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The 1COR Quarterly Medical Law Review

Updates and analysis of the latest legal developments

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Welcome to the fifth issue of the Quarterly Medical Law Review, brought to you by the barristers at 1 Crown Office Row. In this packed edition you will find:

Shaheen Rahman QC explores **vicarious liability,** in the recent **Supreme Court** judgments in *Barclays Bank v Various Claimants* and *Mohamud v WM Morrison Supermarkets plc* and three other recent judgments in the **sexual abuse** context – Page 2. She also looks at a recent **regulatory** decision concerning sanctions and undue lenience – Page 31.

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Finally, see our In Brief section and follow us on Twitter at **@1corQMLR.** If you would like to provide any feedback or further comment, do not hesitate to contact the editorial team at **medlaw@1cor.com**.

VICARIOUS LIABILITY – IS IT STILL 'ON THE MOVE'?

Shaheen Rahman QC

WM Morrison Supermarket plc v Various Claimants [2020] UKSC 12

Barclays Bank plc v Various Claimants [2020] UKSC 13

These parallel judgments, handed down on the same day by the Supreme Court, clarify the two stage approach to determining whether an employer will be held liable for the wrongdoing of an employee. The first stage involves consideration of whether the wrongdoer really is an employee or akin to an employee. If so, the second stage requires consideration of what the employee did wrong – was it closely connected to their employment or were they *'on a frolic of their own'*? The judgments require a reappraisal of the observation of Lord Phillips in *Various Claimants v Catholic Child Welfare Society* [2012] UKSC 56 (the "*Christian Brothers"* case), that "*the law of vicarious liability is on the move"*.

Stage 1: Employment or 'akin to employment'

Barclays Bank is concerned with the first stage. Barclays for many years paid Dr Bates, now deceased, to carry out medical assessments of people they wished to employ, many of them young women aged 16 or under. He carried out the assessments in his own home, and is alleged to have sexually assaulted many of those he examined. The victims could not sue his estate which had been dispersed, but at first instance and on appeal it was held that Barclays could be sued on the basis of vicarious liability for any proven assaults.

The Supreme Court unanimously allowed Barclays' appeal. It was accepted that the circumstances in which one person can be made vicariously liable for the torts of another had expanded from the historic position, where it was limited only to employer/employee relationships. However, the requirement remained for a relationship that was at least *'akin to employment'* as held in *E v English Province of Our Lady of Charity* [2012] EWCA Civ 938.

In the view of the Supreme Court, Dr Bates was not "*anything close to an employee"* of Barclays. It was noted that he had a number of paid positions that included part-time employment for the NHS as well as writing a newspaper column. Accordingly, he was a true independent contractor and vicarious liability did not arise: *"He was in business on his own account as a medical practitioner with a portfolio of patients and clients. One of those clients was the bank."* [28]

So where did the Court of Appeal and first instance judge go wrong?

Lady Hale noted that the recent expansion in the law of vicarious liability had begun with the House of Lords' decision in *Lister v Hesley Hall Ltd* [2001] UKHL 22, where the owners of a children's home were held to be liable for sexual abuse perpetrated by their employee. That case was concerned with stage two – i.e. whether the employer, in the case of an acknowledged employee, should be held liable for the employee's particularly egregious deliberate wrongdoing. But the sorts of policy considerations that had influenced that judgment then found their way into the case law concerning stage one, i.e. whether the relationship is akin to employment.

This is evident in the *Christian Brothers* case, which involved abuse of children at a school by teachers who were employees of the school but also members of an organisation called the Institute of Christian Brothers. There was no dispute that the owners of the school were vicariously liable, as employers, but they argued that the Institute should share liability. The court identified a number of policy reasons why an employer should usually be vicariously liable. These were that (i) the employer is more likely to have the means to compensate the victim; (ii) the tort will have been committed as a result of activity being taken by the employee on behalf of the employer; (iii) the employee's activity is likely to be part of the business activity of the employer; (iv) the employer by employing the employee to carry on the activity will have created the risk of the tort being committed; and (v) the employee will have been to some degree under the control of the employer. Turning to whether the Institute could also be held to be vicariously liable, the court held that it could. The five policy

factors set out above as regards an employer/employee relationship were considered. But Lady Hale considered that the determination of whether the relationship was akin to employment was not restricted to policy reasons but involved analysis of the details of the particular relationship and its closeness to employment. The conclusion was that, notwithstanding the fact that the teachers were not paid or under contract, all the essential elements of an employment relationship were present, in particular that the teaching activity was undertaken in the furtherance of the objective of the Institution and was dictated by its rules. [15]-[16].

Lady Hale acknowledged that the five policy factors set out in *Christian Brothers* played a clear role in the reasons for extending vicarious liability to non-employer/employee relationships at stage 1 in *Cox v Ministry of Justice* [2016] UKSC 10. The MOJ was held to be vicariously liable for the negligence of prisoners working in the catering department of a prison, the absence of an employment contract notwithstanding. However, she considered that there was nothing in this judgment to cast doubt upon the *"classic distinction between work done for an employer as part of the business of that employer and work done by an independent contractor as part of the business of that* contractor.*"* [22]

Likewise, she acknowledged that the *Christian Brothers* policy factors were considered at stage 1 in the Supreme Court's *"difficult"* case of *Armes v Nottinghamshire County Council* [2017] UKSC. Here, it was held that a County Council could be vicariously liable for abuse carried out by foster parents and particular emphasis was placed upon the *'deep pockets'* factor. However, Lady Hale noted that the judgment also laid emphasis upon the fact that the foster parents could not be regarded as carrying on an independent business of their own.

Accordingly, it will be seen that the Supreme Court in *Barclays* was at pains to emphasise a bright line between relationships that are akin to employment and those in which work is done by an independent contractor. In the latter case, vicarious liability will not arise. The court seems, implicitly, to accept that this was not entirely clear from three of its own recent judgments in this area, yet it goes on to cite in support the subsequent decisions of the Court of Appeal in *Kafagi v JBW Group Ltd* [2018] EWCA Civ 1157 and of the Singapore Court of Appeal in *Ng Huat Seng v Mohammed* [2017] SGCA 58. [25]-[26].

Ultimately, the court concluded that it is only in *"doubtful"* cases that the five policy factors identified by Lord Philips in the *Christian Brothers* case may be helpful at stage 1. But in a *"clear"* case, such as that of Dr Bates, that will not be necessary [27].

Stage 2: A close connection to employment

The *Morrisons* case is concerned with stage 2. A disaffected employee had waged a criminal campaign of vengeance against his employer, in which he sent workforce payroll data to the newspapers, leading to group litigation by those affected. The courts below held that Morrisons was vicariously liable for the employee's actions.

Joel v Morison (1834) 6 C & P 501, 503 enshrined the basic principle that: *"The master is only liable where the servant is acting in the course of his employment…but if he was going on a frolic of his own, without being at all on his master's business, the master will not be liable".* A employer is liable if the employee is engaged in furthering the employer's business *"however misguidedly"*: see *Dubai Aluminium* v Salaam [2002] UKHL 48.

The cases turn on their facts. In *Warren v Henlys Ltd* [1948] 2 All ER 935 a customer was wrongly accused by a petrol attendant of trying to make off without payment. The customer flagged down a police car and complained. The police officer said it was not a police matter. The customer said he would report the attendant to his employer. As the police officer was about to leave the attendant punched the customer in the face, knocking him to the ground. The court held that the assault was an act of *"personal vengeance"* and had no connection whatever with the discharge of his duty for his employers. In *Morrisons*, Lord Reed considered that reasoning to be *"unconvincing"* given that the attendant's function was to deal with customers, the assault happened at his workplace, whilst at work and the sequence of events commenced with the attendant acting for the benefit of his employer. The facts were felt to be *"appreciably stronger"* than in the present case [43]

The court also considered its earlier decision in *Mohamed v WM Morrison Supermarkets plc* [2016] UKSC 11, coincidentally involving both the same supermarket chain and an assault by a petrol station attendant. A motorist asked if he could print some documents and was refused, ordered to leave and subjected to a racist tirade by the attendant, who then followed him to his car, opened his door and told him never to come back. When the motorist asked him to close the door the attendant assaulted him. In this instance the Supreme Court held that applying the test of *"close connection"* to employment*,* as set out In *Lister* and *Dubai*, the attendant's acts did fall within the scope of his employment. His job was to attend to the customers and that is what the attendant was doing in the first instance, albeit in a foul mouthed way. The assault that took place was part of a seamless episode in which the attendant gave an order to the victim to stay away from his employer's premises, *"reinforced by violence"*. Accordingly, whilst a gross abuse of his position, it was in connection with the business. [27]

Lord Reed noted that the decision in *Mohamed* had been misunderstood by the courts below as marking a major departure from the previous case law. The comments concerning "*a seamless episode"* concerned the capacity in which the employee was acting rather than simply a temporal or causal connection between the events. Likewise a statement that *"motive was irrelevant"* was taken out of context – it simply meant that the reason why the attendant had become violent could not make a material difference, it having been concluded already that he was going about his employer's business when he did so. [28]-[30]

In the instant case, the deliberate disclosure of the payroll data was clearly not part of the disaffected employee's authorised functions. Lord Reed considered the presence of the *Christian Brothers* policy factors to be irrelevant, apparently on the basis that they were concerned with the determination at stage 1. The close temporal connection was considered insufficient to satisfy the close connection test. However, the fact that the employee was not acting on his employer's business interests but contrary to them, for personal reasons, was highly relevant. In these circumstances his conduct was not so closely connected with acts which he was authorised to do that it could fairly and properly be regarded as done whilst acting in the ordinary course of employment.[47]

Is the law on vicarious liability still on the move?

