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The 1COR Quarterly Medical Law Review

Updates and analysis of the latest legal developments

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THE DEATH OF THE RIGHT TO SILENCE IN REGULATORY PROCEEDINGS?

Robert Kellar QC

Two recent cases have important consequences for regulated professionals who fail to participate in regulatory hearings. In *Kuzmin v GMC* [2019] EWHC 2129 (Admin) the issue was whether a tribunal can draw adverse inferences if a doctor declines to give evidence. *Sanusi v GMC* [2019] EWCA Civ 1172 concerned the tribunal's duty of procedural fairness where a professional fails to attend the hearing at all.

Kuzmin v GMC [2019] EWHC 2129 (Admin)

Background

The Claimant was a GP who faced an allegation of dishonesty. It was alleged that he had failed (dishonestly) to draw his employer's attention to conditions imposed by the Interim Orders Tribunal. The doctor failed in his half-time submission of no case to answer. The doctor then indicated that he would not be giving any evidence and applied to withdraw his witness statement. The GMC sought a preliminary ruling that, as a matter of principle, the Tribunal had the power to draw adverse inferences in such circumstances. The Tribunal agreed whereupon the Claimant sought an adjournment and applied for judicial review.

The Claimant's Argument: Common Law Protection

The doctor relied heavily upon an analogy with the criminal law. In criminal proceedings, there was a well-recognized privilege against self-incrimination. This was supplemented at common law with a further right: no adverse inferences could be drawn from the exercise of the right to silence. As regulatory proceedings were properly regarded as "*quasi-criminal*" it followed that similar standards of procedural fairness were required.

In criminal proceedings Parliament had intervened to enable a Court to draw such inferences as appeared proper from an accused's failure to give evidence (Criminal Justice and Public Order Act 1994, s.35). However, there had been no such statutory intervention in GMC proceedings. Nor had the GMC or MPTS issued any guidance or policy that would abrogate the common law position. Accordingly, the doctor should retain the full protection of the common law in respect of the *"right to remain silent".*

Judgment: The Power to Draw Inferences

The Divisional Court rejected the Claimant's case in emphatic terms. First, a fact finder could draw such inferences as it considered appropriate from the primary facts. This power was implicit in the power to make factual findings from the evidence without the need for any express power. Where an accused had a case to answer but remained silent, inferences might flow from the *"normal processes of reasoning and common sense"*. It may be reasonable to infer that the accused was unable to answer the accusation.

Second, the common law protection available to defendants in criminal proceedings (prior to the 1994 Act) did not apply in regulatory proceedings. Regulatory proceedings were not criminal proceedings or even "*hybrid*" proceedings (see *ex parte Fleurose* [2001] EWCA 2915 and *Panjawani v RPhC* [2002] EWHC 1127).

Third, the Court had not suggested in other regulatory cases that there was any common law prohibition against drawing inferences from silence: see *Iqbal v Solicitors Regulatory Authority* [2012] EWHC 3251 (Admin) , *Kearsey v Nursing and Midwifery Council* [2016] EWHC 1603 (Admin), *Radeke v General Dental Council* [2015] EWHC 778 Admin, *Panjawani v Royal Pharmaceutical Council* [2002] EWHC 1127.

Finally, there was a general burden upon regulated professionals to engage with their regulator and to assist with the resolution of allegations made against them. This was underscored by the guidance in Good Medical Practice which obliged doctors to co-operate with formal inquiries and complaints. Therefore, permitting tribunals to draw inferences from the silence of professionals was in the public interest.

Inferences and Procedural Fairness

However, whether it was appropriate to draw an adverse inference would be *"highly dependent upon the facts of a particular case"*. Generally no inference will be drawn unless [61]:

a. a prima facie case to answer has been established;

b. the individual has been given appropriate notice and an appropriate warning that, if he does not give evidence, then such an inference may be drawn; and an opportunity to explain why it would not be reasonable for him to give evidence and, if it is found that he has no reasonable explanation, an opportunity to give evidence;

c. there is no reasonable explanation for his not giving evidence; and

d. there are no other circumstances in the particular case which would make it unfair to draw such an inference.

Sanusi v GMC [2019] EWCA Civ 1172

In *Sanusi*, a doctor failed to attend an MPTS hearing concerned with his clinical competence and integrity. He stated that he could not afford the cost of legal representation and had a conflicting commitment to his General Practice training programme. He did not apply for any adjournment of the programme and the Tribunal therefore proceeded in his absence. It found subsequently that his fitness to practise was impaired and imposed a sanction of erasure.

The doctor appealed on two grounds. First, that the Tribunal should have notified him of its findings on misconduct and given him a further opportunity to make submissions, by adjourning the hearing, before proceeding to deal with sanction. Second, it was argued that the hearing was procedurally unfair because the doctor had provided relevant documentary evidence to the GMC. Some of these documents had not been forwarded by the GMC to the Tribunal and had not been taken into account when considering sanction.

The Court of Appeal held that here was no general duty upon the MPTS to provide a voluntarily absent doctor with an opportunity to make submissions in mitigation of sanction following adverse findings of misconduct/impairment. Such an obligation would give rise to a "*culture of adjournment*" causing unacceptable costs and disruption. Where a registrant failed - without good reason - to attend a hearing they must be taken to have appreciated the loss of their right to participate.

The failure of the GMC to forward relevant documents to the Tribunal constituted a breach of natural justice. Where a registrant was absent, both the GMC and MPTS should take steps to ensure that all relevant mitigation material was before the panel at the sanction stage. However, that obligation was not unlimited: "*It does not require extensive trawls through archives, nor extend to sifting through large quantities of unindexed or uncategorised documentation provided by a registrant to determine what if any relevance it may have. The obligation extends only to reasonable searches for material that is objectively viewed as relevant".*

On the instant facts, the missing documents did not give rise to a realistic prospect of a different sanction. Accordingly, the appeal was dismissed.

Comment

The decision in Sanusi marks a significant departure from the generous approach to absent practitioners adopted previously in cases like *Sukul v BSB* and *Lawrance v GMC*. The Courts had previously emphasised the need to afford professionals with every opportunity to make representations, if necessary by adjourning the proceedings, before imposing serious sanctions. In future, absent professionals will need to make a formal application for an adjournment supported by evidence. Those who fail to take such steps risk serious sanctions without any further right to make representations.

Practitioners who elect not to give evidence also do so at their peril. However, the Court's judgment in *Kuzmin* does not resolve exactly how the power to draw adverse inferences will be applied in practice.

First, what counts as a "*reasonable explanation*" for failing to give evidence? In criminal proceedings no adverse inference may be drawn if "*it appears to the Court that the physical or mental condition of the accused makes it undesirable for him to give evidence*" (section 35 (1) (b) of the Criminal Justice and Public Order Act 1994). This applies not only where giving evidence would have an adverse effect on the accused's health. It also applies where, for example, a brain injury or psychiatric condition adversely affects the accused's memory or his/her capacity to give evidence (see *R v Dixon (Jordan)* [2013] EWCA 465). A similar approach should apply in regulatory proceedings. However, how serious must a condition be before it will displace an adverse inference? This remains to be seen.

Second, apart from ill health cases, when else would it be "*unfair*" or inappropriate to draw an inference: what will suffice as a good excuse for failing to take the stand? The Court was not prescriptive. This was a matter for the judgment of the Tribunal on the particular facts. The Court observed that it would be useful for the GMC and other regulators to provide published guidance about how the power to make adverse inferences will be exercised in future cases. We should expect the GMC and MPTS to heed the call. The future of the right to silence therefore remains, at least to some extent, in the hands of the regulators.

This article also appeared on 1 Crown Office Row's UK Human Rights Blog.

INJUNCTIONS

Shaheen Rahman QC

Smo v Hywel Dda University Health Board [2019] EWHC 1973 (QB) (25 July 2019)

The High Court granted an interim injunction to a consultant colorectal surgeon facing disciplinary proceedings as a result of allegations about his capability and conduct.

Background

Suspended since 2016 pending resolution of the disciplinary proceedings, he was informed in 2018 that a fresh investigation was to be commenced into whether there had been a breakdown of his working relationships.

The Claimant argued that commencing the fresh investigation constituted a breach of his contract of employment. He relied upon the incorporation of certain terms of the disciplinary procedure "Upholding Professional Standards in Wales" ("UPSW") agreed with the BMA in 2015, equivalent to the MHPS procedure in England, guaranteeing certain procedural safeguards for the doctor such as the right in certain circumstances to legal representation and independent panel members at a hearing. The Defendant disputed that UPSW had been so incorporated insofar as the fresh investigation into working relationships was concerned as it did not concern capability, conduct or performance.

Judgment

Considering the authorities at paragraphs 46-51, Mr Roger ter Haar QC, sitting as a Deputy High Court judge, noted that in some cases it would be clear whether allegations of a breakdown of working relationships were in truth concerns related to the doctor's professional conduct and capability. In other cases, it would not be so clear. In the present case a further issue arose as to whether conducting a separate investigation into working relationships would in itself undermine or appear to reduce the efficacy of an ongoing USPW procedure, thereby constituting an arguable breach of contract.

Applying the well-known test in *American Cyanamid* [1975] 1 AC 396 and subsequent caselaw, e.g. *National Commercial Bank Jamaica Ltd v Olint Corpn Ltd* [2009] 1 WLR 1405, the judge held at [69] that there was a serious issue to be tried at trial as to whether the Defendant was in breach of contract for commencing the fresh

investigation into working relationships. The fresh investigation relied upon interviews with staff conducted as part of the UPSW procedure, which was far from complete, and there was a substantial overlap between the two processes. Findings could be made as part of the working relationships investigation that could appear to pre-judge the UPSW process.

As to whether damages would be an adequate remedy in the event that the Defendant was found to be in breach of contract at trial, the judge considered it impossible to say damages would be adequate, given the difficulties in judging the value of the UPSW process, which *"is intended to protect practitioners in respect of matters at the heart of their professional lives, something which is not lightly to be displaced by an attempt to value damage to professional reputation in money terms"* [74].

As to the balance of convenience, the parties had agreed to a speedy trial within months. The Defendant argued that it was continuing to employ locums whilst the Claimant was not working and thus wished to pursue the working relationships investigation pending trial. The judge noted that the UPSW procedure was ongoing, notwithstanding an extant appeal by the Claimant challenging the referral of the matter to a disciplinary panel. On the basis that the UPSW investigation proceeded the Defendant would continue to need to employ locums, so on the Defendant's own case granting the injunction in this matter would not affect it in monetary terms [81]. On the other hand, proceeding with the working relationships investigation would involve an interview with the Claimant that might put him in a difficult position: *"if he does not attend the interview, he loses the opportunity to put his case. If he does attend, he may be said to have acquiesced in the working relationships process"*[85]. Given the short delay proposed the balance of convenience lay with the Claimant and the Defendant was restrained from carrying out such an interview pending the trial of the issues in the present proceedings. The judge did however consider that inquiries with other staff could continue [84].

Comment

A notable success by a doctor facing two disciplinary processes and under investigation by his employer for several years. However, as noted by the judge, the injunction granted was very limited in time and scope [77]. The Claimant was obliged to offer a cross-undertaking in damages and it was observed that he had some continuing income from the Defendant and other employment. However, giving such an undertaking will be a difficult decision to take in every case. Seeking interim injunctive relief is a high-risk strategy for doctors locked into such disputes, with success at this stage no guarantee of the Defendant backing down as might be hoped.

