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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 sixth issue of the TGC Clinical Negligence Newsletter. Expect from this issue analysis of a wide variety of cases spanning informed consent to interim orders, causation to costs, anonymity orders to apportionment of liability, strike out to summary judgment applications, and the clearest through to the most heavily contested breaches of duty.

There have been no further relevant Supreme Court judgments since the 5th Edition, but the reported High Court cases in this edition are an invaluable resource for understanding how established principles are being applied at the 'coal face' when cases escape the safety net of mediation or other forms of ADR. It is hoped that this Newsletter will continue to inform each of our practices going forward on both common and complex facets of Clinical Negligence Law.

In terms of specific content, the cases analysed should prove helpful in understanding the application of *Bolitho, Bolam, Montgomery, McCulloch* and *Chester* principles, as well as the judgment in *Price v Cwm Taf University Health Board* [2019] EWHC 938 (QB), which had decided that NICE Guidelines do not have the force of law and are no substitute for clinical judgement or expert evidence. As Rochelle Powell explains in the article which opens this issue (re *Biggadike v El Farra and another* [2024] EWHC 1688 (KB)) those authorities continue to determine the scope of the *'Professional Practice Test'* and *'Advisory Duty'*. *Biggadike* itself illustrates the extent to which a doctor is under a duty to take reasonable steps to ensure that a patient is aware of any material risks involved with recommended treatment, and any reasonable alternative or variant treatments. In her article, and Michael Rapp's on *Winterbotham v Shahrak* [2024] EWHC 2633 (KB), the duty of informed consent is unpacked in the context of patients facing alternative options for surgery.

The following cluster of articles deal with various issues on breach of duty and causation that emerge in everyday practice, including allegations of breach in an emergency context; inconclusive foetal heart monitoring and delayed birth deliveries; genuine differences in expert opinion and progression in scientific knowledge over time; cauda equina diagnoses and the sufficiency of evidence needed to prove that a *Montgomery* breach of duty has actually *caused* the relevant injury. As ever, cogent and practical advice is given within these articles as to the importance of medical records, NICE Guidelines and expert evidence.

Turning then to Anthony Johnson's commentary on *Healey v.* (1) *McGrath;* (2) *Ramsay Healthcare* [2024] EWHC 1360, he examines its useful illustration of the approach that will be taken by the Court when faced with apportioning liability (and cost consequences) between two defendants, both of whom have admitted liability in full.

Two important cases addressing the difficulty of succeeding on interim payment applications, *Snudden v Norfolk and Norwich University Hospitals NHS Foundation Trust* [2024] EWHC 615 (KB) and *XS1 v West Hertfordshire Hospitals NHS Trust* [2024] EWHC 1865 (KB), are also summarised, with the key implications for practitioners drawn out.

In the penultimate section of the newsletter, Marcus Grant extracts crucial lessons for claimants when applying for strike out and/or summary judgment from the High Court's judgment in *Lukes v (1) Kent and Medway NHS & Social Care Partnership Trust* and (2) *Chief Constable of Kent* [2024] EWHC 753 (KB).

In the final section, Lindsay McNeil discusses a very recent update on the Court's approach to Anonymity Orders in Clinical Negligence cases. She reviews *PMC v Local Health Board [2024] EWHC 2969 (KB)* and notes, since permission to appeal has already been granted, the 'live' status of this area of law. Any appeal judgment will be awaited with anticipation given the importance of obtaining Anonymity Orders in sensitive cases where a litigant's privacy should be maintained. This judgment will rightly be sending concerned shockwaves for those representing minors and vulnerable parties in valuable claims whose identities would typically remain out of the public eye.

To help you navigate the contents with greater ease, here is a more detailed overview of what you can expect: -

Informed Consent

- To open the issue, Rochelle Powell summarises *Biggadike v El Farra and another* [2024] EWHC 1688 (KB), a High Court decision that considers how much information is enough information, in other words, a case where the Defendants had discharged their Montgomery duty, even where they departed from the NICE (National Institute for Health and Care Excellence) Guidelines.

- In his account of *Winterbotham v Shahrak* [2024] EWHC 2633 (KB), Michael Rapp looks at the key importance of assessing risk, Consent Forms, Guidance Forms and the need for them to be properly contextualised and orally explained.

Breach of Duty and Causation

- Turning to more general issues of liability, in his exploration of Runciman (on his own behalf and as *Executor of the Estate of Susan Alexander Deceased) v University Hospital NHS Foundation Trust* [2024] EWHC 1800 (KB), James Yapp highlights how the 'benefit' of hindsight can distort the urgency of clinical situations. Judges will consider what a reasonable body of physicians would have done not based on subsequent developments in a claimant's condition, but placing them in a 'real-world' context where, in an emergency, time is of the essence.

- In my account of Woods (a protected party by her mother and litigation friend Julie Woods) v *Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust* [2024] EWHC 1432 (KB), I examine the circumstances in which Mrs Justice Lambert DBE concluded that the foetal heart rate tests mandated further investigation, not routine discharge, of the mother of a claimant whose negligently delayed delivery left her severely brain damaged.

- Polina Sokolvska then examines the Judge's recognition in *PXE v University Hospitals Birmingham NHS Foundation Trust* [2024] EWHC 2023 (KB) that medical decision-making should be assessed based on the contemporaneous state of scientific knowledge and that the Court will be slow to find a breach where there would have been *"a genuine difference of opinion"* between experts at the relevant time.

- In the complex context of *Cauda Equina Syndrome (CES), James Arney KC unpacks Karen Spellman v Portsmouth Hospitals University NHS Trust* [2024] EWHC 2011 (KB), a *"delayed diagnosis"* case important for its lessons for expert witnesses and unusual in that no formal diagnosis was ever made.

- Concluding the section, Richard Boyle looks at *Thorp (administrators of the estate of Amanda Louise Thorp (deceased)) and another v Mehta and another* [2024] EWHC 652 (KB), which contains several key reminders concerning the weight of NICE Guidelines, the importance of patient autonomy and of establishing causation even in light of a *Montgomery* breach of duty.

Apportionment of Liability and Costs

- In Anthony Johnson's summary of *Healey v. (1) McGrath; (2) Ramsay Healthcare* [2024] EWHC 1360, he examines its useful illustration of the approach to be taken to (i) the apportionment of blame between two defendants where they have both admitted liability and (ii) assessment of costs in a Part 20 Claim.

Interim Payments

- In his account of *Snudden v Norfolk and Norwich University Hospitals NHS Foundation Trust [2024]* EWHC 615 (KB), Philip Matthews considers the impact of the Supreme Court's decision in *XX x Whittington Hospital NHS Trust* [2020] UKSC 14, explaining that even though foreign commercial surrogacy costs are recoverable, applications for interim payments in respect of such costs will struggle to satisfy interim judges that a future trial judge would likewise find in their favour.

- Andrew Ratomski then examines *XS1 v West Hertfordshire Hospitals NHS Trust* [2024] EWHC 1865 (KB), a recent judgement that invokes the *Eels principles (Cobham Hire Services v Eeles* [2009] EWCA Civ 204) and also reveals the difficulty of succeeding on an interim payment application, especially where much ambiguity about a defendant's evidence remains.

Strike Outs and Summary Judgment

- Turning to an interesting procedural decision, *Marcus Grant analyses Lukes v (1) Kent and Medway NHS & Social Care Partnership Trust and (2) Chief Constable of Kent* [2024] EWHC 753 (KB), which contains useful lessons for claimants when applying for strike out and/or summary judgment against two defendants; here, an NHS Trust and a Chief Constable.

Anonymity Orders

- To conclude this issue Lindsay McNeil evaluates the law concerning Anonymity Orders through the lens of *PMC v Local Health Board* [2024] EWHC 2969 (KB), a High Court case which balances competing Articles of the ECHR and suggests that, unless successfully appealed, reporting restriction orders (RRO) will not now be made where they may be rendered 'futile' by information already in the public domain, or would thwart the pre-eminence of open justice. The danger posed by this judgment is that it essentially erects a barrier to having any open communication with the press even pre-litigation: families and lawyers would be advised as a result of this judgment to say nothing at any time to the press, as well as to apply for an Anonymity Order as soon as the claim is issued.

The importance of the NICE Guidelines and of medical record-keeping: *Biggadike v El Farra and another* [2024] EWHC 1688 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY & CAUSATION – INFORMED CONSENT – MEASURE OF DAMAGES – NOTES – RECORDS – SURGICAL PROCEDURES

By Rochelle Powell
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The Facts

The Claimant presented with symptoms of urinary incontinence and potential pelvic organ prolapse. On 14 January 2017, the Claimant underwent surgery which included the implantation of TVT-Abbrevo ("TVT-A") tape to treat urinary stress incontinence, and a posterior prolapse repair. This was performed by Ms Kamilia El Farra, a consultant urogynaecologist and surgeon ("the First Defendant"). Almost immediately after the procedure, the Claimant began reporting symptoms of abdominal and pelvic pain, headaches and night sweats. She was seen by Professor Sohier El-Neil, another consultant urogynaecologist and surgeon ("the Second Defendant") for the on 2 February 2018. Dyspareunia, a buzzing sensation and back, hip and leg pain were noted by the Second Defendant. An ultrasound was performed on 28 February showing the TVT-A tape located in the mid-urethra and no evidence of erosion. However, the left arm of the mesh was curled and the right arm was at a lower level. The Second Defendant then performed mesh excision procedures, initially on 20 March 2018 when the central part of the tape was removed, and then again on 28 July 2018 when further flecks of tape were excised. As part of the operation performed on 28 July 2018, the Second Defendant performed a colposuspension procedure.

Issues

The Claimant alleged that the First Defendant had negligently managed her pre-operative care by failing to: (i) offer conservative treatment for her symptoms in the form of pelvic floor exercises; (ii) arrange urodynamic studies ("UDS") before deciding to proceed to surgery to treat stress urinary incontinence; and (iii) obtain her informed consent to the implantation of the TVT-A tape and to the posterior prolapse repair. The Claimant contended that in consequence of these breaches, she underwent a TVT-A tape implantation procedure that would otherwise have been avoided, at least until the national pause in TVT-A tape implantation which applied from July 2018.

The Claimant and First Defendant alleged that the mesh excision in March 2018 was in breach of duty because it was without clinical justification. The Claimant and First Defendant further alleged that the colposuspension was an unjustified procedure because it was not clinically indicated and so should not have been performed. Further, it was the Claimant's case that, had she been informed that the procedure lacked clinical justification, she would not have agreed to it. On this basis, the Claimant alleged it was performed in the absence of informed consent.

The Legal Tests

Her Honour Judge Carmel Wall (sitting as a High Court Judge) considered the two key tests for liability in medical negligence claims.

First, the Professional Practice Test: the Supreme Court in McCulloch and Others v Forth Valley Health Board [2023] UKSC 26 recently confirmed the now well-established test for medical negligence set out 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 it was established 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. The Court reiterated the basic principle that a doctor is under a duty to take reasonable steps to ensure that a patient is aware of any material risks involved with recommended treatment, and any reasonable alternative or variant treatments.

The correct approach to the NICE Guidelines was also considered. In Price v Cwm Taf University Health Board [2019] EWHC 938 (QB) the Court concluded that while the NICE guidelines do not have the force of law, they do carry some authority. A clinical decision which departs from the NICE Guidelines is likely to call for an explanation of some sort.

The Second Defendant's evidence

The honesty of the Second Defendant was openly called into question because additions were made to her clinical notes that were not contemporaneous.

In February 2019, the Second Defendant provided a set of medical records to the Claimant. At that time she was not a party to the proceedings but the medical records did not include the report of the results of urodynamic testing carried out at her request on 27 June 2018. She was then joined as a party to the claim. Medical records disclosed in August 2022 included the urodynamics report which had a handwritten annotation dated 6 July 2018. Other handwritten records had annotations that had been added to the original records at some time between February 2019 and August 2022. None of the additional annotations were dated or otherwise identified as having been made at a different time from the original records.

