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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 seventh issue of the TGC Clinical Negligence Newsletter. Expect to find thorough and thought-provoking discussion of the last 12 months' High Court and Court of Appeal judgments which transect Clinical Negligence Law's factual and legal landscape.

This collection of articles covers the most recent judicial guidance on the resolution of outstanding questions; clarification of vexed precedent; and application of settled principles to a manifold of scenarios. Whether representing claimants or defendants, preparing factual evidence or instructing experts, addressing public or private provision of care, or, making or responding to applications, this Newsletter contains learnings for all.

In terms of specific content, to open the analysis of the case law on **breach of duty,** this Edition opens with discussion of the distinction between diagnosis and treatment when it comes to the balance between medical professional judgement and patient consent. The standard of care, more specifically standard of necessary diagnostic investigations, in the context of patients presenting with abdominal and/or pelvic complaints is then examined in *Hodgson v Hammond and another* [2025] EWHC 1261 (KB), a case which should also be reviewed for its resonant commentary on expert witnesses and their impartiality. I explore the arguments levelled on both Bolam and Bolitho breaches of duty and the important reminders for clinicians and hospitals to rule out severe conditions, to keep proper records and to support decision-making with evidence. Hospitals' liability for administrative/triaging errors is considered by Philip Matthews in his unpacking of *Way v University Hospitals Plymouth NHS Trust* [2025] EWHC 1078 (KB), a case in which a defendant NHS Trust was unable to avail itself of another hospital's binary to explain its failure to follow a clinician's instructions, or to expedite care.

Causation then comes under the spotlight in Michael Brooks Reid's sensitive and sobering treatment of *Zgonec-Rozej v Pereira* [2025] EWCA Civ 171, a case which demonstrates the difficulties of attributing patient suicide to negligent psychiatric care. The reader will also benefit from being reminded within this article of the McGraddie principles concerning appeals on the basis of plainly wrong or illogical judicial determinations. Next, *Tuffin v University Hospitals Coventry and Warwickshire NHS Trust* [2024] EWHC 3318 (KB) serves as a compendious summary of the distinction between coincidence, correlation, (material) contribution and causation in respect of consequences post-dating clinical negligence. So too, *Conway v Yeovil District Hospitals NHS Foundation Trust & Anor* [2025] EWHC 2488 (KB) confronts challenging questions of causation, as well as the scope of duty of hospital doctors

(following Meadows v Khan), where a baby was discharged from hospital and later assaulted in his mother's 'care'. *HQA v Newcastle-upon-Tyne Hospitals NHS Foundation Trust* [2025] EWHC 2121 (KB) arguably provides the flip-side to Conway: a known and foreseeable harm case.

As ever, cogent revelations and practical advice is given within these articles as to the importance of medical records, NICE Guidelines and expert evidence.

Turning then to matters of **Civil Procedure,** five poignant cases cover vast terrain from hearsay evidence to sanctions, witness attendance, summary judgment, strikeouts, wasted costs orders, change of experts, discretionary case management powers and the admissibility of surveillance evidence. The practical benefit, to both Juniors and Seniors, of familiarising oneself with each of their content cannot be overstated.

Moving back to the substance of clinical negligence law, Helen Nugent's commentary on *Tosh v Gupta* [2025] EWHC 2025 (KB) distils the principles and precedents underpinning **informed consent,** especially where a rare but serious complication (in this case anal stenosis) arises following surgery (haemorrhoidectomy). The Judge ultimately found, against the backdrop of evidence which took the form of leaflets setting out risks, the consent form, recollections of oral discussions, and the Claimant's Complaint Letter to the hospital, that the Defendant had discharged his Montgomery and McCulloch duty to obtain informed consent. This case also is emblematic of judicial aversion to employing hindsight where a claimant contends only after having suffered a serious complication, that they would not have opted for surgery if reasonably informed.

Revisiting the **procedural** realm, two cases - *Deakin-Stephenson v Behar & Anor* [2024] EWHC 2338 (KB) and *MJF (a Protected Party proceeding by her mother and litigation friend, ITZ) v University Hospitals Birmingham NHS Trust* [2024] EWHC 3156 (KB) – are summarised. Michael Brooks Reid and Rochelle Powell respectively distil the salient learning points concerning witness credibility (vs witness-witness-collaboration); record-keeping; investigating all avenues of a claim or defence early in proceedings so that they make it into statements of case; and experts' duties. Lindsay McNeil then analyses a case wherein a claim was successfully struck out for breach of an unless order, resulting in inadequate amended particulars of claim with insufficient supporting expert evidence on breach of duty and poorly presented allegations of clinical negligence. *Read v North Middlesex Hospital Trust* [2025] EWHC 1603 (KB) thus reminds that the experts sought must be core, not tangential, to the questions of breach of duty and causation for the purposes of early Statements of Case. Lindsay McNeil also highlights the important analysis afforded by the Court to the costs regime, specifically CPR 3.4 and Rule 44.14, in Read.

This Seventh Edition dedicates its next section to an omnipresent concern for practitioners and clients alike: **Fundamental Dishonesty** ("FD"). In Marcus Grant's discussion of *Cullen v Henniker-Major* [2024] EWHC 2809 (KB), he explains why the Defendant failed to discharge its burden of proving FD, a finding partly attributable to the Defendant's unusual use of surveillance to prove a negative i.e., to prove that carers were not attending the Claimant's house. Further lessons concerning FD and its relationship to adverse costs orders are derived from my evaluation of H*akmi v East & North Hertfordshire NHS Trust* [2025] EWHC 2597 (KB). This case separately merits review by any practitioner involved in stroke cases where both breach of duty (on behalf of emergency and stroke clinicians) and causation (in the face of delayed, or non-existent, treatment) quagmires arise.

An interesting and impactful judgment*, Bailey v (1) Bijlani (2) MBNA Ltd* [2025] EWHC 175 (KB) confirms the application of **S 75 of the Consumer Credit Act 1974** to clinical negligence claims. Lindsay McNeil's exposé of this case suggests a potentially radical shift in future litigation towards credit card companies as endowed defendants.

The penultimate section of this Newsletter showcases two cases on **Interim Payments.** The first, *Hill v East Kent Hospitals University NHS Foundation Trust* [2025] EWHC 1241 (KB), contains useful reminder of the legal framework for interim payments based on CPR 25 and the Eeles tests. James Arney KC deftly synthesises the law, the instant case, the enduring relevance of Swift v Carpenter, and explains the application of principles such as "a reasonable proportion of the likely amount of the final judgment" or "a conservative approach to the assessment of damages" to not uncommon facts. Michael Rapp's examination of *CWLX (a child proceeding by his father and Litigation Friend, SWSX) v Aneurin Bevan University Health Board* [2025] EWHC 1531 (KB) does likewise, specifically, in the context of interim payments for accommodation claims.

To conclude, Richard Boyle analyses the outcome of the awaited appeal in *PMC v Cwm Taf Morgannwg University Health Board* [2025] EWCA Civ 1126. Its overturning of the High Court's ruling (discussed in the Sixth Edition of this Newsletter) by making a prospective anonymity order will be welcomed by vulnerable claimants and, ostensibly, much of the legal community. Richard Boyle's thorough and incisive commentary on this appeal decision should serve as mandatory reading for any case where reporting restriction orders, withholding orders, anonymity orders, the open justice principle, media involvement and the private and family life of minors or protected parties are in issue.

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

Breach of Duty & Causation

- To kickstart the issue, Anthony Johnson summarises *Enaholo v Totally PLC & Anor* [2024] EWHC 3249 (KB), a claim brought for allegedly negligent diagnosis of a psychiatric disorder in which the High Court clarified that pure diagnoses are not subject to the Bolam patient-consent standard.

- In my discussion of *Hodgson v Hammond and another* [2025] EWHC 1261 (KB), I extract critical learning points concerning medical investigations in the context of serious suspected conditions; the distinctions between Bolam and Bolitho; and expert duties.

- In another delayed diagnosis case leading to severe rectal prolapse *(Way v University Hospitals Plymouth NHS Trust* [2025] EWHC 1078 (KB)) Philip Matthews examines systemic breaches of duty in a hospital concerning failures to operate a proper pathway of patient classification and expeditious care where indicated.

- Turning towards causation, the Claimant's tragic suicide in *Zgonec-Rozej v Pereira* [2025] EWCA Civ 171 is evaluated with both sympathy and sagacity by Michael Brooks Reid who explains the difficulty of proving that substandard psychiatric care caused (or materially contributed to) a patient's suicide.

- James Yapp's analysis of *Tuffin v University Hospitals Coventry and Warwickshire NHS Trust* [2024] EWHC 3318 (KB) is a salutary reminder of the difference between correlation and causation in the context of multiple conditions and of the need to test experts' opinions thoroughly in advance of trial.

- In *HQA v Newcastle-upon-Tyne Hospitals NHS Foundation Trust* [2025] EWHC 2121 (KB), a case of serious hypoxic brain injury sustained during open heart surgery, Matthew Brunning looks at doctors' duties in respect of foreseeable intra-operative risks, pre-operative planning, and securing informed consent.
- To conclude this section, Andrew Ratomski discusses complex causation and scope of duty arguments raised *in Conway v Yeovil District Hospitals NHS Foundation Trust & Anor* [2025] EWHC 2488 (KB), where a baby was assaulted by his mother subsequent to his discharge from paediatric care. His noteworthy analysis is a reminder of the court's disdain for expert partisanship. It applies Meadows v Khan to questions of whether and when doctors are obliged to conduct further investigations that, now with "the deceptive confidence of hindsight" we know could have avoided ensuing harm.

Civil Procedure/Case Management Decisions

- Turning to procedural matters, in *Richards v Shrewsbury and Telford Hospitals NHS Trust* [2024] EWHC 3384 (KB) Polina Sokolovska considers the applicability (or lack thereof), of applications for relief from sanctions in the context of late hearsay notices, as well as an application for witness attendance for the purpose of cross-examination.

- Lindsay McNeil then distils additional points of procedural significance in *Butler v Ward* [2025] EWHC 877 (KB), examining the criteria for success (or fatal weaknesses) behind applications for the drastic remedies of summary judgment, strike-out and wasted costs orders respectively.

- In his account of *Prescott-Brann v. Chelsea and Westminster Hospital NHS Foundation Trust and anor.* [2024] EWHC 3314 (KB), Anthony Johnson helpfully spotlights a rare case of an appellate court reversing a case management decision; in particular, the decision not to allow the Claimant to rely upon an alternate expert. He clarifies that first instance judges' discretion concerning case management is broad, but not untrammelled.

- Anthony Johnson then summarises *Prudence and anor. v. Gloucestershire Hospitals NHS Foundation Trust* [2025] EWHC 1209 (KB), a Claimant's attempted strike-out of a purportedly 'bare defence' and/or attempted summary judgment.

- Marcus Grant's article on *Perrin v Walsh* [2025] EWHC 2536 (KB) provides useful guidance on the court's treatment of covert surveillance evidence when its efficacy is challenged by the claimant. Whilst surveillance evidence possesses probative value, defendants should be wary of sub-optimal approaches to filming claimants and editing footage.

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

Informed Consent

- Zooming in on informed consent, Helen Nugent analyses *Tosh v Gupta* [2025] EWHC 2025 (KB). The Court considered potential Montgomery and McCulloch breaches in respect of failures to offer non-surgical options and to explain the risks. This case demonstrates the difficulties for claimants of substantiating assertions that they would not have opted for treatment chosen.

Statements of Case and Evidence

- Michael Brooks Reid's case summary of *Deakin-Stephenson v Behar & Anor* [2024] EWHC 2338 (KB) emphasises the valuable guidance offered by this case regarding the Court's resolution of factual disputes, its treatment of lay recollection and the weight to be given to documentary and circumstantial evidence.

- The reliability of memory is again explored in *MJF (a Protected Party proceeding by her mother and litigation friend, ITZ) v University Hospitals Birmingham NHS Trust* [2024] EWHC 3156 (KB). Rochelle Powell explains the court's preference for contemporaneous records as well as the need to posit arguments in advance of trial within statements of case.

- Finally, Lindsay McNeil summarises *Read v North Middlesex Hospital Trust* [2025] EWHC 1603 (KB), illustrating an example of a struck-out claim for non-compliance with an unless order and scrutinising the CPR's cost regime on QOCS.

Fundamental Dishonesty

- The risks of continuing to plead fundamental dishonesty following a claimant's rebuttal evidence, or in reliance upon edited or non-conclusive surveillance footage are unpacked in *Cullen v Henniker-Major* [2024] EWHC 2809 (KB) by Marcus Grant. Practitioners should take heed of the guidance on indemnity costs contained therein.

- I tackle the implications of fundamental dishonesty allegations further in my review of *Hakmi v East & North Hertfordshire NHS Trust* [2025] EWHC 2597 (KB), a victory for the Defendant that verges on the Pyrrhic assortment. Whilst the negligent stroke-management claim against it was dismissed, the Defendant faced an adverse costs order relating to the burden of the Claimant having to defend "increasingly wanting" FD accusations.

The Consumer Credit Act 1974

- A decision which will have reverberating impacts in clinical negligence litigation, Lindsay McNeil synthesises *Bailey v (1) Bijlani (2) MBNA Ltd* [2025] EWHC 175 (KB), a seminal application of s75 of the Consumer Credit Act to medical treatment paid for on a credit card.

Interim Payments

- James Arney KC synthesises *Hill v East Kent Hospitals University NHS Foundation Trust* [2025] EWHC 1241 (KB), as well as a recent further example in his practice *(Kravitz v EUI Ltd)*, to extract an insightful pattern in the case law, being that: IP applications with limited disclosure of expert evidence favour the claimant whereas more advanced claims supported by a counter schedule give a defendant an evidential advantage due to the requirement to assess damages conservatively.

- In this penultimate section, Michael Rapp's commentary on *CWLX (a child proceeding by his father and Litigation Friend, SWSX) v Aneurin Bevan University Health Board* [2025] EWHC 1531 (KB) dissects a Claimant's application for a further interim payment primarily for the purchase of adapted accommodation. He highlights the judgment's clarification of the proper interpretation of Eeles to such claims.

Anonymity Orders

- To conclude this issue, Richard Boyle closes the loop on the status of anonymity applications which was left unresolved following the first-instance decision of *PMC v Cwm Taf Morgannwg University Health Board*, discussed in the preceding edition of this newsletter. Richard Boyle deftly summarises the reversal of said decision on appeal ([2025] EWCA Civ 1126), clarifying that an anonymity order can be made even where an applicant's name is already in the public domain. This decision will no doubt add clarity and comfort to claimants, especially children and protected parties, and serves as essential reading for practitioners to maintain up-to-date knowledge and awareness.

The Importance of Distinguishing Diagnosis from Treatment in the Context of Consent to Treatment: *Enaholo v Totally PLC & Anor* [2024] EWHC 3249 (KB)

CLINICAL NEGLIGENCE – CONSENT – DATA PROTECTION – DIAGNOSIS – DISCLOSURE – HEALTH RECORDS – MENTAL DISORDER - PATIENTS

By Anthony Johnson
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The Claimant brought a claim against the Defendants for negligently misdiagnosing him with a psychiatric disorder and referring him for assessment under the Mental Health Act 1983 (MHA) without his consent, alleging that the same had caused him to suffer injury, loss and damage, including the loss of a job that he would have otherwise obtained.

Between 2018-19, the Claimant reported various physical symptoms and made a complaint to the Metropolitan Police alleging that they had exposed him to irradiation, causing so-called 'electrosensitivity'. He attended medical appointments, where a provisional diagnosis of psychosis was made; his medical notes reflected these concerns, albeit that no further formal steps were taken to report them. Although he was taken to hospital for further testing, he voluntarily left without undergoing an MHA assessment.

The Claimant represented himself as a litigant-in-person in the preliminary issue trial in the High Court. He alleged that it was a 'pure diagnosis' case to which the Bolam test did not apply, relying upon *Muller v. King's College Hospital NHS Foundation Trust* [2017] QB 987. He alleged that electrosensitivity is not a condition outside mainstream medical discourse and experience, but rather that it should have been recognised as a pathological condition.

Dismissing the claim, Kerr J. distinguished treatment from diagnosis, holding that the common-law should not define 'diagnosis' in a technical manner. Diagnoses do not require patient consent, otherwise, medical professional judgement would be hindered: *"A requirement of patient consent would deprive doctors of their objective independent judgment, which is indispensable in enabling them to prescribe the appropriate treatment or recommend further testing."* [54]. He accepted that it had not been unreasonable for the medical personnel to draw the conclusion that the Claimant's medically unrecognised beliefs were a delusion.

The Court went on to dismiss the further claims in data protection and for rectification of the Claimant's medical records.

By Anthony Johnson
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The Importance of Medical Investigations and Medico-legal Impartiality: *Hodgson v Hammond and another* [2025] EWHC 1261 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY OF CARE – CAUSATION – DIAGNOSIS – GENERAL PRACTITIONERS

By Lionel Stride
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The court in Hodgson found that the failure of the Defendant GPs to conduct a pelvic examination or to investigate the Claimant's abdominal pain, vaginal discharge and irregular bleeding in their respective consultations, constituted breaches of duty. She had the warning signs of Pelvic Inflammatory Disease which remained untreated from the index consultation, causing her to suffer complications including development of a tubo-ovarian abscess necessitating removal of her left fallopian tube.

The judge found the Defendants to be negligent on both the Bolam and Bolitho tests because their omissions lacked a logical basis, even if there may be a body of clinicians that would also have exercised their clinical judgement by electing not to conduct a pelvic examination, having already performed an abdominal investigation.

