 January to advise the claimant that:

1. The DAIR procedure was unlikely to eradicate the infection; and

2. There was a greater chance of eradicating the infection if she underwent the first stage of a two-stage procedure.[18]

The Judge commented at length on the importance of patient autonomy. Notably, he made findings of fact on an issue which did not need to be determined. He did so because there was a *'strong public interest in knowing how this lady was in fact treated in circumstances where… the defendant accepts a breach of duty. I judge that there needs to be an independent authoritative public record of it'.*

Factual Causation

What would the claimant have done if a first stage procedure had been offered as an option in January?

The court accepted that the surgeon would nevertheless have advised the claimant to undergo a DAIR. He would not have been negligent to give this advice.

The claimant gave oral evidence at trial. Her counsel asked what she would have done if offered two alternatives. She said she wouldn't know he she would have reacted. When given a chance to clarify her answer, she said *'I think 50-50 I would have followed [the surgeon's] advice'.*

The Judge considered the claimant's history with the surgeon, her trust in his advice and the complexity of the decision.

The surgeon had performed 4 previous surgeries on the claimant. She had accepted his advice on each occasion. She had 'built up a lot of trust' in him. The Court found it 'improbable' that the claimant would have rejected his advice. It was improbable that she would have insisted on first stage procedure in January 2014.

To this, the Judge added the fact that whether to choose a first stage procedure, DAIR or a DAIR plus[19] is a very complex decision, even for surgeons. In this context, it was entirely unsurprising that the claimant did not know what she would have done when faced with the issue in the witness box.

Even if the claimant had been properly informed of the options, it would not have made any difference to her outcome. The claim therefore failed on this ground.

Medical Causation

When was the infection introduced?

The Claimant argued that the Relevant Infection had been introduced by 28th January. The Defendant argued that it was introduced later (possibly in June).

If the Claimant was right, then a first stage procedure on 28 January would have eradicated the Relevant Infection. If she could not prove that the Relevant Infection was present, then a first stage procedure on this date would have made no difference.

The Judge weighed up various factors for and against. Ultimately, the Claimant also failed to prove her case on this ground.

Inevitably, the expert evidence played a significant role in determining this issue. Two themes emerge from the Judge's comments on the expert evidence.

1. Experts should not step outside the bounds of their expertise. The claimant's orthopaedic surgeon claimed expertise in microbiology and infection. He had 'liaised with microbiologists for 24 years' and encountered infection 'very regularly'. The Judge found his evidence on this issue uncompelling. It would have been better if he had deferred to the microbiologists (as he later did).

2. An expert who fails to deal with critical issues is unlikely to impress. The reports from the claimant's microbiologist did not deal with whether the Relevant Infection was more likely to have been introduced in January or June. The Judge found this 'puzzling and unhelpful'.

18. A two-stage revision involves (i) 'removing the infected implant, washing out the joint, [and] inserting spacer (cement, antibiotic-suffused)'; and then (ii) the removal of the antibiotic spacer, washing out the joint, and inserting a new implant ([13]).

19. As explained at [13], a DAIR plus 'denotes performing a DAIR and then the surgeon deciding whether to remove the implant during the surgery itself once more information becomes available intra-operatively'.

Conclusion

Informed consent is an important principle. However, a failure to respect a patient's right to choose does not necessarily cause them to suffer any loss. Proving factual and medical causation can be difficult.

Practice points that emerge from the judgment include:

1. Test witness' evidence on the key issues thoroughly. The claimant's oral evidence as to what she would have done if properly advised was weak. Her witness statement had been far more definitive.

2. When considering causation, a claimant's previous actions can be important. A court may find that past behaviour is likely to correlate with future behaviour.

3. It is important to consider expert evidence carefully. Have your experts answered all of the key questions? Is the right expert answering the right question? Are your experts appropriately qualified to address the issues they comment on?

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Delay, false notes and unpersuasive expertise: *Astley (a minor) v Lancashire Teaching Hospitals NHS Foundation Trust* [2023] EWHC 1921 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY & CAUSATION – DELAYED DELIVERY – ACUTE PROFOUND HYPOXIA-ISCHAEMIA – FALSIFICATION OF RECORDS – EXPERT FAILINGS

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In *Astley*, the High Court found on the basis of agreed expert evidence on foetal heart rate that a midwife had falsified the medical notes relating to a delivery in which the Claimant sustained brain damage through acute profound hypoxia-ischaemia. As Lionel Stride explains, the case contains important observations on the Court's approach to contemporaneous documentary evidence where there is agreement between experts that its contents cannot be accurate. In its excoriating critique of the Defendant's midwifery expert, the judgment also serves as a useful reminder of the need to ensure experts fully address all material issues.

Background

The Claimant, who was born on 22 July 2012, sustained brain injury as the result of an acute, profound hypoxia-ischaemia ('APH') at the time of his birth, the umbilical cord having been wrapped three times around his neck.

It was agreed between the parties' experts that he had been born in an asphyxiated condition, with a heart-rate of less than 40 bpm; that circulation to his brain had been restored only 7 minutes after birth; that a normal, healthy baby can withstand 10 minutes of APH before the brain starts to become damaged; that the APH commenced around 8 minutes before birth and was caused by umbilical cord compression or occlusion; and that, during prenatal APH, the baby would have been severely bradycardic (in the region of 40 bpm).

It was further agreed that the APH became damaging from around 2 minutes after birth; and that delivery 3 or more minutes earlier than the actual time of birth (15:11) would therefore have avoided all permanent brain damage. Accordingly, Martin Spencer J was required to determine two principal issues at the liability-only trial:

i. Whether there was negligence on the part of the hospital staff managing the labour of the Claimant's mother; and,

ii. Whether, but for such negligence, the Claimant would have been delivered at or before 15:08 such that he avoided all permanent brain damage.

Allegations of Breach of Duty

As distilled by the Judge, there were four key allegations of breach of duty (all but the first of which were interlinked):

i. Failing adequately to attend to the fact the Claimant's mother was passing blood-stained liquor and accordingly to commence CTG monitoring and request medical review from around 12:45 onwards.

ii. Failing accurately to monitor the Claimant's heart rate.

iii. Failing to identify the foetal heart rate abnormality in the form of complicated variable decelerations from around 14:45 onwards.

iv. Failing to identify the Claimant's bradycardia from about 15:03 onwards.

Documentary Evidence

The labour was principally documented in two places: the labour notes, all of which were completed by the midwife assigned to the Claimant's mother, who was responsible for her care for the duration of labour until delivery; and the partogram, which was timed at 15 minute intervals from 10:30 to 15:15 (just after birth).

The Judge highlighted several important aspects of this evidence. Firstly, full dilatation had been diagnosed at 13:45, such that a vaginal delivery (including by forceps or ventouse) had been possible from this time. Secondly, there was nothing in the notes to presage the birth of the Claimant in an asphyxiated condition or to suggest this would have occurred absent the delay.

Crucially, the notes disclosed two significant discrepancies between the situation as recorded by the midwife during the latter stages of delivery and events as they were agreed to have unfolded by the relevant experts. Firstly, the Judge noted that, on the basis of the agreed evidence, the recordings of the foetal heart rate taken shortly prior to delivery at 15:07, 15:09 and 15:10 *'cannot have been accurate'* because, given the progress of APH, the foetal heart rate would by that stage have been severely bradycardic: [8(iii)]. The expert neonatologists agreed that the foetal heart recordings in the 5-10 minutes before birth were inconsistent with the heart rates during the expected period.

Furthermore, the midwife's auscultation of the foetal heart as recorded disclosed no evidence of decelerations, even in the later stages of delivery. In the Joint Statement, the expert obstetricians agreed that it was *'likely'* that CTG monitoring would have shown variable decelerations, although at that stage the expert instructed by the Defendant stated that there was no *'fundamental impossibility'* that, by chance, the auscultated rates might have fallen within the normal range: [8(iv)].

During the trial itself, the expert evidence on this issue hardened further. The Claimant's obstetrician stated that the variable decelerations would have become *complicated* from 14:45. Despite the Defendant's counsel taking instructions from the Defendant's obstetrician following this evidence, she did not challenge this opinion and the Defendant's obstetrician was not asked to address the timing. The Judge therefore took the issue to have been agreed: [14]. The significance is that complicated variable decelerations last more than 60 seconds and are heard after a contraction: [35]. They would have worsened until the *'final collapse'* of the foetal circulation.

Expert Midwifery Evidence

The Claimant's midwifery expert stated that, in her opinion, CTG monitoring had been warranted by virtue of the evidence of blood-stained liquor. Her view was that this should have remained in place until blood staining was absent. As to the midwife's monitoring of the foetal heart, her view was that this was unlikely to have been undertaken in the period leading to the birth. She confirmed that recognition of bradycardia would trigger an emergency bell call, with obstetric support expected to arrive within 2 minutes.