The explanation offered by the Second Defendant in her written evidence was that the original clinical records were scanned into an electronic record keeping system and preserved. The paper copies were kept in a patient folder and the annotations had been made on those paper records as an "aide memoire" for her benefit. She accepted that she had not identified the fact that the additions to the original records were not made contemporaneously. However, the Second Defendant said that because the Claimant's solicitors had been provided with both versions of the records, the additions would have been obvious to them.

Notably, the Second Defendant's explanation was rejected for three reasons:

1. If a contemporaneous clinical record is changed much later, it is necessary to identify what has been changed or added and the date the addition was made. It was not accepted that the doctor had genuinely believed that it was sufficient or acceptable to leave it to the diligence of the reader to compare electronic and paper records to determine what was contemporaneous and what was not.

2. The additions themselves were written in a way that suggested contemporaneity. Events that had already occurred were referred to prospectively. For example, a contemporaneous note in the original records set out a plan with four parts. Fifth and sixth parts were added to the plan. *The sixth part read "PIL [patient information leaflet] – mesh complications QOL [Quality of Life questionnaire] – to be filled in".* By the time this annotation was added, the time for completing and evaluating the questionnaire had well passed.

3. The content of the additions had a potentially self-serving character. The additions to one record added a reference to a patient information leaflet on mesh complications, potentially relevant to allegations of a defective consenting procedure.

   Accordingly, it was concluded that, when the Second Defendant made the annotations, she was intending to pass them off as contemporaneously made, and to that extent they were deceptive.

Findings

Preferring the First Defendant's evidence, HHJ Wall found that the Claimant was advised about effective conservative treatments, including pelvic floor exercises. The Claimant was also given a compliments slip with the contact details of a continence nurse to arrange her own appointment for pelvic floor exercises. The Claimant chose not to contact the nurse or pursue pelvic floor exercise treatment elsewhere because she wanted a surgical solution for her symptoms of stress urinary incontinence. It followed from this finding that the Claimant was sufficiently informed about the extent and nature of the procedures involved in a surgical solution; there was a full and sufficient discussion about the material risks and benefits of surgery; and the Claimant was provided with appropriate and sufficient patient information leaflets about each of the procedures and possible alternative treatments. That was sufficient to discharge the *Montgomery* duty.

On the facts, the failure to perform UDS had not been a breach of duty. It was common ground that the First Defendant did not discuss the possibility of undertaking UDS before the Claimant's surgery was booked. The First Defendant's evidence was that she did not overlook this guidance but made the positive decision that urodynamic testing was not mandated in the Claimant's case, based on her holistic assessment of the Claimant and her wishes.

Considering the relevant NICE Guideline for Urodynamic testing, the Court also found that the language used was consistent with the middle category of strength of recommendation. It was stronger than "consider" but short of "must". It was emphasised that guidelines do *not* have the force of law, and that a clinician is not necessarily in breach of duty if he or she departs from them. Further, there was a responsible body who, like the First Defendant, would not have subjected the Claimant to the unpleasantness of UDS. Accordingly, the departure from the recommendation in the NICE Guideline had not been a breach of duty in those circumstances.

However, not unsurprisingly given the findings of dishonesty, the Court gave judgment in favour of the Claimant against the Second Defendant in circumstances where she had, subsequently, performed mesh excision procedures to remove the TVT-A-tape, and a colposuspension. The allegation of breach of duty was proved against her because the colposuspension procedure was not clinically justified in the absence of symptoms of stress urinary incontinence. The omission to report and discuss the normal results of the UDS testing with the Claimant before the second surgery had vitiated the consenting process for the colposuspension. Considerable weight was attached to the unsatisfactory and evolving nature of the Second Defendant's account about when annotations were made, its context, purpose and why this was disclosed so late.

Comment

The decision provides useful reminders and clarification as to the scope and application of the principles set out in *McCulloch and Price:* it reiterates the established principle that guidelines do not have the force of law and a clinician is not necessarily in breach of duty if he or she departs from them. The key issue will always be whether the doctor acted in accordance with a practice accepted as proper by a responsible body of relevant medical opinion.

Further, the established deception of the Second Defendant reminds practitioners on both sides of the need scrutinise medical notes and records at the earliest opportunity in order to inform their case. Whilst medical notes may contain some errors, it is paramount that they are as consistent and accurate as possible. If there are significant inconsistencies, an explanation is likely to be required and, if there is actual doctoring of evidence, this will plainly weigh heavily in the balance.

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The wisdom to advise where risks are high and need to be highlighted: *Winterbotham v Shahrak* [2024] EWHC 2633 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY & CAUSATION – INFORMED CONSENT – RISK – WISDOM TOOTH

By Michael Rapp
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Background

This case was heard in front of Neil Moody KC sitting as a Deputy Judge of the High Court.

C attended the Defendant Dentist 'D', Dr. Shahrak, due to a partially erupted lower right wisdom tooth (LR8). A previous dental X-ray (referred to as an 'OPG') which was reported on 10.09.20 by her GP dentist, flagged that her *'LR8 roots [were] in close proximity to ID canal'* and she was a *'high risk'* for a local extraction under local anaesthetic. It recommended *'Possible CT scan'*. At a further attendance on 11.11.20, the proximity to the ID nerve was flagged again as *'high risk'.*

C was referred to D privately and attended his surgery on 27.11.20. D undertook the lower wisdom tooth extraction on the same day. C's lingual nerve was damaged in the procedure. C claimed that but for her injury, she would have worked full-time as a speech and language therapist (SLT) and as a counsellor, but could now only work in a very limited way on a part-time basis.

Allegations

Extraction of a lower right wisdom tooth gave rise to a risk of injury to 2 nerves, the inferior alveolar nerve (IAN) and the lingual nerve (LN). It was accepted by C that damage to the LN was a risk of the procedure and that the extraction was not carried out negligently. The claim was based on the allegations that she did not give informed consent to the extraction in that:

a) the risks were not properly explained to her, in particular:

   i. the OPG findings were not discussed with her; and

   ii. she was not told (1) that an extraction would be *"high risk"*, (2) that the roots of her tooth were in close proximity to the inferior dental canal, or (3) that a CT scan might be indicated.

b) she was not told about or offered a coronectomy (removal of the crown) which would have been a suitable and lower risk alternative.

Consequently, C alleged that if the risks and alternative treatment had been properly explained, she would have undergone a coronectomy, and the damage to the nerve would have been avoided. In the alternative, C claimed that she would not have undergone the extraction on that day but on another day with a different result.

The Facts

D's surgery had purportedly produced a 'Guidance Note' setting out information about the procedure and its risks. C alleged that she did not receive the Note, either in advance or at the consultation. She said that shortly after she arrived and before she sat down, D told her that he could take the tooth out that day. He was *"very casual"* about it and he gave the impression that it was *"run of the mill treatment"*.

Whilst it was common ground that C was supplied with, and signed, a consent form during the consultation:

a. There was no discussion at all about the consent form or the risks.

b. She denied that she was taken through the consent form or that D completed parts in pen in front of her.

c. She maintained that she was not shown the OPG and it was not discussed.

Both in his Defence and written statement D contended that the Guidance Note had been sent to C in advance. In an email from his solicitors dated 09.01.24, D changed his account contending that he gave C the document in the front room of his premises, left her with it and then called her in to his surgery. In evidence he admitted that he did not remember this clearly because of the *"sheer volume of patients"*. He also contended that he took C through the OPG and the consent form in detail.

D said that the content of the Guidance Note was no different to the consent form. He said the meaning was *"exactly the same"*. He accepted that he did not discuss the possibility of undergoing a coronectomy. When asked whether he was aware that the referring dentist had categorised the extraction a *'high risk'* he said that he might have been aware but denied it was so and asserted that in any event it made no difference because he would assess risk himself.

The Law

At paras 34-41 the judge set out the legal tests including ***Bolan***[1], ***Maynard***[2] *and* ***Montgomery***[3] .

At para 38 the judge flagged the two-limb test set out by ***Hamblen LJ in Duce v Worcestershire Acute Hospitals NHS Trust*** [2018] EWCA Civ 1307:

" (1) What risks associated with an operation were or should have been known to the medical professional in question. ***That is a matter falling within the expertise of medical professionals*** *[83].*

(2) ***Whether the patient should have been told about such risks by reference to whether they were material. That is a matter for the Court to determine*** *[83]. This issue is not therefore the subject of the Bolam test and not something that can be determined by reference to expert evidence alone [84-85]."*

At para 39 the judge identified paras 56-58 of ***McCulloch v Forth Valley Health Board*** [2023] UKSC 26 and the requirement, established by ***Montgomery***, that the clinician should advise the patient as to ***"any reasonable alternative or variant treatments"***.

Informed Consent

The Court found that D failed to obtain C's informed consent; specifically, he failed to:

a) Provide her with the Guidance Note,

b) Discuss the material risks with her and provide a meaningful opportunity to ask questions and discuss the procedure,

c) Explain the material risks, specifically:

(i) that there was an increased risk of injury to the LN;

(ii) that there was a high risk of injury to the IAN; and,

(iii) and that (whether or not there was a high risk to the IAN) this would be a high risk extraction within the meaning of the consent form.

d) Discuss coronectomy as a suitable and safer alternative treatment (because D did not think that a coronectomy would have been a suitable procedure) with a lower risk of nerve injury.

e) Discuss the potential need for a CBCT nor the potential need for a CBCT.

f) Discuss the risk of speech impairment (whether temporary or permanent) in the context of C's occupation as a SLT.

Moreover, given that C was already an SLT, the specific adverse consequences of nerve injury and its potential effect on her tongue and speech should have been discussed because as per para 87 of ***Montgomery***, C was likely to attach significance to the risks and D should reasonably have been aware of this.

The judge rejected D's reliance upon the signed confirmation on the consent form to contend that C had been given sufficient information and a reasonable period of time to consider it. The reality was that C was in no position to confirm that she had been given sufficient information or time because she did not know what information she should have been given. In his judgment, this was a clear case of D *"routinely demanding her signature on a consent form"*, the very practice criticised in ***Montgomery*** at [90]. It could not amount to informed consent.

Was D's assessment of the 'Risk of Procedure' reasonable?

As a result of C's LR8 being distoangularly impacted the extraction did involve an increased risk of injury to C's lingual nerve. The judge found that the close proximity of the root to the IAN as shown on the OPG would have led all reasonable practitioners to require (or at least offer) a CBCT scan. He rejected D's expert liability evidence on the point as not reasonable and hence (per *Bolitho*)[4] could not be a view held by a reasonable body of practitioners. Thus, it was not reasonable for D to conclude on the basis of the OPG alone that the risk to the IAN was an ordinary risk.

Regardless of whether D believed that this was a 'high risk' extraction, the increased risk to the LN meant that it required discrete attention on a consent form. Instead, the consent form did not distinguish between risks to the LN and the IAN but treated them compendiously. The Guidance Note adopted the same approach. It was therefore not possible to treat this as an "ordinary risk" procedure. D's belief that the risks would have been lower in his hands was unevidenced. Accordingly, C should have been told within the consent form that her extraction was high risk and carried a 2% risk of permanent nerve injury, and a 20% risk of temporary injury.

Causation

Primarily, the judge found that if C had been given the information to which she was entitled she would have asked for a CBCT scan. Having then received explanation regarding all appropriate and relevant risks, the Judge found she would then have decided upon a coronectomy. It would have been carried out on a different day by a different surgeon and the risk of injury would not have been the same as for an extraction. Secondly, it was very unlikely that it would have been necessary to remove the distolingual bone in the course of a coronectomy.

C's alternative case was that, even if she would not have chosen a coronectomy, if she had been properly warned about the risks, she would in any event have wished to consider her options further and she would not have undergone the extraction on the same day. C submitted that the principle in ***Chester v Afshar*** [2004] UKHL 41 was engaged, modifying the test on causation.