Background

On 30 August 2016 the Claimant attended an in-person appointment with Dr Hammond, the First Defendant GP, who recorded ongoing abdominal pain, vaginal discharge and irregular bleeding in her history. He noted that she had a "resolving pelvic infection", most likely Pelvic Inflammatory Disease ("PID") on the basis of a soft and non-tender abdomen, an improvement in her symptoms and co-amoxiclav management of her condition. Dr Hammond performed an examination of the Claimant's abdomen, but not her pelvis. He advised that the only further investigations necessary at that stage were blood tests for infection and told the Claimant to phone again if she experienced recurrence of severe abdominal pain, fever and/or vomiting.

On 5 September, the Claimant discussed her bloods with the Second Defendant GP, Dr Dieleman, on the telephone. He did not refer her for urgent pelvic examination. Whilst he did not recollect this consultation at trial, he maintained that pyelonephritis was his suspected diagnosis.

Whilst it was agreed at trial that the Claimant had PID as early as 30 August, by the time a definitive diagnosis of PID was later made on or around 25 April 2018, the Claimant's condition had significantly deteriorated. As a result of her condition remaining untreated for a prolonged period, she had to undergo avoidable surgery and suffered permanent pain and reduced fertility.

Critical Issues

The critical question was whether, applying the Bolam (*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582) test, a responsible body of general practitioners would have supported the omissions to:

1. Perform a pelvic assessment of the Claimant at the index consultation or arrange an ultrasound thereafter by the First Defendant.

2. Urgently refer her for pelvic examination by the Second Defendant.

If either answer was 'yes', then even if supported by a body of experts, the second issue was whether the omissions were negligent for being illogical (the Bolitho (*Bolitho v City and Hackney Health Authority* [1998] AC 232) test).

The Claimant and First Defendant's expert GP witnesses, Dr Hicks and Dr Hampton respectively, agreed on the following: ([77-78])

1) GPs should adopt a *"low threshold for consideration of a diagnosis of PID"* because "untreated or inadequately treated PID can result in severe long-term complications".

2) Classic symptoms for PID included abdominal pain, vaginal discharge and bleeding.

3) PID was a condition which could wax and wane in terms of presentation of symptoms.

On this basis, Dr Hicks did **not** consider any responsible body of general practitioners would support the failure to make a pelvic assessment of the Claimant on 30 August, given she reported warning signs of PID at this consultation.

Dr Hampton, on the other hand, advised that it was a matter for the First Defendant's clinical judgement as to whether a pelvic examination was indicated, and a responsible body of GPs would also elect not to conduct an examination, believing that her PID was resolving.

The Legal Tests

The Court relied upon Bolam to assess whether the standard of care met that of a responsible body of medical opinion, which was *"respectable and reasonable"* (*Maynard v West Midlands Regional Health Authority* [1984] WLR 634 [38])).

Bolitho then enables a judge to make an independent finding of negligence because a doctor's act or omission lacked a logical basis, even if there may be a body of clinicians that would have done the same thing.

Judgment

Whilst the Court acknowledged that negligence must be assessed based on contemporaneous knowledge without the benefit of hindsight that the Claimant was indeed suffering from PID on both 30 August and 5 September 2016 (following *Duchess of Argyll v Beuselinck* [1972] Lloyd's Law Reports Vol.2 172 ([43])), it concluded that the oversights of the Defendants constituted 'Bolam' breaches of duty. The Claimant presented with symptoms and a history consistent with PID; PID was suspected and indeed the First Defendant's 'working diagnosis' ([23]); and the First Defendant's own expert agreed a pelvic examination was mandatory when PID is suspected. No responsible body of GPs, therefore, would support failing to at least consider a pelvic examination ([80]); given the First Defendant's notes were comprehensive, it was unlikely that he considered it, but neglected to record that consideration ([85]).

The Judge explained that the First Defendant was also 'Bolitho'-negligent because his actions were illogical. There was no basis for his judgement that the Claimant's PID would resolve, in light of the expert consensus that symptoms of PID fluctuate in severity (especially after antibiotics). There were numerous and powerful reasons to examine the Claimant's pelvis given the risks of undiagnosed PID versus few and limited justifications against examination ([88]-[99]).

The Court found that the evidence of the Second Defendant was a retrospective reconstruction and failing to arrange a pelvic examination was unreasonable ([103]). This was especially since Dr Dieleman and his expert GP witness, Dr Hall, conceded this at trial, agreeing to the tenor of the Claimant's counsel's cross-examination ([59]-[60])). Whilst not deliberately dishonest or self-serving, he was a *"genuine witness who simply made mistakes in his evidence by not limiting it, in the absence of any recollection, to what he could read or properly infer from his contemporaneous notes and to evidence of his usual practices."* ([62]).

Since the Claimant had received input from multiple clinicians, the delay in the Claimant's diagnosis was also an indication of system-level negligence i.e., the absence of a co-ordinated, escalation-based approach.

The five-day trial concerned breach of duty only. There was no dispute that had an appropriate pelvic examination been conducted on 30 August 2016, signs of PID would have been detectable. Antibiotic therapy could have commenced within 48 hours, preventing the development of a tubo-ovarian abscess, the removal of a fallopian tube, and the cascade of chronic pain, miscarriage and fertility impairment that ensued ([5]).

Expert Evidence

This judgment also contained criticism of the First Defendant's expert who appeared to be attempting to explain away Dr Hammond's actions, had therefore lost independence and was seeking to advocate for him.

Equally, the Second Defendant's expert was criticised for taking as fact the Second Defendant's purported recollection of the events of the telephone call and as fact that pyelonephritis was his diagnosis ([74]-[75]). Dr Hall had *"very concerningly"* failed to address the Claimant's recollection of what transpired during that appointment. In doing so, she had sought to resolve a factual dispute, *"trespassing on the judicial function".* This not only constituted a failure of the expert's *duty* to provide their opinion on **each** potential factual scenario but rendered her evidence redundant when it became apparent during trial that her factual assumptions were incorrect and unsupported evidentially ([76]). She was unable to provide a considered opinion on the accepted version of facts, being the Claimant's case. So one-sided was Dr Hall's opinion that she was compelled to abandon her original opinion during cross-examination.

Key Takeaways

Hodgson does not establish new law but it applies existing principles to cases of suspected PID, as well as any case involving the omission to investigate further; to record the considerations taken; to heed high-stake risks; and to any case of co-ordinated care involving multiple clinicians, face-to-face and telephone consultations.

For both clinicians and practitioners, this case clarifies that in cases in which a clinician has omitted to conduct a clinical investigation where the risks are high (and the downsides are minimal), well-reasoned expert evidence must be gathered to justify such an omission.

The case also serves as a further reminder of the significant judicial weight attached to clinical documentation/medical records (*Synclair v East Lancashire Hospitals NHS Trust* [2015] EWCA Civ 1283 ([42])). The Court praised the First Defendant GP's clear notes which allowed the Court accurately to infer the thought process behind his decision not to escalate the Claimant's care, whereas the Second Defendant's failure to keep contemporaneous records and therefore his vague or reconstructive testimony undermined his credibility. Hodgson thus serves as both a cautionary tale and a professional benchmark.

Further, this case underscores, especially in women's health or nursing negligence claims, that telephone consultations should not be treated as mere administrative follow-ups. Physical assessment is essential where symptoms are ongoing or ambiguous. Defendants should note that Hodgson represents an increasing trend of cases pleaded on the basis of **cumulative, system-level oversight**, especially where handover, triage or inter-practitioner communication is in issue.

Given that professional overreach is commonly encountered in this field, both practitioners and experts are reminded that it is for the court to decide facts, not the expert. Where facts are disputed, experts should give alternative opinions depending on which account is preferred by the court. They will then avoid the 'trap' of appearing to advocate for their instructing party.

By Lionel Stride
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Delayed Prioritisation and Systemic Gaps: *Way v University Plymouth Hospitals NHS Trust* [2025] EWHC 1078 (KB)

CLINICAL NEGLIGENCE – BREACH OF DUTY OF CARE – CAUSATION – CLINICAL GUIDELINES – DELAY – HOSPITALS

By Philip Matthews

In *Way v University Plymouth Hospitals NHS Trust* [2025] EWHC 1078 (KB), the High Court delivered a detailed judgment examining how systemic shortcomings, administrative inertia and an overloaded specialist service culminated in catastrophic consequences for a patient with a severe rectal prolapse. The case turned not on errors in the eventual emergency surgery, but on months of avoidable delay that the Court ultimately found to be negligent.

Factual Background

A Patient in Persistent Pain

The case begins in July 2018 when the Claimant, then 44, experienced a dramatic and very painful full-thickness rectal prolapse. She required oxycodone to manage the pain and steadily lost her ability to work, socialise, or care for her family without distress.

Her GP referred her to various specialists throughout late 2018. By December, a referral had been sent to consultant colorectal surgeon, Mr Christian Oppong, in Plymouth, although the Trust responded with a stock letter stating that no appointment was immediately available.

Frustrated, the Claimant sought private assessment from consultant colorectal surgeon, Mr Faux, in Cornwall. His February 2019 letter to Mr Oppong was striking: it described a young woman whose life was shrinking around a worsening prolapse and asked that her NHS care be *"expedited"*.

Expedited in Name Only

Despite the clinical consensus emerging by early 2019 that the Claimant should be prioritised, her first NHS appointment with Mr Oppong did not occur until 13 June 2019 — eleven weeks after the expedite direction, and six months after the initial GP referral.

It was clear by June that the situation had deteriorated further. The community psychiatric nurse had previously written a stark letter describing the Claimant's suicidal ideation, which she brought to the GP appointment. She was tearful, in constant pain, often housebound, and dependent on oxycodone. The prolapse was readily reproduced during examination.

However, whilst Mr Oppong accepted the Claimant should be treated as a priority patient, there was no evidence that this designation triggered any

concrete administrative steps. No review occurred until the multidisciplinary team process was complete, and a joint colorectal–urogynaecology clinic finally reviewed her on 18 September 2019. There, consultant urogynaecologist Miss Dua echoed the earlier clinical assessment and emailed the administrative staff: *"She needs to be expedited as she has a large rectal prolapse".*

Despite this second plea, surgery was scheduled for 11 December 2019 — almost a full year after the initial referral.

The Emergency that should not have been

The fragile equilibrium broke on 13 November 2019. At a consent clinic for the upcoming December operation, Mr Oppong found the prolapse irreducible and *"extremely tender".* He admitted her immediately for emergency surgery. Although the prolapse was reduced on the ward, surgery was still needed promptly. Theatre shortages delayed the operation to 18 November.

Mr Lai, who performed the surgery, described it as *"very difficult".* Complications followed swiftly: sepsis, rectal perforation, emergency laparotomy, a sigmoid colostomy, and further operations over the next three years. The irreversible stoma was now her permanent reality. No criticism was levelled at the emergency surgical care itself.

Crucially, both expert colorectal surgeons agreed that, if surgery had occurred by the end of October 2019, it would likely have been laparoscopic, less complex, and unlikely to have resulted in a permanent stoma.

The Bolam Defence

On liability, the Defendant Trust advanced a *"Bolam"* defence: that delays were unfortunate but remained within a reasonable range given workload pressures, and that the Claimant's case was not clinically urgent until November. Their expert, Ms Nugent, described a system where only two categories — urgent and routine — were used, and where subjective prioritisation was discouraged.

The Judge's Findings

However, Harrison J observed that the Plymouth department had in fact adopted a third category — "priority/expedite" — and had assigned the Claimant to it. The difficulty was that this category had no defined pathway, no documented administrative process, and no evidence that staff took any action consistent with it.

The Judge accepted Mr Oppong as a caring and dedicated clinician working within an overstretched department recently affected by an influx of regional referrals. But sympathy could not obscure the fact that key clinical decisions were not translated into action.

The Court found:

- The Claimant was consistently identified by clinicians as requiring priority/expedited treatment;
- The Trust took no evidence-based steps to expedite her care at any stage;
- The six-month wait to first appointment was incompatible with the notion of expedited care;
- After June 2019, when it was obvious nothing had been expedited, clinicians and administrative staff failed again to trigger genuine prioritisation;
- The system lacked a clear pathway for this *"middle category"* and therefore could not reliably implement clinical prioritisation.

These failures cumulatively constituted negligence. The judge concluded that on the balance of probabilities, appropriate expedition would have achieved surgery at least two months earlier, before the end of October 2019, avoiding the deterioration that necessitated emergency intervention and ultimately a permanent stoma.

Outcome

The Court held that the Trust was in breach of duty and that its failures caused the Claimant's catastrophic outcome. Damages will follow, subject to quantification or agreement.

Wider Implications

This decision highlights how, even in the absence of individual clinical error, organisational systems can fall below acceptable standards. When clinicians classify a patient as a priority, services must have a robust mechanism to ensure that priority is real, not nominal. For patients navigating overloaded NHS specialist pathways, the judgment emphasises that administrative delay—if inconsistent with a hospital's own clinical categorisation—can amount to negligence.

By Philip Matthews

The Difficulties of Dethroning Exacting Causation Thresholds even where Substandard Care Precedes Tragic Patient Suicide: *Zgonec-Rozej and Ors. v Dr Stephen Pereira* [2025] EWCA Civ 171

CLINICAL NEGLIGENCE – BREACH OF DUTY OF CARE – CAUSATION – FATAL ACCIDENT CLAIMS – MENTAL DISORDER – PSYCHIATRIC EVIDENCE – PSYCHIATRISTS - SUICIDE

By Michael Brooks Reid
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Introduction

On 18 April 2016, at the age of 48, John Jones QC, international criminal law silk, tragically took his own life. His death resonated across the Bar, and my colleagues in Chambers who work in this field will have known him well. Our condolences go out to John's family and friends, for whom no doubt these past nine years have been unspeakably difficult. In the interest of neutrality, I will refer to John for the remainder of this article as Mr Jones.

Facts

Mr Jones came under the care of the Defendant, Dr Stephen Pereira, a consultant psychiatrist at the Nightingale Hospital, in January 2016. He was experiencing severe anxiety and insomnia after returning to London from The Hague. Dr Pereira's working diagnosis was bipolar affective disorder, but Mr Jones doubted this and, in March 2016, emailed requesting to stop the prescribed medication, citing its "catastrophic effect" on his memory and concentration. Dr Pereira's secretary replied, authorising discontinuation of the medication.

On 21 March 2016, Mr Jones' parents telephoned Dr Pereira, with Mr Jones audible in the background. They reported that Mr Jones was in crisis and sought urgent hospital admission. A follow-up email warned that he was a danger to himself and in "a terrible place".

Mr Jones was admitted to the Nightingale Hospital on 22 March 2016. On or around the same day, Dr Pereira went on a three-week period of leave but neglected to inform Mr Jones. Care was transferred to another consultant, Dr Bakshi, but Mr Jones received no explanation of the nature, purpose and benefit of his admission.

A handover discussion took place by telephone between Dr Pereira and Dr Bakshi, with no written record made by either doctor. Mr Jones was put back on the previously prescribed medication.

The Evidential Lacuna

In respect of the period from 23 March to 10 April 2016, virtually no evidence was before the Court surrounding Mr Jones' care. This was because of a confidential settlement reached between the Claimants and the originally second and third Defendants – Dr Bakshi and the hospital – which involved no admission of liability and meant Dr Bakshi's care was effectively off-limits. The limited evidence available during this period showed that Mr Jones had declined group therapy but accepted one-to-one cognitive behavioural therapy (CBT), receiving two mindfulness sessions.

Dr Pereira resumed care on 10 April 2016. Apart from the two mindfulness sessions, Mr Jones received no psychotherapy, despite Dr Pereira having considered it an important part of Mr Jones' treatment and having told the inquest that psychological intervention *"could have made a huge difference."*

On 11 and 12 April, Dr Pereira reviewed Mr Jones as an inpatient. They discussed psychotherapy and Mr Jones indicated he might consider one-to-one therapy. Dr Pereira amended his working diagnosis to obsessive ruminations.

On 14 April, Mr Jones' father contacted Dr Pereira, reporting a "*relapse…into the deepest despair and depression."* A meeting on 15 April took place between Dr Pereira, Mr Jones, and his family, with Mr Jones said to be in a bad way. He was to decide over the weekend whether to remain as an in-patient and access group therapy or to be discharged to outpatient care. He spent the weekend with his family and returned to the hospital on Sunday evening.

Early on Monday 18 April 2016, Mr Jones died at West Hampstead station following a collision with a train. No suicide note was found, but CCTV footage indicated purposeful movements and emotional composure.

First-Instance Decision of Bourne J

Fact-finding

The Judge found significant inconsistencies between Dr Pereira's evidence at trial and at the inquest, describing parts of his evidence as "emphatic and self-serving". He emphasised the difficulty created by the evidential lacuna (my term), which prevented any real assessment of the care provided whilst Dr Pereira was away. The judge held, on the balance of probabilities, that Mr Jones was suffering a depressive reaction to past and present stressful events and did not have bipolar affective disorder.

Breach

The Claimants alleged several breaches of duty. Three were upheld:

1. **Failure to notify Mr Jones of planned absence (Breach 1).**

   Dr Pereira acted negligently in not informing Mr Jones that he would be unavailable for three weeks.

2. **Inadequate handover (Breach 2).**

   The telephone handover to Dr Bakshi was insufficient, and making no adequate written record was a departure from reasonable standards.

3. **Failure to arrange psychotherapy promptly on return (Breach 3).**

   On resuming care on 11 April, Dr Pereira negligently failed to set out a clear pathway for Mr Jones to begin psychotherapy.

Other alleged breaches – such as the incorrect working diagnosis and the lack of detailed discussion with Mr Jones about admission – were found non-negligent.