The Defendant's midwifery expert concluded that foetal monitoring was in accordance with a reasonable and responsible body of midwives. Significantly, however, the Judge highlighted two aspects of her evidence that 'were immediately of some concern': [28]. Firstly, she had responded to the allegations contained in the Letter of Claim and not those in the Particulars of Claim, which were significantly different.

Secondly, and more crucially, she had simply failed to address the most important feature of the Claimant's case: the inconsistency between the foetal heart records from 15:05 onwards and the agreed paediatric evidence that the baby would have been severely bradycardic. The Judge described as 'embarrassing' the expert's failure to provide any adequate explanation of why she had failed to address the relevant allegations, and her purported belief, until cross-examined, that she had in fact done so: [29].

Findings on Foetal Monitoring

On the basis of the neonatologists' agreed opinion that severe bradycardia would have commenced from 15:03 onwards, the Judge determined that the readings taken by the midwife from that point onwards were erroneous. This amounted to a breach of duty per se. However, he also went further in his criticism of the midwife, finding that no intermittent auscultation was undertaken after 15:05 and that 'the entries in the notes and on the partogram for this period were fabricated': [48]. As above, the Judge accepted that, from at least 14:45, the decelerations would have been complicated variable decelerations and should therefore have been detected upon competent intermittent auscultation.

On this basis, the presence of complicated variable decelerations should have been detected earlier than 14:45, leading to the instigation of CTG monitoring and an emergency call being made for the attendance of an obstetrician. Had this occurred, the Claimant would have been resuscitated and the circulation restored to his brain restored before any permanent damage or neurological injury could have been sustained. Delivery would most likely have taken place before the commencement of bradycardia at 15:03, and would in any event have taken place between 2 and 4 minutes thereafter.

Findings on Blood-Stained Liquor

By contrast, the Judge preferred the submissions of the Defendant's counsel on the issue of blood-stained liquor. This was present in a large proportion of normal labours; and there was nothing in either the NICE or local guidelines to suggest that normal blood staining should lead to CTG monitoring: [49]. Furthermore, the Judge accepted that there was an important role for individual judgment, such that an experienced midwife could be expected to distinguish between 'normal' blood loss and fresh blood loss of bleeding of the kind involved in placental abruption.

Commentary

This tautly-constructed and sharply-reasoned judgment addresses several elements of broader significance. Firstly, it underscores the (well-established) risk run by an expert if he or she fails fully and logically to address all aspects of the pleaded case. In omitting to address the central element of the Claimant's case, the inconsistency between the foetal heart recordings from 15:05 and the agreed paediatric evidence, the Defendant's midwifery expert exposed herself both to *'inevitabl[e]'* cross-examination and to withering criticism from the Judge.

Secondly, the judgment shows the Court's willingness, in an appropriate case and when emboldened by sufficiently robust expert conclusions, to find that notes have been fabricated. In the present case, such a conclusion was facilitated by the inability of the midwife to give any plausible explanation for the discrepant readings in oral evidence.

Thirdly, it highlights the need for each party to ensure that an expert has addressed any material issue raised by their counterpart; it will otherwise be taken as agreed by the Court. Here, the conclusions of the Claimant's obstetrician on the timing of complicated variable decelerations were taken to be agreed because, even after counsel had taken instructions from the Defendant's obstetrician, no challenge was made to his conclusions.

Finally, in its findings on blood-stained liquor, the judgment re-emphasises the difficulty of demonstrating a breach of duty where NICE and local guidelines do not mandate a particular action or response to a given sign or symptom and where the appropriate action to be taken is properly a matter of individual judgment.

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Proving a mechanism of surgical injury when neither expert impresses: *OXR (a child) v Mid and South Essex Hospital NHS Foundation Trust* [2023] EWHC 2006 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY – EAR SURGERY – MECHANISM OF INJURY – EXPERT EVIDENCE – CHANGE OF OPINION

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In *OXR*, the Court addressed a single key issue: whether ear surgery that took place on 4 April 2017 was performed negligently such that it produced disruption to the ossicular chain and, ultimately, permanent conductive hearing loss in the right ear. Emma-Jane Hobbs summarises the Judge's careful approach to establishing the mechanism of injury.

Background

This High Court trial was concerned with whether (ear) surgery that took place on 4 April 2017 was performed negligently.

The Issue

OXR was born on 8 May 2011. On 3 April 2017, when he was 5, he inserted a foreign body into his ear. His mother contacted her General Practitioner who advised her to take OXR to a hospital accident and emergency department. After OXR was seen by a triage nurse, an Ear, Nose and Throat ('ENT') Senior House Officer ('SHO') was called and reviewed him. On examination, a yellow semi-translucent foreign body was noted in the right ear canal which, at that point, was obstructing half of the tympanic membrane. The SHO twice attempted removal of the foreign body using a wax hook, crocodile forceps and suction, but was not successful.

No criticism or allegation of breach of duty was made with respect to those attempts by the SHO to remove the foreign body.

It was decided that OXR would need emergency surgical intervention the following day, so he returned to hospital on 4 April 2017.

The surgery to remove the foreign body was undertaken initially by Mr Jain (an ENT Specialty Registrar), who was not able to remove it. He sought assistance from Mr Puvanendran, a Consultant ENT Surgeon. Mr Puvanendran removed the foreign body, which was a gold-coloured, translucent piece of glass – probably a fractured glass bead. Its overall shape was similar to a wedge with rounded and also angled sides, coming to a sharp point like a shard.

Whilst in theatre, OXR sustained a tympanic membrane perforation and disruption to the entire ossicular chain (the three connecting bones in the ear). The oval window (base of the stapes bone) was partially sheared off and there appeared to be leakage of the perilymph. As a consequence, OXR sustained permanent conductive hearing loss in his right ear and needs to wear a hearing aid.

The Principal Issue

The principal issue in the trial was whether the Claimant had proved, on the balance of probabilities, that the injury he sustained in theatre on 4 April 2017 was caused by a breach of duty on the part of either surgeon, while attempting to remove and / or removing the foreign body from his ear.

It was common ground (the experts agreed) that the damage to the tympanic membrane and ossicular chain occurred in theatre and not as the object was inserted, or removal attempted before surgery. Thus, at trial, the timing of the injury was no longer in issue.

The issues for the Judge to decide on the balance of probabilities, were:

a. Does the Claimant prove the mechanism of injury?

b. If so, does the Claimant prove a breach of duty on the part of either Mr Jain and / or Mr Puvanendran?

Evidence

The Judge heard live evidence from OXR's parents; Mr Puvanendran (the ENT Consultant who ultimately removed the foreign body), and the parties' ENT experts. There was no evidence at all from Mr Jain (the surgeon who initially attempted to remove the foreign body, prior to Mr Puvanendran's involvement). Nor was there evidence to explain his absence from the trial.

The Judge considered that OXR's parents had given truthful evidence reflecting their genuine recollection of events, but they were recalling matters from over six years ago. Where their evidence conflicted with contemporaneous notes, the Judge preferred the latter.

The Judge found Mr Puvanendran to be an impressive witness – composed, thoughtful and reflective. Mr Puvanendran accepted, as was inevitable, that his recollection of what happened over six years ago was not as clear as it had been previously, and thus much of his evidence was based on his normal practice and contemporaneous notes.

The Judge did not find either of the parties' ENT experts compelling overall. Each had changed their initial view on significant issues without offering cogent reasons for doing so, and their opinions were vulnerable to challenge for other reasons (e.g., the Claimant's expert had sought the views of unidentified colleagues and allowed them to inform his opinion on breach of duty). Ultimately, however, it was the Claimant's expert's explanation of the likely mechanism of damage which the Judge found to be *'more logical and likely'*. The Judge's impression of the Defendant's ENT expert's evidence was that *'parts … were developed to fit with her theory, rather than being approached on a completely open-minded basis'*.

Findings of Fact

In relation to the mechanism of injury, the Judge found as follows:

- The disruption to the tympanic membrane and ossicular chain occurred in theatre before Mr Puvanendran took over the operation;

- On the balance of probabilities, it occurred while Mr Jain was attempting manipulation and removal of the foreign body, and was caused by him making contact with the ossicles when using a wax hook;

- Before the ossicular chain was disrupted, the operating surgeon would, on the balance of probabilities, have felt resistance from the ossicles before the point of damage. Mr Puvanendran did not feel this resistance. Either Mr Jain did not notice he was experiencing resistance from the intact ossicles before causing damage; or he was aware of the resistance but continued regardless.