WRONGFUL BIRTH

Shaheen Rahman QC

Mordel v Royal Berkshire NHS Foundation Trust [2019] EWHC 2591 (QB)

The Claimant succeeded in establishing liability in this unusual wrongful birth claim before Mr Justice Jay.

Background

She alleged that the Defendant's failure to carry out screening for Down's syndrome during her first pregnancy was contrary to her wishes and understanding that this had been performed. She had subsequently given birth to a child with Down's syndrome. She alleged that had the test been performed she would have been offered and accepted invasive testing which would have identified a high risk of Down's syndrome and she would thereafter have elected to have a termination of pregnancy.

The Defendant relied on the contemporaneous record of the Claimant having declined Down's screening when she attended for her first trimester scan. The fact that the screening had not taken place, notwithstanding the fact that the Claimant was booked for it, was not explored at a later midwife appointment. The Claimant's anger and disbelief at the diagnosis following birth was also contemporaneously recorded – she said she had believed screening to have been undertaken and to have ruled out Down's syndrome.

The Defendant altered its policies after the birth to include a number of fail-safes to ensure that screening was offered. However, in his judgment at [16] the judge noted that there were limitations as to the inferences that can be drawn from changes to systems in such cases, in particular the inference that the previous system was substandard, cf *Jaguar Cars Ltd v Alan Gordon Coates* [2004] EWCA Civ 337.

Judgment

At [17] to [20] of the judgment, the legal principles to be derived from *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 in relation to informed consent are noted. Additionally the judge noted the Court of Appeal's reversal of a finding of his own in *ARB v IVF Hammersmith* [2018] EWCA Civ 2803, in which he had held that a fertility clinic was not in breach of its duty to take reasonable care to obtain the claimant's informed and written consent. He considered the authority to be "*valuable to the extent that it vouches that a system which does not entail the taking of reasonable steps to ensure that relevant consent is informed may be regarded – subject always to a host of other considerations – as irresponsible, unreasonable and unrespectable even if there may exist expert evidence to support it."* [19] Finally, he noted *Goodman v Steel* [2013] EWCA Civ 153 and *Ollosson v Lee* [2019] EWHC 784 (QB), in relation to assessments of witness reliability and the warning against placing too much weight on judicial impressions of body language and demeanour and recommendation that greater attention be paid to contemporaneous evidence, particularly of a documentary nature.

This warning and recommendation notwithstanding, the judge proceeded to set out his impressions of the lay witnesses and the path to his conclusions on their accounts in a high level of detail. There was a direct conflict of evidence between the sonographer and the Claimant as to whether screening was in fact offered and declined at the scan appointment, as recorded.

The relevance of language

A relevant issue was the fact that the Claimant's first language was Polish not English. Jay J has himself been trenchantly criticised by the Court of Appeal in *Serafin v Malkiewicz & ors* [2019] EWCA Civ 852 for failing to have sufficient regard to the fact that the first language of the litigant in person who appeared before him was Polish and not English, amongst other things. His conclusion in that case had been at [117] that: *"The Claimant has a good command of the English language but he has not mastered it. He is not intellectually sophisticated but my assessment of him is that he is extremely bright and quick on the uptake.*"

In the present case, the judge noted that the Claimant had on occasion failed to understand what was being put to her by both counsel. However, he reflected at [21] that: *"with respect to the claimant I put that down not primarily to lack of competence in the English language (although it remains a significant factor) but to her general level of education and sophistication)."* He stated at [22] that "*From my experience, care needs to be taken in not assuming that because a person appears to be reasonably fluent in the English language her comprehension will be at the same level. For many people who are not linguistically gifted passive comprehension is harder than active communication. For obvious reasons, the latter is easier to assess by an outsider than the former, although during her evidence the claimant did make errors of grammar and syntax."* Later he said of one part of the Claimant's evidence that: "*If this evidence had been untrue, and in this respect I repeat that there is virtually no room for judicial manoeuvre, I believe that I would have detected some change in tone or demeanour in the claimant at this important stage in her evidence. There was none. The claimant remained guileless, artless and devoid of sophistication."*

The basis for the assessment of the Claimant as being unsophisticated/lacking in education, as opposed to merely being in a position of having to express herself in court imperfectly in her second language, is not spelled out.

The Claimant's alternative case

In any event, his persistent focus on such matters has advantaged the Claimant, who had an alternative case that there was some sort of misunderstanding that arose between her and the sonographer such that she did not give informed consent. The judge noted at [26] that: *"the less able the claimant may be, the easier it may be for those representing her to persuade me of the correctness of her alternative case, other things being equal."*

Ultimately, this is the argument that the judge accepted, essentially concluding that this was a case of a tragic misunderstanding. What happened at the scan appointment as reconstructed by him is set out in the form of a short script at [55]. The judge did not accept that nothing was said to the Claimant about screening at the scan appointment. The sonographer had asked if the Claimant wanted Down's screening in line with her usual practice and the Claimant had said *"no",* not fully understanding what she had been asked and all the while wishing to have the screening [113-7]. The usual practice, though supported by expert evidence, was not a reasonable one. What was reasonable included consideration of what was at stake. Not merely was the birth of a child with Down's syndrome a life-changing event for most parents, but the steps required to guard against parental choice not being respected were not onerous [86]. More ought to have been done *"to lay the ground properly, if for no other reason than to preclude the real risk that she and her patient were at cross-purposes and/or that the latter was not listening to her properly"* and the process ought to have included *"ascertaining by brief questioning that the patient understands the essential elements and purposes of scanning for Down's syndrome"* [89-92;98]. Moreover, the position ought to have been revisited at the subsequent midwife appointment when it came to light that the Claimant had not had the screening she had been booked for [136-141]. Had it been, the Claimant would have had screening and the judge accepted that ultimately she would have elected to have a termination of pregnancy [152].

Clodagh Bradley QC appeared for the Claimant in this case. She did not contribute to this article.

EXPERT EVIDENCE AND MATERIAL CONTRIBUTION

Dominic Ruck Keene

Arksey v Cambridge University Hospitals NHS Foundation Trust [2019] EWHC 1276 (QB)

Background

On 3 November 2012, the Claimant suffered a cerebral aneurysm rupture. She was taken by ambulance to Addenbrooke's Hospital complaining of symptoms principally of confusion. She was discharged with advice to return if the symptoms re-occurred. The following morning, the Claimant suffered a significant re-bleed from the cerebral aneurysm and a major subarachnoid haemorrhage.

The Claimant alleged that had she been admitted on 3 November and had a CT scan, she would have avoided the re-bleed and subsequent significant disability. The Defendant admitted that she should have been admitted, and a CT scan should have been performed, however, pleaded that there was nothing that could have been done to prevent the re-bleed.

The relevant clinicians gave evidence that the appropriate surgical procedure of 'coiling' could never have been performed prior to the time of the re-bleed. The key issue was therefore whether anything could have been done to prevent the re-bleed from happening prior to when surgery would have been performed. The Claimant relied on a neurosurgeon expert report from a Mr Sandeman whose evidence was that re-haemorrhage whilst waiting for coiling in hospital was very uncommon and, *"on the balance of probabilities, therefore, she would not have had a re-bleed before the aneurysm was coiled."*

Expert Evidence

Martin Spencer J commented that it was unusual to have a liability expert report that pre-dated the exchange of pleadings – *"I say that because, in general, an expert would not submit a final report until certain procedures have been followed through, including, not least, exchange of witness statements, and no reasonable expert reporting for a claimant would want to finalise his report until he had had an opportunity to see any witness statements submitted on the part of the defendant."* He noted that significant and highly material witness evidence from the relevant clinicians was not therefore taken into consideration when Mr Sandeman opined on causation and was not commented on in his addendum report dealing with a different issue.

Mr Sandeman also in respect of a separate causation issue had again not addressed the implications of a particular procedure – giving as his explanation that he had not been given a full set of medical records. Martin Spencer J. stated that "*yet more astonishingly, Mr Sandeman appears not to have drawn this to the attention of his instructing solicitor and he told me that it was only in the week before trial, when he had access to the trial bundle which contained the full medical records, that he had access for the first time to the full medical records. He nevertheless went into the witness box and gave evidence affirming the accuracy and correctness of two medical reports which simply did not stand up to a moment's scrutiny, given that they had been prepared on a false and wholly incomplete basis."* Accordingly, his "*evidence fell far below the standard to be expected of a reasonable, competent expert witness, both in relation to the preparation of his reports and in relation to his preparing to give evidence."*

Causation

Martin Spencer J concluded on the substantive causation issue that being admitted to hospital earlier would not have prevented the re-bleed. He pointed out that there was no comparative evidence as to the risk of a re-bleed out of vs. in hospital, and the only possible factor that could have increased the risk of re-bleeding was a raised blood pressure. However, even if he found (which he did not) that the Claimant's blood pressure was likely to be higher at home than in hospital, he held that this would not have been causative of the re-bleed.

The Claimant had argued that such an increase in risk made a material contribution to her re-bleed and consequent subarachnoid haemorrhage. Martin Spencer J referred to Lord Hoffman's judgment in *Gregg v Scott* [2005] 2 AC 76 and emphasised that "*it is not enough for a claimant to assert that because there are gaps in the evidence arising out of the defendant's negligence, therefore, the claimant is any way relieved of the obligation of the causation. Lord Hoffman says in terms that that is not the case. The Court can, of course, draw inferences and it may be that, in drawing inferences, the Court will be benignly favoured towards a claimant where a claimant is in evidential difficulties because of the negligence of the defendant but the inferences need to be ones which are consistent with the evidence that does exist, and the Court cannot invent past facts or hypothetical facts simply because the evidential basis for the claim is lacking…"*

Martin Spencer J cited *Chester v Afshar* [2004] 3 WLR 297 as authority for the principle that reaching inferences of causation arising from an increase in risk could only be only be done where the 'but for' causation test was satisfied. He also cited *McGhee v National Coal Board* [1973] 1 WLR 1 as authority for the distinction between a material contribution to an increase in risk vs. a material contribution to injury, and that in certain cases "*it may be possible for the claimant to prove that the defendant's breach of duty made a material contribution to his injury by showing that it increased the risk of injury, whereby the Court will draw an inference that there was a material contribution."* However, *McGhee* was not authority for absolving a Claimant from proving that there was a material contribution to the damage occurring where there are concurrent potential causes. He concluded that this case was not one in which he would have made the "*leap of faith"* to translate an increase in risk into equating to causation. There was no medical evidence on which to make such a leap of faith, in particular, there was and could be no evidence as to the relative risk of those kept in hospital, and those discharged to home.

Comment

This case is a useful reminder of the importance of ensuring that experts have not just had access to all the medical records, but more importantly have taken into consideration appropriate and relevant evidence that has come to light following their original report. Whether there is a more onerous requirement to do so formally by way of further written addendum reports is not made explicit in this judgment, but the implication is clearly that this is the safest way to proceed – albeit that this clearly comes at a cost, which should potentially be taken into consideration at the cost budgeting stage.

This case is also a robust assertion of the importance of the 'but for' causation test and a further reminder that pleading 'caused and/or made a material contribution' is not a get out of gaol free card. Material contribution is only relevant in particular circumstances and has to be carefully considered and supported by the medical evidence.