Causation

This is where the case ultimately collapsed. In respect of each of the three breaches of duty, the Claimants failed to prove causation:

1. Breach 1, although showing a "surprising lack of empathy," was not proven to have caused measurable harm.

2. The evidential lacuna meant it was impossible to determine whether any shortcomings in the period under Dr Bakshi's care were attributable to Breach 2.

3. Even if psychotherapy had been arranged promptly on 11 April, the judge could not conclude that Mr Jones would have had even one session before 18 April, nor that such a session would have prevented his suicide.

Contributory Negligence

Following a review of the authorities including *Corr v IBC Vehicles Limited [2008] 1 AC 884, Reeves v Metropolitan Police Commissioner* [2000] *1 ACT 360 and PPX v Aulakh* [2019] EWHC 717 QB, the judge concluded that Mr Jones had not lost autonomy when he took his own life. Had liability been established, he would have applied a 25% reduction.

Court of Appeal (Nicola Davies LJ, Baker and Nugee LJJ)

The Claimants appealed on three grounds.

Grounds 1 and 2: Causation

The Claimants argued that the Judge's causation reasoning was illogical, because psychotherapy was a central part of the treatment plan for both bipolar disorder and post-traumatic depression. Therefore, a competent handover should have included a plan for psychotherapy.

They also relied on the Judge's counterfactual findings, in which he had suggested that, had the correct working diagnosis been made, psychotherapy would have started much earlier.

The Court rejected these arguments. The Judge's counterfactual analysis was irrelevant because of his unappealed finding that the bipolar diagnosis was defensible. In a politely veiled criticism, Nicola Davies LJ opined that the Judge's counterfactual opinion had been unnecessary. Ultimately, the evidential lacuna had made it impossible for the Judge to determine whether omissions by Dr Bakshi were attributable to Dr Pereira or to her own independent decisions.

Material Contribution

At trial, the Claimants had submitted that if the Judge was unable to decide that question on the balance of probabilities, he should consider the 'material contribution' test identified in Bailey v Ministry of Defence [2009] 1 WLR 1052. The Judge held that that material contribution did not arise because it was possible to decide the case on the balance of probabilities.

On appeal, the Claimants took a different approach, arguing that given the number of overlapping factors, the material contribution test was appropriate notwithstanding that the "but for" test could be satisfied. The Court rejected this as contrary to the settled state of the law.

Contributory Negligence

Given its conclusions on causation, the Court did not consider it necessary to address this ground.

Comment

It is not hard to see why this case failed on causation. In a personal injury claim, where a tortious injury causes severe depression culminating in suicide (see, for example, *Corr*), causation may be more straightforward. But in the clinical negligence context, a claimant must prove that, but for a particular failing in psychiatric care, the individual would not have taken their own life. This will almost always present an evidential challenge given the complex, multi-factorial and often poorly understood psychological landscape that leads a patient to suicide.

A key learning point for claimant practitioners is the strategic risk of entering confidential settlements with some defendants but not others. Whilst securing some damages early may be attractive to the client, proper consideration must be given to any harm that could be done to the remaining claim. It will usually be sensible to seek independent counsel's advice on any partial settlement.

Defendant practitioners will conversely see this as an example of the merits of advising clients on strategic early settlement in a multi-defendant claim. It is also (yet another) reminder of the importance of diligent record-keeping and structured communication between medical professionals, particularly in the psychiatric field.

Practitioners interested in the development of this area of law may wish to read *"By Their Own Hand: Self-Inflicted Harm and the Law"* by Lady Justice Philippa Whipple, to whom I served as Judicial Assistant prior to coming to Chambers. Originally the 2024 PIBA annual Richard Davis Lecture, this can now be found in the Journal of Personal Injury Law, Issue 1 2025 (Sweet & Maxwell).

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Causation, Coincidence and Material Contribution: *Tuffin v University Hospitals Coventry and Warwickshire NHS Trust* [2024] EWHC 3318 (KB)

CLINICAL NEGLIGENCE – AMPUTATION – CAUSATION – DEEP VEIN THROMBOSIS – DIAGNOSIS – MATERIAL CONTRIBUTION – MEDICAL TREATMENT – SURGICAL PROCEDURES

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This claim failed following a preliminary issue trial on causation. The decision reminds us of the dangers of conflating correlation and causation. Even in a 'material contribution' case, the fact that two conditions were suffered coincidentally is not sufficient.

It also highlights the need for reliable evidence of cause and effect. Unconfirmed anecdotal reports of "one or two cases" are unlikely to be sufficient.

Finally, it underscores the importance of testing expert evidence on causation. Where a clinical finding potentially undermines an expert's theory as to causation, it is important to explore this in advance of trial.

Summary

The Claimant had a history of chronic back pain. She underwent elective spinal surgery in July 2015. The Defendant admitted it had negligently failed to prescribe the appropriate anticoagulant following surgery. She suffered a deep vein thrombosis ("DVT") and post-thrombotic syndrome ("PTS") in her left leg as a result.

The Claimant went on to develop severe pain, ulceration and a fixed deformity of her left leg. The cause of the pain was not clear. Some treating doctors diagnosed her with complex regional pain syndrome ("CRPS"). She underwent venous stenting to improve blood flow. This had a positive effect, but only temporarily.

The Claimant subsequently underwent an above-knee amputation in 2018.

The Issues

The Claimant argued that the amputation was caused by the Defendant's negligence. She argued that the symptoms leading to her decision to amputate – allodynia, ulceration and the fixed deformity – were caused by the DVT.

The Defendant argued that these symptoms were caused by the Claimant developing CRPS, and not by the DVT. It argued there was no basis for finding that CRPS was caused by the DVT.

The Claimant's alternative case was that, if she did develop CRPS, it was caused by the DVT. Her fallback position was that the DVT made at least a material contribution to the need for an amputation.

On causation, HHJ Dight cited the well-known case of Bailey v Ministry of Defence [2008] EWCA Civ 883:

> ***"…If the evidence demonstrates that 'but for' the contribution of the tortious cause the injury would probably not have occurred, the claimant will (obviously) have discharged the burden. In a case where medical science cannot establish the probability that 'but for' an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the 'but for' test is modified, and the claimant will succeed."***

The Experts

Vascular

The Claimant relied upon evidence from Mr Jenkins. The Defendant relied upon Professor Stansby. Mr Jenkins opined that the DVT was the 'trigger' for a series of clinical complaints leading to the amputation. Professor Stansby took the view that CRPS, rather than the DVT/ PTS, was the cause of the amputation; as such, the amputation would have occurred in any event.

Mr Jenkins made significant concessions in cross-examination. He accepted that the allodynia and the ulceration were not consistent with DVT/ PTS. The failure of stenting to relieve pain also suggested that this was not related to venous insufficiency. These concessions undermined his thesis based upon the DVT being the 'trigger'.

Professor Stansby had never seen or heard of a case where CRPS was caused by a DVT in the leg. There was only one case reported in the literature, and that did not involve a leg. On the other hand, a history of back problems and spinal surgery were both well described causes of CRPS.

Pain

The Claimant relied upon Dr Towlerton. The Defendant relied upon Dr Simpson. If CRPS had developed, then the experts differed as its cause. Dr Towlerton did not accept that the surgery itself (rather than the negligence) had caused the CRPS. However, he reluctantly accepted in cross-examination that there were no reports of DVT or PTS causing CRPS. He ultimately accepted that he could not say the DVT was a causative factor in the development of CRPS.

Dr Simpson explained she had seen hundreds of CRPS cases, but she had never seen one caused by vascular surgery. There were 3 potential causes of CRPS in this case: spontaneous (an unlikely coincidence); spinal surgery (rare but reported); or a vascular cause. A vascular cause for CRPS was "just something we do not see".

The Court's Analysis

The causes of amputation were allodynia, ulceration and the fixed position of the leg. As to each:

a) The vascular experts ultimately agreed that severe allodynia was not consistent with DVT or PTS.

b) They agreed the ulceration seem was not consistent with DVT or PTS.

c) The preponderance of the expert opinion was that the fixed position of the leg was not consistent with DVT or PTS but was consistent with CRPS.

The Judge therefore found that the Claimant was suffering from CRPS, and that CRPS caused the amputation. The Claimant could not prove that CRPS was caused by the DVT. There was nothing to support anything more than *"an anecdotal connection"* between the two:

a) Neither the medical literature nor the experience of the experts supported this.

b) Whilst one treating doctor's note referred to having "seen a couple of cases where this appears to have occurred", this was not accepted. The doctor was not called by either party. No details were given of these cases. This doctor's anecdotal experience conflicted with the experience of the experts.

c) HHJ Dight warned himself against the temptation of deciding the case based upon coincidence between the DVT and the development of CRPS.

Material Contribution

In order to establish liability, the Claimant would have to show that the DVT had added to the decision to amputate. Ultimately, the Judge could not conclude that the DVT made more than a negligible contribution (if any) to the allodynia. In those circumstances, it did not materially contribute to the decision

Practice Points

1) Scrutinise anecdotal reports with care. Is there any support in the literature for a proposed causation mechanism? If not, does it fit with the clinical experience of the expert(s)? In Tuffin, the treating clinician who gave the anecdotal evidence was not called at trial. There was nothing to confirm the ultimate diagnosis in those cases where the outcome "appear[ed] to have occurred". Ultimately, this was an anecdotal, non-specific comment which could not be properly evaluated. Moreover, it conflicted with the experience of the experts.

2) Are there results or findings that are potentially inconsistent with a proposed causation mechanism? It is important to explore with experts how such findings might impact upon their opinion. In this case, for instance, the Claimant's expert ultimately accepted that the failure of stenting to relieve the pain suggested that venous insufficiency (and thus the DVT/ PTS) was not the cause of allodynia.

3) Experts can assist the court by providing coherent critiques of alternative mechanisms. Dr Simpson's exploration of the 3 potential causes of CRPS, and her ability to rule out two of these, was persuasive.

4) Beware the appeal of coincidence. The fact that B follows A does not mean that A caused B.

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When Known Risks Eventuate: Consent and Risk Mitigation: *HQA v Newcastle upon Tyne Hospitals NHS Foundation Trust* [2025] EWHC 2121 (KB)

CLINICAL NEGLIGENCE – CAUSATION – BOLAM TEST – BRAIN DAMAGE – BREACH OF DUTY OF CARE – HEART – INFORMED CONSENT – PRELIMINARY ISSUES – SURGICAL PROCEDURES

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Background

The case was heard in front of Geraint Webb KC, sitting as a Deputy Judge of the High Court. The Claimant ("C") was born with congenital heart issues which resulted in her undergoing elective open heart surgery in the form of a sternotomy when she was 25.

During the surgery, the surgeon unintentionally cut the wall of C's aorta causing catastrophic haemorrhage. It was around 20 minutes before sucker bypass and 24 minutes before full cardiopulmonary bypass was achieved, during which time C sustained a serious hypoxic brain injury.

Specific issues of breach of duty relating to the manner in which the surgery was performed; whether there had been appropriate pre-operative planning/preparation and risk management; and if so, how much time would have been saved but for the breaches; and issues around informed consent were tried as preliminary issues.

Procedural History

C obtained two screening reports from senior cardiothoracic surgeons, one of which was supportive of C's case and the other of which found no breach of duty. By the time C came to serve an Amended Particulars of Claim, which relied on a third cardiothoracic surgeon, she was not seeking to rely on either of the experts who had provided screening reports. Pursuant to the principles adumbrated in *Edwards-Tubb v. JD Wetherspoon plc* [2011] EWCA Civ 136, the Court permitted reliance on the chosen (third) cardiothoracic surgeon on the condition that C disclosed copies of both of the screening reports.

It is not clear, from the Judgment, why it was that C decided not to rely on the expert who provided the positive screening report; but her decision to change expert is a useful reminder of the potential opportunities – and relatively small tactical costs – of doing so at an early stage, if it proves necessary.

History

The Claimant had undergone several operations whilst very young, including two sternotomies with cardiopulmonary bypasses before the age of 7. In her mid-20s, by which time she had had three children, the Claimant required a 're-do' sternotomy and the fitting of an aortic root support.

It was recognised that her aorta was in close proximity to, if not adherent to, the sternum, such that there was a real risk of injuring the aorta when performing the sternotomy. The surgeon did not consider it necessary to place C on cardiopulmonary bypass, and this was agreed not to be negligent.

However, C's femoral vessels had not been exposed; such that when, in the course of the sternotomy, the surgeon cut the wall of the aorta, a significant period of time was taken in attempting to canulate first the left and then the right femoral artery in order to put C on cardiopulmonary bypass. C sustained hypoxic brain injury during the period between when the aorta was ruptured and bypass achieved.

The Law

The Court relied on the usual tests of professional practice as set out in *Bolam, Maynard, and McCulloch*. On the issue of consent, the Judge relied on *Montgomery and McCulloch.*

First allegation: Intraoperative negligence

The surgeon suggested in witness evidence that *"the saw slipped whilst I was going through a section of the anterior table of the sternum… and caused the aortic injury"*. In evidence, he clarified that he meant it cut more deeply than intended, rather than that he had lost control of it.

The experts agreed that, in complex surgery, it is not possible entirely to eliminate the risk of inadvertent damage of a type that was known and recognised. The Judge found that there *"may well have been a momentary misjudgment and it may have been a misjudgment of a matter of a few millimetres",* such that he did not consider the fact of the risk eventuating evidence of negligence on the part of the surgeon.

Allegation two: Planning/Preparation and Risk Mitigation

However, C alleged that the Defendant ("D") was negligent *"in failing to expose suitable femoral/groin vessels and failing to prepare those vessels… in advance of the sternotomy to facilitate the establishment of more rapid cardiopulmonary bypass in the event of injury to the aorta… C's case was that such steps were the minimum mitigating measures which were appropriate given the significant risks of injury to the aorta arising from the proximity of the aorta to the rear of the sternum".*

The surgeon justified the decision not to expose the vessels in advance based on a number of factors, although he conceded that if the aorta had been adherent to the sternum, the chances of damaging it would be extremely high and he would have exposed the groin vessels in advance; and also accepted that the proximity of the aorta to the sternum increased the risk of aortic injury.

The experts agreed that *"the aorta was closely applied to the sternum on the CT scan",* and C's expert considered *"the risk of aortic injury should have been considered medium to high"*. By contrast, D's expert considered *"the risk assessment made by the operating surgeon (low to medium) was reasonable".*

The Judge was clearly persuaded by C's expert's answer in cross examination that *"Injury to the aorta is a recognised risk… and… the aorta was… very close to the rear of the sternum [meaning] that any surgeons would need a plan for "how do I get out of this if [injury to the aorta] happens?""*

The Judge found that "No surgeon could be confident… of being able to open the sternum without causing injury to the enlarged aorta" such that the risk "should properly be classified as medium to high" rather than "low to medium". In those circumstances, he was satisfied that "preparing the relevant groin vessels as a preparatory step in case of emergency bypass can properly be characterised as the minimum level of mitigation required in this case".

Issue 3: Informed Consent

Closely linked to his assessment of the risk of aortic injury as being medium to high, the Judge found that the surgeon "should have explained that there was an option of exposing the groin vessels in advance of the sternotomy in order to facilitate emergency cardiopulmonary bypass should it be required". He made this finding notwithstanding D's expert advising that "a reasonable body of cardiac surgeons would not discuss the details of canulation for bypass and emergency canulation strategies with patients".

He found that *"A patient who is informed that the procedure can be carried out with or without taking a step which may facilitate more rapid establishment of cardiopulmonary bypass in the event of aortic injury is in a position to begin to ask questions to explore the pros and cons of the options and so give informed consent. The surgeon would then be likely to have to explain why they consider that one variant is more appropriate."*

He went on to find that "It is therefore likely, on the balance of probabilities, that had C been properly informed as to this option then she would have opted to proceed with the sternotomy provided that the femoral vessels were first exposed and prepared".

There was no evidence before him to suggest that the surgeon would have refused to take that step had it been requested.

The Judge did go on to find, however, that C would not have deferred surgery had the option not been available.

Causation

The Judge found that, had the femoral vessels been prepared ahead of the sternotomy, there would not have been a nearly ten minutes delay whilst another surgeon scrubbed in; it was more likely than not that canulation would have been achieved without dissecting the left femoral artery; and that, consequently, about thirteen minutes of the twenty minutes before sucker bypass was achieved would have been saved.

There was no neurology evidence as to causation at this early stage. As a result, no further findings as to medical causation were made.

Takeaways

This case provides a very useful example of the way in which ensuring experts advise on the steps that should have been taken to mitigate risk can bring success even in cases where the injury that arises is one expressly foreseen, and which is unavoidable. The higher the risk of injury arising, the greater the steps that ought to be considered to avoid damage from that injury.

Further, the judicial findings on consent were important. The fact that the surgeon did not ordinarily consent around mitigation practices was found not to be reasonable by the Judge. The clear impression is that, had the consent process been appropriate, the surgeon may well have been prevailed upon to take steps that ordinarily he would not.

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Scope of Duty and the Difference Between Needing Something "On Discharge" versus "Very Soon" in a Case of Alleged Negligence by *Paediatric Clinicians: Conway v Yeovil District Hospitals NHS Foundation Trust & Anor* [2025] EWHC 2488 (KB)

CLINICAL NEGLIGENCE – BABIES – BRAIN DAMAGE – BREACH OF DUTY OF CARE – CAUSATION – DOCTORS – FORESEEABILITY – HOSPITAL DISCHARGES – NON-ACCIDENTAL INJURY – ULTRASOUND SCANS

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In *Conway,* Turner J was invited to consider whether paediatric physicians owed a duty of care to the Claimant, a baby, to conduct further diagnostic inquiries that would have led to steps protecting him from an assault perpetrated by his mother shortly after his discharge from their care. This issue arose in circumstances where it was agreed there was no evidence available suggesting that the Claimant was at risk from his mother at the time of the alleged breach. The Claimant's case failed on scope of duty following a two-day hearing and the Judge found in the alternative that he would have dismissed it on breach even had he resolved scope of duty in the Claimant's favour.