This was in breach of duty. Having found the mechanism of injury to be as described above, the Judge concluded that to cause damage to the ossicles with his instrument fell below the standard of care to be expected of Mr Jain.

The Judge (Her Honour Judge Carmel Wall, sitting as a Judge of the High Court) commented:

> ***"There is no evidence from Mr Jain that is capable of rebutting the conclusion that his technique must have been in breach of duty for his hook to have come into direct contact with the ossicular chain. By causing the damage, it must follow that he did not stop attempting to remove the foreign body as soon as he should have done. Inappropriate technique and / or excessive force on his part, on the balance of probabilities, caused the malleus to be torn away and the remainder of the ossicular chain to fail. Having found the damage was caused by direct contact between his wax hook and the ossicular chain, there was a breach of duty for which the Defendant is legally responsible. It was reasonably foreseeable that once in the middle ear, if the instrument pulled on the malleus, damage was likely to follow."***

Liability was proved.

Comment

A notable and significant factor in this case was the lack of evidence from Mr Jain. This meant that there was no factual basis for concluding that disruption of the ossicular chain occurred without negligence, leading the Judge to conclude that there had been a breach of duty.

The judgment should also serve as a cautionary reminder to experts to ensure that they approach the issues and evidence on an open-minded basis and advance cogent reasons for any significant change of opinion. From a procedural point of view, experts should comply with paragraph 9.8 of Practice Direction 35 of the Civil Procedure Rules, so that: 'If an expert significantly alters an opinion, the joint statement must include a note or addendum by that expert explaining the change of opinion'.

By Emma-Jane Hobbs
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A more urgent case? Proving breach of duty for delayed surgery: *Middleton (personal representative of Middleton) v Frimley Health NHS Foundation Trust* [2022] EWHC 2981 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY AND CAUSATION – DELAY – SIGNIFICANCE OF GUIDELINES

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As Rochelle Powell explains, in Middleton the Court was required to determine whether there had been a breach of duty on the part of the Defendant in delaying the revascularisation of the Deceased's leg. The Claimant argued that this surgery should have taken precedence over that of a patient who was taken to theatre before him and that the theatre should have been placed 'on hold' for him.

Factual Background

The Claimant brought a claim for clinical negligence arising out of the Defendant's delay in re-perfusing the leg of her late husband, Ian Middleton ('IM'). It was alleged this delay caused IM to suffer additional leg symptoms between 18 November 2015 and 15 December 2015 when he had further surgery.

IM had a long history of vascular disease and was admitted to Frimley Park Hospital following a CT scan which showed he had new circumferential fat stranding around the proximal aortic anastomosis. IM began to experience symptoms of acute ischaemia (numbness and pain) in his right leg, between 10:00 and 11:00 on 18 November 2015. It was not until 11:30 that these symptoms were recorded in IM's notes. His surgeons considered that his case was urgent and ordered a CT scan. The scan result was received around 16:55 but the hospital only had one emergency operating theatre and three emergency operations were booked ahead of IM's surgery. IM was taken to theatre at 23:56 and underwent surgery at around 00:30 on 19 November 2015. The surgery was successful and restored the blood flow to his leg. However, he suffered subsequent loss of power and sensation in his right leg caused by ischaemia of the lumbosacral plexus ('LSP') until he had further surgery on 15 December 2015.

The Claimant's case was that the Defendant had breached its duty of care by failing to operate on IM earlier. It was alleged that IMs case was more urgent than that of a patient who was taken in for surgery before him ('patient two') and that IM should have been taken into theatre first. Had the surgery been carried out within this timeframe, it would have improved blood supply to IM's pelvis in addition to his leg, thereby avoiding the symptoms caused by ischaemia of the LSP.

Expert Evidence

Significantly, it was agreed between the parties that despite the alleged delay in re-perfusing IM's right leg, the surgery on 15 December 2015 was successful in averting ischaemic damage to the right leg. The vascular experts agreed that the subsequent loss of power and sensation in IM's right leg was caused by ischaemia of the lumbosacral plexus ('LSP') rather than ischaemia of the right leg. However, the experts disagreed as to whether earlier reperfusion of the leg would have made any difference to the ischaemia of the LSP.

The Claimant's expert opined that there had been a clear breach of duty in failing to revascularise IM's ischaemic right leg within six hours of onset on 18 November. She also said that IM should have been treated ahead of patient two because he was a more urgent case and an operating theatre should have been put on hold for him. On causation, the Claimant's expert opined that if revascularisation had occurred earlier, this would have allowed for full recovery of nerve function and avoided significant permanent disability. However, she was unable to point to any cases or literature in support of this opinion and accepted in cross-examination that it was *'conjecture'*.

In contrast, the Defendant's expert considered that the Claimant needed urgent but not immediate surgery. He said that surgery within six hours was something you would aim for in someone with no history of vascular disease; the fact that IM had a history of chronic ischemia improved the chances of survivability. It was noted that the paper relied upon by the Claimant's expert referred to revascularisation within six hours in the context of a patient without underlying vascular disease and an acute arterial blockage. Further, it would not have been reasonable to put an operating theatre on hold as suggested by the Claimant's expert. In respect of patient two, he opined that was a more urgent case and surgery was required within hours. As to causation, the Defendant's expert did not agree that earlier re-perfusion of the leg would have restored blood supply to the LSP.

Breach of Duty

Dismissing the claim, Deputy High Court Judge Jonathan Glasson KC held that the fact that IM was not taken to surgery earlier did not constitute a failure of care for which the Defendant was liable. The Judge made the following critical findings:

i. IM's case did not mandate surgery within a particular timeline. The medical papers referred to by the experts were guidelines, not mandatory timescales for clinical decision-making, particularly in the context of IM's complex medical history. The fact he had a chronic history of vascular disease meant the risks were less severe than for a patient with no background history.

ii. The paper relied on by the Claimant recommending revascularisation within six hours was not directly applicable because it related to patients without underlying vascular disease.

iii. Whilst IM's case fell into the 'urgent' category that did not mean that surgery within six hours was mandatory; it was a question of clinical judgment.

iv. It was reasonable to have waited to obtain a CT scan before surgery commenced.

v. IMs leg was not so severely ischaemic as to require surgery within six hours.

vi. It would not have been reasonable to put operating theatres on hold as suggested by the Claimant's expert.

vii. The fact that surgery successfully restored the blood flow to IM's right leg indicated that his leg was not so severely ischaemic as to require surgery within six hours.

viii. The evidence of the Defendant's expert represented the views of a responsible and reasonable body of vascular surgeons.

Causation

Despite his conclusion that the Defendant had not breached its duty of care, the Judge went on to consider (a) whether patient two was a more urgent case than IM; and (b) if so, what the consequence would been if it had been mandatory for IM to be operated on by 15:00. The Judge considered the Claimant had not proven that IM was a more urgent case. However, even if IM had been taken to theatre in place of patient two, the Claimant's evidence failed to establish that earlier reperfusion of the leg would have had the adventitious benefit of restoring blood supply to the LSP. This view was unsupported by literature and the Claimant's own expert ultimately conceded that it was 'conjecture', lacking any factual basis in cases she had treated.

Comment

The takeaway points from this decision are:

i. If seeking to establish that urgent surgery should have occurred earlier, claimants and their experts should consider the individual circumstances of each case. 'Urgency' will be a matter of degree and individual cases will be a matter for clinical judgment. Proving that a theatre should be put on hold for a particular patient will be challenging.

ii. Literature in support of expert opinion is essential. However, it is important to note that guidelines are often just that and will not on their own be determinative.

iii. Road test your expert's evidence in conference well before trial.

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The difficulty of psychiatry and the difficulty of proving psychiatric negligence: *Zgonec-Rozej (on her own behalf and as executor of the estate of Jones) and ors v Pereira and ors* [2023] EWHC 1770 (KB)

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

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In this tragic and complex case, the wife and children of a barrister who took his own life after his admission for inpatient psychiatric treatment sought damages for alleged negligence on the part of his treating psychiatrist. As Lionel Stride explains, this careful and nuanced judgment offers important insights on the difficulties involved in establishing causative negligence in psychiatric treatment and in demonstrating that a particular clinical approach was substandard.

Factual Background

The Claimants, who were the wife and children of the Deceased, brought a claim under the Fatal Accidents Act 1976 and the Law Reform (Miscellaneous Provisions) Act 1934 in respect of alleged psychiatric negligence on the part of the Defendants. Dr Pereira and Dr Bakshi, the First and Second Defendants, were consultant psychiatrists who treated the Deceased after his admission to the Nightingale Hospital; the Third Defendant was the owner and operator of the hospital.