The Judge upheld the said contention, noting that ***'Chester'*** causation was established in that:

a) There had been a failure to explain a material risk, being the damage to the LN;

b) C suffered her injury as result of that very same risk which should have been warned about eventuating; and,

c) If properly advised of the risk, she would (at worst) have undergone the same procedure on a later date, which, in light of the relevant risks inherent in the procedure, would have resulted, on balance, in a different outcome.

Key Principles

This is a very useful and insightful case for anyone wanting to consider the issues of properly informed consent including consent forms, guidance forms and the need for them to be properly contextualised and subjectively explained. The judgment sets out in a coherent and digestible manner the most recent authorities on properly informed consent, a concise analysis of them and their application to a set of facts which, whilst not commonplace, have many common elements seen regularly by practitioners. It is likely to be an authority which is regularly seen, and relied upon, by claimants in the next few years.

By Michael Rapp
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1. *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 583
2. *Maynard v West Midlands RHA [1984]* 1 WLR 634
3. *Montgomery v. Lanarkshire Health Board (GMC intervening)* [2015] UKSC 11.
4. Whether the body of opinion relied upon is "responsible, reasonable and respectable" and whether it has "a logical basis": ***Bolitho v. City and Hackney HA*** [1988] AC 232 per Lord Browne-Wilkinson at 241.

Hindsight is always 20/20: *Runciman v University Hospital Southampton NHS Trust* [2024] EWHC 1800 (KB), Neil Moody KC (Sitting as a Deputy High Court Judge)

CLINICAL NEGLIGENCE – BREACH OF DUTY & CAUSATION – STROKE – EXPERT EVIDENCE – AVOIDING HINDSIGHT

By James Yapp
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This claim arose from the death of the Claimant's wife who suffered a venous sinus thrombosis ("CVST"). CVST is rare, accounting for 0.5% of all stroke patients admitted to hospital. The appropriate treatment for CVST would be heparin, an anticoagulant. The CVST had been misdiagnosed as an arterial ischaemic stroke ("AIS") and treated with thrombolysis, a "clot-buster".

The Claimant argued that the treating clinicians failed to realise that the deceased's presentation was not consistent with AIS; acted negligently in administering thrombolysis; and negligently failed to carry out a CT Venogram to rule out CVST.

The Defendant argued that the diagnosis, whilst later proven to be incorrect, was a reasonable one to make at the time. It argued that the treatment was appropriate.

The decision contains much of interest for practitioners considering allegations of breach in an emergency context. Where time was of the essence, the Court should recognise this in assessing the steps taken by clinicians. Further, the Court should guard against hindsight and, instead, consider the information available to clinicians at the time. Assessed in that context the Defendant's clinicians were deemed not to have breached their duty of care.

The Importance of Timing

A central factor in the case was the agreed urgency of administering thrombolysis for AIS. The National Clinical Guidance for Stroke from the Royal College of Physicians recommended thrombolysis within 3 hours of known onset. It could be administered at up to 4.5 hours. The "door to needle" time in each hospital was the subject of national audit and monitoring.

The importance of prompt treatment was summed up by the phrase "time is brain". As time passes more brain tissue can die, worsening the patient's prognosis.

The Factual Evidence

The deceased's symptoms began on 11th July 2018 when she developed a bad headache. On 15th July she experienced sudden onset speech disturbance and right sided weakness. Upon admission, headache was apparently not one of the primary complaints.

Dr Nar was the registrar on call. He said – and the Judge accepted – that he carried out a fundoscopy to check for raised intercranial pressure. The result was normal. A CT scan was carried out. The CT scan showed no clear signs of CVST.

Dr Nar discussed the case with Dr Morris, the on-call consultant. They agreed that AIS was the most likely diagnosis. They agreed to begin thrombolysis treatment.

Thereafter the deceased's condition deteriorated. Further imaging indicated CVST. She sadly passed away a few days later.

In her evidence at trial Dr Morris said that she had considered the history, Dr Nar's examination and the radiologist's opinion. She said they had discussed the possibility of CVST. Excluding CVST would have required a CT Venogram. Waiting for this test would have caused a delay in administering treatment for AIS. She took into account the fact that the benefit of treatment would be far less if it was delayed. She said AIS was by far the most likely diagnosis on the evidence before her. She would only have specifically excluded CVST if it was considerably more likely than AIS.

The Expert Evidence

The Claimant's expert made a number of important concessions in cross-examination. He agreed that 4.5 hours was the limit for administering thrombolysis. He also agreed that a reasonable body of opinion would have regarded AIS as the most likely diagnosis on the evidence available.

The Defendant's expert emphasised the rarity of CVST. He noted that the clinicians had seemingly considered the possibility of CVST. He applied his mind to the Bolam test. He concluded that a reasonable body of stroke physicians would have been concerned about AIS and would have pursued urgent treatment for this condition

The Decision

The Judge accepted that his decision must be made against the backdrop of two matters:

- The entire sequence of events, from arrival to thrombolysis, occurred within 45 minutes.
- It was important to guard against hindsight. Instead, he should *"put [himself] in the emergency room at 10am"*.

The Judge was impressed by the evidence of Dr Morris. She *"weighed the material before her, balanced the risks, applied her professional expertise, and reached a judgment in an urgent situation"*. He found that the deceased's presentation was consistent with AIS. It had not been negligent to conclude that this was the likely diagnosis. Proceeding with thrombolysis was time critical. Proceeding with treatment without ruling out CVST in those circumstances was reasonable.

By contrast, the Claimant's case *"depended on hindsight and failed to give sufficient weight to the information that was available… at the time and to the urgency of the situation."* There was no definite evidence that CVST was the more likely diagnosis. A reasonable body of stroke physicians would not have arranged a CT Venogram on admission.

Points to Take Away

Two linked issues come to the fore – the importance of avoiding hindsight, and the need to take the urgency of the situation into account. In particular:

- Whether a decision was negligent must depend upon the context in which it was made. The Court should recognise the need for swift action. In the index case, the deceased's presentation was consistent with AIS. If this diagnosis was correct, then starting treatment forthwith was critical because "time is brain"; and,

- The Court should focus on the information available to the clinicians at the time. On the basis of that information, a reasonable body of stroke physicians would have concluded that AIS was more likely than CVST and started treatment for the former. It was important not to view the evidence through the lens of subsequent discoveries.

The decision is also a reminder of the importance of compelling expert evidence. Expert reports should be comprehensive, thorough and properly apply the relevant legal standards. If they do not, they are likely to come up short at trial. With the benefit of hindsight (permissible this time), the issues faced by the Claimant's expert might have been addressed ahead of trial.

The following matters are of particular note in the judgment:

- The expert was criticised for failing to consider the postmortem results, accepting himself in cross-examination that a "fair analysis" would have done so;

- His report contained little recognition of the time pressure under which the clinicians were operating. Given the centrality of this factor in the Judge's overall assessment of the case, it is perhaps unsurprising that the Defendant's expert evidence was preferred; and,

- Whilst the expert referred at one point to the standard of a "reasonable body of stroke physicians", he was criticised for failing carefully to evaluate the judgements of clinicians against that standard. By contrast, the Defendant's expert considered appropriate clinical guidelines and relevant literature and gave his opinion with the Bolam test clearly in mind.

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The trace left by the failure to investigate further: *Woods (a protected party by her mother and litigation friend Julie Woods) v Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust* [2024] EWHC 1432 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY & CAUSATION – DICHARGE INTO ANTENATAL CARE – FAILURE TO PERFORM FOETAL ASSESSMENTS - DELAYED DELIVERY – CHRONIC PARTIAL HYPOXIA – EXPERT EVIDENCE

By Lionel Stride
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In Woods, the High Court found that the discharge of the Claimant's mother into routine antenatal care was a breach of the doctor's duty to perform the necessary and reasonable foetal assessments which would have returned abnormal, catalysing earlier delivery of the Claimant. Had the delivery not been delayed, she would have been spared the permanent brain damage and neurocognitive impairments that she suffered as a consequence of chronic partial hypoxia.

This case is particularly notable because the Judge, Mrs Justice Lambert DBE, openly preferred the Claimant's expert evidence to that of the Defendant, highlighting deficiencies in the main report of the latter. As Lionel Stride explains, the case contains important observations on the Court's approach to assessing the appropriate standard of obstetric care, reasonable management of pregnancies and the need to follow established guidelines on foetal testing. The judgment also serves as a healthy reminder of the critical need for diligent analysis of the records by the experts in clinical negligence cases.

Background

The Claimant, who was born on 14 October 1998 by emergency caesarean section, sustained brain injury as a result of hypoxic ischaemic encephalopathy caused by chronic partial hypoxia during the perinatal period. She was born in a *"poor condition"* ([14]), with a very low heart rate, and the umbilical cord wrapped around her neck.

It was the Claimant's case that the onset of chronic partial hypoxia was no earlier than around three days before her birth (i.e., no earlier than 11 October 1998); that it persisted until her resuscitation very shortly after her birth; and that, had the delivery taken place before 11 October, the Claimant would have been neurologically intact. Whilst not disputing the likelihood of a period of perinatal partial hypoxia, the Defendant asserted that the effect of the hypoxia was not brain damaging and that the Claimant's current neurological condition was likely to be genetic in origin. Earlier delivery would not therefore have altered the Claimant's neurological condition.

On 28 September 1998, Mrs Woods attended the hospital complaining of a history of leaking per vaginum. After cardiotocography (CTG) monitoring by performing a first, then second, trace, Dr Samy discharged Mrs Woods to be followed up routinely. This was despite the fact that it had not been possible to identify the baseline in the second trace; there were no typical accelerations and for most of the trace the foetal heart was tachycardic, running at faster than expected for a foetus.

It was the Claimant's case that had further foetal heart monitoring, an assessment of liquor volume and an assessment of foetal size been undertaken on 28 September, the further CTG trace would not have been normal or reassuring, mandating delivery on or around 29 September. The pregnancy would by this stage have been at almost 40 weeks' gestation. In addition, the Claimant asserted that Dr Samy ought reasonably to have questioned Mrs Woods concerning foetal movements when he saw her for routine antenatal care on 6 October; she would then have told him about reduced foetal movements and, had he performed foetal heart monitoring, the trace would have been abnormal and a decision to deliver immediately would have been made.

The Defendant denied breach of duty. Mr Derek Tuffnell, Consultant Obstetrician, stated that the second trace was wholly *"reassuring"* and that it was appropriate to discharge Mrs Woods for routine antenatal review. He also opined that any further monitoring on either the 28 or 29 September (or 6 October) would have been normal and equally reassuring.

Critical Issues

In this liability-only trial, the Judge was required to determine three principal issues, namely:

(i). Whether it was reasonable to conclude that the second trace was reassuring;

(ii). If not, and further assessment had reasonably been required, then what on the balance of probabilities would have been the outcome of further assessment on 28/29 September? Specifically, would it have led to a decision that labour should be induced and, if so, when should labour have been induced? and,

(iii). Whether, in the alternative, Dr Samy ought to have asked Mrs Woods about foetal movements on 6 October and, if so, whether the inquiry would have led to the Claimant's delivery on or around 6 October.

Expert Obstetric Evidence

Mr Hare, the Claimant's expert, stated that the first trace showed two abnormal features: a tachycardia (of over 160 bpm) and 2 decelerations. He relied upon guidance from the 1985 FIGO (International Federation of Obstetrics and Gynaecology) Guideline and the Royal College of Obstetricians and Gynaecologists which describe "normal baseline heart rate" as below 150bpm. While the second trace reviewed by Mr Hare was of poorer quality, it was sufficiently legible for him to determine that no baseline was observable. It was therefore unacceptable for Dr Samy to have concluded that the trace was reassuring. Mr Hare concluded that the only reasonable management was a repeat CTG, a measurement of liquor volume and an assessment of the size of the foetus including head circumference. He disagreed with Dr Samy's conclusion in the clinical notes that the trace was accelerative and reactive to foetal activity.