The facts of these cases were highly unusual, and the court considered that they fell squarely on one side of the line. However, it seems likely that the expansion of the law, that commenced with *Lister* and continued in the trilogy of Supreme Court cases discussed in *Barclays,* will continue to be argued for in more nuanced areas such as in the context of private healthcare provision. The court will need to look at the precise relationship in each case. Factors such as the location of the tortious conduct, the extent to which the tortfeasor's activities are part of the alleged employer's business activity and a degree of control can still be considered at stage 1. Moreover, a separate concern for employers exists: as noted in *Barclays* [19], even in situations ultimately viewed as involving independent contractors, a non-delegable duty of care may still arise: see *Woodland v Swimming Teachers Association* [2013] UKSC 66. It is also to be noted that in *Morrisons* the court rejected the argument that an employer can never be vicariously liable for a breach of the Data Protection Act 1988. Therefore, in future an employer could be held to be vicariously liable for a breach of the legislation, as well as of obligations arising at common law or in equity, caused by an employee who is a data controller and commits the breach in the course of his employment.

Lizanne Gumbel QC and Robert Kellar QC acted for the Claimants in Barclays Bank. They did not contribute to this article.

VICARIOUS LIABILITY – CHILD SEXUAL ABUSE

Shaheen Rahman QC

Three recent cases have illustrated the application of a number of legal principles that frequently arise in child abuse cases, including those set out in *WM Morrison Supermarket plc v Various Claimants* [2020] UKSC 12 and *Barclays Bank plc v Various Claimants* [2020] UKSC 13, discussed above.

Haringey London Borough Council v FZO [2020] EWCA Civ 180

The Court of Appeal dismissed the Defendant's appeal against a judgment extending the limitation period by some 25-30 years and awarding £1.1 million to a former pupil abused by a school teacher. The Defendant accepted vicarious liability whilst the pupil had been at the school, but maintained that the relationship was consensual thereafter. This was rejected: the judge was right to hold that conditioned consent resulting from a grooming process was not true consent. The court also rejected the argument that the relationship was not sufficiently close to the teacher's employment for vicarious liability to arise after the pupil left school. The evaluative judgment that the teacher's abuse of trust in the period leading up to his majority continued to operate thereafter would not be disturbed. As to limitation, the argument that adverse factors concerning the teacher's credibility should not be weighed in the balance in considering whether to extend limitation under Limitation Act 1980 s.33 was rejected. Defendants challenging disapplication of the limitation period on the basis of the claimant's lack of credibility took a risk of adverse findings being made about their own credibility and the issue could not be decided without assessing the credibility of rival accounts.

DSN v Blackpool Football Club [2020] EWHC 695 (QB)

The limitation period was extended by some 22 years to allow a claim arising from abuse by a football coach to proceed, notwithstanding the death of key witnesses including the alleged abuser in the intervening period. The low value of the claim was not a *"trump card"* to be played by the Defendant and was not one of the factors expressly identified in section 33(3), though the likely value of an award may be important where limitation is determined as a preliminary issue and there is likely to be some considerable time before trial [66]. For practical purposes it was impossible for the Claimant to raise the claim before he did, given in particular the effect of the abuse upon him. The allegations of abuse were accepted without qualification or reservation. Applying the two stage approach in *Barclays,* the relationship was akin to employment despite the fact that the coach was an unpaid volunteer and it was just and reasonable that vicarious liability should arise. He was a scout for the club and the club lent him credibility by *"lavishing tickets and access on him and his protégés."* [160] At stage 2 it was held that the abuse was so closely connected with the relationship, even on a foreign trip, that the club should be vicariously liable. It was noted that the Claimant's psychiatric injuries had been exacerbated by the club's conduct since being notified of the claim: *"They conceded nothing at all at any point and made no effort to sympathise or to reach out in ways that might have mitigated the difficulties faced by DSN in the years since disclosure"*[189]. The Claimant was awarded general damages of £17,000 and a small amount of agreed special damages.

EXE v Governors of the Royal Naval School [2020] EWHC 596 (QB)

The case concerned whether a school was vicariously liable in tort for the actions of a kitchen porter in 1991 who had sex with a pupil who was 14. The judge declined to extend the limitation period given the deterioration in and availability and cogency of evidence. Moreover, notwithstanding that the acts were criminal offences, the judge considered that they were consensual and did not give rise to claims in tort. Neither was the judge persuaded that the school should be vicariously liable had there been any valid claims – the porter did not use his position at the school to get to know the pupil and the majority of the relationship took place after he left. The judge also held that the school had not been directly negligent in respect of the checks it conducted on the porter, who was not a member of the academic, boarding or administrative staff.

Robert Seabrook QC and Justin Levinson appeared for the Respondent in Haringey LBC v FZO. They did not contribute to this article.

VICARIOUS LIABILITY – ASSOCIATE DENTISTS

Dominic Ruck Keene

Ramdhean v Agedo and The Forum Dental Practice Limited 2020 WL 00620352

The Facts

The claim arose out of allegedly negligent care given to the Claimant at a dental surgery. A preliminary hearing was held at Leeds County Court to consider whether the Second Defendant Practice owed a non-delegable duty of care in relation to the advice and treatment given by the First Defendant (the treating dentist) and/or whether the Practice was vicariously liable for the First Defendant. The Practice argued that the associate dentist was a "*a fully qualified, self employed, individually indemnified, independent dental professional*."

The men of straw

The Dentist (Dr Agedo) had professional indemnity insurance (with Dental Protection), however, had failed to notify his indemnifiers of a possible claim in relation to the Claimant, and had declined cover. The managing director and majority shareholder of the Practice (Dr Jackson) held medical indemnity insurance solely in respect of medical/dental work carried out by him personally. The Practice had public liability insurance, which did not cover negligence in any treatment provided. However, it was accepted that it had ample assets to meet the particular claim.

However, HHJ Belcher held that it was not a relevant consideration that the Claimant's "*only hope of an effective remedy"* was bringing a claim against the Practice:

"It forms no part of my decision making for me to try and find someone to impose liability on simply because they can afford to meet a claim, whether through insurance or from personal assets. There must be a proper basis for imposing a legal liability on a party, regardless of whether or not that party has the ability to meet any judgment sum awarded against it."

Non-Delegable Duty

Unsurprisingly, it was agreed that the appropriate starting point was the Supreme Court's judgment in *Woodland v Swimming Teachers Association & Others* [2013] UKSC 66 ("Woodland").

The Claimant argued that the court was not being asked to hold that an individual dentist owes a non-delegable duty in connection with treatment by another dentist. Instead this was a limited company with its own distinct legal personality, but which, unlike a hospital or NHS Trust, profits from the very service which is the subject matter of the claim. Accordingly 'like a hospital,' it should owe a non-delegable duty for all the clinical treatment provided to patients referred to the practice. The Claimant referred to *Farraj v King's Healthcare NHS Trust* [2009] EWCA Civ 1203 and to *Woodland* as authority for the proposition that there was an obvious non-delegable duty that applied in all healthcare cases. HHJ Belcher rejected the breadth of that argument, holding that:

"…there may be cases involving a hospital where a non-delegable duty does not arise. Whilst it may be the case that the facts of many healthcare cases may produce a non-delegable duty, in my judgment the simple fact that the case involves healthcare provision is not necessarily sufficient, without more, for the court to impose a non-delegable duty."