CAUSATION AND INQUESTS

Dominic Ruck Keene

R (Chidlow) v HM Senior Coroner for Blackpool and Fylde [2019] EWHC 581 (Admin)

The Facts

The Divisional Court heard a challenge to a coronial determination that it was not safe to leave the issue of any potential causal link between an admitted 26 minute delay in an ambulance response, and the subsequent death of the Deceased (Mr Bibby) from a cardiac arrest. At the inquest in respect of his death, the jury heard evidence from a consultant in Critical Care & Emergency Medicine (Dr Andrews) that, had paramedics attended Mr Bibby before he suffered cardiac arrest, he would, on the balance of probabilities, have survived. Nevertheless, the coroner ruled that it was not safe to leave the issue of a causal link between the delay and Mr Bibby's death to the jury.

Expert Evidence

The medical cause of death was deemed by the pathologists to be "1a unascertained."

Dr Andrews's report noted that it was impossible to reach a clear diagnosis as to the cause of death - but the most likely cause was arrhythmia. He stated that had the paramedics arrived and commenced CPR within an earlier time after the onset of cardiac arrest, then the overall rate of return of the circulation in a group of such patients with a cardiac arrest would have been approximately 25% with an overall survival to hospital discharge of 12%, accordingly "*His chances of survival would have initially modestly but incrementally increased from the paramedics arriving at an earlier stage of cardiac arrest, through arriving before the onset of cardiac arrest through to the patient arriving in the Emergency Department (ED) prior to any cardiac arrest*… However, "*By the time the paramedics actually reached this patient, his chance of survival was zero as essentially he was already dead and any attempt at resuscitation would have been futile given the most likely cause was an arrhythmia…Had he arrived in an Emergency Department in a very timely manner, and still alive then in my opinion his chances of survival would have increased very significantly above zero and it is likely he would have more than likely survived rather than die*."

The coroner ruled that "having noted Mr (sic) Andrews' evidence on survivability, it seems to me that, in the absence of knowing the medical cause of death, it would be unsafe to put before this jury the possibility of returning any neglect rider. It cannot be established, in my judgment, that the rendering of care would have prevented the death if we do not know what the cause of death was. Further, I am not at all satisfied that the conduct (and I deal with this generally) of the police and/or ambulance personnel is capable of amounting to a gross failure for the purposes of neglect."

Galbraith Plus

The Divisional Court reiterated the central relevance of both limbs of the *Galbraith* Plus test when considering what issues can safely be put to the jury. The Court cited Haddon Cave J.'s summary of the test in ***R (Secretary of State for Justice) v HM Deputy Coroner for the Eastern District of West Yorkshire*** [2012] EWHC 1634 (Admin), to the effect that (1), the coroner is required to apply an evidential filter and ask whether there is evidence upon which the jury properly directed could properly reach the particular finding. This being the test used by a Crown Court judge in determining whether to leave a criminal charge to the jury: *R v Galbraith* (1981) 73 Cr. App. R. 124, CA; and (2) the coroner is also required to apply a wider and more subjective filter taking into consideration the coronial context as whether it would be safe for the jury to reach the conclusion or finding upon the evidence. The Court held that this particular case concerned the second limb as the coroner accepted that there was evidence of a possible causal link between the delay and death, but nevertheless deemed it unsafe to leave the issue to the jury to find causation based on that evidence.

Causation

The Divisional Court also reiterated the familiar principles of causation found in *R (Tainton) v HM Senior Coroner for Preston & West Lancashire* [2016] EWHC 1396 (Admin), *R (Lewis) v Mid & North Shropshire Coroner* [2009] EWCA Civ 1403, and in *R (Khan) v HM Coroner for West Hertfordshire* [2002] EWHC 302 (Admin):

- The threshold for causation of death to be established is whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to death. (*Tainton*)
- A coroner also has a discretion, but not a duty, to leave to the jury causes of death that are merely possible but not probable. (*Lewis*)
- Where common sense and legitimate inference cannot ground a finding of causation, medical evidence as to whether there would have been a contribution to death is required if the jury are not to be reaching a conclusion based on impermissible speculation (*Khan*)

The Divisional Court noted that in the different, but related area of clinical negligence, that any claim for clinical negligence had to be proved on the balance of probabilities and, if it cannot be so proved, then no separate action lies upon proof of a reduced chance of a positive outcome.

The Divisional Court also considered the validity of Dr Andrews's use of statistics and held that in applying the second limb of the *Galbraith* Plus test a coroner must have regard to all relevant evidence. In addition to evidence relating to the particular deceased and the circumstances of his or her death, that could include general statistical evidence drawn from population data such as the rate of survival in a particular group. Such general statistical evidence alone was, however, unlikely to be sufficient. A raw survival rate for the group into which (without the relevant event or omission) the deceased is said to fall, was unlikely to be sufficient even where the rate is over 50%, because, without evidence supporting the proposition derived from the population data , a jury could not safely conclude that he or she would have fallen into the category of survivors. Being a figure in a statistic does not of itself prove causation.

The Divisional Court concluded that "*In most cases, there will be other evidence as to whether the deceased probably would or would not have fallen in the group of survivors. Where there is apparently credible additional evidence of causation which, if accepted, together with the general statistical evidence could properly lead the jury to find on the balance of probabilities that the event or omission more than minimally, negligibly or trivially contributed to death then it will usually be proper and safe to leave causation to the jury*." After considering Dr Andrews's evidence, the Court held that it was based on a case specific analysis and not just on statistics. Accordingly, the Coroner was wrong not to leave the issue of delay to the jury.

Comment

The Divisional Court's judgment is a very useful re-statement of the key principles that advocates can draw upon when using the requirement for the *Galbraith* Plus to be satisfied as a route by which the coroner can legitimately be addressed as to whether there is any evidence that a particular act or omissions would have occurred as a necessary precursor to that act or omissions on a balance of probabilities having a more than minimal causative effect on the death in question. The judgment also at least implicitly suggests that expert medical evidence will be required where there is a question of whether a delay in treatment more than minimally contributed to death.

ARE HONEST RECOLLECTIONS RELIABLE?

Jeremy Hyam QC

CXB v North West Anglia NHS Foundation Trust [2019] EWHC 2053 (QB)

Background

This was a claim for negligence in the management of the Claimant's birth where unusually the trial focussed on a single key issue of disputed fact. It had been admitted in the Defence that if the Claimant's mother had chosen, at any stage, delivery by way of caesarean section her choice would have been agreed with, which would have resulted in a delivery that would have avoided the relevant damaging event. It was the Claimant's case that she did so elect and the Defendant's that she did not.

At the heart of the dispute was a clinical note, signed by the Senior Registrar which said: "*IOL* [induction of labour] *booked at term. Above discussed with Mr Forbes. Plan ANC* [ante-natal clinic] *2/52*". The Defendant said that this note demonstrated that there was clearly a discussion about mode of delivery and the Claimant had chosen induction of labour over caesarean. The Defendant invited the Court to prefer the reliability and veracity of assertions contained in clinical notes and records to factual accounts in written witness statements and oral testimony of witnesses who asserted the contrary. Considerable reliance was placed by the Defendant on the decision of Leggatt J of *Gestmin SPGS SA v Credit Suisse (UK) Limited* [2013] EWHC 3560.

The Gestmin principles

The case is of interest for the observations of the Judge, HHJ Gore QC, with regard to extent to which the *Gestmin* decision in fact lays down any principles at all. Readers will recall that Leggatt J in *Gestmin* at [15] to [22] set out a number of matters relevant to the judicial assessment of oral evidence at trial - focussing in particular on just how unreliable human memory can be. He said for example, at [16]: "*While everyone knows that memory is fallible, I do not believe that the legal system has sufficiently absorbed the lessons of a century of psychological research into the nature of memory and the unreliability of eyewitness testimony*".

It has become a very influential passage cited in a number of recent clinical negligence decisions (see e.g. *Taylor v Chesterfield Royal NHS Foundation Trust* [2019] EWHC 1048 and *Mills v Oxfordshire NHS Foundation Trust* [2019] EWHC 936). This is largely because Stewart J in *Kimathi v Foreign and Commonwealth Office* [2018] EWHC 2066 (QB) had sanctioned the passage as: "*important as a helpful general guide to evaluating oral evidence and the accuracy/reliability of memory*." Stewart J repeated the observations in *Olloson v Lee* [2019] EWHC 784, and distilled the "principles" relating to the assessment of oral evidence from *Gestmin* as follows at [96]:

- We believe memories to be more faithful than they are. Two common errors are to suppose (1) that the stronger and more vivid the recollection, the more likely it is to be accurate; (2) the more confident another person is in their recollection, the more likely it is to be accurate.
- Memories are fluid and malleable, being constantly rewritten whenever they are retrieved. This is even true of "flash bulb" memories (a misleading term), i.e. memories of experiencing or learning of a particularly shocking or traumatic event.
- Events can come to be recalled as memories which did not happen at all or which happened to somebody else.
- The process of civil litigation itself subjects the memories of witnesses to powerful biases.
- Considerable interference with memory is introduced in civil litigation by the procedure of preparing for trial. Statements are often taken a long time after relevant events and drafted by a lawyer who is conscious of the significance for the issues in the case of what the witness does or does not say.
- The best approach from a judge is to base factual findings on inferences drawn from documentary evidence and known or probable facts.
- This does not mean that oral testimony serves no useful purpose… But its value lies largely… in the opportunity which cross-examination affords to subject the documentary record to critical scrutiny and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and events. Above all, it is important to avoid the fallacy of

> supposing that, because a witness has confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth…

HHJ Gore QC's response to such submissions was trenchant:

"as is …. becoming the fashion, these submissions rely on and repeat intrusions into this difficult area by various judges so as to give the appearance of authoritative statements of principle. So it is that the greater number of cases and the greater number of judges who rely on one of the originators of these arguments, the decision of Leggatt J (as he then was) in Gestmin SGPS SA v Credit Suisse Limited [2013] EWHC 3560, the more authoritative it appears to become. This approach in my judgment is fraught with danger".

HHJ Gore QC considered that the approach outlined in *Gestmin* should be treated with very great caution for a number of reasons of which the first three are the most important. First, he said, the *Gestmin* approach is not a statement of legal principle at all. Second, if and insofar as Leggatt J's remarks are based upon the nature of memory, no expert evidence and no relevant professional literature informed or were evaluated in expressing the remarks recorded. Third, *Gestmin* was a commercial case where the relevant question was whether the relevant witness should be regarded as bound by his signed statement of investment objectives at the time the contractual relationship commenced. The documents said to be more reliable had been signed by the person who then sought to persuade the court that it did not represent his thinking at the time.

Ultimately, HHJ Gore QC upheld the Defendant's argument that the Claimant and her husband's account could not be relied upon but he did so not by following any guidance in *Gestmin* but by adopting the approach endorsed in *Synclair v East Lancashire Hospital NHS Trust* [2015] EWCA Civ 1283, which is to say, viewing the documentary and oral evidence forensically and not simply by subjective criteria such as demeanour of live witnesses, and then giving full reasons for his preference of one account over the other.