Mr Hare said that at birth, the Claimant had intrauterine growth retardation ("IUGR") due to placental insufficiency and that this was the process which had led her to suffer a period of chronic damaging hypoxia in the days leading up to her delivery. The process of IUGR likely started during the third trimester and was present on 28 September 1998. In his opinion, the induction of labour on 28 September was mandatory. Further, he stressed that, on 6 October, Dr Samy should have asked Mrs Woods specifically about her perception of foetal movements. If, as she asserted, she was sensing a reduction in foetal movements then this should have prompted a repeat CTG assessment which would have been non- reassuring and would have led to induction of labour (8 days earlier than the actual birth on 14 October).

Mr Tuffnell, the Defendant's obstetric expert, described at trial that the first trace was 155bpm – 170 bpm which was *"the upper limit of what is considered normal"*: [45]. Mr Tuffnell opined that the second trace had been clearly interpretable with a normal baseline of around 140 bpm, notwithstanding that there were only 3 minutes of stable baseline. He was confident that the foetal heart rate was healthy and accelerating in response to foetal movements. He said that, in September 1998, the Claimant did not have IUGR and that any further assessments would have returned normal, such that there would have been no indication to induce labour.

Findings on the first and second traces

The Judge found that a repeat trace was the only appropriate and reasonable response to the difficulties in interpretation of the first trace. The Claimant's heart rate was beating at a rate of between 155 and 170 bpm, which was at the very least tachycardic.

The Judge found that the second trace was not sufficiently reassuring to justify discharging the Claimant back to routine antenatal care because FIGO and RCOG Guidelines supported Mr Hare's evidence that, in order to determine a baseline heart rate, a minimum period of 5 minutes is required; and, on Mr Tuffnell's own evidence, he identified a block of no more than 3 minutes when the heart rate was stable at 140 bpm. The Judge continued that, on her findings, the tachycardia was not likely due to the foetus being in an active state because otherwise, since the first trace lasted for 100 minutes and the second for 30 minutes, then subject to short blocks of deceleration, the foetus would have been active from 19.45-23.00, far longer than the Claimant's evidence that active phases lasted no more than one hour.

Findings on the question of further investigations

The Judge then considered whether the Claimant was affected by IUGR in September 1998, such that it would have been detected on 28/29 September 1998, had further investigations been properly performed on that day. The Judge accepted the evidence of Mr Hare that the downward trajectory of the foetal heart's compensatory mechanism may be very slow when the underlying mechanism is placental dysfunction; Mr Hare referred to "several days", the 20 authors of the FIGO Guidelines referred to "several weeks". Whilst Mr Tuffnell asserted that IUGR may be a "late stage" condition, this point was not raised in Mr Tuffnell's report, nor backed by literature on the topic. Further, Mr Tuffnell accepted that the placenta had been "gritty"/ sub optimal in the last week or two before delivery, indicating a process which had been ongoing since, even on his assessment, 14 days before delivery i.e., on or after 1 October. Ultimately, had a longer CTG trace and/or a liquor volume assessment been undertaken on 28/29 September, the Judge was satisfied that both would have continued to be abnormal, mandating immediate induction of labour.

The Judge's critique of the Defendant's expert evidence

It is worth considering in more detail why the Claimant's expert evidence was ultimately preferred.

Counsel for the Claimant in part challenged the evidence of the Defendant's experts on the basis that their reports had been prepared with the respective statements of case in mind; i.e., essentially, that their reports were prepared to meet the Defence (rather than objective assessments of the evidence). The Judge disagreed and noted that *"[i]t would be distinctly odd if an expert's final report, prepared for the purposes of disclosure, had not been prepared having had sight of the statements of case."* [61].

There were, however, three features of Mr Tuffnell's report in particular which the Judge did accept were problematic.

Firstly, the improper consideration that it gave to the second trace, the predominant issue in the case. In 2007, when Mr Tuffnell prepared a first report, the second trace was not the subject of criticism. By 2021, when the case was issued, however, the second trace was the focus of the claim. Mr Tuffnell admitted that he had merely imported a section from his initial report, which set out his historic interpretation of the second trace. The Judge deemed this position *"wholly unsatisfactory."* [64]. A better and more legible copy formed a central part of Mr Hare's report. Consequently, Mr Tuffnell should have seen (and addressed) the better copy upon review of Mr Hare's report.

Secondly, the contents of Mr Tuffnell's report were not directly supported by any reference in the medical notes. He both *added* contentions missing in the records (for example that the foetus was moving at the time of trace, for which there was no supportive evidence) and misrepresented the records (stating that there was no leakage on the day of attendance despite a documented report from Mrs Woods of leakage being the presenting complaint and the main reason for self-referral.)

Thirdly, the Judge criticised the fact that the expert relied on little, if any, literature even when he was challenging the use of the Guidelines on which the Claimant's expert relied (for example, FIGO/RCOG and the need for >5 minutes of stable baseline).

Whilst "small" on their own, these deficiencies combined to create an unfavourable picture, leading the Judge to conclude that "*Mr Tuffnell's preparation has lacked the attention to detail which the case demanded.*" [66]. A strong criticism of the expert couched in polite judicial language.

Key Takeaways

Whilst it lays down no new legal principles, this case offers highly relevant guidance on the Court's approach to birth injury cases and its expectations for experts giving evidence.

Guidelines such as FIGO and RCOG are clearly relevant to the standard of care expected of obstetric doctors. Whilst not determinative, the Judge also made remarks about the standard of notetaking, finding that, in the absence of any written record to the contrary, Dr Samy did not ask Mrs Woods about foetal activity on 6 October. Even in 1998, a short note was required: [87].

Further, *Woods* provides salutary reminders of the following:

i. It is completely acceptable (and, indeed, expected) for an expert to review statements of case before completion of their report (standard practice when asking any expert to finalise their report pre-service) but failing to notice or comment on critical medical records (especially if contained in a rival report) will be seen very differently;

ii. Experts need to review all up-to-date, best quality tests performed and comment on the core issues in the case as it evolves; their evidence is otherwise open to easy challenge and will be far less likely to be preferred.

iii. Experts need to be precise when summarising clinical records and should expect to be criticised if there are material inaccuracies: for example, while Mr Tuffnell responded to his failure properly to report "leakage" by saying that this was clumsy wording and that he intended to convey that there had been no further leakage following admission, he could not escape the fact that this was not what he had written in his report: [65].

Overall, it is a glaring warning to experts not to take a *"casual approach to the issues in the litigation"* and rather, *"consider the issues in the case with real care"*: [66]. This is also a clarion call to practitioners to be astute to such deficiencies when considering rival reports and discussing them with their own experts for the purpose of advising their clients and/or preparing for ADR or trial.

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Contemporaneous evidence and "a genuine difference of opinion" between experts: *PXE v University Hospitals Birmingham NHS Foundation Trust* [2024] EWHC 2023 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY AND CAUSATION – PREGNANCY – KIDNEY FUNCTION – BIRTH DEFECTS – EXPERT EVIDENCE

By Polina Sokolovska

A claim alleging breach of duty by an obstetrician in a district NHS hospital failed after the Defendant showed to the Court's satisfaction that in 2008, the link between reflux nephropathy and an elevated risk of IUGR absent impaired kidney function was not known. As per Bolitho, where, as here, there is "*a genuine difference of opinion*" between experts, as long as the arguments of the expert supporting the alleged breach are well reasoned and not illogical, the Court will find that duty of care was not breached.

Factual Background

The Claimant was delivered via an urgent C-section on the 4th of October 2008 with foetal growth restriction. Whilst in his mother's womb, the Claimant developed periventricular leukomalacia ("PVL"), when the white matter surrounding the ventricles of the brain softens after being deprived of blood and oxygen. He now suffers from permanent brain damage.

Prior to the Claimant's birth, his mother had a history of cystitis and kidney scarring. This was noted by a midwife, Ms Carbery, at an ultrasound scan on 16 May 2008, who indicated that the pregnancy was "low risk" and would only require *"midwife led care"*. This classification was reviewed and approved by a consultant obstetrician, Ms Hutchon, on 20 May 2008. Thereafter, the Claimant's mother was in the care of midwives with no consultant obstetrician involvement.

On 3rd October 2008, the Claimant's mother attended Solihull Hospital, reporting that she had experienced reduced foetal movements. She was reviewed by consultants Dr Raj and Mr Griffin, who noted that her cervix was closed and transferred her to Birmingham Heartland Hospital for an urgent C-section.

The Claimant's Allegations

The Claimant brought a claim against the Defendant trust, alleging that his mother's history of cystitis and kidney scarring problems were associated with renal disease. The midwife assessing the Claimant's mother should have noted these as chronic medical conditions that posed risks to the pregnancy outcome, and referred the Claimant's mother to a senior medical obstetric review. It was his case that, had this been done, the senior medical obstetric staff would have recognised that the Claimant was at risk of Intrauterine Growth Restriction ("IUGR") and arranged regular scans to be carried out from around 28 to 30 weeks and for the pregnancy to be closely monitored. These scans would have shown that the Claimant was developing an increasing risk of hypoxic ischaemic damage. A medically planned earlier delivery would then have occurred, which would have avoided the Claimant developing PVL.

Key Issues

The main issues for the court were as follows [8]:

1) Whether the history provided by the Claimant's mother and noted "cystitis: kidney scarring" would have alerted a reasonably competent obstetric consultant in 2008 that she may have been suffering with reflux nephropathy or chronic kidney disease.

2) If the Claimant's mother should have been assessed as low risk by the consultant.

3) Had the pregnancy been assessed as high risk due to the history of kidney scarring, would the Claimant's mother have undergone growth scans at 28 weeks and had a further investigation of the IUGR.

4) Whether, following these scans and investigations, the Claimant would have been delivered earlier and avoided injury.

The Legal Framework

The Court affirmed the principle in *FB v Princess Alexander Hospital NHS Trust* [2017] EWCA Civ 334 that the applicable standard by which a hospital doctor should be judged is by reference to the post which they were fulfilling [28]. HHJ Sarah Richardson accepted the submission of Defendant's counsel that the applicable standard is to be measured by reference to *"the ordinary skilled midwife… at the relevant time before 1st October 2008"* [32].

In relation to the applicable test to determining the actions of the hypothetical ordinary skilled midwife, Judge Richardson highlighted the following passage from *Bolitho v City and Hackney HA* [1998] AC 232 [p241]:

> ***"…the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter." [29]***

Judge Richardson stated that if the court is satisfied that the defendant's expert evidence establishes *"a genuine difference of opinion and technique"* and it is logically reasoned, then this constitutes a competent reasonable body of opinion and duty of care will not be breached [33].