Introduction

Turner J's decision includes a useful application of the Supreme Court's recent guidance on duty of care from *Khan v Meadows*. The case is also an example of the court ultimately concluding that an expert, here Dr Conway for the Claimant, had been partisan. This decision is likely to be of interest to practitioners litigating novel scope of duty issues in a clinical negligence context and particularly those concerning alleged failures to recommend treatment or care where damage has been sustained in an intervening period. It is also relevant to claims where allegations of breach intersect in close proximity to abuse perpetrated by parents or caregivers.

Facts

As the Judge recognised, this was a tragic case of a young life irredeemably blighted. The Claimant was born in November 2014 and was first assaulted by his mother on or around New Year's Eve of that year although this was unknown to his father or any treating clinicians.

On 6 January 2015 the Claimant was admitted to Yeovil District Hospital with vomiting, poor weight gain, poor head and neck control, irritability and an increase in percentile of head circumference measurements. On 9 January he was transferred to Bristol Children's Hospital ("BCH"). The suspected diagnosis was pyloric stenosis but this diagnosis was later ruled out after the

Claimant underwent an abdominal ultrasound scan ("USS") at BCH. On 10 January 2015 he was discharged into the care of his parents with the intention that his head measurements would be kept under review by the health visitor. That decision, as opposed to ordering a very prompt USS of the head, was the focus of the Claimant's litigation friend, his father's, primary criticism of the Defendants.

On 11 January 2015 the Claimant was assaulted again by his mother and suffered a catastrophic brain injuries.

Arguments

It is obvious from the judgment of Turner J that the case on breach and scope of duty changed over time. The Claimant argued initially that a head USS should have been carried out before discharge (or at least before the second assault) but this contention was modified, in line with concessions made by Dr Conway, to be a case that the head USS should have been carried out "very soon" after the abdominal USS. The case was in essence that had that been done, the head USS would have set off a chain of events leading to the second assault not occurring at all. So the criticism focused on the failure by clinicians to recommend a very prompt USS scan of the head after the negative finding of the USS abdomen scan.

Turner J considered this was a case where the refinements to the Bolam test in *Bolitho v City and Hackney Health Authority* [1997] 4 All ER 711 were relevant. The Claimant's case was that the USS head scan should have been planned to take place "within a day or two" of the abdomen USS and that the failure to confirm the pyloric stenosis at this time left a diagnostic gap. Given the percentile increase to the head circumference, not pursuing the head USS was alleged to have been illogical.

The Defendants' arguments were two-fold. First, they argued that the decision to keep the Claimant's head circumference under review fell comfortably within the range of reasonable decisions open to the paediatricians and in particular that all other signs had resolved by the time of discharge home.

Second, it was contended that on the evidence of Dr Conway (for C) the criticism was limited to being that the head USS should have been undertaken "very soon". In response to questioning from the bench, Dr Conway conceded that the duty would have been fulfilled if say it was performed on 12 January being the day after the assault. It was also conceded, central to the Defendants' case, that the discharge in the intervening period was not negligent per se. It was argued that the alleged breach did not involve a duty comprehending the actual damage suffered and so failed on causation.

The decision

The issue narrowed from being whether the USS should have been carried out "before discharge" to only "very soon" after. The case is a notable application of the still relatively novel guidance in *Khan v Meadows* from the Supreme Court to a difficult scope of duty question. The Judge considered that the six questions for analysing a scope of duty articulated in that decision assisted him whilst also acknowledging they were not a comprehensive analysis or a "straightjacket". It still appears that unsurprisingly *Khan v Meadows* was not intended to change the substantive law of negligence but is rather an analytical tool.

The Judge articulated the potential duty on the defendant in line with Bolam/Bolitho as being one to "*take reasonable steps (whether by way of testing, treatment or otherwise) to respond to the risk of any deterioration in or failure to recover from any ongoing condition from which [the Claimant] may have been suffering.*" The Judge then rejected that there was such a duty to take steps to protect the Claimant from any and all consequences of being discharged into the care of his parents (the risk of harms question two in Meadows). Thus the scope of the duty was not *"susceptible to retrospective expansion"* when the Defendants did not know or could not reasonably have suspected that the mother was responsible for injuries leading to the admissions to hospital.

The Judge rejected argument that the issue was only a factual one. If it were so, the scope of the purported duty on the Defendants would encompass any injury sustained after discharge (the example of injuries arising from a road traffic accident on the way home was given, plainly not something that could have fallen within their scope of duty to guard against).

Turner J concluded that the discharge provided the opportunity for the Claimant's mother to assault him again and was unrelated to the nature of the duty owed by the Defendants. On the Judge's analysis even if the "but for" test was satisfied, this was relevant to the fourth question posed in Meadows, whether the loss was the consequence of a defendant's act or omission, and could not be relied on where the scope of duty was not satisfied. The injuries did not fall within the scope of duty owed to the Claimant.

The Judge also held that even if he were wrong on the scope of duty question, he considered the third issue from Meadows (did the defendant breach his duty?) and preferred the expert evidence of Dr Rose (for D) over Dr Conway, resolving that the Defendants' approach was reasonable on a Bolam/Bolitho analysis. The case would have failed on that alternate basis.

Treatment of expert evidence

The central issue in this case was the alleged scope of the duty of care. The court preferred strongly the Defendants' expert evidence over that from the Claimant in resolving that issue. The analysis of Dr Conway's position at trial is certainly a cautionary tale. His significant changes in opinion, coupled with amendments to the case that was run on scope of duty, plainly damaged his credibility in the eyes of the court. The scale of the concessions were difficult to overcome particularly when made without new information or arguments being presented. Further criticism was made of his "mildly combative" answers to questions and tendency to assume the purpose of any given question, both of course best avoided.

Dr Rose for the Defendants was considered "reasonable, logical and fair" as well as consistent. Dr Rose found there was nothing wrong in the plan to have the health visitor follow up the head circumference issue over the next one to two weeks and this opinion was accepted. The Judge considered that the alternative view, that an urgent USS of the head was needed was in fact a criticism of the care emboldened with "the deceptive confidence of hindsight" rather than the "sober application of reasonable foresight".

Comment

The lessons from this case are that claimants are well advised to determine early what their case is on the scope of the defendant's duty that they will allege has been breached. A roving inquiry or evolving case on scope of duty can be damaging. Articulating the scope of duty is particularly important where it is being alleged that but for the negligence some intervening act or damage would not have occurred. The case also illustrates that experts instructed for either side should be encouraged to robustly test and challenge their own opinions before presenting them as final in a report and ensure as wide a range of treatment options or recommendations are considered and commented upon. Finally, the case is also an endorsement of the usefulness of using the six questions posed in Khan v Meadows as a cross-check when resolving difficult duty of care arguments.

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Late Hearsay Notices and Witnesses with Intermittent Seizures: *Richards v Shrewsbury and Telford Hospitals NHS Trust* [2024] EWHC 3384 (KB)

CLINICAL NEGLIGENCE – CROSS-EXAMINATION – EXTENSIONS OF TIME – HEARSAY EVIDENCE – MENTAL CAPACITY

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Facts

This was an interlocutory hearing in an unspecified clinical negligence claim arising from alleged negligence during the Claimant's operation in 2018. Two applications were heard by the court. Firstly, the Defendant sought an extension of time to give a notice under section 2 of the Civil Evidence Act 1995 to rely on the statement of the operating surgeon ("the Doctor") without calling him to give oral evidence ("a hearsay notice"). The Claimant, in turn, applied under CPR 33.4(1) for an order requiring the Doctor to attend for cross-examination.

The Defendant provided two letters from a consultant neurologist in support of their application, describing that the Doctor developed a condition whereby he suffers from ongoing intermittent seizure activity, which is exacerbated by stress-related sleep disturbance. After a seizure, the Doctor experiences confusion and has cognitive slowing and is unlikely to have mental capacity or give accurate responses to questions in that state. The letters also state that he is likely to have an inconsistent ability to recall events from 2018.

This hearing took place before Steven Gasztowicz KC sitting as Deputy High Court Judge.

Extension of Time for Hearsay Notice

The Defendant had not complied with CPR 33.2(4)(a), which requires a hearsay notice to be served no later than the date for service of witness statements. The judge accepted the explanation for late service: the deterioration in the Doctor's condition only came to the Defendant's solicitor's attention recently, and they acted promptly once aware of the issue.

Taking into account the Denton principles, the judge decided that: (1) the breach was not serious in the context of the case; (2) there was a good reason for default and it was not the Defendant's fault; and (3) all the circumstances pointed towards granting the application, including that the evidence was admissible in any event [5].

Relief from Sanctions?

Interestingly, the judge stated that it was unnecessary for the Defendant to make an application for relief from sanctions because no sanction is specified for the failure to serve a hearsay notice [3].

This is consistent with the commentary in the White Book at 33.2.3, which explains that a failure to serve a hearsay notice does not affect admissibility but may influence (i) the weight the court places on the statement, and (ii) the exercise of the court's powers under CPR 32.1, including the potential exclusion of this evidence. The commentary also notes that, if the court does exclude hearsay evidence as a result of non-compliance, this would constitute a procedural sanction and therefore trigger the jurisdiction under CPR 3.9. Otherwise, the relief from sanctions rules are not applicable as no sanction is specified for the failure to give a hearsay notice within the time limit imposed by r.33.2(4)(a), albeit the factors specified in r.3.9 should be taken into account when considering an application to extend this time limit.

It is a curious question, as the prospect of reduced weight being attached to a party's witness evidence, or its exclusion, is arguably a sanction. Indeed, in Goknur Gida v Organic Village Ltd [2019] EWHC 2201 (QB), Chamberlain J stated that relief from sanctions was "no doubt… required" when a hearsay notice was served on the fourth day of trial, nearly a year late [13].

However, this decision appears to be an outlier that is probably best understood within its procedural context. Whilst no detailed reasoning is provided in the judgment, one may deduce that the hearsay notice came at such a late stage that Chamberlain J may have considered it very likely that he would exclude the evidence and therefore heard the relief from sanctions application pre-emptively.

Neither the CPR nor the Civil Evidence Act 1995 express the potential sanction for late service of hearsay notices in mandatory terms. The evidence would either attract reduced weight or be excluded if the other party makes submissions on this point or the judge decided to make a ruling of its own accord. Therefore, this would likely fall within the third category of sanctions stipulated by the Master of the Rolls in FXF v Ishinryu Karate Association [2023] EWCA Civ 891 – cases when "a further step is taken in consequences of the non-compliance, such as the entry of a default judgment" [59] – to which CPR 3.9 does not apply.

Richards therefore sits comfortably with the modern authorities and the White Book commentary: unless the court has excluded hearsay evidence, an application for relief from sanctions is not necessary.

Permitting the Claimant to Cross-examine the Doctor

The Claimant made an application under CPR 33.4(1) to cross-examine the Doctor.

The Claimant highlighted that he is a key factual witness, given that he was the doctor that performed the allegedly negligent surgery and that the Claimant's arm and chest positioning during the surgery was critical to the case. He is also the only person who will most likely be able to give evidence in respect of this issue. The Doctor's witness statement only recounts his "standard practice" and the Claimant wished to cross-examine him on his recollection of the Claimant's surgery in particular, put to him a number of discrepancies in the case and investigate the vagueness of the Doctor's witness statement in cross-examination.

The Court granted the Claimant's application for the following reasons:

1. The court accepted that the Doctor's oral evidence would be particularly relevant due to the nature of the issues between the parties.

2. Neither of the letters showed that the Doctor was unable to give evidence before a court, physically or mentally [21].

3. The letters did not suggest that it would be harmful for the Doctor to give evidence – although the judge also accepted that "the first of the letters says that intermittent seizure activity is exacerbated by sleep disturbance in the context of stress and, of course, giving evidence can be a stressful exercise." [22].

4. The letters suggested that even if the Doctor was experiencing confusion and cognitive slowing after a seizure, he would still be able to give answers, albeit he would struggle. Special measures can assist to minimise stress during cross-examination, such as frequent breaks or giving evidence remotely from a comfortable setting [24, 26].

5. Difficulty recalling past events is faced by many witnesses, not only the Doctor, and part of the reason for cross-examination is to find out what they can recall [25].

6. If at the time of trial the Doctor suffers a seizure or incurs another issue, an application could be made to the trial judge in that respect [27].

Comment

This case highlights the strategic value of CPR 33.4(1) in clinical negligence litigation. The decision in Richards demonstrates that courts are reluctant to deprive parties of the opportunity to test the other side's evidence and upholds the importance of cross-examination to the trial process. The Claimant in this case had a strong case for requiring the Doctor to be cross-examined due to the importance of his evidence to the case, but the question remains if the decision would have been different had it instead concerned the evidence of, for example, an anaesthetist who was present during the surgery but did not participate in the alleged negligence.

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Going for the Triad: A Defendant's Summary Judgment, Strike-Out and Wasted Costs Application: *Butler v Ward* [2025] EWHC 877 (KB)

CLINICAL NEGLIGENCE – BOLAM TEST – INFORMED CONSENT – STRIKING OUT – SUMMARY JUDGMENTS – SURGICAL PROCEDURES – WASTED COSTS ORDERS

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The Court considered the principles underpinning each informed consent, summary judgment, strike-outs and wasted cost orders in this high-value clinical negligence case against a Defendant orthopaedic surgeon. Whilst the Defendant's application for summary judgment on the Claimant's claim concerning inadequate risk warnings before his surgery was refused, the Defendant encountered greater success on its strike-out application, with the court considering that the loss of earnings claim in the Schedule of Loss was incoherent and unevidenced. In declining to order a wasted costs order, the Court reminds that the justifications for such an order are slim and do not necessarily become engaged even where a claimant pursues a 'hopeless' case.

Summary Judgment Application

The Claimant on 24 July 2019 underwent a hip re-surfacing procedure performed by the Defendant. He suffered a post-surgical avulsion injury, causing persistent weakness and restricted movement. This limited his work capacity as a ski instructor. He alleged he had not been adequately advised about this material risk and had he been so properly advised, he would have delayed surgery and opted for conservative treatment. His witness statement articulated, *"Had it been made clear to me that there was a chance I could end up in a worse position, then I would have soldiered on. I wasn't making anywhere near the maximum use of painkillers. I might have continued an appreciable period before surgery became an absolute necessity."* ([11]).

The Defendant's recollection, in contrast, was that he counselled the Claimant about the possibility of an adverse outcome, relying upon a record of the consultation dated 12 March 2019 contained within a letter sent by the Defendant to the Claimant's GP. The Defendant nonetheless accepted it had not warned about the risk of avulsion but stated that this was not contrary to clinical practice. The Defendant argued that, per *McCulloch v Forth Valley Health Board* [2023] UKSC 26, the Bolam (*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582) test applied to whether a particular risk or alternative procedure required discussion, and that only an expert with relevant clinical experience could assess whether the Defendant's conduct met accepted medical standards. It submitted that the

Claimant had no real prospect of establishing that his consent to surgery was uninformed, and that his expert (in ankle, wrist and hand surgery i.e., *upper limbs*) lacked the necessary expertise in *hip surgery* to opine on the appropriate consent process. The Defendant advanced that for an expert to give a view on the adequacy of consent to a procedure and to advise the court about the consideration-set of a 'non-standard patient', it was essential for the expert to have experience taking consent in the context of that procedure. The Claimant's orthopaedic expert, Mr Gilham, did not have such experience, nor of even 'related' procedures such as knee surgery ([29]).

The Defendant's first remedy was therefore for summary judgment pursuant to CPR Part 24.

Summary Judgment Ruling

In rejecting summary judgment, the court analysed *Bolam and Montgomery v Lanarkshire Health Board* [2015] UKSC 26, emphasising that whilst the assessment of reasonable treatment alternatives is a matter of professional clinical judgement, when assessing "materiality of risk", it was for the patient, not the clinician, to decide which risks they were willing to run. A distinction must be drawn between the choice of treatment options on the one hand and the discussion of those options, including their attendant risks on the other. The 'clinician-centred' Bolam test is fundamental to the first but not the second stage ([33]). The Court rejected the Defendant's submission that *McCulloch* alters the *Montgomery* patient-centred test of materiality ([40]).

The critical issue remains: what significance would a reasonable person in the patient's position attach to particular risks?

There were non-fanciful factual issues in *Butler* to determine if informed consent was properly obtained and the Court could not adjudicate on those issues which required oral evidence and thus, a trial to reach a decision (*Easyair Ltd v Opal Telecom Ltd* [2009] EWHC (Ch)).

Whilst there was the "helpful" contemporaneous letter dated 12 March 2019, it did not conclusively undermine/contra-indicate the Claimant's factual account to justify summary rejection of his factual assertions (*ED & F Man Liquid Products v Patel* [2003] EWCA Civ 472 considered). The Judge did not regard the letter's contents as *"sufficiently clear to allow a judge, without hearing oral testimony, to come to a conclusion as to whose evidence is most accurate on the issue of how, and in what terms, risk was discussed."* For example, no mention was made to his occupation as a ski instructor ([13]).

Further, the claim was realistic (as opposed to fanciful) because "it carried some degree of conviction" and was more than merely arguable (*AC Ward and Sons Ltd v Catlin (Five) Ltd [*2009] EWCA Civ 1098 and *Swain v Hillman* [2001] 2 All ER 91 considered). There were also reasonable grounds to believe fuller investigation would affect the outcome (*Doncaster Pharmaceuticals Group Ltd v Bolton Pharmaceutical Co 100 Ltd* [2007] FSR 63).