The Deceased, who had been a KC practising in the fields of immigration and international criminal law, experienced a decline in his mental health in 2016. On 22 March, he was therefore admitted to the Hospital for treatment under the care of Dr Pereira. He remained an inpatient on the morning of 18 April 2016, when, tragically, he left the hospital and jumped into the path of a train, dying instantly.

The Issues

The Claimants alleged a series of deficiencies in the care provided to the Deceased by Dr Pereira. Whilst the negligence alleged was manifold (27 particulars of negligence having been advanced in the Amended Particulars of Claim), the key allegations as they emerge in the context of the judgment can be summarised as follows:

i. Failing to explain the purpose and benefits of hospital admission;

ii. Failing to tell the Deceased that he would be handing over his care to another psychiatrist for the next 3 weeks (because he was going on leave);

iii. Failure to give sufficient handover to the new psychiatrist;

iv. Failure to provide a 'post-traumatic' diagnostic formulation or to ensure an adequate and appropriate care plan was instituted in light of this;

v. Failure to arrange individual therapy with adequate promptitude; and

vi. Failure adequately to assess the risk of suicide.

The Claimants contended that, in the absence of these deficiencies, the Deceased's health would not have deteriorated. With appropriate treatment, they argued that he would have recovered from illness within a few months, returned to full-time practice as a barrister, and would have continued and expanded a successful career specialising in international criminal law and extradition.

Accordingly, the key issues that the Court was required to determine were:

i. Whether the care provided to the Deceased by Dr Pereira was negligent.

ii. If so, whether any breach established caused the Deceased's death.

iii. Whether the Deceased contributed to his death by his own negligence.

iv. The value of the claim, having regard to the likely earnings and career progression of the Deceased and First Claimant.[20]

Breach of Duty

After a detailed review of the allegations of breach of duty, the Judge rejected the hypothesis that, in omitting to abandon his original diagnosis, Dr Pereira had been in breach of duty: whilst the conclusions of the Claimants' expert psychiatrist on this point were compelling, it could not be said that any reasonably competent psychiatrist would have reached them. However, there was a negligent failure to give a sufficient handover to the new psychiatrist; the lack of an adequate record of the conversation was itself a departure from reasonable standards, and the existence of a duty to give a proper handover was uncontroversial.

The only aspect of the treatment itself, however, which could be said to amount to a breach of duty was a delay in arranging individual psychotherapy for the Deceased. The care and treatment plan was deficient because it did not contain a *'clear path'* to the Deceased starting that therapy. There was no negligent failure to assess risk because the Deceased was known to present a risk of self-harm and, despite this classification, there were no particular steps which could and should have been taken to prevent it.

Causation

The Judge began his analysis of causation by addressing the submission of the Claimants' counsel that, if he were unable to decide whether, but for any breach of duty, the Deceased's death would have been avoided, he should instead apply the 'material contribution' test set out by the Court of Appeal in *Bailey v Ministry of Defence* [2009] 1 WLR 1052. In the Judge's view, this was not an appropriate case for the use of such a test because it was possible to decide on balance whether death would have occurred in the absence of each breach of duty alleged: [211]-[212].

The Judge went on to conclude that the limited breaches which had been proved had no causative impact. There was no evidence that Dr Pereira's omission to tell the Deceased about his forthcoming 3-week absence at the time of admission caused any measurable harm or contributed to his death: [214]. The Judge reached the same conclusions in relation to Dr Pereira's failure to give a sufficient handover; as he pointed out, this was inevitable given that he had not heard any evidence of the merits and demerits of the new psychiatrist's treatment: [215].

Whilst the failure to arrange psychotherapy expeditiously was a breach of duty and this process should have begun on or shortly after 11 April 2023, this again had no causative impact. The evidence was that, before being undertaken, a ward visit and assessment by a psychologist would be required to determine the type of therapy needed. Accordingly, it was at best possible that a single session would have taken place before the date of death. In any event, there was uncertainty about whether an initial session would have had a positive or any effect on the Deceased's feelings, especially given the paucity of evidence as to why he had taken his life on 18 April.

20. The Judge's assessment of quantum, which is set out at [237]-[335], is not summarised in this article for reasons of space, but itself repays careful analysis.

The Judge therefore concluded at [221]: *'Combining the uncertainties of whether a session would have taken place, whether it would have given Mr Jones some hope and whether such effect would have been sufficient to change the outcome, it is far from probable that the failure to take prompt steps to arrange psychotherapy caused or contributed to his death.'*

The Judge went on to address causation had he found that it was a breach of duty not to provide a post-traumatic diagnostic formulation (as supported by the Claimants' psychiatrist). On this hypothesis, the Deceased's death on 18 April would, on balance, have been avoided, because for a PTSD-like condition, therapy would have been commenced nearly 4 weeks before the date of death and his condition would likely have remained stable: [224].

Contributory Negligence

The Judge concluded that, whilst the Deceased was obviously *'very unwell'* at the time of his death and his illness *'drove him to take his own life'*, it was not possible to conclude that he had *'lost his autonomy'*: [235]. Reflecting the approach in *PPX v Aulakh* [2019] EWHC 717 (QB), in which the alleged failure consisted in a failure to teat an illness rather than in causing the said illness, the appropriate reduction had liability been established would have been 25%.

Commentary

Perhaps the most important aspect of this detailed judgment is its careful approach to, and commentary upon, the difficulty of determining issues of breach of duty and causation in the context of a complex psychiatric condition. Whilst the legal tests which govern psychiatric treatment are identical to those involved in any other area of clinical practice (as emphasised at [9]), the Judge emphasised the importance of *'some challenges which are often posed by cases of psychiatric illness',* noting that psychiatry *'differs from many other medical fields in important ways'*: [148]-[149].

The Judge highlighted the importance of the following factors which differentiate psychiatry from the majority of clinical practice:

i. Psychiatric conditions cannot generally be diagnosed with blood tests, scans or x-rays.

ii. The medical cause of any psychological symptoms may be impossible to identify with certainty, and where symptoms shade into behaviour, they may lack medical explanation.

iii. Psychiatrists are often more dependent on the history given by a patient than other clinicians. This is especially problematic because psychiatric illness may itself cause the patient to be an unreliable historian.

iv. Psychiatric illness may also cause a patient to be resistant to care and treatment, such that psychiatrists may find themselves having to work without the co-operation which would often otherwise be provided by the patient.

All such factors were present in the *'complex and challenging'* case faced by Dr Pereira: see [153].

The case also serves as a salutary reminder of the difficulty of proving primary liability even where the evidence of a claimant's psychiatrist is both cogent and persuasive.

Addressing the qualities of Dr Meehan, the psychiatrist instructed by the Claimants, the Judge emphasised that he was *'a very impressive expert witness'* and opined that his observations about clinical methodology and how he would have applied it to the facts of this case were both persuasive and logical: [154]. Dr Meehan's analysis of the Deceased's illness was judged more persuasive than both that of the Defendants' expert and that of Dr Pereira. The Judge's findings on causation also make clear that, had Dr Meehan's approach been adopted, the Deceased would not have died.

As would be expected, however, the finding that Dr Pereira's view was *'defensible'*, supported by Dr Meehan's concession that his diagnosis had been reasonable, precluded any finding of primary liability ([159] and [155]). **Accordingly, the judgment underlines the especial difficulty of establishing Bolam non-compliance in a field such as psychiatry where there is often broad clinical discretion as to appropriate diagnosis and treatment.**

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Inappropriate experts and vulnerable witnesses in the civil courts: *GKE v Gunning* [2023] EWHC 332 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY AND CAUSATION – PSYCHOLOGICAL THERAPY – ABUSE OF TRUST – VULNERABLE WITNESSES

In *GKE*, the Claimant pursued her former treating psychologist for psychiatric injury she alleged had been caused by his conduct, including wholly inappropriate sexualised comments he had made during therapeutic sessions. Despite the absence of evidence from an expert psychologist which would allow the Court to establish the relevant standard of care by a treating psychologist, the Claimant succeeded in establishing a causative breach of duty based on the Defendant's conduct. Rochelle Powell addresses the significance of this unusual case below.

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Background

The Claimant brought a claim for psychiatric injuries, alleging abuse of trust in the Defendant's treatment of her as a counsellor. The Claimant received work and life coaching sessions from the Defendant through her work and then paid privately for counselling and therapy for her mental health and lifestyle issues. The Defendant was a member of the British Association of Counselling and Psychotherapy ('BACP') and a qualified counsellor; he provided well-being coaching and later private counselling to the Claimant. The Claimant alleged, *inter alia*, that during and between her sessions with the Defendant, he abused his position of trust by making sexual comments and communications and by specifically asking her to undress and to masturbate in front of him in a therapy session or sessions. The Claimant asserted that she had left her job and that her sexual relationship had broken down as a result of the Defendant's torts. The Claimant had obtained a new job in the prison service but claimed that she was likely to suffer lost earnings and deterioration in her symptoms. She further alleged exacerbation of her pre-existing psychiatric symptoms and claimed general damages, aggravated damages, costs from the conduct panel hearing, future treatment costs and loss of earnings. The Claimant pleaded that she was entitled to aggravated damages because of the Defendant's denial during the BACP disciplinary proceedings.