Judgment

HHJ Richardson decided that the Defendant had not breached their duty of care to the Claimant's mother. The Judge's reasoning can be summarised a follows:

i) Midwife Carbery had breached her duty of care by not referring the Claimant's mother to a consultant obstetrician but this did not cause the actual injuries

In considering the midwifery expert opinion, Judge Richardson preferred the evidence of the Claimant's expert Ms Angela Helleur to that of the Defendant's, Ms Jennifer Fraser. Judge Richardson opined that Ms Fraser's approach was inconsistent and *"there was a lack of logic in the reasoning"* [153]. The Judge decided that Ms Carbery should have referred to the obstetrician Ms Hutchon for further review before making the low-risk classification.
However, the midwife's failure did not cause the Claimant's injuries because his mother was reviewed by an obstetrician in any case [154].

ii) It was reasonable for Ms Hutchon to classify the pregnancy as low risk

The court accepted Ms Hutchon's evidence that whilst she noted the history of recurrent cystitis and kidney scarring, there was no evidence of childhood cystitis [152]. She, therefore, did not think that reflux nephropathy was a serious possibility. The Defendant's obstetric expert, Mr Derek Tuffnell, supported that it was reasonable to classify the Claimant's mother as a low risk pregnancy because of her clinical presentation, stating that she did not have signs of renal impairment, or proteinuria, hypertension or urinary problems with infection [160].

ii) "Genuine difference in opinion" between experts

Judge Richardson decided that the factors considered by Mr Tuffnell were reasonable and there was nothing illogical in Mr Tuffnell's opinion [160]. The Claimant's obstetric expert Mr Mark Denbow had also accepted in his evidence that Mr Tuffnell represented a responsible body of obstetric opinion [97]. HHJ Richardson decided that Mr Tuffnell and Mr Denbow had "a genuine difference of opinion" and the fact that Mr Tuffnell supported Ms Hutchon's risk assessment signified that this was reasonable and *"open to a reasonably competent obstetrician working in a District General Hospital in 2008"* [169].

iv) Contemporaneous medical literature

In her evidence, Ms Hutchon stated that she was not aware in 2008 that there was a connection between reflux nephropathy and IUGR, absent functional kidney abnormality [56]. In response, the Claimant referred to a number of contemporaneous texts to show that this connection was accepted among practitioners in 2008. The Court's discussion of the literature is set out at [123-140] and [162-169]. Judge Richardson decided that the medical literature available in 2008 *"did not paint a clear picture"* on the issue of whether reflux nephropathy without impaired kidney function increased the risk of IUGR [161].

v) The experts' clinical backgrounds matter

Throughout the judgment, HHJ Richardson emphasised that the Court must consider the position of a midwife or obstetrician in a district hospital, including the resources that would have been available to them at that time.

When questioned about the work carried out by Professor Jason Gardosi around the time of the Claimant's birth in relation to foetal growth screening methods, Ms Hutchon noted that such scanning resources were not readily available in district hospitals in 2008 [65]. This was further supported in Mr Tuffnell's expert evidence. Judge Richardson highlighted that Mr Tuffnell, who was a consultant in a large District General Hospital, *"was clearly more familiar with the working conditions that Ms Hutchon was facing in 2008"* [158]. This was in contrast to Mr Denbow, who had always worked in a large teaching hospital and had more resources available to him [158].

Conclusion

This decision serves as a reminder of the difficulty in establishing an historical breach of duty in clinical negligence claims. A court does not need to elect a preferred expert when there is *"a genuine difference of opinion"*. As long as the Defendant's expert opinion is well reasoned, it is sufficient to discharge the Bolam standard of a "*responsible body of medical opinion".* Appropriate expert selection is, therefore, crucial for successfully defending a clinical negligence claim. From a claimant perspective, unless there is a determinative factual dispute, it is also essential to have good grounds to show why the opinion of an expert supporting the defence to the claim has no logical basis.

By Polina Sokolovska

A non-negligent failure to diagnose Cauda Equina Syndrome: *Karen Spellman v Portsmouth Hospitals University NHS Trust* [2024] EWHC 2011 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY AND CASUATION – CAUDA EQUINA SYNDROME – DIAGNOSTIC IMAGING - RADIOLOGY

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The Claimant failed to establish negligent reporting of an MRI of the spine in a claim for delayed diagnosis of Cauda Equina Syndrome, applying the "pure diagnosis" test.

Cauda Equina Syndrome

The cauda equina is a collection of spinal nerves and nerve roots which supply the lower limbs and the pelvis. It is located in the lumbar spine and when compressed, can quickly escalate to permanent damage, including paralysis, if untreated. The diagnosis of the compression of the cauda equina is also referred to as Cauda Equina Syndrome (CES). Delayed diagnosis of CES is a common area of litigation, as urgent decompression surgery is usually required.

The Facts

This was a liability and causation-only trial.

The Claimant had a long history of back pain and urinary and faecal incontinence, having previously undergone a lumbar microdiscectomy at the L4/5 level and two revision surgeries. The Claimant's case was that she had a fall at work on the 5th of June 2017 (trauma to the spine is one of the recognised causes of CES).

The Claimant presented to the GP the next day with pain on the left side of the lower back and some perineal numbness. She was then referred to Queen Alexandra Hospital, where she was assessed by an orthopaedic resident and underwent an MRI of the spine ("the index scan") to investigate if she qualified for urgent surgical intervention.

Dr Witham, a consultant radiologist at the hospital, reported the results of this scan as showing a *"slightly tight"* canal at the L2/3 and L3/4 level, constriction of the thecal sac largely due to epidural fat and *"L2/3 and L3/4 mild central canal stenosis"*. The Claimant was then discharged home with a follow-up outpatient clinic visit scheduled in two months.

The Claimant sought a private medical opinion six days after the index MRI. She was reviewed by a Consultant Spinal Surgeon at Spire Hospital, who diagnosed her with CES without conducting a repeat MRI and proceeded with decompression and lumbar discectomy at the L3/4 level on the same day (note that the Claimant's case was that her cauda equina was compressed at L2/3 level).

Unhelpfully, the spinal surgeon did not make notes during the appointment and it is unclear from the letter prior to the operation or the operation note whether he saw Dr Witham's report. The spinal surgeon was not called as a witness, so Mr Justice Sweeting had to rely on the limited documentation to understand the surgeon's reasons for interpreting the scan as showing CES. An MRI was undertaken post-operatively, but it does not have much utility without a pre-operative image to compare it with.

The Key Issues

The Claimant advanced the following allegations of breach of duty by Dr Witham [43]:

(1) "Wrongly described the scan as only showing "mild" central spinal canal ("CSC") stenosis;

(2) Failed to report that there was "moderately severe" CSC stenosis at L2/3 and "severe" CSC stenosis at L3/4;

(3) Failed to identify that there was "gross pathology" at L2/3 and L3/4 capable of causing the Claimant's symptoms and indicating symptoms of CES;

(4) In light of the Claimant's symptoms and clinical history, failed to recommend a further scan and/or discussion with the local spinal surgical centre."

In order to establish a breach of duty, the Claimant's counsel submitted that the *"single most important question"* for the Court was whether there was radiological evidence of cauda equina compression [45]. During trial, witnesses were questioned on issues which included: at what level of CSC was stenosis visible; whether a facet joint cyst at L2/3 level was visible on the scan; whether cerebrospinal fluid ("CSF") signal was present at all levels of the scan; and whether it was reasonable for Dr Witham not to conduct a repeat MRI, given the poor quality of the index scan.

The Legal Test

The Court held that the applicable test for determining whether a radiological report of an imaging was reasonable is set out in *Penny v East Kent Health Authority* [2000] Lloyd's Rep Med 41 and *Brady v Southend University Hospital NHS Foundation Trust* [2020] EWHC 158 (QB). This is summarised as a two-stage test [80]:

What was to be seen on the imaging? (this is a factual question)

Was the scan reported "in a reasonable manner"? (determined *"by reference to the Bolam test, subject to the Bolitho qualification"*)

The Trial

Dr Witham, the radiologist who reported the index scan, gave evidence at trial. Dr Witham stated that the Claimant was in pain at the time of the index scan and conducting a repeat scan would not necessarily have led to a clearer image [60]. Dr Witham explained that she was looking for a cause of acute CES. She opined that longstanding canal stenosis would not have been a cause of acute CES, and she would have needed to find other evidence on the scan [62]. She stated that there was no evidence of cauda equina compression because there was epidural fat that would have been pushed out if there was severe stenosis [62].

The Claimant's radiology expert was Dr Jonathan Spratt and the Defendant's was Dr James Rankine. In his oral evidence Dr Spratt argued that the scan showed the compression of the cauda equina, as there was evidence of a significant narrowing of the thecal sac at the L2/3 level and absence of CSF [91]. Dr Spratt initially described the stenosis at L2/3 and L3/4 levels as *"severe"*, later agreeing with Dr Rankin's assessment that it was *"moderate"* [94]. Counsel for the Defendant made a number of criticisms of Dr Spratt, including for misidentifying a facet joint cyst as a disc protrusion and misplacing the location of the stenosis [92]. Counsel also submitted that Dr Spratt had made the same mistake on a previous case [93]. Dr Spratt faced further criticism for relying on the post-operative imaging from July 2017, which counsel for the Defendant submitted was unreliable [93].

Dr Rankine gave evidence that, in his opinion, the cyst at L2/3 was merely part of the overall *"moderate"* spinal stenosis that constituted long standing, constitutional generative changes and would not on its own exacerbate CES. He also argued that CSF was visible on the scan at both L2/3 and L3/4 [97]. Dr Rankine explained by reference to the scan that the nerves floated freely within the thecal sac surrounded by CSF without any constriction and because of this, despite the spinal stenosis, there was no effect on nerve function [99].

The Court's Decision

The Court found that Dr Witham did not report the MRI unreasonably and, accordingly, did not breach her duty of care.

Mr Justice Sweeting found that, firstly, Dr Witham's decision not to repeat the MRI was reasonable, given that there was no guarantee that this would provide a better quality image and that the Claimant was referred on an urgent CES pathway.

He further found that, where the radiology experts disagreed, he preferred Dr Rankine's evidence, stating that Dr Spratt's mistakes *"did not inspire confidence"* [118]. He decided that CSF was present at all levels on the scan [119]. Mr Justice Sweeting also accepted Dr Rankine's evidence that the imaging showed that the spinal nerves were not at any point bundled or compressed and that this explained why stenosis does not always cause compression of the spinal nerves [120].

Mr Justice Sweeting also rejected the Claimant's argument that her symptoms between the scan in the hospital and the presentation at Spire Hospital showed deteriorating CES [122-3]. The Claimant herself admitted at trial that she lied about her symptoms when presenting at the GP and hospital in order for her to be taken more seriously, causing the judge to state that he should *"approach[ed] her account with caution"* [122].

Key Takeaways

i. This case highlights the difficulty of proving "pure diagnosis" cases, particularly in the context of interpreting MRIs of the spine, there being no standardised approach to interpreting levels of stenosis[5].

ii. That said, this was an unusual "delayed diagnosis" case in that no formal diagnosis was made. There was also no concrete evidence of the findings of the private surgeon who carried out the decompression surgery to support the contention that there was identifiable CES on the index scan. Usually, claimants seek redress after a formal diagnosis has been made and it is well documented, such that their path to establishing a breach of duty is likely to be less complicated than Ms Spellman's, albeit claimants would still need to establish that no responsible body of radiologists would have missed the diagnosis.

iii. This case also emphasises the importance of key expert witnesses' track record in other cases, particularly where they involve similar subject matter. Previous decisions may also assist in anticipating opponents' arguments or formulating your own, whether aimed at the substance of the claim or discrediting opposing experts. On contentious medical issues, expert credibility is fundamentally important.

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5. *There was some discussion in this case about whether there is a standardised system for classifying the level of canal stenosis. Both sides relied on a number of academic papers in this regard [74-76]. The court decided that there is no fixed standard for language used in the radiology reports [127].*

Montgomery breaches still face causation challenges: *Thorp (administrators of the estate of Amanda Louise Thorp (deceased)) and another v Mehta and another* [2024] EWHC 652 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY & CAUSATION – HYPERTENSION – MEDICAL ADVICE-GIVING – AMENDMENT TO CLAIM – EXPERTS & NICE GUIDELINES

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Introduction

The deceased died from a stroke in January 2018 aged only 42. She had a history of high blood pressure and had been prescribed an antihypertensive drug during pregnancy. Following the expiry of her prescription, and post-partum, the deceased saw two GPs: Dr Chua and Dr Mehta. The GPs chose to await the results of ambulatory blood pressure monitoring ("ABPM") before prescribing further medication. The deceased (via the administrators of her estate) alleged that the GPs ought to have prescribed antihypertensives immediately, rather than awaiting the results of ABPM, which would have avoided the fatal stroke.

Treatment according to NICE Guidelines

The NICE Guidelines suggested that antihypertensives should be started immediately, without awaiting ABPM, in cases of severe hypertension. However, none of the deceased's blood pressure readings amounted to severe hypertension, as defined by the Guidelines, when she was seen by the GPs. In cases of raised, but not severe, hypertension, the Guidelines suggested ABPM to confirm the diagnosis. The deceased's expert did not analyse these provisions of the Guidelines and the deceased relied on the following provision:

"[I]t is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual".