The Court explained that Mr Gilham's upper limb expertise did not automatically render his opinion of no weight and/or inferior to the Defendant's expert orthopaedic opinion in relation to informed consent. The Court indeed found Mr Gilham's position was similar to that of the knee surgeon whom the Defendant accepted could assist the court ([40]).

Consequently, the Defendant failed to prove that the Claimant had no real prospect of showing that his consent to the hip resurfacing procedure was uninformed.

Strike-Out Application

The Defendant also applied for strike-out of the Claimant's Schedule of Loss under CPR 3.4(2)(b), contending that it obstructed the just disposal of proceedings. £2.5 million of the £2.6 million total claimed was comprised of past and future loss of earnings.

The Court struck out the loss of earnings part of the Claimant's Schedule of Loss as it was incoherent and, unsupported by evidence. Relevant historic business accounts were not disclosed and the Claimant failed to explain its method for calculating projected earnings/the multiplicand ([55]). Reasonable Part 18 questions asked by the Defendant went unanswered and the Claimant even agreed with the Judge that his high-order claim did not make any sense ([58]).

However, despite also being *"sparsely"* and *"inadequately"* pleaded respectively, neither the claims for surgery nor care were struck-out because it was for a trial judge to decide whether the evidence justified any award and, if so, how much ([50]-[51]).

Costs

The Defendant's third application was for a wasted costs order against the Claimant's former solicitors who had come off the record shortly before a previously listed trial date. The Court was required to adjudicate on whether those solicitors had acted negligently, unreasonably or improperly such that they should be required to 'show cause' concerning why a wasted costs order was not warranted in this case.

The Defendant relied upon:

i. The signing of "a statement of truth schedule of loss" by the former solicitors containing an incoherent earnings claim;

ii. Failures to deal promptly or properly with required procedural steps e.g. preparing a trial timetable;

iii. Costs wasted by the adjournment of the trial;

iv. Pursuit of a hopeless case; and,

v. Improper conduct i.e., the failure to deliver a document to her properly.

Having considered the three-stage test for wasted cost applications enumerated in *Williams-Henry v Associated British Ports* [2024] EWHC 2415, the court declined to order wasted costs against his former solicitors as it found no prima facie case of improper, unreasonable or negligent conduct. It concluded there were possible innocent explanations for the above failures; it would not be proportionate or just to investigate them further; and, it was the Claimant's, not the solicitors, decision to apply for an adjournment. The underlying case was not hopeless and had not clearly caused wasted expenditure.

In any event, pursuing a hopeless case would not by itself justify a wasted costs order (*Ridehalgh v Horsefield* [1994] Ch. 205). The Claimant had suffered a real injury and was entitled to explore whether he had given informed consent.

Key Takeaways

Butler serves as an "archetypal" case in which summary judgment should be rejected. The issue of consent depended on the Claimant and Defendant's oral evidence; the Defendant did not make his application until after the trial date and his skeleton argument for trial was predicated on evidence being required ([42]).

Whilst unevidenced claimed losses, especially high value sums, risk being struck-out, the Court reminds that strike out of a claim, or part of a claim, should be a last resort ([49]). Given the Court's preference to adjudicate issues and hear submissions at trial, even "sparsely" or "inadequately" pleaded claims will not categorically obstruct the just disposal of proceedings.

Essentially, whatever reasonable criticisms may be made of a claimant's evidence (lay and expert), defendants will again face an uphill battle to prove it is an abuse of process to put it before the court.

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Change of Experts Illustrates that the Court's Broad Discretion in Case Management Matters is Far from Limitless: *Prescott-Brann v Chelsea and Westminster Hospital NHS Foundation Trust* [2024] EWHC 3314 (KB)

CLINICAL NEGLIGENCE – CASE MANAGEMENT DIRECTIONS – CAUSATION – EXPERT EVIDENCE

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Prescott-Brann v. Chelsea and Westminster Hospital NHS Foundation Trust and anor. [2024] EWHC 3314 (KB) is an interesting example of a rare instance where an appellate court was persuaded to reverse a case management decision, notwithstanding the extremely high threshold for allowing such an appeal to account for the broad discretion afforded to first instance judges in relation to the exercise of their case management powers.

Factual Background

The Claimant brought a claim against the Defendant hospital Trust and a diagnostic clinician alleging that the negligent delay in the diagnosis and treatment of his stroke had caused or materially contributed to an ongoing thromboembolic event in his left vertebral artery, thereby worsening a neurological injury. It was essentially alleged that if he had been prescribed aspirin and remained in hospital as an in-patient then this would have prevented a further thromboembolism.

Procedural Background

At a case management hearing at a relatively late stage in the proceedings, Master Eastman rejected the Claimant's application to rely upon an alternative neurology expert, Dr. Chandratheva, in place of the current neurologist, Professor Wills, upon whom he had the Court's permission to rely. Master Eastman refused to allow the Claimant to change neurologists and rely upon Dr. Chandratheva because: *(i)* the application had been made late; *(ii)* Professor Wills had maintained his view throughout the proceedings; *(iii)* the change of experts might be thought to amount to expert shopping; *(iv)* Dr. Chandratheva's report would not greatly assist the Claimant in any event; and *(v)* Dr. Chandratheva had been provided with partial and inappropriate documents.

The Appeal

On the appeal against that decision, Sweeting J. emphasised that the legal test for appeals against a case management decision was whether the judge's decision could be said to have been 'wrong', pursuant to the Court of Appeal's decision in *Walbrook Trustee (Jersey) Ltd. v. (1)Fattal (2)RSA* [2009] EWCA Civ 297. He noted that Lord Neuberger in the Supreme Court in *HRH Prince Abdulaziz Bin Mishal bin Abdulaziz Al Saud v. Apex Global Management (No.2)* [2014] UKSC 64 had observed that *"Given that it was a case management decision, it would be inappropriate for an appellate court to reverse or otherwise interfere with it, unless it was* ***'plainly wrong in the sense of being outside the generous ambit where reasonable decision makers may disagree'",*** the underlined words being a direct quotation from the judgment of *Lewison LJ in Broughton v. Kop Football (Cayman) Ltd.* [2012] EWCA Civ 1743.

Dealing with the facts of the instant case, the Judge held that Professor Wills' views were not actually consistent throughout his three reports; Master Eastman had referred to and quoted from the first unsupportive report in the course of the judgment, but he had not maintained that view throughout. His initial opinion had been made subject to a caveat dependent upon factual findings- he had not had a full statement from the Claimant, nor examined him, at the time of writing the first report. It was significant that he had refused to engage with another one of the Claimant's experts. The Master had mischaracterised the effect of Dr. Chandratheva's evidence by misattributing an observation to him that had actually been made by a radiologist.

Judgment on Appeal

The Judge's conclusion was summarised in paragraph 34 of the judgment which stated, *"I am satisfied that the Appellant has demonstrated a good reason to change experts. The application is not so late as to be prejudicial to the Respondents, and I do not consider that the Appellant is engaging in expert shopping."*

Dealing with the legal considerations relating to changing experts, the Judge referred to CPR 35.4 which provides that *"No party may call an expert or put in evidence an expert's report without the Court's permission",* along with the well-known authorities relating to when parties should be permitted to rely upon a new expert in substitution for an existing one (e.g. *Edwards-Tubb v. JD Wetherspoon Plc.* [2011] EWCA Civ 136 and *Murray v Devenish* [2017] EWCA Civ 1016). From those sources, the Court derived a general rule that permission will only be granted if the first expert's report has been disclosed, and the Court has considered the following four matters:

(a) whether the proposed change had been made too close to the trial date or may disrupt the proceedings and cause delays;

(b) whether it is made solely to find an expert who will give a more favourable opinion (i.e. expert shopping);

(c) whether the change would unfairly disadvantage the other party; and

(d) whether a change would be contrary to the Overriding Objective.

The Judge went on to clarify at paragraph 32 of his judgment that:

"There is some evidence in the e-mail correspondence that Professor Wills had become frustrated with the process in which he was being asked to engage but I accept for present purposes that the Appellant's legal advisors have raised a legitimate concern. Professor Wills is an eminent clinician and I should make it clear that I am not, in this judgment, expressing any view about the performance of his duties as an expert witness. ***It is a feature of complex litigation in this area that from time to time parties lose confidence in the experts they have instructed. Where that loss of confidence has a foundation beyond mere assertion and where there is a good apparent reason for a change of expert, then subject to the principles set out above it is rarely productive for there to be satellite litigation drawing in the experts themselves."*** (emphasis added)

Commentary

Whilst the judgment certainly makes for interesting reading, and will no doubt be a useful decision to refer to and potentially rely upon when intimating or pursuing an appeal against a case management decision and/or seeking to change experts fairly late in the day in any claim, on close analysis it does not create or develop any new propositions of law.

The judgment does not appear capable of altering the generally accepted propositions that appeals against case management decisions will invariably be few and far between due to the high threshold required for success. The policy considerations in favour of interlocutory determinations almost always being treated as the final say on the issue are strong.

Prescott-Brann is probably best viewed as an application of the existing law (both related to changing experts and to overriding case management decisions) on the particular facts of the index case and the particular findings of the judge at first instance, rather than as an 'authority' that expands the law on either of these topics in a new direction.

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Applications for Strike Out and/or Summary Judgment on Account of an Alleged Inadequately Pleaded Amended Defence Dismissed: *Prudence and anor. v. Gloucestershire Hospitals NHS Foundation Trust* [2025] EWHC 1209 (KB)

CLINICAL NEGLIGENCE – BIRTH – MIDWIVES – PRIMARY VICTIMS – PSYCHIATRIC HARM – STATEMENTS OF CASE – STRIKING OUT – SUMMARY JUDGMENTS

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The Claimants were midwives who had attended to a mother and newborn baby during an emergency ambulance transfer from a birth unit to hospital and claimed that the experience had caused them psychiatric injury as primary victims, basing their claim on the admitted negligence of the Defendant in its care of the baby, who later died, and her mother.

After the Court had accepted the Defendant's criticism that no scope of duty arguments or allegations of breach of duty had been pleaded by the Claimants at an earlier hearing, the Particulars of Claim were amended, followed by an Amended Defence. The Claimants alleged that the Amended Defence contained 'bare' defences' that failed to plead a positive case when they ought to do so, pursuant to *SPI North Ltd. v. Swiss Post International (UK) Ltd.* [2019] EWCA Civ 7. On that basis, they applied to strike out ten paragraphs of the Amended Defence and/or for Summary Judgment on their claims.

Master Thornett held that none of the paragraphs which the Claimants sought to strike out fell into the classification expressed in SPI North of *"stonewalling ... full of indiscriminate non-admissions".* Neither, with reference to CPR PD 3A 1.4(1), did they *"consist of a bare denial or otherwise set out no coherent statement of facts".* The starting point was that the Amended Defence sought to defend claims that arguably still called for more precise presentation and clarification as to the nature and scope of the duties relevant to the Claimants personally rather than to the baby and mother. It was also noted that some of the allegations fell outside the Defendant's knowledge and some of them were counter-factual matters that the Defendant was unable to properly admit or deny.

In terms of Summary Judgment, the Judge did not accept that the claim was as self-contained and self-proving as the Claimants had contended. He held that it was not clear whether earlier transfer of the mother to hospital (as should have occurred) would have been an emergency transfer. The non-negligent causes of the baby's deterioration may have precipitated emergency transfer in any event. Those were questions for expert evidence, and thus the Defendant's challenges to the Claimants' case demanded resolution at trial.

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Surveillance Evidence Under the Microscope: *Perrin v Walsh* [2025] EWHC 2536 (KB)

ADMISSIBILITY – COVERT SURVEILLANCE – EXPERT REPORTS – PERSONAL INJURY CLAIMS – SPECIFIC DISCLOSURE

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This is a useful case management decision reminding legal practitioners, courts and experts of the caution that should attach to interpretation of surveillance evidence.

On the facts of the case, C resisted D's application to rely on covert surveillance evidence on the ground that it was tainted by significant flaws; specifically: that (1) the footage had been edited in such a way as to remove footage supportive of C's case, (2) there were inexplicable gaps in the filming from which an inference could be drawn that filming had been stopped deliberately at a time when C was manifesting consequences of her injuries, (3) removing reference to one of the surveillance operatives from the logs disclosed and thereafter failing to provide unedited footage from that operative when requested to do so was unsatisfactory, and (4) there had been a failure to retain the SD cards used to record the original footage.

C alleged that the surveillance company in question had engaged in a 'deliberate and cynical manipulation' of the surveillance evidence to paint her as less disabled than she was in an attempt to bolster D's allegations of exaggeration.

His Honour Judge Grimshaw setting as a Deputy Master in High Court set aside considerable time to review the allegations. The surveillance company whose work was under scrutiny (The Surveillance Group ("TSG")) produced statements from various employees including two fraud investigation analysts responding to C's concerns. The Court found some of those explanations in statements verified with statement of truth to have been misleading and untrue.

However, on the facts before the Court, the Judge rejected C's central contention that the manipulation and shortcomings in the surveillance were the product of a 'deliberate and cynical attempt to manipulate' the evidence for malign purposes. Instead, the more likely explanations were poor editing, poor execution of the original filming and poor administration on the part of TSG in recording, editing and retaining edited footage.

The Court expressed 'real concern about how TSG had approached their assignment in the case'; however, taking a step back, the Court found that the probative value of the unsatisfactory surveillance outweighed the prejudice arising from its deficiencies and permitted D to rely on it.

Along the way, the Judge referenced several of the leading surveillance decisions, not least the recent comments of His Honour Judge Ambrose in the case of Cullen v Henniker-Major [2024] EWHC 2809 (KB), (addressed later in this Update) in which he observed:

"…I accept that if something is shown on the footage, that is determinative of it happening. However, I do not accept that the absence of something on the footage is determinative of it not happening" [107]

His Honour Judge Grimshaw went onto comment generally about the limitations of surveillance in injury litigation, saying:

"I would also add that the value of surveillance evidence is in what is seen, not what might have been seen on another day or at another time or place. One must be particularly cautious when, as is alleged in the present case and in Cullen, the footage obtained appears incomplete and where there are gaps in what was recorded. Surveillance footage cannot definitively show what the subject is feeling or how much pain they are in. It is merely a snapshot in time. I also accept that an individual's condition may vary throughout the course of a day, week, month or year, and maybe in response to activity that had occurred prior the obtaining of such footage. It is therefore only a piece of evidence in the jigsaw." [18]

HHJ Grimshaw also counselled experts to interpret covert surveillance footage with similar caution, saying:

"Medical expert witnesses, like the Court, must understand the utility and limitations of such evidence and thus the weight that it should be given. Questions of honesty, dishonesty and exaggeration are matters for the trial judge, not for medical expert witnesses to decide upon, noting that the role of medical expert witnesses is to assist the Court." [18]

The decision is a useful reminder to all practitioners about the limitations of silent edited snippets of surveillance footage of claimants who are generally out and about at times of their choosing, usually on their better days in the case of chronic pain or mTBI patients, when they feel able to engage in more activity. The footage does not capture any pain including headaches or cognitive fatigue they might be experiencing on the footage. It does not capture any payback pain or heightened cognitive exhaustion and necessary recovery time required once they reach home following a burst of activity.

The reputation of TSG was damaged by the judgment, not so much from the factually unreliable statements made by some of its employees, but more by the judicial comments of what he considered were their sub-optimal business practices when filming claimants and in their approach to editing and retaining unedited footage and the original SD cards used by their operatives.

If a claimant is in open view and under surveillance, then there ought to be a presumption that the footage will not be subject to edits, from which questions might later arise as to the efficacy of the subsequent edited footage disclosed.

This case followed on from an earlier case management decision challenging the efficacy of surveillance footage in the case of Sampson v. Ali [2012] EWHC 4146 in which the court permitted the claimant permission to rely on a surveillance video expert to comment on allegations that excerpts of the footage had been sped up, that the timestamp camera had been tempered with, that vehicle trackers had been used to monitor the claimant and that the footage was tainted by inexplicable edits raising an inference of bias. That case never made it to trial.

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Informed Consent and the Danger of Hindsight: *Tosh v Gupta* [2025] EWHC 2025 (KB)

CLINICAL NEGLIGENCE – CAUSATION – BREACH OF DUTY OF CARE – CONSENT

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Overview

This matter arose from a standard haemorrhoidectomy from which the Claimant developed the recognised, but rare and serious, complication of anal stenosis. The Defendant was a general, colorectal and laparoscopic surgeon. The Claimant had been referred to him for the purpose of investigating rectal symptoms. A diagnosis of haemorrhoids had been made and she was considered a suitable candidate for surgical intervention.

At trial, the issue of liability (breach of duty and causation) remained in dispute.

It was the Claimant's case that she had not given informed consent for the procedure. Specifically, she alleged that there had been failures on the Defendant's part (i) to discuss and offer non-surgical options as alternatives to surgery **(McCulloch)** and (ii) properly to explain to her the risks and benefits of the surgery, such that she could not make an informed decision about it (Montgomery). She maintained that she would not have elected surgical intervention, but for those failures.

There were wider criticisms levelled at the Defendant, in respect of his grading of the haemorrhoids.

The claim had also included allegations about surgical technique, but those were abandoned on receipt of the experts' joint statement.

There was an unusual complication for the Claimant on medical causation. It was common ground between the Parties' experts that had the Claimant's condition been conservatively managed, she would likely have required surgery in any event, in two years' time.

In terms of factual causation, the Claimant therefore had to prove that (i) had she been adequately advised, she would not have elected surgery when she did and that (ii) that she would still not have opted for surgical intervention two years later, by which stage non-operative treatments would likely have failed.

The Decision

The claim failed on liability/breach of duty in respect of both the grading of the Claimant's condition, and consent.