Comment

The judge's remarks about *Gestmin*, are of interest and should serve to discourage uncritical application of the passage at paragraphs 16-22 of *Gestmin*, even though – to many readers, this author being one, the cautious judicial approach to oral testimony which Leggatt J commends is both cogent and consonant both with human experience and relevant professional expert psychological literature. Notwithstanding, it should be noted that HHJ's Gore's cautionary words have since been expressly approved by the Court of Appeal in *Kogan v Martin and others* [2019] EWCA Civ 1645. *Kogan* was not a commercial case, but a QB action about the disputed authorship of a screenplay. The Court of Appeal confirmed that *Gestmin* is not to be taken as laying down any principle for the assessment of evidence. Rather it is one of a line of distinguished judicial observations that emphasise the fallibility of human memory and the need to assess witness evidence in its proper place alongside contemporaneous documentary evidence and evidence upon which undoubted or probable reliance can be placed. The Court of Appeal emphasised the crucial point that proper awareness of the fallibility of memory does not relieve judges of the task of making findings of fact based on all of the evidence. As they commented at [88]:

"*Heuristics or mental short cuts are not substitute for this essential judicial function. In particular, where a party's sworn evidence is disbelieved, the court must say why that its, it cannot simply ignore the evidence."*

That last point was of crucial importance in *Kogan* because that was not a case where the conflicts in the written and oral evidence of the parties could be described as "*honest differences of recollection*". If the judge's findings were correct, the claimant's written and oral accounts of the process of writing the screenplay were simply untrue.

Perhaps the real lesson from these cases is that there is no judicial short-cut to rejecting oral evidence given by one party and preferring the evidence of another. Judges (not least because they are taught about it by the Judicial College) are keenly alert to the shortcomings of human memory. It is the trial process which should give the judge the opportunity of being able to evaluate and, if necessary, reject honest recollection of witnesses, by reference to the totality of the evidence before the court.

ASSESSING THE STANDARD OF CARE - JUNIOR DOCTORS

Rajkiran Barhey

George Andrews v Greater Glasgow Health Board [2019] CSOH 31

Background

This Scottish case arose from the death of Ms Jean Graham and was brought by her partner of 20 years, Mr George Andrews. Ms Graham had attended hospital on 6 January 2013 and was assessed by a junior doctor, Dr Izzath, who discharged her. Before discharging Ms Graham he discussed the patient, via the telephone, with the on-call consultant, Dr Cleland. She subsequently died.

Breach of duty – the arguments

The Claimant's core allegation was that Dr Izzath's decision to discharge Ms Graham was negligent. The Defendant effectively admitted that Ms Graham should have been offered admission to hospital on 6 January 2013. The expert evidence from both parties also pointed to this conclusion.

However, in defence of Dr Izzath's actions, the Defendant sought to argue that, because he had discussed Ms Graham's case with Dr Cleland, and Dr Cleland had approved the decision to discharge the deceased, Dr Izzath was effectively absolved of liability for failing to advise Ms Graham that she should be admitted.

Breach of duty – the judgment

The judge rejected this argument. First, he found that the evidence suggested that Dr Cleland was not told the correct information about Ms Graham's condition, therefore, at [104], his *"approval of the proposed discharge was based on inaccurate information. For that inaccuracy Dr Izzath must, in my view, be held liable."*

The Defendant had attempted to rely on a passage in Jones on Medical Negligence (5th ed paragraph 3.115) which stated: *"Inexperienced doctors will discharge their duties of care by seeking the assistance of their superiors to check their work, even though they may themselves have made a mistake."* The Defendant sought to make an analogy with *Locke v Camberwell Health Authority* [2002] Lloyd's Rep PN 23 in which it was held that a solicitor was generally entitled to rely on the advice of counsel. It was argued that a similar relationship between a senior and junior doctor existed.

In response to this, the judge noted at [105]: *"I am unconvinced by the argument. It seems to me that the nature of the relationship between counsel and his or her instructing solicitor is one that arises in a very different professional context to that of junior and more senior hospital doctors. The differences are numerous, but amongst them is the obvious fact that the instructing solicitor pays counsel for his or her specialist expertise or advice."*

The judge reiterated the well-known principle that a learner driver must show the same standard of care as any other driver. He went on to consider the application of this principle in a number of medical cases, including *Wilsher v Essex Area Health Authority* [1987] QB 730 in which Mustill LJ (as he then was) rejected the idea of a duty of care specific to the individual, as opposed to the role which they have to perform. The judge noted that Glidewell LJ stated that: *"the law required the trainee or learner to be judged by the same standard as his more experienced colleagues."*

He also referred to the more recent Court of Appeal judgment in *FB v Rana* [2017] PIQR P17 in which a trial judge had held that, in taking a case history, a junior doctor owed a lesser duty of care than a more experienced colleague. This was not supported by the Court of Appeal. The judge in *Andrews* cited this helpful passage from Thirlwall LJ's judgment in *FB*:

"I have had the advantage of reading the judgment of Jackson LJ in this case. He there sets this appeal in the context of the law of negligence generally and of professional negligence in particular. I agree with his analysis

and add only that in every case of alleged clinical negligence the court is concerned with the acts and/or omissions of a doctor or other medical professional in the context of a particular task or tasks whether it be the delivery of a baby, the examination of a patient, the performing of surgery, the taking of a history and so on. There is often a correlation between the complexity of the task and the seniority of the doctor but many tasks are carried out by doctors of different seniority; surgery is often performed by a consultant surgeon. When it is performed by a registrar the standard of competence required is the same as that required of the consultant. As Jackson LJ observes, where a doctor in a particular post does not exercise the degree of skill required for the task in hand, the health trust is liable."

Furthermore, Jackson LJ made clear in his judgment that a doctor is always judged by the standard of the post which they are filling, not according to their level of experience. Consequently, if a trust puts a person in a particular position and they do not have the requisite skill for that position, the trust is liable.

The judge therefore concluded, applying those principles to the case, that any reasonably competent hospital doctor would have advised Ms Graham that she should be admitted, and the fact that Dr Izzath discussed Ms Graham's case with Dr Cleland did not exonerate him from his failure to exercise reasonable care. The pursuer therefore succeeded on that allegation of breach of duty.

Comment

Andrews is a helpful restatement of well-established legal principles as to the duty of care and the standard required of junior doctors. Whilst at first blush it may seem unfair to require the same standard of care from junior doctors as their more senior colleagues, a number of considerations must be borne in mind.

First, the law does not necessarily require junior doctors to provide an *equivalent* level of care as their more senior colleagues, but it does require all doctors, junior or senior, to provide a *competent* and *reasonable* standard of care appropriate to their role, regardless of their level of experience. This distinction is important to bear in mind.

Second, and connected to this point, is that junior doctors should not be placed in roles unless they have the knowledge and experience to provide a non-negligent standard of care. In so far as they are placed in a role for which they are not sufficiently experienced, and a patient suffers as a result, it is surely right that a Trust is liable to that patient. Liability falls on the Trust as an organisation, not the individual doctor.

ASSESSING THE STANDARD OF CARE – PAST OR PRESENT?

Rajkiran Barhey

Jones v Taunton and Somerset NHS Foundation Trust [2019] EWHC 1408 (QB)

It is trite law that if a doctor acts in accordance with a responsible body of medical opinion at the time of the treatment, their actions are not negligent, even if later developments in knowledge would render those actions negligent in the present day.

The opposite scenario is much rarer however. What happens if the actions of a doctor were not in accordance with a responsible body of medical opinion at the time of the treatment, but later developments vindicate their actions, such that by the time of trial their actions *would* be in accordance with a responsible body of medical opinion?

This unusual point was raised in the judgment of Stewart J in *Jones* which only concerned breach of duty. The Claimant's central allegation on breach was that in 1995 her mother was negligently administered Nifedipine, a drug which suppresses or postpones pre-term labour. As to causation, it was alleged that the administration of

Nifedipine was followed by a fall in maternal blood pressure, leading to a hypoxic episode which caused periventricular leukomalacia.

The Claimant's expert, Mr Hare, gave evidence that in 1995 it would have been negligent to administer Nifedipine as there was insufficient evidence to justify its use whereas the Defendant's expert, Professor Thornton, gave evidence that in 1995 it was not negligent to administer Nifedipine. It was common ground that by 2002 it was not negligent to administer Nifedipine.

Thus, as Stewart J commented in [135]:

"…In clinical negligence cases the question is often whether a clinician kept up with advancements in treatment/knowledge, and whether s/he should be held in breach of duty for seeing matters through the eyes of a clinicians at the time of the alleged negligence. This case is the opposite. The question in effect is whether the clinicians were ahead of their time in prescribing a drug about which it is alleged insufficient was known to prescribe it in late 1995, but which, seen through the eyes of clinicians from (at least) 2002 onwards, would have been an entirely appropriate treatment. This is despite the fact that then, as now, it remains unlicensed for the purpose for which it is used and there have still been no convincing double-blind studies or further primary research. Though the claim, when so analysed, may seem strange, yet it is an entirely logical proposition. I shall consider the claim by looking at the state of knowledge in November 1995."

As made clear, the judge went on to consider the claim through the state of knowledge in November 1995 and he ultimately concluded at [146] that it was not negligent to administer Nifedipine in 1995.

In an epilogue at [159] to [160] Stewart J noted:

"I have previously stated in this judgment that I shall try the issue of the prescription of Nifedipine as a tocolytic drug by the standards of November 1995, not subsequently. This accords with the traditionally understanding of the authorities. On that basis I have found for the Defendant. However, there were brief submissions by Mr Moon QC that there is nothing in the Bolitho test that requires me to do this. If a doctor who would have been held liable in 1995 for breach of duty in prescribing a drug whose use was not accepted as appropriate by a responsible body of practitioners is subsequently vindicated, such that a doctor prescribing the same drug in 2002 would not be in breach of duty because of changes of opinion in the profession, should the 1995 doctor be held to be negligent in a trial taking place after 2002? The point has not seemingly arisen before. Mr Sweeting QC submitted that a Claimant is entitled to be treated by reference to the standards at the time of treatment.

It is not necessary for me to decide the point and I do not do so, leaving it for consideration of a higher court if and when it arises."

Comment

Stewart J effectively avoided having to decide this interesting issue in *Jones* as he concluded, in accordance with ordinary principles, that the Claimant's treatment was not negligent by standards in 1995. However, the question of what happens where treatment *is* negligent by past standards but has subsequently been shown to be correct later is fascinating and it is notable that it has not yet arisen for consideration.

On the one hand, it may appear counterintuitive for a Claimant to succeed where the treatment complained of is subsequently shown to be correct and/or responsible. On the other hand, it might be said that permitting Defendants to succeed in such a scenario could legitimise the actions of 'maverick' doctors who act irresponsibly and, in extreme cases, treat their patients as guinea pigs. This consideration may hold particular weight in light of developing attitudes towards consent and the patient/doctor relationship.

What will happen remains to be seen.

EXPERT EVIDENCE – DO'S AND DON'TS

Gideon Barth

ZZZ v Yeovil District Hospital NHS Foundation Trust [2019] EWHC 1642 (QB)

Following a car accident in 2011, XXX brought proceedings against ZZZ. The claim was settled for £3 million plus annual periodical payments. ZZZ then brought contribution proceedings against Yeovil District Hospital, alleging that there was a failure by the Hospital to protect XXX's spine on presentation to the emergency department.

Garnham J found that the Defendant was in breach of duty by its failure to consider a trauma call and its failure to treat XXX on the assumption that she may have suffered significant spinal injuries. However, the claim failed on causation.

Expert evidence

Significantly, Garnham J weighed up the evidence given by the eight expert witnesses. His analysis, praise and criticism are a lesson in how (and how not) to give independent expert evidence.

His criticisms focused on the evidence provided by Mr Jamil, expert surgeon for the Claimant. He found that he was *"a thoroughly unsatisfactory witness"* [80] with *"numerous and fundamental"* deficiencies [81]. Mr Jamil's expert reports failed to take into account important features of the case [82-85]. Further, in those reports which were directed towards causation, he *"volunteered his views relevant to breach of duty. Surprisingly, he did not defer on that issue to the experts instructed to consider breach of duty. More fundamental, it was apparent in the course of the evidence that Mr Jamil did not know what the test for breach of duty is in a professional negligence case. He only succeeded in articulating something approaching the correct test after it had been explained to him by Mr Counsell"* [87].