Turner J concluded that the deceased's expert had failed to take into adequate account the Guidelines from the outset. As a result, the expert's subsequent analysis became incoherent. There was no breach on a Bolam basis: a reasonable body of GPs would have followed the Guidelines.

Strong Advice

The deceased alleged that the GPs should have advised the deceased, in clear and strong terms, of the importance of attending ABPM appointments. The judge held that this would have been a counsel of perfection. The deceased knew why ABPM had been recommended and it was important not to apply hindsight. Moreover, *"there is a risk that advice expressed over-emphatically may discourage a patient from re-attending for fear of admonishment"*.

Treatment Options

At the start of trial, the deceased applied to amend her claim to plead that Dr Mehta should have presented her with two options: (a) continue with the diagnostic assessment (i.e. ABPM); or (b) prescribe treatment (i.e. antihypertensives).

As per *Montgomery v Lanarkshire Health Board* [2015] AC 1430, a practitioner is under a duty to ensure that the patient is aware of any material risks involved in recommended treatment and of any reasonable alternatives. The judge allowed the amendment despite opposition.

The judge accepted that Dr Mehta should, at least, have raised the alternative of an immediate prescription of antihypertensives, given the deceased's raised blood pressure readings, her failure to attend previous appointments and the possibility of further delay for ABPM. Accordingly, there had been a breach of duty as per Montgomery principles.

The court went on to consider causation: if the deceased had been informed of the option to take antihypertensives, without waiting for the results of the ABPM, would she have done so? The judge concluded that the deceased would probably have continued to opt for ABPM. It may have avoided a lifetime on antihypertensives. It was speculative to suggest that Dr Mehta would have positively encouraged the deceased to choose to take the tablets.

Facebook Posts

The deceased has posted a number of very high blood pressure readings on Facebook, alongside comments indicating that she was stressed. However, the judge held that the readings may have been posted against a background of lower readings and so did not establish chronic hypertension at the time of the stroke.

Points of Wider Application

The case raises a number of points of wider application:

1. The importance of experts framing their conclusions by reference to NICE Guidelines. While Guidelines are not intended to be entirely prescriptive, the court held that they should be taken *"fully into account"*;

2. The weight to be placed on NICE Guidelines. The court held that cases where practitioners are found negligent, despite following Guidelines, are likely to depend on the specific circumstances. In other words, it is possible to establish negligence when the Guidelines are followed. Indeed, the Guidelines make it clear that they are not mandatory and practitioners are to consider the circumstances of the individual. However, the implication is that this would be unusual and fact specific, which is surely consistent with *Bolam* principles;

3. A hospital discharge summary stated that the deceased was to have a medication review. However, this was not to be treated as if it were an instruction to the GPs working at the surgery. Each had to exercise an independent judgment as to the appropriate way forward;

4. The importance of patient autonomy. The judge dismissed the allegation that the GPs should have given the deceased "strong" advice. The deceased was aware of the need for ABPM and a strong prompt might have been counter-productive;

5. It may not be too late to amend. The judge allowed the deceased to amend at the start of trial to plead a new breach of duty. His ex-tempore judgment is not reported but likely relied on the fact that the amendment was prompted by the Defendant's expert. Claimants should remain alive to pleading issues raised by a joint report;

6. The ongoing impact of *Montgomery.* The judge stated that Dr Mehta's decision not to ventilate the alternative options was an example of the more paternalistic approach to the doctor-patient relationship that would almost certainly have survived the *Sidaway* threshold of breach of duty but was vulnerable to the more patient-centred *Montgomery* analysis;

7. *Montgomery* breaches still face causation challenges. The judge held that there was no breach under Bolam principles but there was a breach under *Montgomery* principles. However, the fact that options should have been discussed was not enough. The deceased had to establish that she would have chosen the alternative option. *Montgomery* must be seen in light of its unusual facts: the practitioner in question had deliberately failed to mention an option out of fear that the patient would choose it, despite the practitioner's view that the option was not in the patient's best interests; and

8. Social media posts should not be treated as gospel. The judge recognised that social media points are likely to include the most striking information and overlook the mundane.

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The approach to be taken to apportionment in a Part 20 Claim: *Healey v. (1) McGrath; (2) Ramsay Healthcare* [2024] EWHC 1360

CLINICAL NEGLIGENCE – CAUSATION – CONTRIBUTION – APPORTIONMENT – ABSENT PARTIES - RULES OF COURT - COSTS

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The High Court's recent decision in ***Healey v. (1)McGrath; (2)Ramsay Healthcare*** [2024] EWHC 1360 is a very useful example of the judicial approach to the apportionment of blame between two defendants in a situation where both have admitted liability in respect of a claim. It also illustrates the way in which the Court might exercise its discretion as to costs in such a situation.

The claim was brought by the widow of Mr. Healey, who had died as a result of the admitted negligence of both Ramsay Health Care (the Second Defendant in the main claim) and the First Defendant, a Consultant General Surgeon who had performed a right hemicolectomy (surgical) procedure on him at the Second Defendant's hospital. Following that procedure, there had been an anastomosis leak and resulting sepsis, with fatal consequences.

The First Defendant's liability was premised upon breaching his duty of professional care towards the Claimant due to failing to act upon his marked deterioration, and being responsible for a consequent delay in diagnosing and treating the leak. The Second Defendant admitted that its employed nursing and auxiliary staff at the hospital had been negligent in failing to ask for more frequent medical reviews and should have carried out more frequent, and then later continuous, observations. The main claim was settled by the Second Defendant on a unilateral basis for £1.2M.

The matter came to trial in order for the Court to rule upon the Second Defendant's Part 20 contribution claim against the First Defendant, whose solicitors had come off the record back in November 2022. He failed to attend the trial of the contribution proceedings, failed to file any lay or expert evidence and failed
to file a Skeleton Argument in breach of a Court Order. Dexter Dias KC (sitting as a Deputy High Court Judge) determined that he had to proceed with the Part 20 trial in the First Defendant's absence and to consider carefully such aspects of his case as he could determine them.

Apportionment

The Court held that:

i. since both defendants had admitted liability, some proportion of liability had to be attributed to each of them;

ii. the First Defendant's breach of duty had been more causative of the death;

iii. the sepsis had been caused by the anastomosis leak, which had needed to be repaired and the peritoneum cavity washed out;

iv. the First Defendant's failure to have arranged diagnostic imaging to either confirm or exclude the leak had been the direct cause of the death;

v. the First Defendant's breach of duty had significantly exceeded that of the Second Defendant. The nursing failures were considered to be 'dwarfed' in comparison to his failures: but for the First Defendant's delay in diagnosis, death would not have resulted from a condition that was probably otherwise salvageable. The causative contribution of the nursing failures was limited by comparison. It was also noted that the First Defendant was the surgeon in charge and the nurses were his subordinates; and

vi. the just and equitable apportionment was 75:25 in favour of the Second Defendant and so, therefore, the First Defendant had to pay a contribution of 75% of the agreed damages of £1.2M (i.e. £900,000).

Having considered section 2(1) of the Civil Liability (Contribution) Acy 1978, the Judge referred to the guidance of *Hobhouse LJ in Downs v. Chappell* [1997] 1 WLR 426:

> ***"The extent of a person's responsibility involves both the degree of his fault and the degree to which it contributed to the damage in question. It is just and equitable to take into account both the seriousness of the respective parties' faults and their causative relevance. A more serious fault having less causative impact on the plaintiff's damage may represent an equivalent responsibility to a less serious fault which had a greater causative impact. The present case is such a case. The judge was entitled to decline to distinguish between the responsibility of the two defendants for the damage to the plaintiffs."***

Costs

Moving on to consider the issue of costs, the Judge further held that, in circumstances where the Second Defendant's nursing staff had been heavily dependent on the First Defendant's expertise, experience and medical leadership, and where his negligence had set in train a sequence of ultimately catastrophic events, the First Defendant had to pay: (a) 75% of the costs that the Second Defendant had paid to the Claimant (£417,500); (b) one-third of the Second Defendant's costs of defending the main claim; and (c) the entirety of the Second Defendant's costs of the Part 20 contribution proceedings in respect of which it had been the successful party.

Whereas (a) and (c) might ordinarily be expect to follow the event given the decision on apportionment, (b) is a much more unusual, bespoke order, which the Judge confirmed was made using his wide discretion afforded by section 51 of the Senior Courts Act 1981 and CPR 44.2 (applying the decision in *Mouchel Ltd. C, Van Oord (UK) Ltd.* [2011] EWHC 1516). The Judge believed that the First Defendant's Defence had been fundamentally flawed. He was criticised for his limited engagement in the contribution proceedings, which were held to reveal a course of conduct that was *"unsatisfactory, unrealistic and uncooperative."* It was noted that only the Second Defendant had been *"realistic enough to compromise the claim"*.

Comment

Whilst cases on issues of this nature invariably turn upon their own specific facts, and it must be borne in mind that the First Defendant in *Healey* was unrepresented in the contribution proceedings, the Judge's application of *Downs* by taking into account the causative relevance of negligence, i.e. the extent to which acts contributed to the damage in question, as well as the degree of fault, is likely to be of wider application in cases involving apportionment.

One of the main points that comes across from the judgment is the additional blame that was placed upon the First Defendant due to his senior role as the surgeon, which involved overall responsibility for the Claimant's surgery even where he was not specifically aware of the neglect of the nursing and auxiliary staff that amounted to admitted negligence. It is likely that such a finding would be replicated in many cases involving apportionment between a surgeon and nurses or other subordinates, unless the situation could clearly be distinguished on its facts.

With regards to costs, it appears that the decision that was unusually punitive to the First Defendant in relation to the Second Defendant's costs of the main claim arose from the conduct issues identified. This approach would not ordinarily be expected to be followed in a different situation where a party unsuccessfully defended a Part 20 claim, but had not been subject to same criticisms of the First Defendant in this case. All litigants would be advised to avoid being seen to have 'buried their head in the sand' when facing a Part 20 claim.

The Court effectively rewarding the Second Defendant's realistic approach to settlement of the main claim no doubt reflects the general move towards promoting and rewarding ADR (or punishing a failure to engage in ADR) shown in multiple cases, most notably the Court of Appeal's decision in *Churchill v. Merthyr Tydfil BC* [2023] EWCA Civ 1416.

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Interim payments for foreign commercial surrogacy: recoverable, but rare: *Snudden v Norfolk and Norwich University Hospitals NHS Foundation Trust* [2024] EWHC 615 (KB)

CLINICAL NEGLIGENCE – DELAY – INTERIM PAYMENTS – SURROGAGY – UNITED STATES

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Snudden v Norfolk and Norwich University Hospitals NHS Foundation Trust [2024] EWHC 615 (KB) considered an interim payment application in respect of foreign commercial surrogacy costs.

Factual Background

In February 2018, the Claimant underwent a cervical smear test. The results of that test were misreported by the Defendant hospital trust. By 2019, the Claimant was diagnosed with a grade-3 primary squamous cell carcinoma of the cervix. She required cancer treatment, resulting in her entering premature menopause and being unable to conceive naturally. She was 28, and had not yet had any children. The Defendant conceded liability.

The Application

The Claimant issued an application for an interim payment of £400,000 to enable her to proceed with a surrogacy arrangement in the USA. The Defendant confirmed that it would make an interim payment in the sum of £150,000 on a 'voluntary basis'. However, the Defendant did not accept that any surrogacy costs would be recoverable in this matter.

The issue before the Court was whether, per CPR 25.7(4), the interim payment sought by the Claimant represented a reasonable proportion of the likely final award. In determining this question, the Court specifically had to consider whether it could be stated with a high degree of confidence that a future trial judge would conclude that it was reasonable for the Claimant to be awarded damages to enable her to pursue a foreign commercial surrogacy arrangement.