HHJ Belcher also rejected the argument made by the Practice that the Primary Care Trust was in effect as responsible as the Practice. She held that while the PCT had entered into a contract with the Practice to provide

dental services, that fell within the general rule that any duty to take reasonable care could be discharged by entrusting performance of the task to an apparently independent contractor: "*The PCT did not undertake the care, supervision and control of the patient in this case*." Conversely, she was entirely satisfied that the Claimant was a patient of the Practice, and therefore satisfied the first limb of the *Woodland* approach (dependency through being either a patient or especially vulnerable). This was particularly so when considering the terms of the agreement ('the IMOS') between the PCT and the Practice for the provision of effectively secondary care in the community:

"The IMOS contains terms and conditions relating to those performing the services and conditions for their employment or engagement, and expressly permits subcontracting of clinical matters … The IMOS also impose positive obligations on FDPL, such as, for example, ensuring that any dental practitioner performing services under the IMOS was maintaining and updating his skills and knowledge in relation to those services he was performing … What it does illustrate is that, on any view, FDPL was not (or should not have been) the simple administrative referral service which Dr Jackson sought to suggest."

HHJ Belcher then looked to whether there was an antecedent relationship of control (the second limb of *Woodland*), and held that the Claimant was under the actual care of the Practice, even if the IMOS permitted that to be by way of employing associate dentists, under whose care the Claimant would also be. The Practice had control over the decision to refer the Claimant to the dentist in question by accepting her as a patient and directing her to Dr Agedo. The Claimant could not be referred directly to Dr Agedo.

With regards to whether the Claimant had any control over how the Practice chose to perform its obligations under the IMOS (i.e. whether personally or through employees or other third parties) – the third limb of *Woodland* – HHJ Belcher held that the Claimant plainly had no control over such measures.

HHJ Belcher then held that the fourth limb of *Woodland* was satisfied as the function delegated to Dr Agedo was an integral part of the function of providing minor oral surgery. The care of the Claimant was accepted by the Practice when it accepted her referral, and then was delegated to Dr Agedo, together with the function of making the relevant clinical decisions.

Overall, it was fair, just and reasonable to impose a non-delegable duty of care on the Practice.

Vicarious Liability

HHJ Belcher referred to the judgments of the Supreme Court in *Cox v Ministry of Justice* [2016] UKSC 10 and *Mohamud v WM Morrison Supermarkets PLC* [2016] UKSC 11.

She held that it was in the Practice's control to determine that work should be passed to Dr Agedo, even if it could not direct him to carry out any particular treatment or in fact to carry out any treatment at all if he considered it appropriate:

"… the only reason that Dr Agedo was in a position to carry out treatment on Ms Ramdhean, was because she was referred to FDPL under the IMOS, and FDPL passed her on to Dr Agedo for treatment. In my judgment there is sufficient control."

For the same reason, Dr Agedo's treatment formed part of the Practice's business activities under the IMOS.

With regards to the creation of risk, HHJ Belcher held that:

"…without the IMOS, Miss Ramdhean would never have been referred to Dr Agedo. In my judgment FDPL's business activities did create the risk, in exactly the same way as an employer who employs an employee to conduct his business creates the risk, in the sense of creating the situation in which a negligent act might occur. I should make it clear, given the tenor of cross examination, that I am not saying that FDPL created the risk by a poor appointments process/appointing an individual with known difficulties or anything of that sort. I have already made it clear I do not consider it necessary for me to make findings on that issue. I base my assessment simply on the fact that FDPL used Dr Agedo to deliver, and thereby perform, FDPL's obligations under the IMOS

in terms of treating oral surgery patients. In my judgment it is self-evident that in doing so, FDPL created the risk."

Accordingly, there was vicarious liability.

Comment

Any decision in the field of vicarious liability on the basis of 'being akin to employment' and/or direct non delegable duty of care in the field of healthcare provision is of course highly fact specific. This is also a county court judgment, and further is potentially subject to appeal and was decided prior to the recent Supreme Court judgments on vicarious liability covered by Shaheen Rahman QC. However, this case is significant as it both represents another brick in wall of imposing liability on healthcare providers outside the pure NHS hospital context, and also is relevant to many other dental practices as similar agreements appear to have been place between many PCTs and dental providers. It is worth noting that the practice in question had subsequently taken out insurance against harm arising from negligent treatment by associate dentists.

DAMAGES FOR THE COST OF SURROGACY

Suzanne Lambert

Whittington Hospital NHS Trust v XX [2020] UKSC 14

In a majority decision, the Supreme Court has confirmed that a claimant is entitled to recover as damages not only the costs of surrogacy using her own eggs, but also the costs of surrogacy using donor eggs, as well as the costs of commercial surrogacy in the US.

Background

The Appellant NHS Hospital Trust had admitted liability for a negligent failure to detect signs of cancer in the Respondent (XX) during routine smear tests performed in 2008 and 2012, and from biopsies performed in 2012. It was admitted that, as a result of the admitted negligence, XX's cancer diagnosis was delayed so that she lost the opportunity to have the surgery which would have preserved her fertility and her ability to bear her own child. However, the Trust disputed the damages payable to XX as a result of her loss of fertility, specifically the claim for the costs of US commercial surrogacy arrangements and of UK surrogacy arrangements using donor eggs (as opposed to XX's own eggs which had been collected and stored prior to her cancer treatment). Although it was probable that XX would be able to have two children using her own eggs through surrogacy arrangements ("own egg surrogacy"), she wished to have a further two children, which would require the use of donor eggs ("donor egg surrogacy"). Her preference was for commercial surrogacy arrangements in California rather than in the UK.

In assessing damages at first instance, Sir Robert Nelson held that the claim for Californian surrogacy expenses had to fail as the court was bound by the Court of Appeal decision in *Briody v St Helens and Knowsley AHA (Claim for Damages and Costs)* [2001] EWCA Civ 1010. In accordance with *Briody*, commercial surrogacy arrangements remained illegal in the UK under the Surrogacy Arrangements Act 1985 s2(1) and thus it would be contrary to public policy to compensate for such costs. In contrast, non-commercial surrogacy arrangements in the UK were legal and therefore XX would be entitled to recover the reasonable costs for such arrangements. However, again in accordance with *Briody*, such costs would only be recoverable if they involved the use of her own eggs. The position was different for donor egg surrogacy as that would not be restorative of XX's loss, which was XX's inability to have "her" own child, not "a" child. Therefore, XX was awarded the costs of own egg surrogacy in the UK for two children (£37,000 for each surrogacy).

XX appealed against the rejection of her claim for damages for the cost of US commercial surrogacy and for the cost of donor egg surrogacy in the UK. The Trust cross-appealed against the allowance of damages for UK surrogacy expenses (as well as against the level of damages awarded for PSLA). The Court of Appeal declined to

follow *Briody* and allowed XX's appeal: XX was entitled to recover the costs of commercial surrogacy arrangements in California as well as the costs of surrogacy arrangements in the UK (both with her own eggs and with donor eggs). The Trust's cross-appeal was partially allowed only in relation to PSLA so that the award was reduced from £160,000 to £150,000 to reflect the fact that an additional award of £15,000 had been made in respect of the commercial surrogacy arrangements in California.

The Trust appealed against the award of damages for the cost of commercial surrogacy arrangements in California and of UK surrogacy arrangements using donor eggs.

Judgment

The Supreme Court affirmed the decision of the Court of Appeal and dismissed the Trust's appeal, holding unanimously that XX was entitled to recover the costs of surrogacy arrangements using her own eggs as well as donor eggs. By a majority of 3:2, the Supreme Court also held that XX was also entitled to the costs of the commercial surrogacy arrangements in California.

Lady Hale gave the majority judgment, with which Lord Kerr and Lord Wilson agreed. Lord Carnwath gave a dissenting judgment, with which Lord Reed agreed, on the issue of recoverability of damages for commercial surrogacy only.

Recoverability of costs of surrogacy arrangements using own eggs vs donor eggs

As Lady Hale noted, the UK law on surrogacy was "*fragmented and in some ways obscure*" and surrogacy arrangements were "*completely unenforceable*". However, there had been "*quite dramatic*" developments in attitudes to assisted reproduction and in the law since the Court of Appeal decision in *Briody* in 2001. In particular, amendments to the Surrogacy Arrangements Act 1985 introduced by the Human Fertilisation and Embryology Act 2008 meant that non-profit bodies can now initiate (although not actually take part in) negotiations and facilitate surrogacy arrangements for reasonable payment. Nevertheless, commercial surrogacy agencies remain banned from receiving money for surrogacy arrangements, whether from the surrogate or commissioning parents. However, the offences could only be committed in the UK so that there was nothing to stop agencies based abroad from helping to make commercial surrogacy arrangements abroad. Nor was there anything to stop commissioning parents and surrogates from making arrangements directly, whether in the UK or abroad and even on a commercial basis. Any such agreements would be unenforceable however and could result in the refusal of a parental order in favour of the commissioning parents subsequently. In contrast, commercial surrogacy is well-established, with the arrangement being binding and enforceable so that it was "*scarcely surprising*" that XX's preference was for a Californian commercial surrogacy arrangement.