On the issue of consent, the Trial Judge found that the Defendant had taken reasonable care to ensure that the Claimant was aware of the material risks associated with the procedure, and that she knew about the alternative non-surgical treatment options.

This is a good example of staged consent process.

There had been a discussion in clinic between the Parties and clinic correspondence sent to her. She had been provided with an EIDO leaflet (which she had read and not asked any questions about); the experts agreed it contained a good and comprehensive summary of the surgical risk. It also described the specific risk of anal stenosis in appropriate terms; that risk had been quantified. The Defendant was not expected to advise the Claimant on the very rare complications that were associated with the condition.

Furthermore, the Claimant had read and signed a consent form on the day of surgery, and manuscript additions had been made to that document, again, to highlight the risk of the proposed procedure.

The evidence taken as a whole was consistent with there having been a proper discussion between the Parties, and proper consent given.

Had the Claimant succeeded on liability/breach of duty, she would, in any event, have failed on factual causation. The question was a subjective one: what would this claimant have done? (*Smith v Barking Havering and Brentwood Health Authority* [1994] 5 Med LR 285 applied).

The assertion that, properly advised, she would not have agreed to surgery was made with the benefit of hindsight, at a time when she had suffered serious complication from the surgery. That had likely affected her recollection. Her response was an artificial one. That factor did not adversely affect her credibility (she was found to have been an honest witness), but her account (and its reliability) had to be treated with caution. She needed to show extraneous or additional factors to substantiate her "But For" decision.

Otherwise, the claim would be limited to a two-year acceleration period (Chester applied).

Commentary

This decision highlights the difficulties that claimants face on factual causation in informed consent cases. It is easy, without more, for a claimant to say that they would have made a different decision, when the treatment they consented to has gone wrong; but that is unlikely to pass the evidential threshold. The Court will be alert to the prospect of hindsight bias. There will need to be a proper, claimant-specific explanation. If a reasonable patient would proceed with the recommended treatment, then the claimant will need to show why their decision-making would be different.

As an ancillary observation, this decision also serves as a salutary reminder about the importance of expert objectivity and independence, and careful selection of experts.

The Claimant's expert had limited, and no recent, experience of haemorrhoidectomies and that placed him at an obvious disadvantage. It made it difficult for him to identify the standard of a reasonably competent haemorrhoid surgeon at the time of the Claimant's operation.

He had also failed to comply with his procedural duty under CPR Part 35. There had been a failure on his part to consider the Defendant's case in both his substantive report and the joint statement. In respect of the latter, he conceded that his commentary on the grading of the Claimant's piles had been a *piece of advocacy for the Claimant.* That was plainly a contravention of his duty and it had the effect (with other difficulties in his evidence) wholly of undermining his expert input. Where there was conflict between the Parties' experts, the Defendant's expert was preferred.

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Guidance on Witness Evidence: *Deakin-Stephenson v Behar & Chelsea and Westminster Hospital NHS Foundation Trust* [2024] EWHC 2338 (KB)

CLINICAL NEGLIGENCE – CAUSATION – BREACH OF DUTY OF CARE – INFORMED CONSENT – SECOND OPINIONS – SURGEONS – VICARIOUS LIABILITY

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Background

The Claimant was admitted to hospital in November 2016 with diverticulitis and a localised perforation. Following allegedly negligent treatment, she required a permanent stoma. The central disputes at trial, which took place nearly 8 years after the events, concerned what had or had not been said and done at the time—particularly, whether the Claimant and her family had requested referral to a colorectal surgeon, and what advice was given to her about treatment options. Determination of liability depended heavily on the Court's resolution of factual disputes and much turned on the reliability of lay recollection and the weight to be given to documentary and circumstantial evidence.

The Judgment

Dexter Dias KC (sitting as a Deputy High Court Judge) set out at [53] no less than 13 principles, derived from leading authorities, to guide judicial fact-finding and the evaluation of witness evidence. He described this as an *'iterative, contextual and evidence-based approach'.* Paragraph 53 (which stretches to over four pages) is mandatory reading for practitioners, and will no doubt be of great assistance when planning closing submissions in factually complex cases in which findings are likely to play a significant role in determining liability.

Whilst the remainder of the lengthy judgment may be of less general relevance to practitioners, suffice to say, on each of the issues going to breach and causation in the case, the Claimant failed to discharge the burden of proof and the claim was dismissed.

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Medical Records and the Contents of Pleadings Weigh More than the Memory of Witnesses and Late-stage Arguments: *MJF (a Protected Party proceeding by her mother and litigation friend, ITZ) v University Hospitals Birmingham NHS* Trust [2024] EWHC 3156 (KB)

CLINICAL NEGLIGENCE – ACCELERATION – BREACH OF DUTY OF CARE – CAUSATION – STANDARD OF CARE – SURGICAL PROCEDURES

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Background

MJF ('the Claimant') underwent surgery to insert a Percutaneous Gastrostomy ('PEG') feeding tube in 2016. Two days after the procedure she was found unresponsive on the floor. She was taken to hospital and an emergency laparotomy was performed which showed necrosis around the gastrostomy site due to the PEG being too high and resulting in tension. The Claimant experienced acute respiratory distress syndrome, sepsis, and multi-organ failure requiring ventilation.

The Claimant asserted she suffered a loss of mobility, an acceleration of a progression to complete incontinence, an acceleration to complete feeding by PEG and the need for a tracheostomy. She sought damages for personal injuries and associated losses arising from the alleged negligent performance of surgery to insert the PEG.

The Claimant's case on breach of duty was that the PEG was inserted with too much tension between the internal bumper and the external bumper. It was alleged that this tension prevented blood supply to the stomach wall at the site of the PEG, causing the tissue to die, and thus allowing the contents of the stomach to escape into the abdominal cavity causing peritonitis and sepsis with a hypoxic episode.

The Defendant denied breach of duty and asserted that reasonable care was taken to site the PEG in an appropriate position, the distance between the bumpers was not too tight and there was no tension on the PEG. The Defendant denied that the breakdown of the tissues surrounding the PEG was caused by pressure between the internal and external bumpers.

Issues

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

(i) Whether the PEG was placed with too much tension between the internal and external bumpers in breach of the duty of care owed by the Defendant.

(ii) If so, whether the tension prevented the supply of blood to the stomach wall causing the tissue to die resulting in peritonitis and sepsis.

(iii) If so, whether the admitted deterioration in the Claimant's condition is wholly caused by the negligence or whether it accelerated an inevitable deterioration in the Claimant's condition by a period of six years.

Evidence

The Court heard evidence from Dr Andrew, the consultant gastroenterologist who performed the PEG procedure. In his written evidence, Dr Andrew said the distance between the Claimant's skin surface and stomach was only about 1 cm and that there was a distance of 1.5cm between the external bumper and the skin surface. The endoscopy report stated there was a *"skin-gastric lumen distance 2.5cm".* Dr Andrew stated in written evidence that this was an incorrect record and he meant that the flange to gastric lumen distance was 2.5cm. He maintained under cross-examination that the record was incorrect. However, in re-examination he said that if he had been able to measure the skin-to-gastric lumen distance at the end of the Claimant's procedure, he would have expected it to be roughly 2.5cm.

Expert evidence was provided in the fields of general surgery, gastroenterology and neurology/ neurorehabilitation. The general surgeon experts agreed that excessive tension between the internal and external bumpers could cause necrosis at the PEG entry site. However, they disagreed as to the likely skin-to-gastric lumen distance: the Claimant's expert opined the distance would have been 2.5cm and the Defendant's expert concluded it was 1cm. As to the cause of necrosis, the Claimant's expert could "not conceive of another cause for necrosis other than excessive tension". The Defendant's general surgery expert identified four potential causes of necrosis in his initial report. Three of these four potential causes had been ruled out during discussion between the experts. The remaining fourth factor was not pleaded in the Defence and therefore not subject to joint discussion.

The gastroenterologists agreed that the standard of reasonable care requires a PEG to be fitted without any tension between the internal and external bumpers and with a centimetre or so of 'play' between the two. If the skin-to-gastric lumen distance was found to be 2.5cm, then the outer bumper would have been right up against the skin surface.

Decision

Her Honour Judge Emma Kelly found in favour of the Claimant on liability. The court considered that contemporaneous medical records are inherently likely to be accurate (*Manzi v King's College Hospital NHS Trust* [2018] EWCA Civ 1882 applied). The contemporaneous record in the instant case was the endoscopy report, which recorded the skin-to-gastric lumen distance as 2.5cm. In contrast, the oral evidence of Dr Andrew included his *"revelation"* in re-examination that, once the stomach was no longer under the inflation of the endoscope, the Claimant's skin to- gastric lumen distance would have been roughly 2.5cm. This was a significant concession which meant that, at the conclusion of the procedure, if the external bumper was fixed at 2.5cm as recorded in the endoscopy report, it must have been lying snug to the Claimant's skin. It also meant that the recording of the skin-to-gastric lumen distance in the endoscopy report at 2.5cm was correct, contrary to Dr Andrew's written and oral evidence. Applying the approach set out in G*estmin SGPS SA v Credit Suisse (UK) Limited* [2013] EWHC 3560 (Comm), as to the fallibility of human memory and assessing witness reliability, the court found as a fact, that the Claimant's uninflated skin-to-gastric lumen distance at the relevant time was around 2.5cm, as detailed in the endoscopy report.

On causation, the Judge noted that the Defendant's case as to the possible causes of necrosis which had developed over time. The final position advanced by the Defendant (referred to as 'the Alternative Theses'), was not raised until day three of the trial. The Claimant submitted in closing that the Defendant was seeking to postulate the Alternative Theses in circumstances where they had not been pleaded in the Defence. The Judge agreed and excluded the late-advanced Alternative Theses as un-pleaded and prejudicial (*Satyam Enterprises Ltd v Burton & another* [2021] EWCA Civ 287; *Al-Medenni v Mars UK Ltd* [2005] *EWCA Civ 1041; and Ali v Dinc* [2022] EWCA Civ 34 applied). Finding causation established, the court found that the evidence pointed *"overwhelmingly"* to the excessive tension as the probable cause of necrosis.

Key Takeaways

Whilst it lays down no new legal principles, this case offers highly relevant guidance on the court's approach to witness evidence, medical records and the importance of statements of case. Practitioners should be alive to the following:

- Statements of case are essential. They ensure that the parties are on an equal footing and know, well in advance of the evidence being heard, which issues need to be addressed and what evidence they may wish to garner in support of their case. Any issues not properly pleaded may be excluded.

- Whilst it is not uncommon for positions to evolve as litigation progresses, full investigations and any amendments should be made as early on as possible. However, multiple amendments are likely to undermine the credibility of a party's case.

- Take care with witness evidence, particularly where it contradicts with contemporaneous medical records. The fallibility of human memory is well established and in most circumstances, contemporaneous medical records will be preferred.

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Clarification on the Provisions of the CPR Concerning Strike Outs and Qualified One-way Costs Shifting (QOCS): *Read v North Middlesex Hospital Trust* [2025] EWHC 1603 (KB)

CLINICAL NEGLIGENCE – AMENDMENTS – PARTICULARS OF CLAIM – QUALIFIED ONE-WAY COSTS SHIFTING – STRIKING OUT – UNLESS ORDERS

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Following a Defendant's application for the Claimant to better particularise his claim, or, for it to be struck out, an 'unless order' was made by the Judge. The Claimant was ordered to file and serve an Amended Particulars of Claim which further set out particulars of the allegations of breach of duty and causation, and a condition and prognosis ("C&P") report. The Claimant then submitted Amended Particulars of Claim and a report from a consultant neurosurgeon and spinal surgeon. Following this, the Defendant applied to strike out the claim for non-compliance with an unless order on the basis that (i) the Claimant had failed to obtain a report from at least an accident and emergency consultant, if not an orthopaedic surgeon also, and (ii) the Amended Particulars of Claim continued to be wholly lacking in specificity.

The Court found that the Claimant should have amended its Particulars of Claim with supporting expert evidence on breach of duty. The breach of duty allegation was not clear from the neurosurgeon's C&P report, nor did the Amended Particulars present the Claimant's allegations in terms recognisable in clinical negligence claims; consequently, it was deemed inadequate and fell foul of the unless order. The claim was automatically struck out pursuant to the provisions of CPR 3.4(2)(a) and/or (b). The Statement of Case disclosed no reasonable grounds for bringing the claim; represented an abuse of process; had no real prospect of success; and, no compelling reason had been provided for the claim proceeding to trial ([100]).

As to costs, the court clarified that CPR rule 44.15 applied such that it had discretion to disapply qualified one-way costs shifting (QOCS). Rule 44.15 encompasses the "procedurally various" ([97]) reasons why a claim could be struck out and then classifies those relevant for the purposes of QOCS disapplication. The grounds for strike-out under r. 44.15 may straddle one or more of r. 3.4 (2)(a), (b), (c), or r 3.4 (5), therefore r. 44.15 must be considered independently, its reasons for strike-out going beyond those exclusively listed at r. 3.4(2). Further, the High Court retains an inherent jurisdiction to strike out claims ([96]).

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Scrutinise Claimants' Evidence Raised in Rebuttal to Fundamental Dishonesty or Face the Costs: *Cullen v Henniker-Major* [2024] EWHC 2809 (KB)

CLINICAL NEGLIGENCE – CANCER – DELAY – DIAGNOSIS – FUNDAMENTAL DISHONESTY – FUTURE LOSS – PAST LOSS

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"If you are going to plead fundamental dishonesty, make sure you scrutinise the strength of that allegation upon receipt of rebuttal evidence, or run the risk of a large claimant settlement, judicial criticism and indemnity costs".

This nine-day clinical negligence quantum trial arose out of an admitted negligently delayed diagnosis of laryngeal cancer. That led unnecessarily to the Claimant ("C") undergoing a total laryngectomy, leaving her with a stoma through her neck and a voice valve which needed changing.

She claimed that she was unable to change this valve by herself and accordingly needed care on a 24/7 on-call basis.

The Defendant ("D") identified some treating records in late 2022 and early 2023 which referenced C changing the valve herself, culminating in a reference that she was a *"competent self-changer".* D amended its Defence to allege fundamental dishonesty ("FD") against C. It was a wide-ranging document with numerous allegations, though this was the central FD allegation.

Also, D asserted that C had dishonestly raised invoices claiming payment for carers during Covid lockdown periods when she was self-isolating without carers, and also whilst she was on holiday without carers. D asserted by reference to edited surveillance evidence of the comings and goings through the front door of C's house that she was not receiving the 24/7 care she asserted she needed.

D garnered support for its central FD allegation from its CPR 35 ENT expert.

C responded to the central allegation with a statement from her treating clinical lead Speech and Language Therapist ("SLT") who explained that the terminology *"self-changing"* in the context of valves indicated that she no longer needed a treating SLT team to complete her voice valve changes at hospital and instead could do those changes at home with one of her carers. Also, C adduced evidence from her carers that she **always** assisted them with changing the voice valve, but that they were always involved to some degree as she could not change it on her own.

D did not ask its CPR 35 ENT expert to consider this further witness evidence.

D subjected C to 3½ days of cross-examination by leading counsel, described by the judge as *'hostile, exhaustive and exhausting'.* Her treating carer and the clinical lead SLT were also cross-examined. D's ENT expert conceded swiftly in cross-examination that it was SLTs not ENT consultants who managed voice valves and who arranged patients' valve care regimes at home. The ENT expert conceded shortly after entering the witness box that she accepted C's SLT witness' clarification of what *"self-changing'* meant in the clinical records.

With regard to the invoices for the carers during Covid and whilst C was on holiday, the Court accepted her evidence that she had been instructed by the NHS Continuing Health Care ("CHC") funding her carers through the Integrated Care Board ("ICB") to continue paying the carers because they were not zero hours contractors.

D did not call any evidence from the CHC to refute C's evidence which was accepted by the Court. The Court found that as there was no claim for these payments which had been paid for by the CHC rather than D, that it would have been a 'collateral' not a 'fundamental' issue if dishonesty were established, which it was not. Ditto with regard to the invoices for the payments made when she was on holiday without the carers

As for the surveillance evidence, the Court was critical of D for seeking to ask it to draw inferences from the edited footage that were not there to make. The Court observed that if something was shown on surveillance footage that was determinative of it happening, but the absence of something on the footage was not determinative of it not happening. The Court found that the footage was haphazard and that the *pro forma* statements from the surveillance operatives were unsupported by the surveillance evidence itself. Accordingly, the court declined the invitation to draw an inference that she was without care for substantial periods.

The Court awarded C a substantial seven figure judgment. When it came to costs, the Court was critical of D for failing to scrutinise its FD allegations in light of C's response to them, in particular the evidence from the senior treating SLT. Such a review ought to have resulted in a withdrawal of the central allegation of FD.

Instead, D pressed on with hostile cross-examination. An original trial estimate of 6 days extended to 9 days. The Court was critical of D's failure to get its ENT expert upon whom it based its FD allegation to review her opinion in light of the rebuttal evidence. The Court was critical of the expert for sitting in court and not addressing her mind to these developments and to communicate the product of her further thoughts before getting into the witness box.

The judge described the cross examination as *'hostile, exhaustive and exhausting'* and observed that the allegation of dishonesty was put to several of the other lay witnesses as well.

The Court found that the way that the case had been run took it outside of the norm to quote Lord Woolf's headline test for indemnity costs in *Excelsior Commercial And Industrial Holdings Limited* [2002] EWCA Civ 879 and took account of the comments of *Coulson LJ in Thakkar v Mican* [2023] EWHC 2313 @ §22 & Tomlinson *LJ in Manna v Central Manchester University Hospitals NHS Foundation Trust* [2017] EWCA Civ 12 @ §42. The Court ordered that the costs of the action after the date by which that crucial witness statement should have been considered by D should be paid on an indemnity basis.