Garnham J continued [88-89]:

"That piece of incompetence was underlined by the fact that in a county court in March of this year, Mr Jamil had again been unable to articulate the test he was applying when advising that another doctor was negligent… I regard Mr Jamil as a wholly unreliable witness."

This was in stark contrast to his assessment of other experts. For example, he commented that Professor Schapira, a neurologist, was *"an impressive witness in many ways, not least in his willingness to acknowledge the limitations of his expertise…"* [77]. Mr Thumbikat, a spinal injuries expert, was similarly *"highly impressive and credible"* who gave detailed and clear evidence, made reference to literature and made appropriate concessions [90-94].

And the majority of his praise went to Mr Mannion, a neurosurgeon, who he described as *"quite exceptional"* [96]. Among his attributes were his impressive CV, his great experience and expertise, in particular, his current and ongoing experience of treating the very condition from which XXX suffered [96-97].

Comment

This case is yet another reminder that clinical negligence cases stand and fall on expert evidence. It is not always possible to find an expert as suitable as Mr Mannion. But there are ways of avoiding the sorts of criticisms faced by Mr Jamil. Experts should only comment on matters within their expertise, reports should be scrutinised and amended at an early stage, and experts should be aware of the standards and tests applied by the court.

WHAT IS A "MOTHER", IN LAW?

Charlotte Gilmartin

TT, R (on the application of) v The Registrar General for England and Wales [2019] EWHC 2384 (Fam)

A person who undergoes the physical and biological process of carrying a pregnancy and giving birth, irrespective of gender? This was the ruling of the Rt. Hon. Sir Andrew McFarlane P, President of the Family Division, on 25th September in *TT, R (on the application of) v The Registrar General for England and Wales* [2019] EWHC 2384 (Fam). He decided that the Claimant, (known as "TT"), who was legally recognised as male at the time of giving birth to his child, ("YY"), is correctly registered as "mother" on YY's birth certificate.

Factual Background

TT's registered gender at birth was female. He has lived for many years as a transgender male. In 2016, he engaged in treatment to become pregnant through use of inter-uterine insemination ("IUI") using donor sperm (pausing hormone treatment in order to conceive). He subsequently gave birth to YY. Before attending the fertility clinic, a Gender Recognition Certificate ("GRC") was granted confirming his gender as male. TT's experiences of fertility treatment, pregnancy and birth are explored in depth in the 2019 film "Seahorse".

By the Births and Deaths Registration Act 1953 and the Registration of Births and Deaths Regulations 1987 ("BDRA" and "RBDR"), the birth of every child in England and Wales must be registered by entering the details prescribed on a 'Form 1'. This includes details relating to the identity of the 'father' (more recently, 'father/parent'), and the 'mother'. The Registrar refused to register TT as the father, insisting that he be registered as mother.

By his claim, TT sought a declaration that as a matter of law he is to be regarded as YY's father and he should be so registered. If domestic law required that he be registered as 'mother', the outcome would be a breach of both TT and YY's Article 8 rights under the ECHR.

Legal Background

The judgment is one of the first domestic cases to deal with the impact of gender change with respect to parenthood. The case of *R (JK) v The Registrar General* (The Secretary of State for the Home Department and others intervening) [2015] EWHC 990 (Admin); [2016] 1 All ER 354 brought by JK, a transgender woman who challenged her registration as the "father" of her two children on their birth certificates, guided the court's ECHR analysis; however, it had little direct bearing on the first part of the claim relating to domestic statutory interpretation [36-42].

Domestic Law: was the Registrar General required to register TT as the father?

The court framed its task as defining, for the first time, the legal term "mother" [1]. The sole authority cited in support of a common law definition was a passage from Lord Simon's judgment in The Ampthill Peerage [1977] AC 547 at 577:

"[m]otherhood, although a legal relationship, is based on a fact, being proved demonstrably by parturition."

Whilst this was acknowledged to be looking back to a time where "*conception and pregnancy other than through sexual intercourse was unknown and when gender was primarily determined by genital examination at birth and then maintained for life"* [133], it was essentially adopted as the starting point. The question became whether this was dislodged by statutory developments – namely, by the Gender Recognition Act 2004 ("GRA"), and/or the Human Fertilisation and Embryology Acts 1990 and 2008 ("the HFEA Acts").

GRA 2004

S9 of the GRA provides that:

- *"Where a full gender recognition certificate is issued to a person, the person's gender becomes for all purposes the acquired gender…"*
- *"Subsection (1) does not affect things done, or events occurring, before the certificate is issued…"*

Section 12 'Parenthood' provides that: *"the fact that a person's gender has become the acquired gender under this Act does not affect the status of the person as the father or mother of a child."*

TT argued that sections 9 and 12 of the GRA require that following the issue of a GRC, the individual is to be regarded as having acquired that gender "*for all purposes*", including parentage. Section 12 applied retrospectively: it was *"designed to protect the child of a parent who subsequently transitions, by providing legal certainty… regarding pre-existing familial relationships"* [85]. Key to TT's case was the assumption that for all purposes, the gender of a parent determines whether that parent is a 'mother' or a 'father'.

The President disagreed, finding that *"the essence"* of a mother's role is in the biological process of conception, pregnancy and birth, rather than their particular sex or gender [139]. As in *JK*,

"the law has, in recent times, readily recognised mothers, who are to be regarded as male, and fathers, who are to be regarded as female" [140–142].

He further held that if s12 of the GRA were entirely retrospective, it would be otiose where section 9(2) is explicit that issuing a certificate *"does not affect"* previous events. [142-145].

HFEA Acts

It was agreed that the provisions of HFEA 2008 did not directly provide a statutory answer to TT's claim to be a "father"; however, its provisions guided the court's analysis.

Section 33 provides a meaning of "mother" where 'an embryo' or 'sperm and eggs' are placed into the womb of the person who then carries the pregnancy. It provides that:

"(1) The woman who is carrying or has carried a child as a result of the placing in her of an embryo or of sperm and eggs, and no other woman, is to be treated as the mother of the child." Section 33 was not factually engaged; however, it was considered *"difficult to envisage that Parliament would have intended the binary alternative outcome"* where the difference was the specific process of assisted reproduction [165].

Not explored in depth was how the HEFA licensing scheme applied to TT at the time of his treatment. The Human Fertilisation and Embryology Authority declined the court's invitation to appear; however, considerable "ambiguity" was noted [159].

European Convention on Human Rights

Again, the precise question as to whether insistence on registration of TT as "mother" infringed the Article 8 (alone or with Article 14) rights of TT or YY found little direct analysis in ECtHR case law.

TT argued that he was placed in precisely in the unacceptable "*intermediate zone"* identified by the ECtHR in *Goodwin v United Kingdom* (2002) 35 EHRR 18, where the UK was held to have breached Article 8 in failing to recognise the acquired gender of a transgender woman in law. TT argued that an individual in his position would have to choose either to have a family, and enter a state of legal limbo in relation to gender, or abandon the prospect of parenthood and retain their acquired gender for all purposes. On the basis of the *Goodwin* decision, a strict and narrow margin of appreciation would be applied to any state which sought to establish an exception [207-210]. Further, whilst the risk of unwanted disclosure of the Birth Certificate details might be small, the impact of such disclosure and its deterrent effect were significant [211].

TT and YY further adopted the submissions of the AIRE centre. If the primary case of TT and YY failed, it was said that the current legislative framework would have a harmful impact on the children of transgender parents through the state's inability to recognise the child's parent appropriately [173-4; 202-206].

The Rt. Hon. Sir Andrew McFarlane P noted the view of the ECtHR that

"the right to gender identity and personal development is a fundamental aspect of the right to respect for private life" (as held in *Van Kück v Germany* no. 35968/97).

In approaching proportionality, a weight of a

"*high order must therefore attach to these rights… such as to require clear and substantial grounds before it could be said that any interference is justified and proportionate"* [255].

However, the specific rights of YY required close analysis: the best interests of the child were the *"primary"* consideration [261]. In *Mennesson v France* (Application No: 65192/11), the ECtHR observed that every person must be able to establish details of the identity of their parents, and that this was "*an essential aspect of an individual's identity"* ([96], *Mennesson*). By extension, a core element of that right must normally include the right to know who gave birth to them [256]. The evidence produced by YY's Litigation Friend did not, in the opinion of the court, adequately explore this need [260].

Further, Parliament had made a social and political judgment and afforded priority to the need for clarity as to parental status, with *"sound child-focussed reasons in favour of striking the balance in that way*" [263]. The *"single element"* of recording the person who gives birth as the mother was at the "*centre of the coherent and certain scheme*", which was of a high order of importance in social policy [265-266]. It was accepted that the number of occasions where a full birth certificate may be produced and TT's status as mother disclosed, would be small, and so the admittedly significant adverse impact for TT was outweighed by the interests of third parties and society at large [272].

The application for a declaration of incompatibility therefore failed.

The impact of the decision

As acknowledged by the judge, at the centre of the case was the purported need to register the person who gives birth to the child as *"mother"*. He considered that it was this title, rather than the need to register birth, to which TT objected: "*if the registration scheme were to record the identity of the person who carried and gave birth to a child as the 'gestational parent' or some similar gender-neutral phrase, then, as I understand TT's and YY's case, there would be no issue"* [268]. Indeed, if the conclusion on the first aspect of the case, namely that *"the term 'mother' is free-standing and separate from consideration of legal gender…"* [251] is accepted, there appears to be little compelling reason for a gendered term to be used for birth registration. TT's forceful submission was that as gendered terms, the ascription of the registration "mother" or "father" go "*to the very heart of the nature of gender dysphoria"* [213], and it is inescapable that the decision endorses a tension between legal parentage and social/psychological parentage in transgender cases.

Within the constraints of the language currently used in the 'Form 1', the court's concerns provide sound, though of course challengeable, reasons for registering TT as "mother". However, the specific justification for the use of the terms "mother" and "father", as opposed to gender neutral terms, is likely to be explored further as a matter of policy. The President commented that his conclusion that

"the term 'mother' is free-standing and separate from consideration of legal gender… is not TT's perspective and is unlikely to be the perspective of others who, like TT, suffer from gender dysphoria" [251].

He further makes an explicit request to the Government and to Parliament to specifically consider the status of a trans man who has become pregnant and given birth to a child. He noted that

"the issue which has most properly and bravely been raised by the Claimant… is, at its core, a matter of public policy rather than law… the existing legislation and the extant domestic and ECHR caselaw… do not themselves directly engage with the central question" [125].

The judgment carefully and at length engages with a wealth of domestic and international authorities on issues relating to both parents and children in transgender families, the exposition of which should inform both public debate and future legal development.

This article also appeared on 1 Crown Office Row's UK Human Rights Blog.

FAILURE TO SERVE A DEFENCE ON TIME AND RELIEF FROM SANCTIONS

Rajkiran Barhey

Kember v (1) Croydon Health Services NHS Trust (2) King's College Hospital NHS Foundation Trust [2019] EWHC 2297 (QB)

Background

Proceedings were issued on 6 June 2018 and served on 28 September 2018 following a limitation extension. The Defence was due to be served on 26 October 2018 but three extensions were agreed between the parties, with the final extension agreed until 4pm on 15 March 2019.