The Supreme Court was not bound by the Court of Appeal's ratio in *Briody* but, in any event, *Briody* did not rule out the award of damages for surrogacy arrangements made on a lawful basis in the UK using own eggs. Rather, *Briody* held that whether it was reasonable to seek to remedy the loss of a womb through surrogacy depended on the chances of a successful outcome. The law permitted damages for the cost of surrogacy arrangements using own eggs in the UK. More dramatically, there have been developments in "*the law's idea of what constitutes a family*", including the recognition of male same-sex couples, so that there is a spectrum of surrogacy arrangements and the use of donor eggs in fertility treatment has become more acceptable and widespread.

Lady Hale went on to address whether it is possible to claim damages for UK surrogacy arrangements using donor eggs and addressed head-on her own comments in *Briody* that the use of donor eggs was "*not truly restorative of what the claimant had lost.*" She stated plainly that it did not matter whether her comments were technically obiter or not as in her view "*it was probably wrong then and is certainly wrong now.*" Similar to a claimant who has lost a limb is entitled to claim for the cost of an artificial limb, XX was being supplied with "*a replacement womb*", albeit temporarily, in order to compensate her for not being able to have a child. Therefore, subject to reasonable prospects of success, damages can also be claimed for the reasonable costs of UK surrogacy using donor eggs.

Recoverability of costs of commercial surrogacy arrangements abroad

As to the "*most difficult question*" of the recoverability of costs of foreign commercial surrogacy, the court was divided. The court had the advantage of comparing the costs of UK and Californian surrogacy and found that most items in the bill for Californian surrogacy would be recoverable if the surrogacy had taken place in the UK, albeit at higher costs (e.g. the fee to the surrogate mother in California is higher than the reasonable expenses paid to surrogates in the UK). Although commercial surrogacy arrangements were not enforceable in the UK, Californian surrogacy was lawful in the US and, as indicated above, UK law did not preclude agencies from facilitating commercial surrogacy arrangements abroad in a country where it was not unlawful. Nor was it illegal under UK law to enter into such arrangements. Additionally, bearing in mind all the developments since *Briody*, the fact that the courts now "*bend over backwards*" to recognise the relationships created by surrogacy, including foreign commercial surrogacy, and the fact that the Law Commissions have provisionally proposed that a surrogate child should be recognised as the child of the commissioning parents from birth, thus bringing the law closer to the Californian model but with greater safeguards. The majority therefore held that it was no longer contrary to public policy to award damages for the costs of a foreign commercial surrogacy.

Lady Hale made clear a number of important caveats to the availability and extent of such awards. First, the proposed programme of treatments must be reasonable. Second, it must be reasonable for the claimant to seek the foreign commercial arrangements proposed rather than to make arrangements within the UK. This is unlikely to be reasonable unless the foreign country has a well-established system in which the interests of all involved, the surrogate, the commissioning parents and any resulting child, are properly safeguarded. Third, the costs involved must be reasonable.

The dissenting speech

Whilst Lord Carnwath agreed that the Court was not bound by *Briody* and that there was nothing illegal about XX travelling to California for the purpose of surrogacy arrangements or in the commercial surrogacy arrangements being made from the UK, in his dissenting speech, he disagreed with the majority as to whether the costs of such arrangements should be recovered. He analysed the issue not through the prism of illegality but instead through the prism of the broader principle of legal coherence. In his view the case was not concerned with illegality and therefore *Mirza v Patel* was not relevant. Rather, there was a need to preserve consistency between civil and criminal law. It would go against that principle for civil courts to award damages based on conduct which, if undertaken in the UK, would offend its criminal law. Although society's approach to surrogacy has developed, there has been no change in the critical laws on commercial surrogacy, which remained prohibited in the UK and which led to the refusal in *Briody* of damages on that basis.

Comment

This decision is to be welcomed as bringing the law of damages in relation to commercial surrogacy up to date to reflect the changes in attitudes and legislative developments since *Briody* so that a woman like XX could be compensated for the reasonable costs of surrogacy arrangements, regardless of whether the surrogacy involves her own eggs or donor eggs. Lord Carnwath's dissenting speech, however, is a reminder that views on surrogacy are not uniform and that, notwithstanding Law Commissions proposals, the regulation of surrogacy arrangements in the UK is more stringent than they are in places like California. As observed by William Edis QC in his detailed and insightful analysis of this case on ukhumanrightsblog.com, the fact that the operation of commercial surrogacy agencies in the UK remains unlawful and the fact that costs recoverable for surrogacy arrangements are lower in the UK than in California may be a source of disquiet, particularly when the treatment sought is available more cheaply in the UK.

DUTY TO TELL A CHILD ABOUT RISK OF GENETIC CONDITION?

Rajkiran Barhey

ABC v St George's Healthcare NHS Trust & Ors [2020] EWHC 455 (QB)

This fascinating judgment of Yip J considers whether the Defendants had a duty of care to alert the Claimant ("ABC") to the risk that she had inherited the genetic mutation for Huntington's disease in time for her to terminate her pregnancy.

Background

As noted by Yip J at [6], the facts of the case were both *"tragic and unusual."* ABC's father ("XX") murdered her mother in 2007. XX was convicted of manslaughter by reason of diminished responsibility and detained at a hospital run by the Second Defendant ("D2"). He was under the care of a multi-disciplinary team which was led by Dr Olumoroti, a consultant forensic psychiatrist.

XX was investigated for Huntingdon's Disease by the First Defendant ("D1"). By around July 2009 it appeared probable that XX had Huntingdon's Disease, but he refused to be conclusively tested and did not want his two daughters to be told about the investigations. He was aware that it would likely impact upon their decision to have children. Neither daughters had started a family.

Huntingdon's Disease is a neurodegenerative disorder. It is genetic and incurable with symptoms normally appearing in adulthood. Children of those with the condition have a 50% chance of inheriting the genetic mutation.

All of the Defendants became aware of XX's potential diagnosis and the implications this could have for ABC and her sister.

In July 2009 ABC became pregnant. She was initially unsure about the pregnancy and was not in a settled relationship. ABC told a social worker, under the responsibility of the Third Defendant, about the pregnancy. She also told her father who told his psychologist. He was adamant that ABC should not be told about the potential for Huntingdon's Disease *"and 'so jeopardise the pregnancy'".*

XX underwent genetic testing and in November 2009 it was confirmed that he had Huntingdon's Disease.

ABC gave birth in April 2010. In August 2010, D2 and D3 visited the Claimant and told her about her father's diagnosis. It is accepted that this was a breach of the father's confidentiality.

By this point, ABC's sister was also pregnant and in the early stages. Neither ABC nor her father wanted her sister to know about the diagnosis. Following much discussion by clinicians at D2, it was agreed that ABC's sister would not be told. She gave birth and found out about the diagnosis afterwards.

ABC tested positive in 2013 for Huntingdon's Disease. She will likely develop the condition in 5-10 years. It is not yet known if her child has the condition. ABC's sister was also tested and found to be negative.

The legal basis of the claim

The claim was brought in negligence and under the Human Rights Act 1998 for breach of Article 8 ECHR. However, almost all of the argument focused upon the negligence aspect of the claim.

As summarised at [23], ABC had to prove that the Defendants ought to have given her enough information to warn her of the risk of Huntingdon's Disease at a time when termination of pregnancy was still an option. She then had to prove that, if she had known of the risk, she would have undergone genetic testing and found out that she had the Huntingdon's gene, and that she would have had a termination.

Legal background

The claim was originally struck out in 2015 by Nicol J on the basis that there was no reasonably arguable duty of care. This decision was appealed to the Court of Appeal who, in 2017, quashed the decision striking out the claim and remitted the case for trial. It then came before Yip J for a full trial in late 2019 with judgment in February 2020.

Is there a duty of care?

The Claimant had to show that one or all of the Defendants had a duty of care to give her information as to her genetic risk. The Claimant relied on 3 alternative arguments summarised at [30].

However, for the purposes of this article, I will focus only on the last argument, which was that a new duty of care should be found to exist. That new duty was summarised at [158] as *"a duty to balance the Claimant's interest in being informed of her risk of a genetic disorder against her father's interest in having the confidentiality of that diagnosis preserved."*

The duty contended for was limited to serious genetic conditions and first-degree relatives. Furthermore, the standard of care would be measured by reference to the well-known principles set out in the *Bolam and* Bolitho cases. The Claimant's case was that, having balanced the respective interests, the only right outcome was disclosure.