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The Costs of Pleading Fundamental Dishonesty even where the Claimant's Claim is Dismissed: *Hakmi v East & North Hertfordshire NHS Trust* [2025] EWHC 2597 (KB)

CLINICAL NEGLIGENCE – CAUSATION – CONSULTANTS – FUNDAMENTAL DISHONESTY - STROKE

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This claim arose from the decision of the Second Defendant's stroke consultant, Dr Metcalf, not to offer the Claimant, Mr Hakmi, thrombolysis to treat his stroke, as a result of which it was alleged that he suffered serious disability. Negligence could not be proven, predominantly on the basis that there was insufficient evidence that, on the balance of probabilities, thrombolysis would have altered the outcome; this was in turn influenced by what the Judge found to be the Claimant's very good recovery in fact.

Whilst the claim was dismissed, the Defendants' 'victory' was dampened by its unsuccessful allegations of Fundamental Dishonesty, meriting an adverse costs order against it. Important lessons for both claimants alleging negligent management of strokes and defendants considering raising FD emerge from this High Court Case.

Background

The Claimant, a distinguished former consultant orthopaedic surgeon, sustained two strokes in short succession: on 26 September 2016 and 16 November 2016. He made a good recovery after the first and returned to work on 15 November 2016.

The Claimant's evidence (accepted by the judge ([51])) was that at about midnight on 15 November he suffered from an episode of light headedness and a very slight weakness in his right hand which lasted a few minutes, then resolved. He did not feel that he was having a stroke. Then, at 0340 he said he *'felt numbness in my right hand up to my elbow. My right shoulder and right hip felt heavy. My speech was alright but the right side of my face felt slightly altered. I woke my wife up and told her that I thought I was having a stroke."* Whilst his wife drove him to the hospital, he called and explained his symptoms on the telephone to the hospital's stroke nurse. The Claimant's version of events over the evening/early morning of 15th/16th November was accepted by the Deputy HC Judge David Pittaway KC, notwithstanding the possibility of his reconstruction of the events with the passage of time; the effect of having English as his second language on his oral evidence; and the challenge to his credibility raised by allegations of Fundamental Dishonesty.

When assessed by Dr MacDonald-Nethercott in A&E, the history given by Mr Hakmi and his wife of two separate incidents, at midnight and about 0340, was not recorded in the Stroke Proforma (A), nor symptoms of right leg weakness. Hospital attendance records merely described: *"R arm subjective weakness + reduced sensation, Onset 2345. Presented A & E 0415. O/E Power 5/5 throughout. Speech facial muscles normal."* The judge accepted Dr MacDonald-Nethercott's explanation that the time-pressure of carrying out treatment with thrombolysis within 4 1⁄2 hours of the onset of the stroke necessitated brevity of history-taking; however, he still **considered that the documentation fell below the standard required of an Emergency Doctor ([19]).**

At Lister Hospital, the Claimant had a CT scan at 0449 and spoke to Dr Metcalf, Stroke Consultant, *on the telephone* who did not think the Claimant had suffered a stroke and did **not** consider him "thrombolysable". He told the Claimant and his wife that he may have had multiple transient ischaemic attacks (TIAs) and suggested epilepsy, a brain tumour and migraines as alternate causes. Consistent with Lister Hospital's policy, Dr Metcalf considered his 26 September 2016 stroke (a stroke within the previous 3 months) as a relative, but not an absolute, contra indication for thrombolysis because it created a higher risk of bleeding.

In respect of the assessments performed in hospital, the judge confirmed that it was not Dr MacDonald-Nethercott's duty as an Emergency Registrar to perform a full neurological examination. Regardless, the judge found that the Claimant did not disclose sufficient signs of a stroke to merit an NIHSS score (National Institutes of Health Stroke Scale) above zero on the Stroke Proforma (A). Nurse Woodward's repeat examination at 0520 also recorded an NIHSS score of zero except for sensory which was recorded at *"??? 1".* A third examination at 0810, recorded *"3 with facial palsy 1, right arm drift query 1 and right leg drift query 1, sensory loss 1 making a total of 3, or arguably 4".* None of these examinations were judged inadequate.

The Absence of Causative Negligence

Whilst the judge found that Dr Metcalf should have contacted another consultant to ensure that there was visual observation of the Claimant by a stroke consultant, rather than rely on a mere telephone call ([65]), the judge found that *"it is a matter of speculation as to whether if Mr Hakmi had been referred to another stroke consultant, the decision to offer thrombolysis would have been different."* In the judge's view it was unlikely because the agreed expert evidence was that an NIHSS score of 4 would have been required before a recommendation for thrombolysis would have been considered ([74]). The Claimant should, however, have been checked hourly post-admission, especially in light of his previous stroke ([75]).

The Claimant's argument on causation, however, ultimately failed. **The judge highlighted the absence of literature evidence as to the extent to which thrombolysis is effective with a lacunar stroke** ([77]). In assessing whether, had the Claimant been treated with thrombolysis within 3.5 hours of the onset of the stroke, he would have had a good outcome, the judge considered the DRAGON score and his Modified Rankin Scale of 2. The judge preferred the Defendants' expert evidence that thrombolysis would not have altered the outcome in this case where the likely cause of his stroke was a clot not atherosclerosis and "in circumstances where Mr Hakmi has made a very good, if imperfect, recovery from his second stroke." The most that could be said was that he lost the chance of a better recovery, which was insufficient to prove negligence ([97]).

Fundamental Dishonesty

The Defendants pleaded **fundamental dishonesty by accusing the Claimant of exaggerating the impairment effects of stroke,** alleging that he had deliberately failed to put the required effort into the neuro-psychological testing. His scores fell substantially below his expected level of performance pre-stroke which, based on his educational and employment history, was agreed as being in the high average range.

Dr Bach's (the Defendants' neuropsychologist)'s assessment in 2024 revealed significant cognitive impairments in attention, memory, learning and speed of processing. He failed TOMM tests of performance validity, indicating to Dr Bach that his cognitive performance could not be taken as reliable, especially because he resumed work as an orthopaedic surgeon from November 2017. The Defendants relied upon the variation in test scores between medico-legal experts as highly suspicious and suggestive of a non-organic cause ([125]). The Claimant denied all accusations.

The court (at [123]) considered the legal test for fundamental dishonesty, set out by Ritchie J at paragraph 47 in *Cojanu v Essex Partnership University NHS Trust* [2022] 4 WLR 33:

i) the section 57 Criminal Justice and Courts Act 2015 defence should be pleaded;

ii) the burden of proof lies on the Defendant to the civil standard;

iii) a finding of dishonesty by the Claimant is necessary;

iv) dishonesty must relate to a matter fundamental in the claim, not incidental or collateral; and,

v) it must have a substantial effect on the presentation of the claim.

The judge found that the Defendants failed to prove FD, preferring the Claimant's neuropsychologist's evidence, which explained that the TOMM assessment was not suitable for all stroke or moderately-severe, brain-injury patients, and certainly not the Claimant. Further, his performance on Dr Bach's tests could be explained by his psychological condition; fatigue from serious familial issues; the particular stressful circumstances of Dr Bach's examination ([127]); and the organic effects of stroke rather than deliberate malingering. The Claimant's case was also supported by *"statements and letters from four colleagues at the hospital which attest to his honesty and integrity, as well as the steps that he has put in place to mitigate his disability following his stroke."* ([128]).

Costs

An **adverse costs order** was made relating to the Claimant having to defend this limb of the action. Such an order does not "undermine the costs regime". The court highlighted that the Claimant had put the Defendants on notice that if FD was pursued to trial and ultimately failed, then there would be an application for costs; the Defendants could have abandoned its FD allegations during or at the conclusion of trial; a FD finding would have been disastrous for the Claimant's reputation and career as a distinguished orthopaedic surgeon; he had already suffered negative press coverage; and that, *"defendants should not have free tilt at raising the issue of fundamental dishonesty"* ([133]).

Whilst the Claimant sought 25% of its costs from the date of the FD allegation in the Defendants' counter-schedule, an order of 15% was made on the basis that some costs would have been incurred in any event. These would be subject to a detailed assessment on the standard basis in default of agreement. Otherwise, the Claimant was ordered to pay the Defendant's costs, not to be enforced without the court's permission ([135]).

Learning Points

This case illuminates the hurdles faced by claimants – in respect of both breach and causation - to succeed in stroke negligence claims where there is an allegation that thrombolysis was required, short of a clear timeline in the progression and/or documentation of stroke-symptoms.

For defendants it sounds as a warning should they raise, but fail to prove, FD. Defendants should keep under close review their decision to rely on this defence, being prepared to drop "increasingly wanting" allegations during or at the conclusion of a trial ([133]). The point at which the allegation was formally raised, the extent to which associated costs would have been incurred in any event to defend the underlying claim, and the consequences of an FD allegation for a claimant's career and reputation, are relevant factors in determining adverse cost orders.

Where raised on weak grounds, Claimants should now feel encouraged to seek adverse costs orders, in light of this decision, knowing that defendants cannot plead FD with impunity.

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Credit Card Companies Beware – the Application of s 75 the Consumer Credit Act 1974 to Negligent Clinical Services: *Bailey v (1) Bijlani* (2) MBNA Ltd [2025] EWHC 175 (KB)

CLINICAL NEGLIGENCE – CREDIT CARDS – DENTAL SERVICES – FINDINGS OF FACT – JOINT AND SEVERAL LIABILITY – MEASURE OF DAMAGES

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S 75 of the Consumer Credit Act 1974 (CCA) gives consumers who have been the victim of a misrepresentation or breach of contract by the supplier of goods or services paid for on a credit card the option of seeking redress against the supplier, the credit card company, or both. It was successfully used in this case by a dissatisfied patient who paid for substandard dentistry treatment on a credit card. A dentist had breached her duty of care to a patient in several respects, causing the patient to lose two teeth and the nerves in three teeth, and to develop ischaemic colitis. Her total damages award of £87,663.30 was recoverable against the credit card issuer which was jointly and severally liable.

S 75 applies to "a transaction financed by" a credit agreement, without any restriction as to the subject matter of the transaction. In Bailey itself, MBNA had conceded at an early stage that it would in principle be jointly and severally liable; whilst this concession strictly meant that the point was not judicially tested, it is apparent in this watershed judgment that the width of s 75 is sufficient to encompass medical treatment cases.

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A recent Application of Eeles 1 in *Hill v East Kent Hospitals University NHS Foundation Trust* [2025] EWHC 1241 (KB) and a further recent example: *Hill v East Kent Hospitals University NHS Foundation Trust* [2025] EWHC 1241 (KB)

CLINICAL NEGLIGENCE – BRAIN DAMAGE – INTERIM PAYMENTS – MULTIPLE SCLEROSIS

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Background

The Claimant had commenced Tysabri infusion treatment with the Defendant Trust for multiple sclerosis ('MS'). She was warned that the treatment carried a risk of developing progressive multifocal leukoencephalopathy ('PML') but reassured that this would be monitored through regular MRIs. The Defendant Trust accepted that their employee negligently failed to notice an abnormality on one of the scans, and the Claimant then developed PML and left-sided paralysis as a result. The Claimant has impaired mobility and significant care needs, and lacks capacity.

The Claimant had received a total of over £1.5 million in interim payments to date, which was used to purchase a new property on the basis that the nursing home the Claimant resides in was unsuitable for her needs. A further £500,000 was sought to fund a package of care and support to facilitate her move into the purchased property.

The Preliminary Schedule pleaded past loss and PSLA at £2.9 million, and the Claimant asserted that a conservative approach, based on discounts between 0-30%, would reduce this to £2.5 million. The Defendant estimated the provisional loss at £1.9 million.

The hearing took place before the formal exchange of expert evidence, with trial set to take place in 2027. The Claimant served reports from Neurology, Care and Accommodation experts, but the Defendant did not rely on any expert evidence at that stage.

The Law

Our readers will be familiar with the two-stage Eeles test in relation to interim payments. It was recently restated by Master Stevens in *XSI (A Child Proceeding by her Mother and Litigation Friend XS2) v West Hertfordshire Hospitals NHS Trust* [2024] EWHC 1865 and the following passage from the judgment was cited in Hill [13] (emphasis added):

(a) *"CPR Rule 25.7(4) places a cap on the maximum amount… open to the Court to order by way of interim payment at…* ***no more than a reasonable proportion of the likely amount of the final judgment.****"*

(b) *"…. the Court should make its* ***assessment on a conservative basis;*** *having done so, the reasonable proportion awarded* ***may be a high proportion*** *of the figure." (the Court in Hill cited at [18] two decisions where 90% was deemed a reasonable proportion)*

(c) *"…the objective of an award of an interim payment… is to ensure that the* ***Claimant is not kept out of money*** to which he is entitled, whilst ***avoiding any risk of an overpayment.".***

(d) *"The likely* ***amount of a final judgement*** *is that which will be* ***awarded as a capital sum, not the capitalised value of a PPO"***

(e) *"The Court must be careful not to fetter the discretion of the trial judge to deal with future losses by way of periodical payments rather than a capital award."*

(f) *"The Court must also be careful* ***not to establish a status quo in the claimant's way of life which might… [inhibit] the trial judge's*** *freedom of decision", and create "an unlevel playing field."*

(g) *"Accordingly the first stage is to make the assessment in relation to heads of loss which the trial judge is bound to award as a capital sum, leaving out of accounts heads of future loss which the trial judge might wish to deal with by a PPO", which strictly speaking includes general damages, past losses and interest on this.*

Annabel Darlow KC, sitting as a Deputy High Court Judge, also cited at [16] the principle from *PAL v Davison and others* [2021] EWHC 1108 (QB) that the court should not *"embark upon a mini-trial at the interim payment stage, or seek to determine issues more properly left to the trial judge."* The court should keep in mind that the Defendant's assertions may be accepted at trial and that allocating too much on the lump sum element could fetter the judge's discretion.

Readers will be aware that stage 2 of Eeles allows the court to consider some elements of future loss if the judge can confidently predict that the court would wish to award a larger capital sum than that assessed under stage 1 and real need for this payment is demonstrated. However, the Claimant in *Hill* did not attempt to go down that route, restricting the court's consideration to stage 1.

Decision

The Court went through each head of past loss, taking into account each side's arguments and making reductions between 10–40% (some of which were proposed by the Claimant herself). The assessment produced a conservative estimate of £2,100,000. Applying the 90% "reasonable proportion", the available figure was £1,900,000 and the court therefore awarded the remaining £353,000 by way of an interim payment.

The heads of loss that took the biggest reductions were accommodation (see below) and deputyship costs (due to an overestimation of prospective costs). General damages and therapies were also reduced to take into account the Claimant's underlying MS and its effect on her life expectancy and her but-for care needs, pursuant to *Reaney v University Hospital of North Staffordshire NHS Trust* [2016] PIQR Q3. Interestingly, the Defendant did not seek to reduce the care claim on the same basis.

A few interesting points emerged from this case:

1. *Swift v Carpenter Award in Short Life Expectancy Cases*

   The question of whether the *Swift v Carpenter* [2020] EWCA Civ 1295 formula produces full and fair compensation in short life expectancy cases continues to be debated. Under the formula a shorter life expectancy leads to a higher reversionary interest, substantially reducing the accommodation award, which in some instances may compromise a claimant's ability to purchase the special accommodation.

Defendants might be expected to argue that such claimants can sell the reversionary interest to bridge the gap between the amount recovered and the cost of the property. Conversely, claimants may seek to re-open this question, citing the comments from Irwin LJ and Underhill LJ that different considerations and argument could be applied to short life expectancy cases and that the guidance in Swift may be inappropriate in certain cases [171], [210], [228].

This is what the Claimant in Hill sought to do, based on her life expectancy of 12 years. At [39] Darlow KC noted:

"It is at least arguable that such a consequence may not in due course be considered by the trial judge to be reflective of the underlying principle that an award should constitute full and fair compensation …"

For Interim Payment purposes, this question was not addressed further. As must be expected, the "conversative" figure put forward by the Claimant applied the Swift formula.

The accommodation award was reduced from £863k to £700k, taking into account the expensive property purchased, the adaptation costs being based on a different property recommended by the accommodation expert and the lack of information as to the ownership of the Claimant's previous property.

2. *Past Losses were Assessed to the Date of Trial*

There was some limited discussion about whether past losses should be assessed to the date of the interim application or trial. The judge cited PAL v Davison, which states that the starting point should be special damage "to date" but that in many instances it would be appropriate to include losses to trial. I would also note that the quotation from *XS1,* replicated at [13] of the Hill judgment and above, explicitly states at point 7(b) that past losses are to be *"taken at the predicted date of the trial rather than the interim payment hearing".* The judge stated at [30] that she was *"in principle… prepared to proceed"* on the basis that future costs should be calculated to the date of trial, the Defendant not having argued to the contrary.

A Further Recent Example

I recently appeared for the Defendant at an interim payment hearing in *Kravitz v EUI Ltd,* which applied the principles from *Hill.* The hearing took place in June 2025 before Deputy Master Bard. The Claimant, who suffered a spinal cord injury in a road traffic accident, had already received £667,500 in interim payments and sought a further £200,000 to fund rehabilitation. Litigation was significantly more advanced than in *Hill* or *Eeles* as expert evidence and joint statements were available, with trial scheduled for early 2026. The Schedule was pleaded at £11 million (including £1.2 million in past losses) while the Counter Schedule conceded only £550,000 in total, signifying that the Claimant may have already been over-compensated. At the IP Hearing, the defendant presented a detailed counter schedule specifically focussing on the IP issue, drawing on the served expert evidence, and quantifying loss "conservatively" to the scheduled date of trial.