The Defence was not ready by 4pm on 15 March 2019. The Defendants contacted the Claimant's solicitors to seek a further extension but the case handler was not in the office. Therefore at 5:34pm the Defendants' solicitors faxed an application for an extension of time for 6 weeks to the court office. They had apparently been told by court staff that faxing the application was appropriate.

On 11 April 2019 the Defendants' solicitors rang the court office to find out if the application had been received and when it was to be heard. They were told that it had not been received and that applications by fax were not accepted. Therefore the solicitor issued a further application for an extension of time and an application for relief from sanctions. The Defence was served on 23 April 2019.

The Master's ruling

On 26 April 2019 Master Gidden heard the applications and rejected them. He found that the failure to serve a Defence was serious and significant and there was no good reason for the delay. He found that the application for an extension for time was made promptly but the application for relief from sanctions (which he found was the right application) was not made promptly. He also found that the Defendants had a relaxed attitude towards deadlines and the court should not send out the wrong message and indulge delay. The Defendants appealed this decision.

The appeal

The main issue of wider relevance raised in the appeal was whether Master Gidden was right in finding that the correct application which should have been made on 15 March 2019 was an application for relief from sanctions. The Defendants argued that CPR 15.4 does not prescribe the effect and consequences of a failure to serve a Defence within time, nor was there any order in the litigation which stipulated a sanction in the event of failure in compliance. Therefore, there was no need to make an application for relief from sanctions. It was accepted, however, that the Defendants' application for an extension of time made after expiry of the deadline would be determined according to the *Denton* principles in any event.

At [13] Lambert J agreed that the appropriate application was for an extension of time and not for relief from sanctions *"given that neither CPR 15.4 nor any of the court's orders in this litigation prescribed a sanction in the event of default… If no sanction is prescribed then the proper application is, in the context of this case, one for an extension of time adopting the three stage Denton test."*

Lambert went on to find that, despite the Master's misdirection in law, it was not material and his decision to refuse the extension of time was not wrong. In the event she was incorrect, she considered the exercise of her discretion afresh and found that the appeal should be refused.

Comment

The decision serves as a useful restatement of when an application for relief from sanctions will be required.

It is easy to fall into the trap of assuming that any failure to meet a deadline requires an application for relief from sanctions. Indeed, as noted at [14] of the judgment, both the Defendants' solicitors and counsel at the original hearing accepted that an application for relief from sanctions was required and so Master Gidden was

not criticised for going wrong and finding that such an application was necessary. It was only at the appeal hearing that the Defendants sought to argue that such an application was not required.

The key is to consider whether a sanction is imposed by a rule, practice direction or order of which the applicant was in breach. As noted by Moore-Bick LJ in *Altomart Limited v Salford Estates (No. 2) Ltd (Rev 1)* [2014] EWCA Civ 1408, which was cited in *Kember: "Most rules, practice directions and orders, however, do not provide specific sanctions for their breach, leaving it to the court to decide what, if any, consequences should follow. In my view rule 3.9 does not, therefore, apply to such case…"*

Also of interest to readers may be Lambert J's dismissal of the Defendants' justifications for the delay. She found that the claim was not particularly complicated, as alleged by the Defendants, and that the fact that two Trusts were involved was not a good reason for the delays. She also noted that the Defence was only provided to the Trusts for approval 2 days before the deadline for service which demonstrated a *"relaxed attitude"* to rules and court orders. She also commented that the faxed application was not valid. She accepted that the solicitor had been told by court staff that faxing the application would be acceptable but *"speaking with court staff is no substitute for reading the rules."*

Paul Reynolds was instructed by the Defendants in this case. He did not contribute to this article.

CAUSATION AND PRAGMATISM

Rajkiran Barhey

Marshall v Schembri [2019] EWHC 283 (QB)

In this judgment of Stewart J the court considered a claim brought by the widower of a woman who died due to cardiac arrest. She had a history of pulmonary embolism ("PE"). It was admitted by the Defendant, a GP, that he should have referred the deceased to hospital when she attended his surgery with chest pain and breathlessness. In fact, he did not refer her, and she died at home the next morning. The only issue was causation.

A large amount of detailed evidence was led as to what would have happened to the deceased had she been admitted to hospital, and whether such treatments would have led to her survival. Of note, however, is [128] of the judgment in which Stewart J commented: *"As is accepted, the Claimant has the burden of proving causation. Yet the Claimant needs to prove no more than that Mrs Marshall would probably have survived had she been admitted to hospital. The Claimant does not need to prove the precise mechanism by which her survival would have been achieved."*

Stewart J then went on to make a number of findings on the balance of probabilities as to what would have happened had the deceased been admitted to hospital.

However, he then stated at [139] to [140] that:

"All these possibilities set out in closing submissions have been individually assessed on the evidence. There cannot be an inference, much less a finding, merely on the basis that a number of possibilities amount to a probability that death would have been avoided. That said, this concentration on each possible stage of what would have happened where much is uncertain and difficult to resolve, must be considered against some important overall evidence.

Overall most people do not die of PE when they are in hospital. The deceased was not very elderly and had no comorbidity. In addition, Professor Empey said that his experience and that of many of his colleagues is that once a patient is admitted to hospital, properly assessed and given the appropriate treatment: heparin, oxygen, monitoring and other observations they do not die. It is very, very unusual. Similarly, Doctor Gomez said that he would have fully expected the deceased to survive because of the package of care that would be given to her."

He ultimately went on to find in the Claimant's favour on causation, making the following comments at [145] to [146]:

"Thus the expert medical evidence to which I have referred and the statistical evidence demonstrate that at the time when Mrs Marshall should have presented at hospital, anybody rating her chances of survival would have put them at being very high. Tragically, she did in fact die out of hospital. In the situation which occurred, detailed analysis of such evidence as we have cannot lead the court to find that by such and such a mechanism, or at any particular stage, the course of events would probably have been different. This is overwhelmingly because of a large number of unknowns.

The court, in looking at the evidence as a whole, must take a common sense and pragmatic approach to that evidence, in circumstances where it is equivocal. The court must also be wary of relying on the statistical evidence in the literature which has a number of variables. Had the statistical evidence, in conjunction with the expert evidence, have led to the conclusion that Mrs Marshall's chances of dying would have been assessed on presentation as only slightly better than 50-50, I would have found for the Defendant. However, the above evidence of Professor Empey and Doctor Gomez, in conjunction with the medical literature, drives me to the conclusion that on the clear balance of probabilities she would have survived."

Comment

The judgment is notable for the somewhat broad-brush and pragmatic approach to causation taken by the judge. Whilst a number of detailed findings as to causation were made, these were expressed in terms of 'possibility' as opposed to 'probability' at [133] to [138]. He then ultimately considered these in the context of expert evidence that, by one treatment or another, deaths from PE in hospital are extremely rare and also statistical evidence that deaths from PE in hospital are very low. This then appeared to lead him to the conclusion that the Claimant would likely have survived had she been admitted to hospital, but with no clear findings as to exactly how.

An appeal is outstanding to the Court of Appeal and so it is likely that further analysis of the correctness of this approach is to come.

SECONDARY VICTIM CLAIMS AND CLINICAL NEGLIGENCE

Paul v The Royal Wolverhampton NHS Trust (Rev 1) [2019] EWHC 2893 (QB)

This was an application for strike out and/or summary judgment heard by Master Cook in a secondary victim claim.

Background

Mr Paul had a significant medical history including diabetes, chronic kidney disease and cardiac symptoms. In November 2012 he attended hospital complaining of chest and jaw pain but no cardiac investigations were performed apart from an ECG.

In January 2014 Mr Paul was on a shopping trip with his two daughters when he collapsed. They managed to call for help, an ambulance arrived, and the girls witnessed their attempts at resuscitation. He was taken to hospital, but Mr Paul died soon after.

It was alleged that Mr Paul should have been offered coronary angiography in November 2012 and, if this procedure had been undertaken, it would have shown coronary artery disease, he would have been treated and he would likely have survived.

The arguments

The Defendant argued that Mr Paul's daughters could not be secondary victims as there was no relevant event and no proximity.

Particular emphasis was placed on the case of *Taylor v Somerset Health Authority* [1993] 4 Med LR 34, a clinical negligence claim arising out of a failure to diagnose and treat the Claimant's husband's worsening heart condition, which months later led to him suffering a heart attack at work and dying in hospital. The Claimant attended the hospital and was told of her husband's death within 20 minutes. Auld J held in that case at p267 that:

"There are two notions implicit in this exception cautiously introduced and cautiously continued by the House of Lords. They are of:

(i) an external, traumatic, event caused by the defendant's breach of duty which immediately causes some person injury or death; and

(ii) a perception by the plaintiff of the event as it happens, normally by his presence at the scene, or exposure to the scene and/or to the primary victim so shortly afterwards that the shock of the event as well as of its consequence is brought home to him.

There was no such event here other than the final consequence of Mr Taylor's progressively deteriorating heart condition which the health authority, by its negligence many months before, had failed to arrest. In my judgment, his death at work and the subsequent transference of his body to the hospital where Mrs Taylor was informed of what had happened and where she saw the body do not constitute such an event."

The Defendant pointed out that this had been approved by the Court of Appeal in *Taylor v A Novo* [2014] QB 150.

The Defendant further emphasised that in *Taylor v A Novo* the Court of Appeal clearly set out the two senses in which the Claimant must prove proximity – the legal sense (the overall legal test for whether there is a duty of care at all) but also the physical sense – i.e. whether the Claimant was physically proximate to the event.

The Claimant emphasised that the present case was challenging as it was a negligent 'omission' case as opposed to a negligent 'act' case. She went on to distinguish *Taylor v Somerset* by arguing that, in that case, Mrs Taylor did not witness the collapse or death of her husband, and the court's conclusions were made on that premise.

The Claimant also referred to *Sion v Hampstead Health Authority* [1994] 5 Med LR 170 and *W v Essex County Council* [2001] 2 AC 592. In *Sion*, the claim was struck out as there was no evidence the Claimant had suffered nervous shock. But, obiter, Peter Gibson LJ stated: *"I see no reason in logic why a breach of duty causing an incident involving no violence or suddenness, such as where the wrong medicine is negligently given to a hospital patient, could not lead to a claim for damages for nervous shock, for example where the negligence has fatal results and a visiting close relative, wholly unprepared for what has occurred, finds the body and thereby sustains a sudden and unexpected shock to the nervous system."*

In *W v Essex* the court noted that the categories of primary and secondary victims are not closed.

The Claimant placed particular emphasis on the decision in *North Glamorgan NHS Trust v Walters* [2002] EWCA Civ 1792, which concerned a baby whose jaundice was not diagnosed. Three weeks later the baby suffered a seizure and deteriorated over the next 36 hours, eventually dying. The Court of Appeal found that the period of 36 hours was a single horrifying event causing nervous shock to the mother, who was present throughout.

The Claimant also referred to *Galli-Atkinson v Seghal* [2003] EWCA Civ 697 in which the court found that the aftermath of an event may constitute part of the overall event if it retains sufficient proximity to the event.

The Claimant argued that in *Walters,* the event was taken to start with the infliction of damage, i.e. the first clear manifestation of the breach of duty which had occurred earlier [27]. *Taylor v A Novo* was distinguished on the basis that the event in that case caused damage immediately, but the Claimant nevertheless tried to argue that the relevant 'event' was the death, several weeks later.

The Claimant finally argued that the application of the law on secondary victims to clinical negligence cases is unclear and militates in favour of allowing the case to go to trial.

The judgment

Master Cook acknowledged that the only issue in this application was whether the Claimants succeeded in establishing the control mechanism of 'proximity' – all of the other control mechanisms were satisfied [33].