Proximity and foreseeability of harm

Yip J went on to recognise that in previous cases, the courts had recognised that doctors may owe duties to multiple people, not just their own patients, but that such a duty may only arise where there is a proximal relationship between the claimant and defendant.

At [171], Yip J found that there was no proximal relationship between D1, including the geneticists, and ABC. They knew of ABC's circumstances but no more, and only met ABC's father in October 2009. Likewise, the claim against D3, the social worker, fell away.

The issue was therefore as to the existence of a duty between ABC and D2. At [173] to [174] Yip J found that there was both proximity and foreseeability of harm between ABC and D2:

"As I have found, the claimant was a patient of the second defendant. Although I have found that the decision whether to provide her with information about her genetic risk lay outside the scope of the duty owed to her in the context of family therapy, her participation in the family therapy is an important part of the factual matrix. The second defendant's clinicians had a significant amount of information about the claimant and her circumstances. They knew that she had suffered psychological harm as a result of her father's offence and was in a vulnerable situation. They were working with her to help her understand and come to terms with the offence. They were also anticipating that she would support her father in the community and had previously shared medical information with her. They also knew that the claimant had very little support available to her. They knew of the family dynamics. Her mother had been killed and her sister was struggling with her own situation. They knew the claimant was not in a settled relationship. There was a direct line of communication with the claimant. Had they decided to disclose the information to her, the family therapy team offered a route to do so in a supportive environment. In those circumstances, there was a close proximal relationship between the claimant and the second defendant.

That the claimant was at risk of suffering harm if the information about her genetic risk was withheld from her was not only foreseeable, it was actually foreseen by the second defendant. That is clear both from the medical records and the evidence of the defendants' witnesses at trial. Dr Olumoroti accepted in cross-examination that he had thought it might be harmful to the claimant if information was kept from her. He said he had discussed that with XX.

Fair, just and reasonable

As to whether it was fair, just or reasonable to impose a duty, this was considered at [176] to [188]. The Defendant advanced a number of policy reasons as to why it would not be fair, just and reasonable to impose a duty:

> *"i) The stark and direct conflict with the duty of confidence owed to XX, rendering doctors and healthcare professionals liable to be sued whatever decision they reached.*
>
> *ii) The negative impact the imposition of such a duty would have on the duty of confidence and, in turn, the relationship of trust and confidence between doctors and patients.*
>
> *iii) Third parties may not wish to receive the confidential information or may suffer harm as a result of receiving it. It would be difficult for a doctor to weigh that risk in the case of a non-patient.*
>
> *iv) It is unclear how far the duty would extend, and it would potentially have enormous resource implications for the NHS.*
>
> *v) There is no need for the law to impose a legal duty where a professional duty already exists."*

Each argument was considered, and rejected, by Yip J. As to (i), she noted that it was already recognised that the duty of confidence was not absolute and, in these situation, doctors were already at risk of being sued whichever decision they took. She found at [178] that the courts would likely "*allow considerable latitude to clinicians faced with the dilemma of conflicting obligations."* She rejected (ii) at [179], again noting that the duty of confidence was already not absolute, and this had not damaged the relationship of trust and confidence between patients and doctors.

As to (iii), at [180] Yip J noted that this issue simply did not arise on the facts of the present case. Furthermore, she commented that post-Montgomery, the paternalistic viewpoint that doctors could withhold information for the patient's own benefit was no longer good law and that, if the Defendants had found out the information about C's genetic risk in the context of their own patient/doctor relationship to her, they would have been bound to tell her and could not have withheld that information.

As to (iv), Yip J rejected [182] the argument that recognition of this duty could open the 'floodgates'. She noted that the facts of this particular case were very unusual and *"recognising a duty to her is nowhere near the giant leap that might be required to recognise a duty to multiple relatives around the world."*

Furthermore, she rejected at [183] the argument that imposition of the duty would use up NHS time and/or resources. As encapsulated by one of the doctors involved, "*Arguably, the time and resources spent in not informing ABC were in the instance much greater than had she been informed as part of the relationship she already had.*"

At [184] Yip J also refused to limit the imposition of the duty of care to genetic cases. As she noted at [184], other clinicians in other disciplines come across information which may reveal a serious risk to another person, and there is no reason to treat genetic information differently. At [185] she found that: *"the need for close proximity before a doctor is found to owe a duty to any person outside the immediate doctor-patient relationship acts as sufficient restraint on uncontrolled extension of the duty of care owed by medical professionals."*

As to the final argument, (v), Yip J found at [186] that, contrary to the Defendants' submission "*Imposing a legal duty which is consistent with the professional guidelines acts to enforce the guidance and potentially allows an injured party to recover compensation where their interests have not been properly considered in line with that guidance."*

She also noted that [187] that recognition of a duty in this case would be consistent with Article 8 ECHR, which encompasses both the right to medical confidentiality and a right to medical information about oneself and reproductive autonomy. Thus "*recognising a common law duty to both parties to conduct a proper balancing*

exercise in accordance with the professional guidance is consistent with the way in which the law has developed to take account of the Convention."

Finally, at [188], Yip J found that "*it is fair, just and reasonable to impose on the second defendant a legal duty to the claimant to balance her interest in being informed of her genetic risk against her father's interest in preserving confidentiality in relation to his diagnosis and the public interest in maintaining medical confidentiality generally."*

If a duty exists, what is the standard of care?

She explained that the *Bolam* and *Bolitho* tests would be applied by a court in deciding whether the duty had been breached, noting at [193] and [194] that:

"If a defendant has conducted a balancing exercise properly in accordance with the professional guidance and has reasonably concluded that disclosure should not be made, they will have discharged their duty. No liability can then arise even though others may have taken a different view, allowing considerable latitude to clinicians faced with a difficult decision where the competing rights of two individuals are concerned. The courts will also recognise that taking a decision of this nature in the course of day-to-day clinical practice is very different from taking a decision after several days of evidence and submissions in the Royal Courts of Justice.

If a defendant has not conducted a proper balancing exercise (applying the Bolam test), the court will have to go on to consider what the defendant would have done if the exercise had been properly performed. If, on a balance of probabilities, the defendant would have disclosed, a potentially actionable breach will be made out. If the defendant would not have disclosed, the court will have to consider whether such a decision would have been negligent, in the sense that no responsible body of medical opinion would have supported it (applying Bolitho.)"

Was the duty and standard of care breached?

At [197] Yip J considered whether the duty of care was breached, such that the Claimant should have been told of genetic risk while she was pregnant.

She considered in detail the evidence of a number of different professionals, some of whom considered that disclosure was the only reasonable option, and some of whom supported the decision taken not to disclose. Ultimately, Yip J found at [231] that there was no breach of duty:

"In short, this was a difficult decision which required the exercise of judgment. The relevant guidelines for psychiatrists made it clear that confidentiality should not be breached unless the doctor was certain that this was in the public interest. The GMC guidelines supported breaching confidentiality to avert a risk of death or serious harm. There was room for reasonable disagreement as to how the judgment should be exercised. That is demonstrated by the lack of consensus in the medical opinion before me. The claimant has not demonstrated that the views of the defendants' experts are illogical. I therefore conclude that the decision not to disclose was supported by a responsible body of medical opinion and cannot be considered to have amounted to a breach of the duty I have identified."

Furthermore, the judge noted that, although she had placed little weight on it, the Defendants were entitled to point out that the Claimant, upon finding out about the genetic risk, decided not to inform her pregnant sister. She commented at [232]: *"It does seem to me that it would be unduly harsh to hold the second defendant liable in negligence for reaching the same decision as the claimant did in relation to her sister."*

Causation

Although the judge had found no breach of duty, she independently went on to consider the issue of causation i.e. whether, on a balance of probabilities, the claimant would have terminated her pregnancy if the genetic risk had been disclosed to her.

The evidence before the judge established that, in the hypothetical scenario where the Claimant had been told about the genetic risk, she would have had to undergo testing and counselling incredibly quickly to establish whether she was carrying the genetic mutation, in order to have sufficient time to terminate the pregnancy.

The judge found that it was unlikely that the Claimant would have acted so quickly. In particular, Yip J took account of how the Claimant behaved when her sister became pregnant noting at [245] that: *"It appears inconsistent for the claimant to say that she would have reacted to being told during her pregnancy by immediately requesting testing, yet for her not to insist her pregnant sister be immediately informed so that she could be tested during pregnancy."*

Overall, the judge found that, on the balance of probabilities, if the Claimant had found out about her father's condition in October 2009, it is unlikely that she would have terminated her pregnancy, and therefore the Claimant also lost on the issue of causation.