The issues before the Court were: (i) whether the Defendant had owed the Claimant a duty of care; (ii) if so, the nature and extent of the duty of care and the standard of care; (iii) whether the Defendant had breached any such duty of care; (iv) whether any breach of duty had given rise to a foreseeable risk of personal injury being suffered by the Claimant; (v) whether an intentional tort had been committed; (vi) whether aggravated damages should be awarded; and (vii) the nature and extent of any personal injuries and losses caused by the alleged breaches

The Vulnerable Witness Order

During the course of proceedings, the Claimant had obtained a vulnerable witness order. This stated that the cross-examination questions should be sent to the Claimant's legal team in advance. It became apparent half-way through re-examination of the Claimant that not only had the Claimant's lawyers seen the questions, but the Claimant herself had been shown the questions before the trial and so had (potentially) been through them with her lawyers. The Judge held that the order should not have been construed as one where the Claimant herself was allowed to see the questions and discuss them with her legal team. It was found that this was unfair, created an unlevel playing field and degraded the Claimant's evidence.

The Duty of Care

The principles set out in *Bolam v Frien Hospital* [1957] 1 WLR 582 and *Bolitho v City and Hackney Health Authority* [1998] AC 232 applied. The Claimant and the Defendant had a relationship of proximity and an imbalance of power in that the Claimant was vulnerable and disclosing her vulnerabilities and the Defendant was powerful in his advisory, coaching or counselling role. Accordingly, the Defendant owed to the Claimant a duty of care both whilst coaching in well-being between August 2016 and March 2018 and whilst she was his counselling client in April 2018. The nature of the duty was: (1) to use all the reasonable skill and care of a reasonably skilled counsellor when he provided his services to the Claimant; (2) to do and say what a reasonable counsellor would do and say in the circumstances; and (3) not to use words which a reasonable counsellor in the circumstances would not use. In addition, the Judge considered that foreseeability of harm applied to the relationship between the Claimant and the Defendant in their respective roles. If at any time in sessions during inter session communications the Defendant gave the Claimant advice which would foreseeably injure her mental health by causing psychiatric injury or aggravating her pre-existing psychiatric conditions, then the three constituent elements of the tortious duty of care were engaged: duty or care, breach of the relevant standard of care and foreseeability of harm.

Findings

The issue the Claimant faced was that in order to determine what a trained counsellor would and should have done in the shoes of the Defendant, evidence was required from a counsellor or psycho-sexual counsellor. Instead, the Claimant called evidence from a neuropsychologist. This left a '*fundamental gap*' in the Claimant's case. Accordingly, the Court could not be satisfied that the Claimant's expert was sufficiently expert to be able to satisfy the burden of proof in relation to the bulk of the Claimant's allegations.
The Judge did find for the Claimant in respect of two allegations. There was no therapeutic justification for asking the Claimant: (1) to undress in the last private counselling session and (2) to masturbate in front of the Defendant and/or at home whilst recording herself and that those actions would give rise to a foreseeable risk of personal injury.

The claim that the Defendant also committed the tort of intentional harm by words (IHW) and for a separate award of aggravated damages failed. The Court was satisfied that the Defendant's words were deliberate and that he should have foreseen that they would probably cause personal injury to the Claimant. However, it was not accepted that the Claimant has discharged the burden of proof in relation to the requisite intention to cause harm to the Claimant. The Defendant was not found to have formed that intention or considered what effect his words might have on the Claimant. He was reckless as to the consequences of his actions but in law that is not enough. In so finding, the Judge rejected the view of the editors of *Clerk & Lindsell on Torts* suggesting that foreseeability of harm is not relevant for intentional torts which are verbal torts. Foreseeability of harm affected both the existence and scope of the duty of care and the standard of care. It followed that the claim for aggravated damages was not made out.

The Claimant was awarded damages in the sum of £10,000 for her pain, suffering and loss of amenity, £774 for counselling and £1,320 for the legal costs of the BACP hearing.

Comment

The key points from this decision are:

i The existence of a duty of care for a qualified counsellor should be construed in the usual way, with regard to *Bolam v Friern Hospital* [1957] 1 WLR 582 and *Bolitho v City and Hackney Health Authority* [1998] AC 232.

ii Despite the passage of over 100 years there is still a lack of clarity surrounding the long-term effects of the decision in *Wilkinson v Downton* [1897] 2 QB 57. However, this decision makes clear that in the case of verbal torts foreseeability of harm is a relevant consideration: recklessness is not enough.

iii Ensuring the correct expert is instructed is vital. Failure to do so may result in the dismissal of the case.

iv The introduction of the Civil Procedure Rules Practice Direction relating to vulnerable parties or witnesses was intended to introduce appropriate safeguards for the claimant, but not to the extent that the defendant is placed at a disadvantage. Vulnerable witnesses should not be shown cross-examination questions.

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Part I: Quantum Issues: *CCC v Sheffield Teaching Hospitals NHS Foundation Trust* [2023] EWHC 1770 (KB)

CLINICAL NEGLIGENCE – QUANTUM – DAMAGES – LIFE EXPECTANCY – GRATUITOUS VERSUS COMMERCIAL CARE – NIGHT CARE – EXPERT EVIDENCE – 'BUT FOR' ACCOMMODATION

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As James Arney KC explains in the first of two articles on this important case concerning quantum, *CCC* is a case which repays careful reading. The judgment provides much-needed clarification of emerging areas of debate in high-value clinical negligence cases.

CCC v Sheffield Teaching Hospitals NHS Foundation Trust [2023] EWHC 1770 (KB) is the first quantum trial of its kind since *JR v Sheffield Teaching Hospital NHS Trust* [2017] EWHC 1245 (QB). The Claimant, a young girl aged 8 years and 4 months, sued the Defendant for negligence in failing to prevent her from suffering severe chronic partial hypoxic ischaemia before and during her birth, which resulted in her cerebral palsy. Liability was admitted in full, and the issues heard before Ritchie J at trial related to various substantial heads of loss. The Claimant, lacking capacity and with her mother acting as her litigation friend, sought a lump sum of £9,214,862 (gross of IPs) and a periodical payments order of £394,940 pa.

Calculating Life Expectancy

The issue of life expectancy was resolved before the trial commenced: the Defendant abandoned their position and agreed to a life expectancy of 29. The Defendant's Paediatric Neurologist expert sought to argue that life expectancy should be based on median survival data and calculated to age 23, whilst the Claimant's expert adopted the *'correct'* approach of calculating life expectancy to age 30 based upon the adjusted *Strauss et al and Brooks et al* data: [82].

Gratuitous and Commercial Care

Due to the Claimant's extensive needs, care was a highly contentious issue at trial. The award of gratuitous care to which the Claimant was entitled, per *Housecroft v Burnett* [1986] 1 All ER 332, was agreed to be of commercial value. The Claimant successfully argued that past gratuitous care should not be subject to any deductions to reflect the considerable financial, physical, and psychological difficulties faced by Claimant's mother in her role as carer (see Ritchie J's comment at [8]). Having considered six main factors ([134] and [146]), Ritchie J awarded £3,000 pa in future care for life with a 14.3% discount on the approximate commercial value of £3,500 pa.

The Defendant failed to discharge the burden of proving that there was a failure to mitigate losses in respect of past commercial care. However, the Court held that the Claimant's case manager lacked qualifications which may have contributed to the unreasonably high cost of care during COVID. Therefore, past commercial care was valued at the sums spent to trial (£1,287,334) less a deduction of 80% of the Thornbury agency fees between December 2019 and 20 March 2020: [151].

Waking Night Carers ('WNC') and Sleeping Night Carers ('SNC')

A key area of dispute at trial was whether the Claimant required two WNCs or one SNC and one WNC. Following extensive discussion by expert and lay witnesses ([60] & [64]), the Court held that the threshold between SNC and WNC is two disturbances lasting no more than 30 minutes per night. Based on the Claimant's care expert (Maggie Sargent's) evidence, supported by accounts from the Claimant's mother, case manager and support workers, it was held that the Claimant's sleep regime exceeded this threshold: [173]. The Court found it would be unreasonable to expect the Claimant's mother to provide future gratuitous care to alleviate the need for a second WNC and therefore awarded the costs of a 2:1 care regime, including provisions for two WNCs indefinitely to reflect the severity of the Claimant's disabilities and her interrupted sleep pattern.