He concluded that the case could not be sensibly distinguished from *Taylor v Somerset Health Authority,* and that the ratio of that case was clear – that "*his death from a heart attack could not amount to a relevant event for the purpose of the proximity test."* [36].

As to *Walters,* Master Cook quoted from the decision in *Taylor v A Novo,* namely a passage in which the Court of Appeal explained that in *Walters* the court was able to hold that the 'event' was the period of 36 hours from the moment when the baby suffered a seizure, to the misdiagnosis, the correct diagnosis, and the baby's death i.e. "*the events from the misdiagnosis in Walters could be seen as one event connected in space and time."* [39].

Master Cook disagreed with the Claimant's approach of focusing upon the death of Mr Paul as the first point at which the Defendant's negligence manifested itself. He stated that: *"To do so overlooks entirely that there must be a proximate connection between the initial negligence and the shocking event… It is this proximity which has been found to exist in all successful secondary victim claims including Walters and it is the lack of such proximity which explains why the claims in cases such as Taylor v Somerset Health Authority and Taylor v A Novo failed."* [40].

He ultimately concluded *"Mr Paul's tragic death 14 ½ months after the negligent incident, in circumstances separated in space and time from the negligence I must assume occurred in the hospital, cannot possibly be said to be the "relevant event" for deciding the proximity required to establish liability under the established control mechanisms."* [41].

DISHONESTY – SERIOUS PROFESSIONAL MISCONDUCT

Suzanne Lambert

Collen Nkomo v General Medical Council [2019] EWHC 2625 (Admin) (9 October 2019)

The High Court dismissed an appeal of a locum general practitioner against the decision of the Medical Practitioners Tribunal ("the Tribunal") erasing his name from the register of medical practitioners.

Background

The Appellant locum general practitioner, Dr Nkomo, was convicted on two separate occasions of different offences. The first occasion was in October 2015 in relation to an incident where he was stopped by the police on suspicion of drunk driving and he failed to provide a breath sample at the roadside and in custody. Although he was sentenced to 60 hours of unpaid work and was disqualified from driving for two years, he did not report the charges or convictions to the General Medical Council ("GMC") at the time. The second was a conviction of fraud by misrepresentation in May 2017 arising from his failure over a period of almost 3 years (including when interviewed under caution) to provide full and accurate details of his income in connection with maintenance payments for his child, which deprived his son and ex-partner of over £40,800 in maintenance.

In August 2017, Dr Nkomo belatedly self-referred to the GMC in respect of both convictions, which led to a hearing before the Tribunal. Dr Nkomo admitted six misconduct matters including the convictions and sentences and the fact that he had failed to notify the GMC without delay. The Tribunal found that Dr Nkomo's fraud conviction related to sustained dishonesty, and that this amounted to misconduct, which impaired his fitness to practice. As to sanction, the Tribunal held that suspension would not be appropriate because Dr Nkomo's behaviour lay at the top end of the spectrum of gravity of misconduct given that his fraud had lasted for two years and seven months; it deprived his son and ex-partner of £40,800; he had failed to report his fraud; he only had partial insight; and he had made little acknowledgement of the impact of his actions on the profession as a

whole. Having regard to the Sanctions Guidance, the Tribunal found that Dr Nkomo's dishonesty was fundamentally incompatible with being a doctor and therefore erasure was the appropriate sanction.

Dr Nkomo appealed against the sanction only. He did not seek to appeal the findings of fact or of impairment. His grounds of appeal were that the Tribunal had failed to give due weight and consideration to the circumstances prevailing at the time of the fraud and had failed to distinguish adequately between standards of conduct meriting suspension as a sanction as opposed to erasure.

Judgment

Julian Knowles J reviewed the principles governing appeals from the Tribunal to the High Court under section 40 of the Medical Act 1983 [33-37]. Although such appeals are by way of re-hearing, he explained that they are in fact a re-hearing without hearing again the evidence (*Fish v GMC* [2012] EWHC (Admin) 1269).

As to the scope of an appeal under section 40, Knowles J cited Cranston J's comprehensive summary in *Yassin v GMC* [2015] EWHC 2955 (Admin) at [32] of that judgment, of the propositions to be derived from the authorities [34]. Of particular note is the recognition that the Panel is a specialist Tribunal whose understanding of what the medical profession expects of its members in matters of medical practice deserves respect (*Gosalakkal v GMC* [2015] EWHC 2445 (Admin)); The Panel has the benefit of hearing and seeing the witnesses on both sides and questions of primary and secondary facts and the overall value judgment made by the Panel are akin to jury questions to which there may reasonably be different answers (*Meadows v GMC* [197], per Auld LJ); findings of primary fact, particularly founded upon an assessment of the credibility of witnesses, will be virtually unassailable (*Southall v GMC* [2010] EWCA Civ 407 , [47]); if the court is asked to draw an inference, or question any secondary finding of fact, it will give significant deference to the decision of the Panel, and will only find it to be wrong if there are objective grounds for that conclusion (*Siddiqui v GMC* [2015] EWHC 1966 (Admin), paragraph [30](iii)); a principal purpose of the Panel's jurisdiction in relation to sanctions is the preservation and maintenance of public confidence in the medical profession so particular force is given to the need to accord special respect to its judgment and as an expert Tribunal it is afforded a wide margin of discretion so that the court will only interfere where the decision of the Tribunal is wrong (*Fatnani and Raschid v GMC* [2007] EWCA Civ 46, [19], per Laws LJ).

Finally, as to the proper approach of an appeal court to the sanctions determination of a Tribunal, Knowles J referred to the recent decision of the Court of Appeal in *Bawa-Garba v GMC* [2018] EWCA Civ 1879, [60]-[67]. The Court of Appeal described the Tribunal's decision as a *"multi-factorial decision"*, which is a mixture of fact and law that has been described as *"a kind of jury question"* about which reasonable people may disagree. Again, there is limited scope for an appellate court to overturn such a decision of a specialist adjudicative body.

Turning to the decision under appeal, that Dr Nkomo's erasure was the appropriate sanction, Knowles J concluded that the Tribunal had not erred in such a way as to allow him to overturn its finding on appropriate sanction as it had reached a conclusion which was open to it. Referring to the Sanctions Guidance, Knowles J explained that dishonesty by a doctor is almost always extremely serious and lies at the top end of the spectrum of gravity of misconduct *(Theodoropolous v GMC* [2017] EWHC 1984 (Admin)). Where dishonest conduct (as in this case) is combined with a lack of insight, is persistent or is covered up, nothing short of erasure is likely to be appropriate (*Naheed v GMC* [2011] EWHC 702 (Admin)), even where it occurs in a non-clinical performance. Misconduct involving personal integrity that impacts on the reputation of the profession is harder to remediate than poor clinical performance (*Yeong v GMC* [2009] EWHC 1923 (Admin)). In such cases, personal mitigation should be given limited weight.

Therefore, the Tribunal was entitled to conclude that Dr Nkomo's dishonesty was fundamentally incompatible with his continued registration and that erasure was the appropriate sanction.

Comment

This case provides a useful overview of the case-law relating to dishonesty in professional disciplinary proceedings and demonstrates the importance of honesty and integrity in the medical profession. Findings of

dishonesty will almost always be regarded as extremely serious and doctors who are dishonest, whether in the clinical setting or in their personal life, are at risk of erasure particularly where the misconduct impacts on the reputation of the profession. Moreover, such a doctor will face an uphill struggle in persuading the appellate court to overturn the specialist Tribunal's decision to erase rather than suspend.

BEST INTERESTS

Alice Irving

Tafida Raqeeb (By Her Litigation Friend XX) v Barts NHS Foundation Trust [2019] EWHC 2531 (Admin)

In a tragic case concerning five year-old Tafida Raqeeb, MacDonald J considered whether withdrawal of life sustaining treatment was in her best interests. He ultimately concluded that treatment should not be withdrawn.

The case raised two interesting issues: First, the relationship between the right to freedom of movement (Art 56 TFEU) and best interest determinations in circumstances where medical services are offered in an EU Member State. Second, how a disabled child's best interests should be determined where they retain a minimal level of awareness, feeling no pain but equally experiencing very little, if anything, of a positive nature.

The facts

Tafida Raqeeb ('TR') was born on 10 June 2014. On 9 February 2019, aged 4, she collapsed after complaining of a headache. Examination revealed a large blood clot on TR's brain, caused by a ruptured arteriovenous malformation. She had suffered extensive and irreversible brain damage. Her condition was stabilised, however she was dependent on artificial ventilation to remain alive. If ventilation continued, she could survive for 10 to 20 years. There was a possibility she might eventually be cared for at home. There was no chance of any significant improvement in her mental functioning. If TR was aware at all, she was minimally so. It was likely she did not feel pain.

It was the view of the medical team treating TR that it was not in her best interests to continue life sustaining treatment. Her parents disagreed, stating that withdrawal of treatment was against their Muslim beliefs. Doctors at Gaslini Hospital in Italy agreed to receive TR for ongoing care. TR could be transferred to Italy without risk and the proposed treatment in Italy was not experimental, but a continuation of what she was receiving in England. The material difference in opinion between the English and Italian doctors was simply whether sustaining TR's life was in her best interests.

Barts NHS Foundation Trust ('the Trust') would not agree to transfer TR to Gaslini Hospital. They applied to the High Court for a declaration that it was in TR's best interests for life-sustaining treatment to be withdrawn. Judicial review proceedings were brought by TR, challenging the Trust's decision to refuse her transfer to Italy.

Freedom of movement and best interests

The decision to refuse to transfer TR to Italy was challenged on a number of grounds. The most significant concerned TR's right to freedom of movement under Art 56. It was submitted that "*where a child has a right under Art 56 to receive healthcare services in another Member State as a function of her EU rights, public authorities in this jurisdiction may not restrict the right to receive such services unless there [is] an imperative public policy reason for the purposes of Art 52"*. The Trust admitted that it had not considered TR's freedom of movement rights at all in reaching their decision. Accordingly, it was submitted, that decision was unlawful.

It was further submitted that the interference with TR's right to freedom of movement could not be justified in accordance with EU law. That is, the Trust could not lawfully block TR's transfer to Italy. The clever legal twist in this argument came at its end: if the court accepted these submissions, "*the court would be functus as to Tafida's wider best interests"*. That is, her best interests would then be a matter for the Italian doctors alongside her parents, and not for the High Court to consider at all.

MacDonald J agreed that the Trust should have considered whether their decision interfered with TR's EU rights under Art 56 and, if it did so interfere, whether that was justified on grounds of public policy. The Trust's failure to do so rendered the decision unlawful. Further, the Trust's decision to refuse transfer was a plain interference with TR's Art 56 rights. Nevertheless, MacDonald J held at [146] that had the Trust considered TR's rights, it would have reached the same decision, because the interference with her rights could be justified.

Justice MacDonald noted that Art 8 of Council Regulation (EC) 2201/2003 confers jurisdiction for the use of national procedures to resolve a dispute as to a child's best interests. He went on to confirm at [148]-[154] that having recourse to the national procedure for determining a child's best interests and refusing transfer of that child pending a determination of those proceedings would be a justifiable derogation of the child's right to freedom of movement.

The important corollary of this conclusion was that the best interest determination in the High Court would take precedence over any claim to freedom of movement. As MacDonald J held at [154]: "*Where receipt of treatment is held to be in the child's best interest then the relevant EU right is implemented. Where it is not held to be in the child's best interest, then EU law would not require… the implementation of an EU right in a manner that is antithetic to the child's best interests"*. Accordingly, the clever legal submission that the High Court was ousted from considering TR's best interests did not succeed.