Comment

This fascinating judgment raises a wide range of issues. It arguably represents a loss for all involved – the Claimant as she was unable to establish a breach of duty or causation – and the Defendants, as the court found that a duty of care did exist, albeit it was not breached.

In an area of clinical judgment as contested as disclosure to non-patients, it will inevitably be difficult for Claimants to establish that the only responsible decision was to disclose. This may mitigate some of the fear amongst medical professionals that *ABC* opens up the floodgates to litigation. Furthermore, Yip J emphasised a number of times the fact that her decision was confined to the somewhat unusual factual situation of the present case, in which there was a close relationship between D2 and the Claimant which arose on the particular facts. Each case will require close consideration of those facts before any duty can arise.

1COR members Philip Havers QC and Hannah Noyce acted for the Defendants and Lizanne Gumbel QC acted for the Claimant. They were not involved in the writing of this article.

THE STANDARD OF CARE IN PURE DIAGNOSIS CASES

Thomas Beamont

Brady v Southend University Hospital NHS Foundation Trust [2020] EWHC 158 (QB)

In the bulk of actions for clinical negligence, the standard of care owed to the patient is one point which attracts relatively little judicial consternation. In *Brady*, and cases involving 'pure diagnosis', not so.

Facts

The Claimant had undergone an appendectomy for acute appendicitis in May 2013. She attended her GP in August with acute epigastric pain and, following a referral, underwent a CT scan on 5 August 2013. The consultant radiologist reported "*omental infarction".*

On 18 September 2013, the Claimant was reviewed again and a "*craggy lump*" was noted in her upper abdomen. A second CT scan was performed and discussed by the consultants in surgery and radiology. The scans were sent for review by a specialist at the Royal Free Hospital who had advised that it appeared "*like omental infarction*." As a result, the Claimant did not require an urgent gastroscopy. She was discharged home following improvement with antibiotics.

On 16 February 2014 the Claimant attended A&E with complaint of abdominal pain and vomiting. A CT scan the following day and associated investigations revealed an infection. A consultant in infectious diseases wrote to the Claimant's GP that she was *"noted to have what, at the time, was thought to be an omental infarction although with hindsight possibly were deposits of infection."*

The Claimant's case on breach of duty was that the first and second CT scans showed an actinomycosis infection, and not an omental infarction. This negligent diagnosis led to a further negligent failure to arrange a biopsy. The Defendant's case was that the Claimant probably had two conditions: an omental infarction, and actinomycosis, but that the conclusion reached of omental infarction was reasonable.

The legal background

The judge began by reciting the classical statement of the standard of care required of a doctor as set out by McNair J in *Bolam v Friern HMC* [1957] 1 WLR 582:

"[The doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art…"

As is well known, this was refined by Lord Browne-Wilkinson in *Bolitho v City and Hackney HA* [1998] AC 232: respectable minority practice must have a sound and logical basis.

However, as HHJ Andrew Lewis QC observed in *Brady*, the Bolam test and its refinement in Bolitho concerned 'treatment cases', in which a doctor recommends, or undertakes, treatment or further diagnostic procedures. In those cases there may be a reasonable range of treatment. By contrast, a diagnosis on review of a scan is, usually, either right or wrong:

"In [treatment] cases, there are often choices and options available and risks and benefits that need to be considered. However, it has been recognised that in some areas of medical practice, such as radiology or histopathology, there should be limited scope of any genuine difference of opinion. A diagnosis based upon a scan is usually right or wrong. In these "pure diagnosis" cases, there is no weighing of risks against benefits, and no decision to treat or not to treat, just a diagnostic or pre-diagnostic decision, which is either right or wrong, and either negligent or not negligent." (at [23]).

Notwithstanding these evident concerns, the judge observed that he was bound by Court of Appeal authority in *Penney v East Kent HA* [2000] Lloyds Rep Med 41, which concerned a failure to diagnose cancerous cells in cervical smear tests.

At first instance, the judge in *Penney* found that the Bolam test was "*ill-fitting to the facts of Mrs Penney's case".* The Bolam test applies where experts hold differing views as to acceptable medical practice. As the experts agreed that the interpretation was wrong, no question of acceptable practice arose. However, the judge went on to say that if he were wrong about that, the opinion of the defendant's expert on breach of duty could not withstand logical analysis, and therefore fell within the Bolitho exception.

However, counsel in the Court of Appeal agreed that the Bolam and Bolitho tests applied, and Lord Woolf, giving the judgment of the majority, did not take the opportunity to consider the merits of the comments to the contrary of the judge below. Accordingly, there were three questions to be asked:

1. What was to be seen on the slides?
2. At the relevant time could a screener exercising reasonable care fail to see what was on the slide?
3. Could a reasonably competent screener, aware of what a screener exercising reasonable care would observe on the slide, treat the slide as negative?

Importantly, the first question is a question of fact, to which the Bolam test has no application. The second and third questions are to be analysed by reference to the Bolam test, as refined by the Bolitho exception.

Disposition of Brady

Turning to the facts of *Brady*, the judge conducted a careful analysis of the experts' evidence and found that the scans in August and September showed an infection. Their reporting was therefore wrong.

However, the conduct of the radiologist reporting the August CT scan was not negligent. At that stage of the Claimant's illness he had a proper basis for his opinion which was supported by radiological appearances.

So too in respect of the September CT scan: while her report was "*sub-optimal*" as it failed to identify differential diagnoses, it provided a *"clear view from a radiological perspective*" of further investigations which were required. The fact that she had discussed the scan with the consultant surgeon "*cured*" the criticism that her report failed to identify that the previous working diagnosis of omental infarction was by that time less likely than before.

Finally, the alleged negligent failure to carry out a biopsy was not made out: it was reasonable to have taken a second opinion from clinicians at the Royal London Hospital.

Comment

Brady raises interesting issues, both legal and practical.

As the judge observed, the adequacy of the Bolam/Bolitho test in relation to 'pure diagnosis' cases has been doubted. The judge cited at length the comments of Kerr J in *Muller v Kings College Hospital* [2017] EWHC 128 (QB), a claim where a pathologist had failed to recognise a malignant melanoma following a biopsy. While he was bound by *Penney* to adopt a Bolam/Bolitho analysis, he did so "*with regret*". As Kerr J simply put, in 'pure diagnosis' cases *"the experts expressing opposing views on that issue cannot both be right."* The judgment in *Brady* arguably demonstrates similar unease.

As judicial discomfort with the application of the Bolam/Bolitho tests in 'pure diagnosis' cases is something of a recurrence, it is perhaps unfortunate that the Court of Appeal in *Penney* was not in a position to deal with the concerns of the judge below. The standard of care owed to patients has been considered by the higher courts in recent years: in relation to consent, and duties owed by non-clinical staff, as the most prominent examples. This issue might benefit from appellate consideration.

More practically, two points emerge. The first is the curative role played by discussion with colleagues of the September 2013 scan and its proper documentation. The second is the importance of referral to a different hospital for further investigations in rendering the failure to perform a biopsy non-negligent.

For now, clinicians can be reassured that an incorrect diagnosis will not constitute a breach of duty if its diagnosis would be supported by a responsible body of their peers.

"THE RACE IS NOT (YET) TO THE SWIFT": WITH APOLOGIES TO ECCLESIASTES 9:11

William Edis QC

So *Swift v Carpenter* rumbles on. The restrictions imposed during the Covid-19 pandemic have meant that the adjourned appeal of 24 July 2019, due for hearing on 23 March 2020 and listed for four days, has been postponed. The appeal is now due to start remotely on 22 June 2020. The Court of Appeal has ruled, however, on whether the Claimant was entitled to a Protective Costs Order pursuant to s 51 of the Senior Courts Act 1981 and CPR part 44.4.

To recap, the Claimant called no evidence at a trial designed to undermine the decision in *Roberts v Johnstone ("R v J")*, a fact noted in the judgment by Lambert J. The trial judge considered herself bound by *R v J* and declined to award any damages in respect of the cost of purchasing suitable accommodation but also found, no doubt in case of a successful appeal, that those costs amounted to £900,000. She herself gave permission to appeal and the Claimant duly took up the invitation.

At the hearing in July 2019 the Appellant's primary position was that additional evidence - or indeed evidence at all - was not required for a just resolution of the appeal but, in case this were wrong, she sought to admit the

evidence of an actuary expert in valuing reversionary interests. His evidence had only been obtained after the first instance decision.

The Respondent opposed the admission of this fresh evidence but, in the result, the court allowed expert evidence and acceded to the Appellant's application for an adjournment. Currently the parties have permission to call evidence from an actuary, a valuer, an economist, a chartered surveyor and an IFA. The Intervener, PIBA, is also allowed to adduce evidence.