The Court rejected the evidence of the Defendant's care expert, Mr Chakraborty, as 'flimsy and inadequate': [88]. This was notwithstanding an error in which Miss Sargent mistakenly advised one WNC and one SNC in the first joint expert report (April 2023), revising her position in her final report to advise two WNCs (January 2023) which in turn required updating witness statements in October 2022. Mr Chakraborty also failed to identify a discrepancy between the trial bundle report and the report produced at trial; however, whilst Miss Sargent alerted Mr Chakraborty to her mistake within two weeks, he had waited until trial eight months later.

Expert Criticism

The Court expressed strong criticisms of the Defendant's experts in five specialisms: Care, Occupational Therapy, Paediatric Neurology, Physiotherapy and Accommodation. The experts were described as lacking in impartiality, deficient in assessing the needs of the Claimant, and, overall, failing to adhere to their CPR Part 35 responsibilities.

These shortcomings were particularly evident in Mr Chakraborty's evidence on the Claimant's transport needs. He failed to include details of the width, height, or adaptation costs for recommended vehicles (including one which was no longer in production at the time of trial) and ignored key evidence from the case manager concerning the Claimant's needs (see [95]). The Court, preferring the Claimant's expert Deborah Martin's evidence, awarded the cost of an adapted Mercedes extra-long wheelbase (£85,614).

Hydrotherapy Overview

The High Court ruling also provided welcome clarity on the law relating to claims for the installation and maintenance costs of hydrotherapy pools. Ritchie J discussed eight key cases on the issue ([117]-[128]); in only one was an award made.[21] In the remaining seven, the definitive factor was the Claimant's ability to access appropriate alternative facilities. Crucially, in *CCC* such access was lacking.

Ritchie J also considered the test for proportionality, per *Whiten v St Georges Healthcar*e [2011] EWHC 2066 (QB), at [5], but he stated that greater emphasis should instead be placed on a two-part test: (i) reasonable need for the expense; and (ii) whether the claimed expense is reasonable compared with less expensive methods of satisfying the reasonable need.[22]

Ritchie J outlined the five factors to be considered when assessing whether the cost of the pool should be granted ([185]-[192]). The Claimant physiotherapy expert Susan Filson's evidence and video footage of the Claimant participating in hydrotherapy were also persuasive. Balancing the competing factors, Ritchie J allowed an award of £607,100, demonstrating that where appropriate such a claim may be deemed reasonable.

21. Robshaw v United Lincolnshire Hospitals [2015] EWHC 923 (QB).

22. See Richard Wilkinson's article on proportionality in CCC in the Temple Garden Chambers Personal Injury Newsletter, issue 2 (2023).

Carer's 'But For' Accommodation

The Defendant submitted that a deduction to the award for 'The New House' was necessary to account for the Claimant's mother's 'but for' accommodation expenses: [135].

Ritchie J noted the contrasting case law in this area: whereas the Court had deducted the parents' 'but for' living expenses in a comparable case, *Lewis v Royal Shrewsbury* [2007] 1 WLUK 628, they had declined to do so in *Iqbal v Whipps Cross* [2006] EWHC 3111 (QB), *Whiten, and Ellison v University Hospitals of Morecambe Bay NHS Foundation Trust* [2015] EWHC 366 (QB). Refusing to deduct the 'but for' accommodation was justified both for practical reasons (the parents were not paying rent to the injured Claimant's deputy) and for principled reasons (any benefit gained from the child's award was necessary and incidental, and they will no doubt have sacrificed greatly as carers).

Therefore, although the Claimant's mother would live rent free in the new accommodation while the Claimant received commercial care, precedent, and the future care likely required of the Claimant's mother dictated that the parents' future 'but for' accommodation costs should not be deducted: [141]. The Claimant's future 'but for' accommodation costs were deducted, and her past accommodation savings were considered in respect of past gratuitous care.

Food for Thought

It is difficult to do justice to Ritchie J's well-reasoned judgment in *CCC* and it warrants a read in full. It provides much needed clarification for emerging areas of debate in high-value clinical negligence cases and serves as a reminder to experts of their Part 35 duties and the impact that their non-compliance may have on a client's case.

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Part II: Consequential Matters: *CCC v Sheffield Teaching Hospitals NHS Foundation Trust* [2023] EWHC 1905 (KB)

CLINICAL NEGLIGENCE – QUANTUM – PART 36 – CPR 36.17(2) – PERIODICAL PAYMENT ORDERS – LOST YEARS CLAIMS

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Following the extensive quantum analysis of the *CCC* judgment handed down on 12 July 2023, Mr Justice Ritchie ruled on two further matters of importance on 13 July 2023, both of which are addressed by James Arney KC. First, whether the Claimant had beaten their own combined Part 36 offer for the purposes of CPR 36.17. Secondly, whether a leapfrog appeal to the Supreme Court should be granted in respect of the claim for compensation for savings accrued during the Claimant's 'lost years'.

Part 36 and PPO Offers: Better in Terms of Money?

At trial the Claimant was awarded a gross lump sum of £6,866,615 and periodical payments for life of £394,940 per annum. The Court was invited to consider whether this award was more advantageous to the Claimant than the Part 36 offer she had made prior to trial to accept a gross lump sum of £7m and periodical payments of £360,000 per annum for life with the first indexation in December 2024. The Claimant's award was a substantial improvement on her settlement offer for periodical payments, however it failed to beat the lump sum figure, included in the same offer, which she had also offered to accept.

The Court therefore had to assess whether, under CPR 36.17(2), the Claimant's award was *'more advantageous to the Claimant'* (per paragraph [9]), i.e. 'better in money terms', than the offer she had put forward. The Claimant argued that if the agreed lifetime multiplier was applied to the periodical payments award, then the capital value of the total awarded sum would have exceeded her own Part 36 offer: [16].

Mr Justice Ritchie held that there were three fatal defects in the Claimant's proposed approach (see paragraph 16):

1) In many cases the parties would be unlikely to agree on any multiplier used and the Court would be forced to use the awarded multiplier which was not in existence at the time an offer was made.

2) The purpose of periodical payments was to order a multiplicand only and rely on the annual loss the Claimant is expected to suffer. To reintroduce a multiplier would be to undermine the very principle of the PPO which avoids the use of multipliers in instances of uncertain life expectancy.

3) Combined offers should not be treated differently from single offers when it comes to monetary value. The value of a single offer for a periodical payment was the figure stated as the multiplicand and the same should apply to combined offer values.

As there is no prior authority on the issue of determining whether a combined offer has been beaten, Mr Justice Ritchie considered the principles behind Part 36 offers and by extension the inducements in CPR 36.17 to incentivise settlement with sanctions and rewards: *'commensurate with those objectives, the system by which the MTV [Money Terms Value] of an offer is to be determined should be kept simple and clear and should fulfil those objectives'*: [18]. He held that the value of the combined offer should be assessed by way of simply combining the figure of the lump sum and the figure of the periodical payment rather than capitalising the financial value of the periodical payment.

Therefore, the Claimant's award would need to have beaten both parts of her proposed settlement offer: lump sum and periodical payment. Mr Justice Ritchie held that where an offeror wishes to protect individual aspects of the offer, separate offers should be made: *'if a combined offer is made it is a "take it or leave it" offer. It seems to me to be inferred that no protection is gained unless both the lump sum and the PPO offers are beaten, because the quantification of each depends upon the multiplicands in each head and on which heads of loss are included in each part of the combined offer':* [14]. As such, the Claimant's award was not viewed as being 'better in terms of money' than the lump sum she had offered to settle for. The Claimant was therefore awarded her costs on a standard as opposed to an enhanced basis which may be granted to those who have beaten their own Part 36 offer.

'Lost Years' Claims: Leapfrog Appeal

At [172] of his judgment on 12 July 2023, Ritchie J declined to assess damages for a claim for future lost savings in the 'lost years' on the grounds that he was unable to grant such an award, being bound by the decision of the Court of Appeal in *Croke v Wiseman* [1981] 3 All ER 852. However, he did recognise the 'conflicting case law and principles' in treatment between adult and child claimants in recognising claims for 'lost years' due to negligence: [172].