The Claimant recognised that he could not secure the desired interim payment under *Eeles 1* due to the level of the past loss figures (which could not be subsidised by the accommodation claim figures as the need for accommodation was hotly disputed). The Claimant contended that this was not a case where the trial judge would make a PPO, arguing that (i) if the Defendant's figures were accepted, damages would be so low that there would no prospect of a PPO, and (ii) if the Claimant's figures were accepted, damages would be high enough to justify the IP being sought.

The Defendant submitted that the extent of the Claimant's condition and later deterioration remained firmly disputed, that he had become over reliant on his rehabilitation, and that the Claimant's claimed but-for earnings based on the progression of his business venture were unrealistic.

The Defendant highlighted the decision of Master Thornett in *EF v Darkwa and MIB* [2019] EWHC 1005 (QB), in which the Defendant contended that the Claimant had become overly dependent upon his care regime and the Master dismissed the interim payment application on the basis that this was an arguable and fundamental point which would impact on both past and future losses. The Court was also referred to the guidance in *Farrington v Menzies-Haines* [2019] EWHC 1297, which highlights that the court should not only avoid real risk of overpayment, but the court should also avoid **any** risk.

Decision

Deputy Master Bard rejected the interim payment application.

He accepted the Defendant's contention that he could not conclude that there would be no realistic prospect of a PPO, being a matter for the trial judge, and where such a conclusion would necessitate a mini-trial. Deputy Master Bard decided that all of the Defendant's arguments were plausible and supported by its medical experts, who themselves had also taken a reasonable approach to their investigations. He could not dismiss any of the points raised by the Defendant as obviously wrong and there was, at its lowest, a genuine possibility that they would be accepted at trial. Nor was there a "real need", as required under *Eeles 2*, for the interim payment, the Defendant's psychology expert having opined that the Claimant's overreliance on rehabilitation makes its reinstatement undesirable and counterproductive.

Following this decision, the Claimant was unable to re-establish a status quo of (what the Defendant had argued was) an excessive rehabilitation regime. The claim subsequently settled before trial following mediation.

Practical considerations

1. The legal principles are now relatively settled in respect of IP Applications, with Hill providing a further useful recent reference point.

2. Expert evidence can be critical in supporting the parties' positions in interim payments.

   (a) For early applications (e.g. *Hill*) where defendants have yet to serve their expert evidence, claimants hold an evidential advantage, such that a broader brush approach, discounting from the claimant's pleaded figures, may be likely.

   (b) Conversely, where claims are more advanced and defendants have served expert evidence (e.g. *Kravitz)*, the evidential advantage switches to the defendant due to the requirement to assess damages conservatively. A carefully crafted IP-focussed counter schedule, calculated to the presumed trial date and supported by the defendant's expert evidence, is more likely to provide the basis for the IP calculation.

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'A Reasonable Proportion of a Conservative Sum' yields a Claimant-friendly Interim Payment: *CWLX (a child proceeding by his father and Litigation Friend, SWSX) v Aneurin Bevan University Health Board* [2025] EWHC 1531 (KB)

CLINICAL NEGLIGENCE – INTERIM PAYMENTS – MEASURE OF DAMAGES – SUITABLE ALTERNATIVE ACCOMMODATION

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This was a recent application for a second interim payment (IP) under the Eeles criteria which is particularly useful for Claimants and one of which both sides should be aware. The Claimant suffered a very serious birth injury leading to global developmental delay, autistic spectrum disorder, avoidant restrictive food intake disorder and significant cognitive impairment. He had significant lifelong care needs.

Judgment had been entered on an 85% basis. The Claimant had initially sought an IP of £3 million. At the first hearing Master Stevens awarded an IP of £1.16 million and permitted the Claimant to renew their application for a further IP, if they were able to support it with better evidence as to the reasonable cost of a property to meet the Claimant's needs. That application then came back before him.

The Claimant sought a further £2.2 million to enable his Deputy to be put in sufficient funds to proceed with the purchase of an adapted forever home, to reimburse past expenses and provide a payment towards further expenses to be incurred prior to trial. The Claimant accepted that it might not be possible to fund the level of IP they were contending for under the first limb of Eeles. As the liability judgment was for 85%, the Deputy was alive to the fact that the property purchase price could need to be subsidised by other heads of loss.

The primary question before Master Stevens was what figure was reasonable to allow for accommodation on a conservative basis, i.e. what was *"reasonably necessary"* as per Eeles. Master Stevens also dealt with the following points:

1. The sum allowed for accommodation even on a conservative basis could be far greater than the Defendant's expert view, even having regard to the need to be *'extremely careful not to tilt the playing field by allowing too great a sum for accommodation, such that the trial judge's decision-making could be fettered'.*

2. How to quantify conservative estimates for other past losses, particularly in the absence of any contrary evidence from the Defendant's experts.

3. Eeles limb 2, including the identity and quantum of heads of future loss which could be taken into account when assessing the capitalised lump sums which a trial judge would be likely to make.

4. The allowance to be made for losses to be incurred between the hearing and trial.

Evidence

Prior to the first application hearing the Claimant had served a schedule of loss and expert evidence in key fields including paediatric neurology, neurosurgery, clinical psychology, educational psychology, care and OT and, of course, accommodation. For the renewed IP application, the Claimant provided a further letter from the accommodation expert, a witness statement from the Deputy and one from his Litigation Friend.

In contrast, although the Claimant had been assessed by Defendant's paediatric neurologist and a care expert, the Defendant chose not to serve these, or any brief letter from such experts on any specific point in contention. The Defendant submitted that an interim payment of £1.16 million, or certainly no more than £1.5 million was appropriate.

Accommodation

The Claimant's family had identified a particular property which their experts supported as reasonable to meet the Claimant's needs, costing £1,257,000 plus adaptations costed at £955,189. The Defendant's expert contended for a property price of £410,000 plus adaptations of £97,369. Whilst not departing from their expert evidence counsel for the Defendant also provided the judge at the second hearing with figures suggesting that a property could be purchased for £800,000.

The Master found difficultly with aspects with both sets of accommodation experts. Whilst he considered in detail specific properties that were put in front of him he confirmed that he was fully aware that he should not approve any a specific property. Nevertheless, in assessing the amount to be awarded as necessary to meet the pressing housing needs of the Claimant, he preferred more of the Claimant's accommodation evidence whilst at the same time confirming that he was not predetermining the ultimate stance (a matter for the trial judge).

Therefore, he rejected both the figures put forward by the Defendant's expert, and the increased figure offered by Defendant's counsel of £800,000 and considered that an initial purchase price of £900,000 would not be unreasonable as a conservative estimate. At para 41 he flagged, *"In approving a figure for reasonable property costs in excess of the Defendant's estimate I have in mind what Mrs Justice Whipple (as she then was) said in* ***AC (A minor suing by his litigation friend MC) v St George's Healthcare NHS Trus****t [2015]* EWHC 3644(QB*) at [39] when approving a sum for accommodation in excess of the Defendant's evidence, "I do not believe that ordering payment of this sum by way of interim damages will fetter the trial judge's discretion, or create an unlevel playing field which would be to the Defendant's disadvantage at trial. But even if there is a risk of prejudging the accommodation issue by this award, I remind myself that this is merely one factor to be weighed in the balance. The Claimant's entitlement to damages, and his obvious need to be re-housed in advance of trial, tip the balance firmly in the Claimant's favour." She continued at [40], "the Defendant can, if so advised, challenge these figures and indeed any property purchase which has by then taken place at trial, by expert evidence, as excessive or unreasonable. It is open to the trial judge to make whatever findings are appropriate on the evidence presented at that stage."*

He then allowed further costs associated with the accommodation and on the whole took a mid-figure between the 2 experts.

Care

This was the largest element of past loss, claimed on the basis set out in the Claimant's care expert's report. The Master stressed that:

1. The Defendant's care expert visited the Claimant a year prior to the second hearing.

2. The Defendant had been in receipt of the Claimant's care evidence and costings for a number of weeks prior to the second hearing.

3. The Defendant elected not to produce even a brief letter setting out specific objections.

In such circumstances the Master allowed 75% of the past gratuitous costs within the Claimant's care expert's report and found such sums to be a valuation on 'a conservative basis.'

Time to trial

1. The Master allowed the cost of introducing paid care between the hearing and trial on a tapered approach, as costed by the case manager for one year.

2. He flagged that he was conscious that the introduction of any care package could be accompanied by unexpected difficulties so costings could be an evolving picture, but in his view this award did not introduce any risk of overpayment; it was more a question of timing.

3. The principle of awarding losses through to trial was not controversial between the parties on the facts of the case, where there was a relatively short time frame to trial and the case manager had identified urgent needs.

4. The Master concluded: *"I have no difficulty in making provision for such sums within my award. However, I do not consider it appropriate to add interest as monies are being awarded now before sums are incurred."*

Eeles Limb 2

The Master made the following preliminary points:

1. The Claimant's Deputy would need to find funds for 100% of the property purchase price, the introduction of the commercial care regime and continuation of case management and some therapies before the trial.

2. The PLSA award could be used to subsidise some of the shortfall, but this would also be needed to cover shortfalls on other losses over the lifetime of the Claimant.

3. It was not his role to keep the Claimant out of his money, but simply to avoid risk of overpayment or fettering of the trial judge's discretion at this interim stage.

4. He was cautious about taking into account the past gratuitous care element of the award for use by way of subsidy as strictly speaking that money was held on trust for the Claimant's parents, rather than being the Claimant's monies per se.

5. It would be extremely rare for a trial judge to award the whole future losses award by way of periodical payments order.

6. During submissions it was clear that the Defendant accepted that in this case some heads would likely be capitalised and therefore were available to the Court as part of an *Eeles 2* calculation.

7. The Defendant accepted that, even after allowing reduced sums than contended for, in respect of future therapies, equipment, transport and holidays, those heads of loss would likely result in a future 7-figure lump sum award.

8. The Master accepted the well-established principle only to release an award on account of such future sums at the time where there was a *'real and immediate need for them'.*

In the circumstances he found:

1. Such a real and immediate need and considered it would be appropriate to make an award under Eeles 2, but only if the identified immediate needs could not be provided for within the Eeles 1 calculation.

2. Any amount to be provided under Eeles 2 could be amply met from the likely capital award for future losses.

3. He did not need to be specific about which losses that might be, given the nature of the submissions from both parties accepting there was sufficient value in the claim to do so.

4. The authorities required him to award no more than a reasonable proportion of his conservative estimate on an interim payment application.

5. He then would have awarded 90% of his conservative figures.

However, once the Master underwent his arithmetical task he found that he was able to award the Claimant the IP of £2 million without having to award any sum under Eeles 2. Nonetheless, he made clear his view on Eeles 2 in his conclusions stating at para 69:

" I would have had no hesitation in ordering the necessary "top up" under Eeles 2 and am satisfied there will be sufficient capitalisation of some future heads of loss to make that lump sum provision now, without fettering the trial judge."

Conclusion

1. In the circumstances of the case and in light of the evidence before the Court, had the Claimant asked for a greater IP he probably would have succeeded.

2. It was relevant that this application was no more than 6 months prior to the listed trial date.

3. This case is particularly useful for Claimants who are looking to urge a Master at an interim stage to consider both Eeles 1&2 and their combined effect.

4. For both sides it is highly pertinent that the Master felt able to reject the Defendant's accommodation expert and find that a reasonable yet conservative figure was well above the expert's opinion.

5. It is also a salutary case for Defendants as to the dangers inherent in choosing to hold back evidence from the court when its existence is known.

6. Certainly, here it was particularly surprising that the Defendant did not even produce a letter from their care expert. It is difficult to envisage that the Master would have allowed 90% of the figures from the Claimant's care expert if the Defendant had produced some evidence for counsel to rely on rather than simply figures from the Counter-schedule.

7. I would certainly expect this to become a regular part of the case law 'armoury' of claimant's counsel at IP hearings in the future.

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Is it Fatal to an Anonymity Application if the Applicant's Name is Already in the Public Domain? *PMC v Cwm Taf Morgannwg University Health Board* [2025] EWCA Civ 1126

ANONYMITY – CHILDREN – HEARINGS IN OPEN COURT – INFANT SETTLEMENTS – OPEN JUSTICS – PERSONAL INJURY CLAIMS – PROTECTED PARTIES – REPORTING RESTRICTIONS - VULNERABILITY

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The Court of Appeal recently considered an anonymity application in circumstances where the applicant's identity was already in the public domain. Was anonymity appropriate in those circumstances? Was it better than nothing or, by that stage, futile?

Background to the Appeal

The last edition of this newsletter covered this case at first instance before *Nicklin J: PMC v Local Health Board [*2024] EWHC 2969 (KB). I am indebted to the summary of the facts set out in that article by my colleague, Lindsay McNeil, which I paraphrase below.

The Claimant developed cerebral palsy as a result of asphyxia prior to birth and during labour in 2012. In 2016, the Defendant admitted liability for negligence. In 2020 and 2021, the Claimant's mother engaged with a journalist, following which two articles were published. A media organisation also covered Claimant's story. The media coverage commented on the Claimant's injuries, his difficulties, how well he was doing in the circumstances and the support that his family had received. Nicklin J noted that the Claimant had *"featured prominently in all the media publications" and that "the Claimant is likely to be readily identifiable, particularly in his local area, as a very high-profile victim of medical negligence".*

The claim was issued in 2023. Substantial damages were sought and a quantum only trial was scheduled for December 2025. In October 2024, the journalist contacted the Claimant's solicitor, explaining that he had a copy of the pleadings and wished to publish a news article about the case. In November 2024, the Claimant's mother applied, as litigation friend, for an immediate interim anonymity order. The application was made without notice. The judge refused the application for without notice interim relief, on the basis of s.12 of the Human Rights Act 1998 and the article 10 ECHR rights of the media; instead ordering an urgent hearing with the application served on the media and for the Claimant to file further evidence about media coverage and any open court hearings that had already occurred.

By this stage, 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 on 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). Further, the articles from 2020-2021 identifying the Claimant remained available online.

Nicklin J refused the Claimant's application for an anonymity order. In short, he did so because anonymity was unjustifiable and futile, given the amount of material about the Claimant and the claim already in the public domain.

The Claimant/Applicant was granted permission to appeal because this is an area of significant wider importance and because of the need for scrutiny of the case of *JX MX v Dartford & Gravesham NHS Trust* [2015] 1 WLR 3647 which had been critiqued by Nicklin J. The Court of Appeal handed down judgment on the appeal on 28 August 2025.

Analysis of the Court of Appeal

The Court of Appeal, per Sir Geoffrey Vos MR at [2], firstly explained the distinction between the different types of order in this context:

1. A withholding order: *"An order sought within court proceedings to withhold or anonymise the names of a party or a witness, including withholding information that would identify that person";*

2. A reporting restrictions order: "*An order sought within court proceedings which has the effect of restricting the reporting of material disclosed during those proceedings whether in open court or by the public availability of court documents";*

3. An anonymity order: *"An order made within court proceedings which has the effect of both withholding or anonymising the names of a party or a witness and restricting the reporting of material disclosed during those proceedings whether in open court or by the public availability of documents".*

The Court of Appeal analysed the case law and summarised the legal principles, reaching the following conclusions:

1. The appeal raised a question about the jurisdiction of the court. The Court concluded that there is a limited common law power for civil and family courts to make both a withholding order and a reporting restrictions order. Such an order would prevent the publication of specified material disclosed during proceedings, regardless of whether the material was raised in open court or included in disclosure placed before the court;

2. JX MX v Dartford remained good law, in large part. Different factors apply to applications for anonymity in approval hearings under CPR 21.10 as opposed to other anonymity applications;

3. It was not a pre-condition for a reporting restrictions order that the name of the applicant had been withheld throughout the proceedings (the court disagreed with the dicta In *Re Press Association* [2012] EWCA Crim 2434);

4. The judge at first instance was wrong to refuse the anonymity order. While the anonymity order would not prevent the possibility of jigsaw identification, given the articles in the public domain, that was not a reason to refuse the Claimant a modicum of protection. However, the terms of the anonymity order would only be prospective and would not require retrospective anonymity in relation to publications already made.

Key Takeaways

The answer to the rhetorical question posed at the start of this article is, therefore, that an anonymity order in these circumstances is appropriate and "better than nothing".

A number of practical points emerge:

1. It is not fatal to an anonymity application if:

    a. There is already reporting about the subject matter of the application – even if the applicant features prominently in that reporting;

    b. The application was not made immediately at the start of proceedings meaning that information about the claim has been accessible on the CE-File;

2. The assessment is fact specific and will depend on the nature of the previous publicity. Nevertheless, these are important factors, are likely to weaken the application and should be avoided where possible: applicants should avoid publicity and issue applications as early as reasonably practicable;

3. An application will be weaker still where the material in question has already been deployed in open court before an anonymity order is sought ([82]);

4. In general terms, anonymity applications should be made on notice to the media, given they are likely to interfere with the media's article 10 ECHR rights. In circumstances where there is pre-existing publicity, the application should be made on notice to the media organisation that published that pre-existing reporting;

5. Where there is previous publicity, the applicant should provide details of all such publicity in its application;

6. It is very unlikely that the media will be required to remove pre-existing articles about the applicant;

7. A more streamlined approach can be taken in the context of approval hearings under CPR 21.10. An anonymity application must still be made. However, if there is no pre-existing publicity, then it is not necessary to notify the media in advance of the application. They will be notified once the order is published on the Judiciary's website under CPR 39.1(5). Applications under CPR 21.10 should be heard in open court but can be listed under a pseudonym; and

8. The Civil Procedure Rules Committee was invited to consider revisions to the PF10 so expect to see a new version published.

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