The Law

Interim Payments

The Court's power to make an order for an interim payment is set out in CPR 25.7. However, CPR 25.7(4) clarifies that *"the court must not order an interim payment of more than a reasonable proportion of the likely amount of the final judgment".*

This position is echoed in the authority of *Eeles v Cobham Hire Services Ltd* [2009] EWCA Civ 204, which provides that that the interim judgment must not only assess the likely amount of the final judgment (stripping out the heads of loss which might be dealt with by way of periodical payments), but also whether the Claimant has established a real need for payment now.

Recovery for Foreign Commercial Surrogacy Costs

In *XX x Whittington Hospital NHS Trust* [2020] UKSC 14, the majority of the Supreme Court (Lady Hale, Kerr and Wilson LJJ) held that a claimant was entitled to recover damages to fund the cost of commercial surrogacy arrangements using donor eggs in a country where such arrangements are not unlawful.

Having concluded that the recoverability of such damages was no longer contrary to public policy in broad principle, Lady Hale went on to set out three 'limiting factors': -

i. The proposed programme of treatments must be reasonable, i.e., but for the negligence, would the claimant have had the number of children proposed?

ii. It must be reasonable for the claimant to seek the foreign commercial arrangements proposed rather than to make arrangements within the UK. This is unlikely to be reasonable unless the foreign country has a well-established system in which the interests of all involved – the surrogate, the commissioning parents, and any resulting child – are properly safeguarded.

iii. The costs involved must be reasonable.

The Parties' Submission

The Claimant submitted that the *XX* tests were made out. In particular, it was highlighted that the Claimant would suffer unacceptable prejudice if she had to wait to commence the surrogacy process; given that she was already 33, and the trial was not set to commence for two years.

On the other hand, the Defendant submitted that any determination of this issue would be premature, and that an interim payment of the sum sought would pre-judge a central issue. The Defendant contended that there were significant points of dispute between the parties as to whether the Claimant would have had children in any event; whether the Claimant would undertake the foreign surrogacy arrangement; the reasonableness of using a foreign surrogacy arrangement, instead of pursuing a surrogacy arrangement in the UK; and the costs of the arrangement.

Judgment

Alison Morgan KC (sitting as a Deputy High Court Judge) noted that the application had been presented at an early stage in proceedings. This had the inevitable consequence of the parties having not yet gathered all of the relevant expert evidence. Equally, the precise details of the surrogacy arrangement that the Claimant was seeking to undertake in the USA had not been identified, including the particular State where the arrangement would be pursued. It was noted that a future trial judge would have the benefit of considering, amongst other matters: a fully particularised schedule of loss which would allow a clear determination as to the appropriateness or otherwise of making a periodical payment order; further details of the Claimant's proposed surrogacy arrangements including the costs; and further evidence as to the competing merits of the UK and USA systems.

Flowing from the above, the interim judge held as follows: -

> ***"Whilst I note the considerable force in the submissions advanced on behalf of the Claimant as to the reasonableness of her decision to seek a foreign surrogacy arrangement at this time, it is not possible for me to determine at this stage that I have a high degree of confidence as to the likely approach of a future trial judge on that topic, which will determine the likely amount of the final judgment". [§69-70]***

The Claimant's application for an interim payment was therefore refused.

Analysis

XX was a landmark decision in terms of opening the gates for claimants rendered infertile through clinical negligence to recover the costs of commercial surrogacy abroad. Nevertheless, *Snudden* stands as a sobering reminder of the steep evidential hurdles that claimants will need to overcome in order to actually be awarded such damages, particularly at the interim application stage.

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Lessons for claimants and defendants from an unresolved application for an interim payment: *XS1 v West Hertfordshire Hospitals NHS Trust* [2024] EWHC 1865 (KB)

CLINICAL NEGLIGENCE – CEREBRAL PALSY – INTERIM PAYMENTS – LOSSES – MEASURE OF DAMAGES – SUFFICIENCY OF EVIDENCE – SCHEDULES OF LOSS - SUITABLE ALTERNATIVE ACCOMMODATION

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Introduction

XS1 concerns an unsuccessful application for an interim payment in a clinical negligence action brought on behalf of a ten-year old girl with profound disabilities (although the application was adjourned rather than refused to enable the Claimant to remedy evidential gaps). I want to highlight some pitfalls to avoid when making significant interim payment applications and where, crucially, much ambiguity about a defendant's evidence and position remains present. The judgment of Master Stevens is also an excellent refresher on the well-known Eels principles (*Cobham Hire Services v Eeles* [2009] EWCA Civ 204).

Facts

The Claimant suffered from a number of severe disabilities and was diagnosed with Cerebral Palsy. Liability was admitted with a 30% reduction negotiated for contribution. The most recent Schedule of Loss dated 27 June 2024 sought a sum of £19.3 million before the liability split, interim payments to date totalling £825,000 and deductions for CRU payments.

The Application

The Claimant sought a further interim payment of £2.15 million to facilitate the purchase of a £1.65 million single-story property identified by her litigation friend as meeting her accommodation needs.

The provisions of CPR rule 25.7(4) were a source of contention between the parties: *"the court must not order an interim payment of more than a reasonable proportion of the likely amount of the final judgment"*. The judge directed himself to para. 42 of Eels and relied on the *"useful and succinct"* summary of the ten factors the court will grapple with when considering an interim payment application set out by Whipple J in AC *(a minor suing by his litigation friend) v St Georges Healthcare NHS Trust* [2015] EWHC 3633 (QB) (*"AC"*) itself drawn from *Smith v Bailey* [2014] EWHC 2569 (QB).

In simple outline under the first limb of the Eels test, the Court will make a conservative assessment of the likely amount of the future award a judge would be bound to award as a capital sum which will strictly and typically be the award of general damages for pain, suffering and loss of amenity, past losses calculated to the predicted actual trial date plus interest on both sums. Future losses are excluded at the first stage to avoid fettering the discretion of the trial judge to consider periodical payments versus a capital award.

At the second stage, the court may in addition include future losses where the court has a high degree of confidence that the trial judge will award them as a capital sum and a real need for the interim payment requested exists now. Accommodation costs are usually (but as *XS1* explores, not always!) assessed during stage 1 given it is common for these to be awarded as a capital lump sum.

Eels Stage 1

The Claimant relied on expert reports in paediatric neurology, care, occupational therapy and physiotherapy. The judge was prepared to assess PSLA by adopting the Defendant's conservative estimate uplifted for inflation and interest from service of the claim form, a total of £449,424.

On past losses, the judge highlighted *"there was no real forensic attempt by the Defendant to persuade me of the invalidity of the numbers contended for"* in the Schedule of Loss and Defendant's counsel adopted a *"broad brush"* approach by contending for a conservative valuation of 66% of the losses claimed. The lack of analysis equivalent to a Counter-schedule was considered unimpressive.

However an assessment of past losses even up to those conservative figures was not possible. On past care, the judge concluded that he had not received sufficiently detailed submissions and was troubled in particular that paid care was not offset. Questions were also asked about claims for what appeared to be normal household expenditure and therapy trips to the US totalling £271,396.81.

The Defendant also took issue with the Claimant claiming past losses through to trial (approximately one year away) rather than to the application hearing. The judge considered the recent judgment of Yip J in *PAL v Davison* [2021] EWHC 1108 (QB) and was troubled by the absence of evidence on the deputyship account and nor was it clear from the Schedule what the expense rate was to trial. Given liability was apportioned at 70% (unlike in *PAL*), additional caution was required as a shortfall relative to needs was inevitable.

On accommodation, the Claimant acknowledged she would need a further top-up sum under *Eels* 2 in any event to purchase the identified intended property. The Claimant's own accommodation expert considered that the current rental property was unsuitable in the long-term, as was the previous family home. Future accommodation of £2,235,891.72 (including purchase price, adaptions and two further rental years) was sought but the judge observed that life expectancy calculations were an *"integral"* part of the valuation of the reversionary interest. Counsel for the Claimant had conceded there was an error with double counting of rent and so revised the claim during the hearing to £1,900,000 (before adjusting for the liability split or a "reasonable sum").

Under *Eels* 1, the judge found himself *"distinctly uncomfortable"* with the figures put forward by each party and was critical of the Claimant for the arithmetical errors and of the Defendant for being *"broad-brush"*. The judge was, crucially, troubled by not having the benefit of evidence on the range of opinions on life expectancy and considered this need was more acute given the liability split.

Eels Stage 2

Of most concern, at stage 2 the court held it had insufficient evidence to conclude that the Claimant had a real need for new accommodation. This was so even where deferring a decision on the assessment of the cost of a suitable alternative property risked losing the purchase of a home and incurring the additional costs. It was plainly a significant, and for the judge *"unusual"*, factor of the application that the Claimant had commissioned plans for a through lift to be installed and other adaptions including ceiling hoist tracking. The second unusual factor was that both parents had retained their previous properties and were prepared to sell them to make up any shortfall.

There was also debate about how confident the court could be on the likelihood of future losses being awarded as capital sums under *Eels* 2 at trial. The judge concluded he was not satisfied there was a real need for alternative accommodation now and considered this finding was determinative. In any event, consistent with the approach to other aspects of the application, the judge considered he did not have sufficient evidence. Whilst the additional costs of adaptions and remediation at the current rental property were *"regrettable"*, the judge found the *"appropriate assessment for the baseline accommodation cost of the alternative property"* was *"incomplete"*.

A joint schedule?

The court directed the parties to compile a joint schedule in order to progress the application for an interim payment and for the Claimant to remedy the gaps in evidence and information identified in the judgment.

Comment

There is much to reflect on for those either preparing or responding to a significant interim payment application, especially where it is intended to meet an accommodation need.

i. First, this decision on an interim application is an excellent example of where earlier and more fulsome communication between the parties might well have assisted and resulted in a different outcome. On one view, it is particularly harsh that the Defendant's failure to provide a preliminary or without prejudice counter-schedule or even position statement ultimately put the Claimant at a significant disadvantage. The preparation for the hearing on both sides is something that could have been negotiated in advance. There is also a question about whether the Defendant's decision to avoid serving any evidence for the application supported or hampered its position.

ii. Second, errors in the Schedule in respect of the accommodation claim were unfortunate. This decision illustrates why some concerted thought should be given to not only the trial and final award but also how a Schedule will support the needs of interim applications especially in a case where an interim payment application for accommodation was foreseeable. In a case where accommodation provision will change, there is a real need for care to ensure the judge can easily understand what the monthly/annual run rate on past losses will be to trial, to anticipate milestones such as when a likely interim payment application might be made.

iii. Third, make sure the evidence is there and consider how any gaps can be addressed throughout the Court's assessments under *Eels* 1 and 2, which as the judge wryly observed serve as significant fetters on the court's discretion. Life expectancy evidence may not have been essential for this application but more material on that topic as well as others was needed in the context of this claim.

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Lessons for Claimants where there is an application for strike out and/or summary judgment: *Lukes v (1) Kent and Medway NHS & Social Care Partnership Trust and (2) Chief Constable of Kent* [2024] EWHC 753 (KB)

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PERSONAL INJURY – BREACH OF DUTY OF CARE & CAUSATION – MENTAL HEALTH ASSESSMENTS – POLICE POWERS AND DUTIES – STRIKING OUT – SUMMRY JUDGMENTS

The NHS Trust (D1) and the Chief Constable (D2) applied to strike out the Claimant's ("C's") personal injury claim under *CPR r.3.4* and/or for summary judgment under *CPR r.24.3(a)*.

Essential facts

In January 2019 C was detained by D2 under s. 136 of the Mental Health Act (MHA) 1983 after being coaxed from railings on a railway bridge. Upon examination by an Approved Mental Health Professional ("AMHP"), he was discharged into the community. No evidence of psychosis was found.