In instances of reduced life expectancy due to negligence the House of Lords held in *Pickett v British Rail* [1980] AC 136 that adult claimants are permitted to make a claim for earnings which could have been earned during the period of their life expectancy which has been 'lost' because of injury. The same permission has been granted to teenage claimants in *Gammell v Wilson* [1982] 2 AC 27. For child claimants, however, the position is different, as established in *Croke*. Any loss of earnings can only be claimed until the date to which the Claimant is expected to live and not for any income from work or pensions that would have accrued after this date. The reasoning of the Court of Appeal was that *'in the case of a severely disabled child, who could not and never would acquire financial dependents the claim for lost years damages was not permissible'*: [36]. This reasoning, however, was not explored or applied in *Pickett*, an inconsistency highlighted in the Court of Appeal case of *Iqbal v Whipps Cross University NHS Trust* [2007] EWCA Civ 1190. The Court of Appeal expressed reservations in respect of the inconsistencies in the two approaches but stated that it would be a matter for the Supreme Court. Permission to appeal to the Supreme Court was granted in *Iqbal*; however, the appeal was ultimately settled, and the matter left unresolved.

In *CCC*, Mr Justice Ritchie, noting the previous consideration of the issue by the Court of Appeal and the contentiousness of the head of loss since the 1960s, determined that the point of law was of public importance. He gave permission for a leapfrog appeal to the Supreme Court, bypassing the Court of Appeal, in accordance with the Supreme Court Practice Direction 1 and s.12 of the Administration of Justice Act 1969. He considered that the necessary two-limb test had been met: first, the Claimant had a realistic prospect of success, and secondly a sufficient case had been made out to justify an appeal under s.12(1) of the AJA 1969: [41] and [47].

If the question of whether a child claimant is entitled to a claim for potential lost earnings or savings accrued during their lost years is answered in the affirmative, the implications of the judgment would be wide reaching.

Conclusion

The case of *CCC* has been instructive not only for its in-depth quantum analysis, but subsequent litigation has also provided further clarification for assessing combined PPO and lump sum Part 36 offers. A potential landmark appeal concerning claims for compensation for 'lost years' from child claimants also warrants our continued attention.

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Failure to approve a settlement, the rule in *Henderson v Henderson*, and strike-out applications: *Bayless and ors v Norfolk and Norwich University Hospitals NHS Foundation Trust* [2023] EWHC 2986 (KB)

CLINICAL NEGLIGENCE – STRIKE OUT – COSTS – SETTLEMENT – CHILDREN AND PROTECTED PARTIES – THE RULE IN HENDERSON V HENDERSON – LIMITATION – DATE OF KNOWLEDGE

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As Lionel Stride explains, the Judge in *Bayless* was required to determine the appropriate order for costs upon the defendant Trust's withdrawal of an application to strike out the Claimants' claim in highly unusual procedural circumstances. His conclusions reinforce the need for both parties to ensure approval is obtained of any settlement involving children or protected parties.

The Admitted Negligence

On 24 April 2016, the Deceased collapsed and died after the Defendant's admittedly negligent failure to diagnose the presence of an acute type A aortic dissection. The Trust accepted that the surgical treatment which should have taken place would have been successful. The Deceased was survived by his wife (the First Claimant) and two young children (the Second and Third Claimants).

The First Claim and Intended Settlement

In July 2018, the Defendant admitted liability and invited the Claimants to serve a schedule of loss. In spring 2019, the Claimants' legal representatives proposed settling the claim of the Deceased's widow alone (his children's claims for psychiatric injury not then being ready), which comprised the following elements:

i. Claims on behalf of the estate under the Law Reform (Miscellaneous Provisions) Act 1934 for the Deceased's PSLA, funeral expenses, and a claim for past care.

ii. A claim under the Fatal Accidents Act 1976 for a bereavement award.

iii. Claims for loss of dependency under the 1976 Act on behalf of the Deceased's widow and their two young children.

In August 2019, the Trust made a Part 36 offer to settle the claim, which was accepted in September 2019 and the settlement monies paid out. However, contrary to the requirements of CPR 21.10(1), no action was taken by either party to secure the approval of the settlement by the Court even though the claim was made, in part, on behalf of the Deceased's minor children. Accordingly, acceptance of the Part 36 offer was not effective to settle the claim.

The Second Claim, Application to Strike Out, and Subsequent Withdrawal

In December 2022, the Claimants issued the present proceedings against the Trust, each claiming damages as secondary victims for psychiatric injury suffered by reason of witnessing the death of the Deceased. The Deceased's wife, anticipating a limitation defence, pleaded that she had not been aware she had suffered a recognised form of psychiatric injury until she had been diagnosed with a post-traumatic stress disorder in April 2020.

On 18 May 2023, the claim was met with an application notice on the part of the Trust which sought an order striking it out as an abuse of process. The Trust's primary case was that the claim had already been settled by acceptance of the Part 36 offer in 2019. In the alternative, it argued that the claim should be struck out as an abuse of process pursuant to the rule in *Henderson v Henderson* (1843) 3 Hare 100.

Shortly before the application was listed to be heard, however, it was identified that the 2019 settlement had not been approved by the Court and was not therefore binding on the parties. The Trust therefore abandoned the application. The sole issue before Pepperall J was whether the Deceased's widow should be awarded the costs of the abortive application or whether (as the Trust contended) there should be no order as to costs.

Costs Consequences

It was conceded by the Trust's counsel that the lump-sum settlement could not be severed so as to construe it as a valid settlement of the widow's claim. On this basis, the Trust accepted that there was no possibility it could have succeeded on its strike-out application. However, the Trust contended that the Claimant's previous solicitors were *'clearly negligent'* in failing to obtain the Court's approval and, in effect, responsible for the state of affairs faced by the parties.

Whilst the Trust accepted that it had not (and could not) succeed on the application, it contended that the Court should only consider the general rule that the unsuccessful party should pay costs once it had first answered the '*threshold question'* of whether to make any order as to costs at all. It also argued that it had not acted unreasonably by bringing the application and suggested that the Trust would have been *'fully justified'* in seeking a wasted costs order against the widow's solicitors.

By contrast, counsel for the Claimants argued that the failure to obtain approval was as much an issue for the Trust as for the Claimants. Unsurprisingly, they argued that the Trust, having withdrawn its application, was the unsuccessful party; and that, in considering the parties' conduct under CPR 44.2(5), the unreasonableness of its behaviour in making the strike-out application should be considered. Even if the settlement had been effective, the Claimants argued that the application had been misconceived because:

i. The settlement had not compromised the widow's psychiatric injury claim since it only settled the claim that had then been made (which advanced no claim for personal injury on her behalf).

ii. The second action would not have been struck out under the rule in *Henderson v Henderson* because the widow had acted in good faith, had not been aware of her psychiatric injury at the time the Part 36 offer was accepted, and the new action was not oppressive.

The Judge's Analysis

Pepperall J had no hesitation in rejecting the Trust's arguments. Given the Trust's concession that there had been no effective settlement of the 2019 claim, the strike-out application was bound to fail because it could not be said that the purported settlement compromised the widow's psychiatric injury claim or that the rule in *Henderson v Henderson* was engaged: [13]. More broadly, it could not be said that the lack of approval was a matter known only to the Claimants' solicitors: rather, on the material that was available to the Trust upon proper investigation, the strike-out application was *'hopeless'* from the start: [16].

As the Judge emphasised at [15]:

> ***"The Trust has paid out £340,000 plus costs in settlement of a claim without obtaining a good discharge. It is elementary that one does not pay sums in settlement of a claim brought by or on behalf of children or protected parties without first requiring such claimants to obtain the court's approval. It is no answer to say that the Trust's lawyers assumed that that had been done."***

Whilst the failure to seek approval placed the Claimants at risk, the Trust was *'equally'* at risk because there was a risk that the former would seek to resile from their earlier acceptance of the Part 36 offer. Further, even if the parties agreed to abide by the terms of the earlier settlement, the youngest Claimant remained a child and the settlement could only be made binding on obtaining the Court's approval, which would be sought on the basis of the 2023 value of the child's dependency rather than the sum agreed in 2019.

Interestingly, the Judge went on to make clear that, even if the 2019 settlement had been approved, he was not in any event convinced that the application had been reasonable. This was because:

i. On the proper construction of the intended settlement, the parties compromised (or sought to compromise) only the claims that had been advanced in the pre-action correspondence and schedule of loss. These did not include a personal injury claim by the Deceased's widow.

ii. As to the issue of *Henderson v Henderson* abuse, it was 'never likely' that the Court would strike out a psychiatric injury claim of which the Deceased's widow was not aware at the time of the 2019 settlement when the Trust would in any event have faced claims for psychiatric injury from the Deceased's children.

Commentary

Beyond the unusual set of procedural circumstances from which it arises, this brief judgment has two implications. Firstly (and unsurprisingly), it confirms that the requirements of CPR 21.10(1) are rigid, with no realistic scope for arguing that settlement monies can be 'severed'. It underscores the shared responsibility that both parties' legal teams bear to ensure that steps are taken to approve a settlement agreement in circumstances where rule 21.10(1) is engaged – itself in part a corollary of the risk at which failure to obtain approval places both parties.