In November 2019 the Appellant applied for a Protective Costs Order, the effect of which would have been to protect her against any costs liability to the Respondents for costs incurred after the date when the appeal was originally listed. In essence her argument was that the issue was of wide and considerable importance and that continuing uncertainty was detrimental to the community of claimants needing special housing, insurers meeting such claims, lawyers handling the claims and others (presumably including NHS Resolution). She gave various eye-watering estimates of the costs incurred and to be incurred since July 2019 in support of a submission that an adverse costs award would either wholly consume or at the very least substantially erode any damages she may be awarded and therefore leave her legitimate needs, caused by the fault of another, unmet. She argued too that the expansion of the appeal to include many experts had made it a much longer and consequently more expensive hearing, something she had not anticipated. It was accepted that the QOCS regime applied to both first instance hearing and appeal.

The Decision

In *R (Corner House Research) v Secretary of State for Trade and Industry* [2005] EWCA Civ 192 the Court of Appeal set out the circumstances surrounding the making of a PCO, which were that:

1. A protective costs order may be made at any stage of the proceedings, on such conditions as the court thinks fit, provided that the court is satisfied that:
    i. The issues raised are of general public importance;
    ii. The public interest requires that those issues should be resolved;
    iii. The applicant has no private interest in the outcome of the case;
    iv. Having regard to the financial resources of the applicant and the respondent(s) and to the amount of costs that are likely to be involved it is fair and just to make the order;
    v. If the order is not made the applicant will probably discontinue the proceedings and will be acting reasonably in so doing.
2. If those acting for the applicant are doing so pro bono this will be likely to enhance the merits of the application for a PCO.
3. It is for the court, in its discretion, to decide whether it is fair and just to make the order in the light of the considerations set out above.

Clearly precondition (iii) set out in paragraph 1 is the one most relevant to the present case as the Claimant has a very significant financial interest in the outcome of the appeal and no doubt would not be pursuing the appeal otherwise. The court also found, however, that she would not discontinue her appeal if no PCO were made but might feel constrained by fear of costs to settle her claim in advance for less than it was truly worth. There was no great discussion of the impact of the fifth precondition.

In *Swift* the court approved and held itself bound by the decision in *Eweida v British Airways plc* [2009] EWCA Civ 1025. This was an appeal from the Employment Appeal Tribunal, a no costs jurisdiction. In *Eweida* it was decided that a PCO could not be made in a private law claim even if the subject matter of the claim was of general importance. Reliance was placed on observations by Hoffmann LJ in *McDonald v Horn* [1995] ICR 685 to

the effect that the normal rule that costs would follow the event was a "formidable obstacle" to a PCO in a private law claim. In *Eweida* Lloyd LJ said at [38]:

"In my judgment, the court cannot make a PCO in this case. This is not public law litigation, but a private claim by a single employee against her employer. A PCO cannot be made in private litigation."

Eweida was followed in *Jolyon Maugham v Uber Limited* [2019] EWHC 391 (Ch) where the claimant sought a VAT invoice from Uber for a trip that cost him £6.34 and then sued when he was refused one. His motive was of course not financial but instead a desire to bring to light, and thus no doubt to stop, "*financially meaningful tax avoidance*" in the UK. The public interest lay in the exposure of Uber's alleged mischaracterisation of its relationship with drivers and HMRC's inactivity in the face of that mischaracterisation and in preserving public confidence in the taxation system. He had made a tactical decision to proceed via a private law claim rather than an application for judicial review. Indeed, the Court in *Maugham* noted that whilst the case was no doubt of some public importance it raised no issues of public law or at least none that was readily ascertainable. No PCO was made as this was private litigation.

There is thus a distinction between private law actions, where no PCO may be made, and public law claims where it remains possible though exceptional order. What then is the yardstick by which one may judge whether a public law claim will qualify? The words of Dyson J (as he then was) in *R v Lord Chancellor ex p CPAG and others* [1999] 1 WLR 347, 353 provide a useful starting point. In that case he said:

"I should start by explaining what I understand to be meant by a public interest challenge. The essential characteristics of a public law challenge are that it raises public law issues which are of general importance, where the applicant has no private interest in the outcome of the case. It is obvious that many, indeed most judicial review challenges, do not fall into the category of public interest challenges so defined. This is because, even if they do raise issues of general importance, they are cases in which the applicant is seeking to protect some private interest of his or her own." [Emphasis added to the original].

So, the absence of a defined stake in the outcome of the litigation, other presumably than that which flows from simply being a member of society, may be crucial.

Those thinking of applying for a PCO should also heed the cautionary tale of this case. Although the possibility of applying for a PCO had been raised at the adjourned hearing of July 2019 no application was in fact made until November of that year. The Court of Appeal said that even if it had held that there was reason otherwise to make a PCO it would nevertheless have refused one on the ground of delay. At [49] it said:

"If a party wishes to have the protection of a PCO, the application must be made as soon as possible as its existence will be highly likely to have a material effect on decisions by the other party as to the incurring of costs and the making of offers of settlement."

CONSENT AND CAUSATION

Judith Rogerson

Pepper v Royal Free London NHS Foundation Trust [2020] EWHC 310 (QB)

The Claimant alleged that she unnecessarily underwent a laparotomy and Whipple's procedure, an operation undertaken to remove cancerous tumours from the head of the pancreas. The procedure was carried out as it was believed that she was suffering from pancreatic cancer. In fact there was no malignancy and she instead had pancreatitis and cholecystisis. As a consequence of the pancreatic resection the Claimant had developed a range of problems including maldigestion, disturbance to bowel function, and weight loss. The question for the court to decide was whether the Claimant had properly given her consent for such surgery.

The outcome of the case largely turned upon the facts concerning what the Claimant was advised by the surgeon and how she reacted to that advice. In many consent cases it is an uphill task for the Defendant to persuade the court that the Claimant would not have consented to surgery had alternative advice been provided. Interestingly, this was an issue considered in some detail in the present case.

The claim was dismissed following a liability only trial in the High Court before Geoffrey Tattersall QC.

Background

The Claimant attended hospital with right abdominal pain. Following various investigations it was suspected that she was suffering from a malignant tumour of the pancreas. She was advised to undergo the surgery which was performed several months later. During the procedure an intra-operative biopsy was negative for tumour, but the surgeon nevertheless continued to the Whipple's procedure after concluding that the head of the pancreas felt hard. Subsequent histology confirmed that there had been no malignancy.

The key issue for the Court was whether the Claimant's consent to the Whipple's procedure was contingent on evidence of malignancy during the intraoperative biopsy or whether this could proceed also in circumstances where the surgeon concluded that the appearance of the pancreas was very suspicious. The Claimant's case was that she would not have undergone the Whipple's procedure had she received appropriate advice and treatment. She claimed that, had there been a further period of observation, the abnormality would have resolved, and she would not have undergone any surgery.

The Law

The Claimant relied upon the well-known decisions on consent of *Chester v Afshar* [2004] UKHL 41 and *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, the former dealing with when justice might require a modification of the normal approach to causation and the latter which set down the test of 'materiality' defined as, "*…whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.*"

Both *Chester* and *Montgomery* have proved to be highly controversial, both departing from previously well-established principles and placing a particular emphasis on patient autonomy: one in the context of the scope of the duty of care, the other in respect of causation.

The Court also considered authorities such as *R (Bancoult) v Secretary of State for Foreign and Commonwealth Affairs (No 3)* [2018] 1 WLR 973 dealing with the importance of contemporaneous documents as compared to oral witness evidence.

Judgment

The Court considered in detail the factual background to the claim, focusing on what advice the Claimant was given about her condition and the appropriate treatment.

When making findings of fact the court kept in mind the role of a doctor to ensure that a patient understands the serious consequences of their condition, the treatment options, the risks of undergoing or not undergoing treatment and the patient's right to make an informed decision as to whether to undergo that treatment. A doctor should provide sufficient information in an appropriate manner to enable the patient to make an informed decision. In his judgment Geoffrey Tattersall QC said that, "*…the law does not require a court to micromanage the words used by a doctor to a patient provided that they do not involve putting a patient under pressure to accept a certain form of treatment.*"

There was careful consideration as to whether the language used to advise the Claimant placed too much pressure on her to undergo surgery. The judge decided that, "*Although in other situations it might be considered that the use of such language was inappropriate, I have no doubt that it was fully justified on the facts of this case to emphasise to the Claimant the gravity of her situation.*" It was held that the surgeon, "*would have been*

failing in his duty if he had not used such stark language when he believed that the Claimant did not fully appreciate the gravity of her situation."