In the circumstances, MacDonald J refused to grant any judicial review remedy at all, despite finding the Trust's decision to refuse transfer of TR to be unlawful.

A practical point for NHS Trusts

Accordingly, where NHS Trusts are faced with a request by parents of an EU citizen child to transfer that child for medical treatment in another Member State, in deciding whether or not to agree to that transfer the Trust will need to consider the EU rights of the child, including freedom of movement. However, where an NHS Trust, having properly considered the child's EU rights, decides that a transfer would not be in the best interests of the child and that an application to the High Court is required to determine the resulting dispute, it is highly likely that that decision will constitute a justified derogation from the EU rights engaged.

Best interests and minimal awareness

In determining TR's best interests, MacDonald J faced a circumstance where, in a purely medical sense, there was no benefit to TR in continuing to maintain her life. Nor, however, was there any burden, as TR was unlikely to experience pain or suffering. In his own words at [192], cases of this sort "*place the objective best interests test under some stress*. *Absent the fact of pain or the awareness of suffering, the answer… must be looked for in subjective or highly value laden ethical moral or religious factors extrinsic to the child..."* While every case will turn heavily on its facts, there are a few points of interest in how MacDonald J approached the matter.

MacDonald J at [172] set out a concept of benefit that went beyond mere medical benefit. Drawing on the judgment of Lord Hoffman in *Airedale NHS Trust v Bland* [1993] ACR 789, he argued that it was wrong to conclude "*we have no interests except in those things of which we have conscious experience*". Such an approach "*does not accord with many people's intuitive feelings about their lives, and particularly those people who have a strong religious faith.*"

As to the dignity of sustaining TR's life, the Trust submitted that, even if TR felt no pain, further invasive treatment over an extensive period would impose an unacceptable burden on her human dignity. In response, MacDonald J held at [176]: "*The term 'human dignity' does not lend itself to precise definition and there is no universal agreement as to its meaning. The concept of human dignity must, accordingly, contain a significant element of subjectivity and thus be influenced by, for example, the religious or cultural context in which the question is being considered."*

MacDonald J ultimately concluded there was a benefit and an innate dignity in TR being cared for by a loving and dedicated family at home in a manner consistent with the religious code and community values within which

she had been raised. Accordingly, MacDonald J dismissed the application for a declaration that withdrawal of life-sustaining treatment was in TR's best interests.

IN BRIEF

Lesforis v Tolias [2019] EWCA Civ 487 – appeal against a decision of Martin Spencer J in which, following a full liability trial, he had concluded that a consultant neurosurgeon had been negligent in giving an inappropriately early prescription of antithrombotic medication to the respondent, which caused or materially contributed to the formation of a haematoma, leading to spinal cord compression and neurological deficit. Ground of appeal was that the judge failed to directly address the case that the relevant question was not whether Mr Tolias' general practice of giving antithrombotic medication within 6 hours was a breach, but whether giving such medication to this patient within 3 hours was a breach given risk factors in her case. Appeal dismissed.

Ahmed v The General Medical Council [2019] EWHC 2173 (Admin) – appeal against an erasure decision on the basis that the tribunal was wrong to find that he made knowingly false statements and that he acted dishonestly. Appeal dismissed, issues were predominantly factual.

AXO v Salisbury NHS Foundation Trust [2019] EWHC 1454 (QB) – causation only trial. Issue was whether a negligent overdose of a muscle relaxant given to a newborn caused brain damage leading to cerebral palsy. Yip J found that, on a close analysis of the evidence, there was insufficient evidence to establish a causal link.

Bell v Bedford Hospital NHS Trust [2019] EWHC 2704 (QB) – The Claimant alleged that there was a failure to diagnose transient ischaemic attacks and, had they been diagnosed, she would not have suffered a major stroke which left her with significant disabilities. Judge found in C's favour on breach but found that, even if TIA had been diagnosed, the advice and medication given to C would have been the same as what she had already received and she had not managed to change her lifestyle (e.g. quit smoking, weight loss) and her compliance with medication was poor. Therefore C failed to prove causation.

Boyle v West Calder Medical Practice [2019] 8 WLUK 32 – A failure by a GP to diagnose Cushing's disease was not negligent – it was rare and difficult to diagnose.

Dootson v Newhouse [2019] 10 WLUK 329 – Defendant GP applied for relief from sanctions arising from late service of a witness statement. Breach was significant – 5 and a half months – and there was no good reason for the breach. However, the judge found that it would not affect the trial date, the Claimant had sufficient time to consider the statement, and the trial judge would want to see the statement. Therefore relief was allowed.

Flanaghan v University Hospital Plymouth NHS Trust [2019] EWHC 1898 (QB) – liability and causation in issue, allegations related to spinal surgery. Fact-specific judgment in favour of Defendant.

Okpara v General Medical Council [2019] EWHC 2624 (Admin) – MPTS had not erred in upholding allegations against a doctor of sexually motivated misconduct towards a nurse. It had also not erred in finding that erasure was the correct sanction.

Rai v University Hospitals Coventry And Warwickshire NHS Trust [2019] EWHC 2488 (QB) – Claimant alleged that, following a laparoscopic sleeve gastrectomy, there was a failure to diagnose and manage a post-op staple line leak. By the time it was diagnosed she was suffering with severe abdominal sepsis. She also suffered a persistent fistula and lengthy complex treatment, all of which was avoidable. The judge found against the Claimant on breach and causation.

RXK v Hampshire Hospitals NHS Foundation Trust [2019] EWHC 2751 (QB) – Claimant's application for a further interim payment on account of quantum costs. Master Cook adjourned the application on the basis that it did not address the relevant issues, but provided guidance as to what ought to be considered in these sorts of applications.

Shaw v South Tees Hospitals NHS Trust [2019] EWHC 2280 (QB) – Wrongful birth claim. Concerned whether it was negligent for a consultant to fail to spot brain abnormalities in a fetal anomaly scan at 21^{+6} weeks. HHJ Simpkiss found that it was not negligent to have failed to spot the abnormality.

Younas v Okeahialam [2019] EWHC 2502 (QB) – Causation trial. the Claimant's undiagnosed heart condition led him to lose consciousness and fall, suffering a serious spinal cord injury. Issue was whether, had the GP referred the Claimant for investigations following an abnormal ECG, the Claimant would nevertheless have suffered the fall and subsequent injury. Ay [77] judge referred to the concept of "Claimant benevolence" and giving the claimant the benefit of the doubt in establishing the timetable of the referral and hospital process. Ultimately found in Claimant's favour.

EVENTS & NEWS

New Tenants

We are delighted to announce that Darragh Coffey and Thomas Beamont have joined 1 Crown Office Row. Both were previously 12-month pupils at 1 Crown Office Row.

Podcast

Further news and events information can be found on our website.

Letters to the Editor

Feel free to contact the team at medlaw@1cor.com with comments or queries.

CONTRIBUTORS & EDITORIAL TEAM

Jeremy Hyam QC (Call: 1995, QC: 2016) – Editorial Team

Jeremy is a specialist in clinical negligence, administrative and public law, inquests, public inquiries, and professional regulatory work. He has particular experience in all aspects of health law and has appeared in a number of leading cases in the field at all levels including in the Supreme Court and Privy Council.

Shaheen Rahman QC (Call 1996, QC: 2017) – Editorial Team

Shaheen Rahman QC specialises in public law, clinical negligence and professional discipline. Recognised by the legal directories as a leading practitioner in multiple areas, she is instructed in complex and high value clinical negligence matters including catastrophic brain injury cases, has particular expertise in judicial review challenges to healthcare funding decisions, appears at inquests involving detained or otherwise vulnerable patients and acts for healthcare professionals in regulatory and MHPS proceedings.

Robert Kellar QC - Contributor

Robert Kellar QC has a broad practice which encompasses clinical negligence, professional discipline, judicial review and human rights, healthcare, personal injury and inquests. In clinical negligence both claimants and defendants instruct him in all types of case. He acts for both individuals and healthcare institutions. He has particular experience in complex, multi-party and high value litigation e.g. the Ian Paterson Group Litigation. Robert acts for healthcare and other professionals in cases before regulatory and disciplinary tribunals.

Suzanne Lambert (Call: 2002) – Editorial Team

Suzanne has a broad practice, with a particular focus on healthcare/medical law. She has experience mainly in clinical negligence and inquests, but also in disciplinary law and judicial review. Suzanne is instructed by claimants and defendants in a wide variety of cases involving serious and catastrophic injuries e.g. cerebral palsy, spinal injuries, loss of fertility, and delayed diagnosis of cancer. She has experience with complex legal issues such as contributory negligence, apportionment between defendants, and consent.

Matthew Flinn (Call: 2010) – Editorial Team

Matt's practice spans all areas of Chambers' work, including clinical negligence, personal injury, public law and human rights. He is developing particular expertise in inquests, and clinical and dental negligence claims, acting for both claimants and defendants. He undertakes a wide range of advisory and court work. He also has experience in information law and has advised in private litigation stemming from the Data Protection Act 1998.

Dominic Ruck Keene (Call: 2012) – Editorial Team

Dominic has considerable experience of acting in clinical negligence claims for both claimants and defendants: drafting pleadings, advising on merits, quantum and settlement; successfully representing parties at RTMs and at mediation; as well as appearing in case management hearings, application hearings, and at trial in both the county and High Courts. As a result of his background in the Army, Dominic has a particular interest and expertise in all nature of cases involving service personnel and National Security. He is on the Attorney General's C Panel.

Gideon Barth (Call: 2015) - Contributor

Gideon has a busy practice spanning all areas of Chambers' work. In terms of clinical negligence, he has experience in high-value claims, complex causation arguments, secondary victim claims, issues of informed consent and Fatal Accidents Act claims. Gideon appears in inquests relating to topics ranging from medical negligence, mental health issues, nursing care to road traffic accidents. He was instructed as junior counsel to the Coroner in the Inquests into the Birmingham Pub Bombings (1974).

Charlotte Gilmartin (Call: 2015) - Contributor

Charlotte Gilmartin accepts instructions in all areas of Chambers' work and is developing a broad practice, in particular in clinical negligence, personal injury, and inquests. Charlotte joined Chambers as a tenant in March 2018. She regularly acts for both claimants and defendants in complex clinical negligence matters, settling a variety of pleadings and advising in conference. She has appeared in court in a variety of civil hearings and regularly appears before Coroners. Charlotte is instructed as junior counsel to the Infected Blood Inquiry.

Rajkiran Barhey (Call: 2017) – Editorial Team

Rajkiran accepts instructions in all areas of Chambers' work and is developing a broad practice, particularly in clinical negligence, personal injury, inquests and public law and human rights. Kiran joined Chambers as a tenant in September 2018 following successful completion of a 12-month pupillage. She is currently instructed by the Grenfell Tower Inquiry and is also undertaking a secondment at a leading clinical negligence law firm.

Alice Irving (Call: 2018) - Contributor

Alice Irving joins chambers as a third six pupil, having completed pupillage at another top public law set. Before coming to the bar, Alice worked for several years as a Stipendiary Lecturer in Law at the University of Oxford. She also has experience as a research assistant to academics and the Law Commission. Alice has volunteered with Oxford Pro Bono Publico and also interned at the Women's Legal Centre in Cape Town, South Africa and the Crown Law Office in Wellington, New Zealand.