Secondly, the obiter comments with which the judgment concludes suggests a defendant will face an uphill battle in persuading the Court that the rule in *Henderson v Henderson* is engaged where a claimant brings a claim for psychiatric injury arising out of clinical negligence where damages have already been recovered under the 1976 Act – at least where there is a further claim or claims to which the rule cannot be said to apply.

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Absent Claimant guilty of contempt of court on basis of records and surveillance: *Nottingham University Hospitals NHS Trust v Bogmer* [2023] EWHC 1724 (KB)

This was an application for committal for contempt of court on the basis that the Defendant (the Claimant in the underlying claim) had advanced a false and dishonest claim for compensation in relation to a coronary artery bypass procedure which the Trust had performed in October 2014. The Defendant, who was by that stage suffering with an unrelated kidney cancer, elected not to attend the remote hearing. In the original proceedings, the Defendant had alleged he had suffered a nerve injury to the right arm as a result of the harvesting of his right radial artery for use as a graft in the bypass procedure.

The Trust contended that the Defendant had made false statements regarding the loss of function in his right arm and/or falsely represented that the symptoms he experienced were caused by the index surgery, when any loss of function in fact predated the surgery. Its contentions were based on both a detailed review of medical and DWP records and on covert surveillance. The original proceedings had been concluded when the Defendant accepted a 'drop hands' offer after the Trust served its surveillance evidence and the joint statement of Neurosurgery/Hand Surgery experts addressing the footage.

Constable J had no hesitation in finding the Defendant guilty of contempt of court. Both the footage and the expert evidence left no doubt that he had lacked an honest belief in the truth of his statements as to his restrictions, and that he had made them with the deliberate intention of deceiving the experts and the Court. It was also appropriate for the Court to proceed in the Defendant's absence because he had been given adequate notice, and was fully aware, of the importance of the hearing; there was no evidence he had taken steps to secure representation, despite his eligibility for legal aid; there was no medical evidence before the Court to justify an adjournment; and, in any event, an adjournment was not likely to secure future attendance. Furthermore, the disadvantage to the Defendant in not being able to give his account of events was negligible given the nature of the evidence against him.

Fixed Recoverable Costs in Lower Damages Clinical Negligence Claims: Government Response (September 2023)

Oliver Brewis summarises the key features of the Government's planned introduction of a Fixed Recoverable Costs regime and accompanying pre-action procedure for lower-value clinical negligence claims, which is intended to apply to claims notified from 6 April 2024 onwards.

In September 2023, the Government published its response to the consultation on fixed recoverable costs in lower damages clinical negligence claims ('LDFRC') which was held between 31 January and 22 April 2022. The response follows a previous consultation in 2017 on introducing fixed recoverable costs in the clinical negligence arena, Sir Rupert Jackson's treatment of the topic in his *Review of Civil Litigation Costs: Supplemental Report – Fixed Recoverable Costs* (2017), and the 2019 Civil Justice Council report on the same topic.

The key features of the proposed regime as they emerge from the Government's response are as follows:

- **Unless a specified exception applies, the LDFRC regime will apply to all clinical negligence claims with a value between £1,501 and £25,000 based on a final value at settlement or following judgment.** A claim will be excluded from the regime if the claimant would be required to adduce expert evidence on liability from more than three experts; if there are two or more defendants and the allegations of negligence against each are materially different; if the claim arises from a stillbirth or neonatal death; or if limitation is raised as an issue by the defendant. Claims by litigants in person are also excluded.

- **Where the claimant considers a specified exclusion from the LDFRC scheme applies, the existing Pre-Action Protocol for the Resolution of Clinical Disputes should be followed and the claimant should explain why an exclusion applies.** These reasons should also be cited in any Particulars of Claim.

- **The scheme applies only to the pre-issue phase for eligible clinical negligence costs and only to pre-issue costs.** Fixed costs under the LDFRC scheme apply only until a claim is settled during the LVCD protocol processes or until a claim form is issued by the Court.

- **A new Low Value Clinical Disputes ('LVCD') pre-action protocol will govern pre-action conduct.** The LVCD protocol will begin with the Letter of Claim and will be considered complete after (a) 28 days have passed following receipt of a neutral evaluation outcome; (b) a claim is settled during the LVCD process; (c) the claimant confirms he or she is discontinuing; (d) the parties agree, following a mandatory stocktake, not to proceed with neutral evaluation; or (e) the defendant does not agree, after the mandatory stocktake, to participate in a neutral evaluation requested by the claimant.

- Where the defendant informs the claimant in writing that it considers the claim may be time-barred, or fails to respond to a Standard Track Letter of Claim within 6 months, the claim will exit both the LVCD and LDFRC and will not be limited to recovery of fixed costs.

- **Following the end of the LVCD protocol, if the claim is not settled, the claimant may proceed to litigation and, unless the claim is settled prior to allocation, the Court will allocate the claim to a case management track.**

- **There will be two separate tracks for qualifying low-value clinical negligence claims with a dedicated process for either track.** The Light Track is designed for claims where it is not anticipated there will be any dispute over liability or that the issue of liability can be resolved quickly. These include circumstances in which the defendant has made a binding admission, the cause of action arises out of a 'never event', or a Serious Incident Report has identified substandard care. The Standard Track will otherwise apply. Where a Light Track Letter of Claim does not yield an admission of breach of duty and causation of some loss within 8 weeks, the claim will 'transfer' and restart in the Standard Track.

- **A Standard Track Letter of Claim will include the claimant's 'core' records, the reports of up to 3 liability experts, up to 2 witness statements in template form, a separate condition and prognosis report (if relevant), and details of the claimant's losses. It must also include an offer to settle the claim.** The Light Track equivalent omits the requirement for medico-legal reports but must contain an explanation for the claim being in the Light Track.

- **In the Standard Track, the defendant must respond to the Letter of Claim within 6 months, with provision for a mandatory stocktake and discussion if any offer by the defendant is not accepted.** A neutral, non-binding evaluation must be held within 4 weeks if the claim is not settled at the mandatory stocktake. The outcome of the neutral evaluation must be issued no later than 4 weeks from the start of the evaluation. There will then be a period of 28 days from the neutral evaluation outcome where the parties are encouraged to make offers to settle the claim.

- **In the Light Track, the defendant must respond (with an admission or otherwise) within 8 weeks of the letter of claim.** A mandatory stocktake and discussion must take place within 4 weeks of the response and a decision be taken on whether further evidence is required. Within 2 weeks of the stocktake, a joint expert should be instructed if required. The expert should then provide a report within 8 weeks of instruction (if no assessment is required) or within 12 weeks (if assessment is required). A 'further evidence' stocktake must then be held within 12 weeks after the mandatory stocktake (if assessment is not required), or else within 16 weeks. A neutral evaluation must take place within 4 weeks of the initial stocktake, if no further evidence is required, or, if it is, of the 'further evidence' stocktake. The same 28 day 'offer period' will then commence.

- **It is envisaged that the neutral evaluation process will be run by barristers, solicitors and other 'suitably experienced' legal professionals**. The evaluator will be jointly instructed and the matter referred to a 'Protocol Referee' if the parties cannot agree on an evaluator. The fee is covered by the defendant. Where any party wishes neutral evaluation to take place, unreasonable refusal to engage with the process will be met with costs sanctions for the claimant (in the event of an unreasonable refusal on his or her part) or the ability immediately to issue proceedings (if a defendant refuses to engage).

- **Costs sanctions will apply where a claimant rejects a post-neutral evaluation offer then fails to beat an evaluator's recommendation by 20% or more.** Where the parties do not settle following neutral evaluation and the claimant goes on to issue a claim, if the claimant does not obtain judgment for a sum at least 20% greater than the amount recommended by an evaluator, the fixed costs recoverable from the defendant will be reduced 50%. The regime contains further sanctions aimed at ensuring adequate evidence is provide by the claimant, the defendant's response is prompt, and that the deadlines set out in the protocol are met.

The new FRC arrangements will apply to claims where the date of notification of the claim falls on or after the date on which the new rules come into force, which the Government anticipates will be 6 April 2024. A supplementary consultation on disbursements, the relevant question having been missed from the Government's original online survey, will close on 22 December 2023.[23]

It is presently envisaged that fees for expert reports and ATE premiums covering the cost of expert reports will be separately recoverable.

Counsel's fees will be separately recoverable only where a claim involves a child or protected party, but not in other cases to which the FRC arrangements apply.

23. See https://www.gov.uk/government/consultations/fixed-recoverable-costs-in-lower-damages-clinical-negligence-claims-a-supplementary-consultation-on-disbursements

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