In September 2019, C was arrested for assault and admitted to hospital from custody under s. 2 of the MHA 1984. He was found not be suffering from any acute mental illness despite presenting with grandiose delusions believing he had been reincarnated into Jesus and running out of the house the night before saying he wanted to kill himself. He was assessed following release. No evidence of psychosis was found. C's father reported a history of suicide attempts. He was discharged into his GP's care.

On 11.08.20, C was arrested for assaulting two family members and for criminal damage. He was detained. He did not give any indication that he was suffering with a mental health issue at the time of arrest. C's mother informed the arresting officer that C had been sectioned in September 2019 and had not been right since and asked for someone from the mental health team to see him.

In the early hours of 12.08.20, D2's Custody Officer ("CO") received information from C's family raising concerns about his mental state, following which the CO revised C's mental health assessment and arranged for him to be examined by an AMHP in accordance with Code C of the Police and Criminal Evidence Act (PACE) 1984.

D1's employee, Mr Parish, a Community Mental Health Nurse ("CMHN") attempted to assess C. C did not wish to be examined by Mr Parish. Mr Parish recorded that C had no need of D1's Criminal Justice Liaison Service ("CJLDS"). Later that day Mr Parish attempted to speak to C again. On this occasion C also declined to be examined and refused to consent to Mr Parish to liaising with his mother of his GP.

Mr Parish assessed C fit for a PACE interview. Later that evening, D2 (relying on Mr Parish's assessments) recorded that C was at no heightened risk of suicide following release; was not suffering from any mental health issues; and was not a vulnerable adult or any risk to himself or others following release. He was given bail and went to stay at a hotel away from his family.

On 15.08.20, C's father contacted D1's Crisis Resolution & Home Team who instructed Ms Hatfull, a different CMHN to assess him. Ms Hatfull conducted a screening of C following speaking with him. She recorded that C was not known to local mental health services or other agencies, that there was no history of mental illness in the family and that he had never attempted suicide. He was released back into his family's care.

On 19.08.20, C became increasingly agitated and was reported by his mother as having a psychotic attack, talking nonsense, was irritable, shouting, and seizing a hammer. He then left the family home and disappeared. D2 were called. Later that day he was found with serious injuries having jumped 25 feet from a bridge onto railway tracks below.

Resolution of the strike out applications

D2 and D1 brought separate strike out applications (in that order) against C. They were heard by Mr Justice Julian Knowles on 18.10.23. He handed down a 48-page judgement on 15.04.24. The case raised no novel points of law.

D2's application succeeded. On the facts, the court found that once D2 had arranged for C to be assessed by an appropriate healthcare professional in accordance with Code C of PACE, it had discharged its duty of care to him. D2 was under no duty to audit the quality of that mental health assessment.

The court observed that on the pleaded case, C had failed to plead any loss caused by the breach of duty alleged against D2. The summary judgement /strike out applications pursuant to *CPR r.24.3(a)* / *CPR r.3.4* respectively were granted in favour of D2.

In contrast, the summary judgement/strike out applications brought by D1 failed.

The court rehearsed the legal principles governing such applications. The court reminded itself that it must consider whether the claimant had a 'realistic' as opposed to a 'fanciful' prospect of success. The court should not conduct a mini trial when evaluating that consideration. The court should consider the stage at which the application was made and take into account the fact that further evidence may place the trial judge in a better position to judge the merits than the interlocutory judge - on the facts of this case, neither witness statements nor expert evidence had been exchanged.

The court found that there was merit in the criticism that Mr Parish did not fully ascertain C's history of threatened self-harm. Specifically, there was more to his threatened risk of self-harm than simply the isolated incident in January 2019 referenced by Mr Parish in his notes. Had he reviewed the medical records available to him, that would have been clear.

Further, there was merit in the observation that Mr Parish had wrongly determined that he was unable to speak to C's mother or to his GP to find out more information about C's mental health. He did not require C's consent to do so. Had he done so, both would have been able to provide relevant evidence that may well have resulted in C being sectioned and therefore unable to jump from the bridge on 19.08.20.

Importantly, the fact that C did not present with psychosis to Mr Parish would not have prevented a compulsory detention determination under section 2(2) of the MHA 1983. Further, having capacity was not a bar to being compulsively detained. Both submissions formed parts of D1's application and both were misconceived in the court's view.

Whilst it was evident that Mr Parish was unable to conduct a proper assessment of C because of his refusal to engage in his mental health assessment, there were other options available to him to assess his mental health. Had he availed himself of those options, it was arguable that C would have been compulsorily detained and unable to jump from a railway bridge on 19.08.20.

Similar observations could be made about Ms Hatfull's assessment of his mental health on 15.08.20.

It was part of D1's application that following his fall from the railway bridge, C reported to clinicians that he had jumped because of a breakup with his girlfriend. The judge found that was a factual matter properly left to the trial judge to weigh and may well provide D1 with a powerful argument as to why C's claim may fail on causation. However, it was not the sort of fact to determine a strikeout application.

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A formidable obstacle to an application for an Anonymity Order: information already in the public domain: *PMC v Local Health Board* [2024] EWHC 2969 (KB)

CLINICAL NEGLIGENCE – ANONYMITY – CHILDREN - FREEDOM OF EXPRESSION – LAW REPORTERS – MEDIA – OPEN JUSTICE – REPORTING RESTRICTIONS – RIGHT TO RESPECT FOR PRIVATE AND FAMILY LIFE

By Lindsay McNeil

The Court refused the Claimant's application for an anonymity order on the grounds that the volume of material about him that was already in the public domain rendered any effort to anonymise his name both unjustifiable and futile. In reaching that conclusion, the Court balanced the Claimant's ECHR art.8 rights with the art.10 rights of the media parties, a third-party publisher and the public. Nicklin J condemned the terms of the 'standard form' proposed anonymity order which resembled Form PF10, and identified problems that would have arisen had it granted the application. While anonymity orders are characteristically premised upon "without notice" applications, this decision puts Claimants 'on notice' in terms of when and how they should apply for one.

Chronology

In 2012, the Defendant admitted liability for negligence in respect of the Claimant's birth. In 2020 and 2021, the Claimant's mother engaged with a media party (MP1), following which two articles were published. A second media party had also covered Claimant's story. The claim form, particulars of claim and acknowledgement of service were later issued/filed in March, July and August 2023 respectively. Substantial damages were sought, interim payments approved by the Court and a quantum only trial was scheduled for December 2025.

In October 2024, a journalist from MP1 contacted the Claimant's solicitor, explaining that he had a copy of the particulars of claim and wished to publish a news article about the case. The Claimant's mother applied, as his litigation friend, for an immediate interim anonymity order on behalf of her son. The application was made without notice in relation to the assessment of damages proceedings pending the upcoming December 2025 hearing.

By this stage, however, the "Dockets" section of Westlaw UK, which enabled subscribers to search for details of pending cases, contained identifying information about the claim. That information was published in the courts electronic filing system (CE-File), which was publicly available, and could be made available to non-parties under CPR r.5.4C(1) following the filing of the acknowledgement of service. Further, the articles from 2020-2021 identifying the Claimant remained available online.

Ultimately, after a hearing on 6 November 2024 in which he considered the case law and legal tests, Nicklin J refused the Claimant's proposed anonymity order.

Legal Grounds for the Refusal

The Court considered the law on anonymity orders, concluding:

- There had to be a **statutory basis** for the order sought (s11 The Contempt of Court Act 1981 ('the 1981 Act') and s39 The Children and Young Persons Act 1933). The necessary precondition for the making of a s11 order under the 1981 Act was the prior grant of a withholding order from the Court. The operative power to restrict non-party access to documents from the Court's record was r.5.4C(4).

- It must be **necessary** to displace the principles of open justice.

- An anonymity order must not be thwarted or rendered **futile by information already in the public domain.**

- A Claimant's Article 8 ECHR right to privacy does not justify an anonymity order if that would represent **a disproportionate interference with the Article 10 ECHR** rights of media parties, Westlaw UK and the public.

Given the pre-existing media coverage, the Judge found that those four pre-conditions could not be decided in favour of the Claimant; he had not satisfied the Court that the relevant derogation from open justice was necessary. In fact, there was a *"clear and continuing public interest in the Claimant's claim going beyond the inherent public interest in court proceedings generally. It is not the case that legitimate journalistic interest in the Claimant's case has waned."* [138]

Irrespective of the decision on anonymity, Nicklin J made an observation of broader application, namely that the Court cannot order that *"the identity of the claimant ... is confidential"* [154]. He clarified the distinction between the withholding of information from the public and confidentiality; if satisfied that it was necessary to do so, the Court could perform the former by directing that a claimant's name be replaced by a cipher in hearings in open court and documents, but, Nicklin J stressed this was not the same as making a claimant's name confidential.

Commentary on the Terms of the Proposed Order

The Judge also noted that on this complex cardinal topic of open justice, standard form orders such as the Claimant's proposed order, taken from Form PF10, were inappropriate.

As one of its terms (Para 2), the Claimant sought a retrospective reporting restriction order (RRO) on any "further publication" which included existing publications. The Court held that it should rarely grant RROs which would require amendment to or removal of an existing lawful publication, and not without at least giving the relevant publisher notice of the application so that they could have an opportunity to make submissions before the order was granted. A court should either remove para.2 of PF10 or include a public domain exception which excludes pre-existing publication from the scope of the RRO.

Lessons from this case concerning Anonymity Orders

1. **Anonymity orders are more fiercely guarded than once thought:** At paragraph 93, Nicklin J concluded: "*In cases where the reporting restriction is sought after the litigation has been pending before the Court for some time and has progressed through several phases, a fortiori where the information now sought to be withheld has been published and is now lawfully in the public domain, it is likely to be very difficult (if not impossible) for the applicant seeking the reporting restriction to [show by clear and cogent evidence that without an order being made the Court would be acting incompatibly with a Convention right].*" Even if there are concerns about a claimant's exploitation or vulnerability in the event of reporting on the case, this will not automatically justify a restriction order, especially if these concerns have not been clearly explained/supported by witness statements. Only *"extreme cases"*, where the applicant demonstrates that, without a reporting restriction being imposed, there is *"a credible risk of serious harm reaching the required threshold to engage Articles 2/3"*, may compel the Court to grant orders that require existing lawfully published material about the proceedings to be removed from online platforms. Even then, such orders will be *"wholly exceptional."*

2. **Do not leave the making of an anonymity order until it is too late** and the volume of material (especially that voluntarily shared) precludes the possibility of securing meaningful anonymity in circumstances where the claimant's name has become "embedded in the public domain" [55]. This stern warning is applicable even where it is the identity of children and vulnerable protected parties at issue.

3. **An application for an RRO is effectively a without notice application, with the corresponding obligation of full and frank disclosure on the applicant.** Proposed orders must set out clearly their statutory basis and what could not be published. The order should also state for how long the restrictions are to last. Parties cannot "consent" to any such order; the court remains the exclusive arbiter.

3. **Ensure that clear and cogent evidence is provided in support of the application.** Applicants should file with the court evidence demonstrating the extent to which the information it sought to restrain was already in the public domain. That would include any pre-existing media coverage, documents available to public inspection under r.5.4C(1), details of any open court hearings, and related content on third-party providers such as Westlaw UK.

5. **If the effect of a RRO would have a retrospective effect on pre-existing publications, the application should be made on notice.**

6. Rather than using standard orders like PF10, practitioners should consult examples of a withholding order and an RRO made under s.11 included in th**e Administrative Court Guide 2024, para.7.12.9.**

The Pending Appeal

Permission to appeal the Judge's decision has been granted for two reasons. Firstly, this is an area of significant wider importance. Secondly, PMC's criticism of the Court of Appeal's decision in JX MX v Dartford & Gravesham NHS Trust [2015] 1 WLR 3647 - which has, for the last decade, been relied upon in applications for anonymity orders - merits scrutiny.

PMC ostensibly leaves anonymity orders involving protected parties in peril. It will be for the Court of Appeal to decide whether to resurrect them, or, to reassert their "exceptional" status.

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