When it came to the issue of consent, the judge found that the surgeon did not say that intra-operative biopsies were unreliable, however, he was also satisfied that the Claimant was already aware of this from other experiences. It was also found as a matter of fact that the surgeon had explained that, even if the biopsy was negative, it could not be assumed that the Claimant did not have pancreatic cancer such that he reserved the right to perform a Whipple's procedure.

As a result, it was held that the Claimant had given her consent to the Whipple's procedure if the intra-operative biopsy was positive *or* if the surgeon had found a very suspicious appearance on examining the pancreas.

The judgment also considers the evidence given by the parties' respective experts, in particular with regards to the risks of which the Claimant should have been warned prior to consenting to surgery, the efficacy of intra-operative biopsy and whether, in light of that advice, she would still have consented to the surgery.

The gravity of a diagnosis of pancreatic cancer was recognised by all parties. It was found that the Claimant would have been risk-averse to waiting to see if the pancreatic lesion grew to such an extent that cancer became inoperable rather than undergoing surgery which, if there was no cancer, would leave her with unnecessary disabilities.

The judge concluded that the Claimant should have been advised that the risk of malignant pancreatic cancer "*was greater than 50% and probably significantly more*" and that, "*I have absolutely no doubt that in these circumstances she would have consented to surgery.*" It was also found that, whilst the surgeon had conceded that he had not given the Claimant the percentage risks of a Whipple's procedure, "*…on the facts of this case no further explanation in percentage terms as to each risk of such procedure would have assisted the Claimant or might have persuaded her not to consent to the procedure in the manner she did.*"

HOW TO IMPROVE PATIENT SAFETY POST-PATERSON

Charlotte Gilmartin

Report of the Independent Inquiry into the Issues raised by Paterson

The report of the Independent Inquiry into the case of surgeon Dr Ian Paterson was published on 4 February 2020. It makes for harrowing reading.

One of the Inquiry's key aims was to review what went wrong and why at a systemic level, in effect using patients' experiences of Dr Paterson's malpractice as a "case study" for wider learning. This was in order to make recommendations in relation to improving safety and quality of care in relation to all patients. Such a task is particularly challenging given the finding of the Inquiry that "*there were many regulations and much guidance in place during Paterson's years of practice. It is significant that a lot of these were disregarded or ignored by Paterson and others. There is no single legislative or regulatory fix which would ensure safety for all patients in the future*" [p218].

How then, to ensure that it could not happen again?

Background to the Inquiry

Dr Paterson was trained as a general surgeon but was appointed as a specialist breast surgeon in 1998 at Solihull Hospital, part of the Heart of England NHS Foundation Trust (HEFT). He also practised as a surgeon in the independent sector and treated a large number of private patients at Spire Parkway Hospital. Serious questions were raised about his surgical procedures and practices in 2003; he was suspended by HEFT in 2011 and Spire suspended his right to practise at its hospitals later that year.

In April 2017, he was convicted of 17 counts of wounding with intent and three counts of unlawful wounding relating to nine women and one man, receiving a prison sentence of 20 years.

Many of his patients felt that there were still questions about his malpractice which were unanswered. A non-statutory inquiry was therefore commissioned in December 2017 to investigate Paterson's malpractice and to make recommendations to improve patient safety.

The terms of reference were broad, allowing for consultation with patients and others to shape the scope of the Inquiry's work. In total, 211 patients or their relatives gave evidence. Their accounts are set out in detail in chapter three of the report [at pp 11 – 97]. In the words of the Inquiry Chair, Bishop Graham James, they tell "*the story of a healthcare system which proved itself dysfunctional at almost every level when it came to keeping patients safe, and where those who were victims of Paterson's malpractice were let down time and time again*" [p1].

Findings of the Report

Chapters four, five, six and seven of the report present the Inquiry's findings in four key areas: safety and quality of care; responding when things go wrong; working with others to keep patients safe; and governance, accountability and culture. The Inquiry's recommendations to Government are at chapter eight, and can be summarised as follows:

Information to Patients:

1. There should be a single repository of information about consultants across England, which is accessible and understandable to the public, setting out their practising privileges and other performance data including the number of times they have performed a procedure and how recently.

2. It should be standard practice that consultants working both in the NHS and privately write to patients outlining their condition and treatment in simple language, copying in their GP, rather than the other way around.

3. Differences in NHS and private treatment should be clearly explained to patients who are treated privately, and to those who are treated in the private sector but whose care is funded by the NHS. This information should include clarification of practising privileges, indemnity, and arrangements for emergency care.

Consent

4. There should be a short period introduced into the process of patients giving consent for surgical procedures to allow them time to reflect on their diagnosis and treatment options. The GMC should monitor this as part of "Good Medical Practice."

Multidisciplinary Team (MDT)

5. Every patient with breast cancer should have their case discussed at an MDT meeting, in line with up-to-date national guidance.

6. The CQC should, as a matter of urgency, assure itself that all hospital providers are complying effectively with up-to-date national guidance on MDT meetings, including in breast cancer care, and that patients are not at risk of harm due to non-compliance.

Complaints

7. Information about the means to escalate a complaint to an independent body should be communicated more effectively in both the NHS and independent sector. All private patients should have the right to mandatory independent resolution of their complaint.

Patient Recall and ongoing care

8. The University Hospitals Birmingham NHS Foundation Trust Board should check that all patients of Paterson have been recalled, and to communicate with any who have not been seen. Spire should check all patients of Paterson have been recalled and communicate with any that have not been seen.

Improving Recall procedures

9. A national framework or protocol with guidance should be developed, setting out how recall of patients should be managed and communicated.

Clinical Indemnity

10. The Government should, as a matter of urgency, reform the current regulation of indemnity products for healthcare professionals and introduce a nationwide safety net to ensure patients are not disadvantaged.

Regulatory System

11. The Government should ensure that the current system of regulation and collaboration of regulators serves patient safety as the top priority, given the ineffectiveness of the system identified by the Inquiry.

Investigating Healthcare Professionals' practice and behaviour

12. When a hospital investigates behaviour, any perceived risk to patient safety should result in the suspension of that professional. If that professional works at another provider, any concerns about them should be communicated to that provider.

Corporate Accountability

13. The Government must address as a matter of urgency the gap in responsibility and liability.

14. When things go wrong, hospitals should apologise at the earliest stage of the investigation and should not hold back for fear of the consequences in relation to liability.

Adoption of the Inquiry's Recommendations in the Independent Sector

15. If the Government accepts any of the recommendations concerned, it should make arrangements to ensure that these are to be applicable across the whole of the independent sector, if independent sector providers are to qualify for NHS contracted work.

Next Steps

Many of the recommendations target regulatory structures and call for national frameworks or guidance touching the healthcare sector generally, suggesting that statutory reform may be required if they are to be implemented. Notably, the report highlights the current regulation of indemnity products as a candidate for change, as well as recommending reform of regulation and collaboration of regulators.

Steps have already been taken by the Independent Health Providers Network (through its Medical Practitioners Assurance Framework) to improve consistency of clinical governance across the independent sector, notably by setting out expected practice for healthcare providers and medical practitioners in relation to patient safety, clinical quality, and raising and responding to concerns.

However, the recommendations made by the Inquiry will remain pertinent. The Chair of the Inquiry sadly notes in his opening statement to the report that "*thousands of people are still living with the consequences of what happened. It is wishful thinking that this could not happen again*", and the scale of the change which is recommended suggests that there will be incremental reform on a long term basis.

Upon the report's release, Nadine Dorries commented that the "*sensible*" recommendations presented a "*route-map*" for government upon its publication. Unfortunately, there has been delay in the Government providing a formal written response to the proposals, explained by the Department of Health and Social Care on 28 April 2020 to have arisen as a result of "*diverted resources*" caused by the COVID-19 crisis. Notwithstanding, the report provides a framework for large scale change to healthcare regulation, and its impact will need to be closely monitored as the response to its findings takes shape.

TRANSGENDER FATHERS AND BIRTH CERTIFICATES

Charlotte Gilmartin

R (McConnell and YY) v Registrar General [2020] EWCA Civ 559

The Court of Appeal has revisited the tension between the wish of a transgender person to have their legal gender recognised on their child's birth certificate and the right of the child to discover the identity of their biological mother.

Alfred McConnell was assigned female at birth but is legally recognised as male, as confirmed by a Gender Recognition Certificate issued in April 2017. Subsequent to his recognition as male, he became pregnant through inter-uterine insemination using donor sperm and gave birth to YY. When he came to register the birth, the Registrar General determined that Mr McConnell would have to be registered as YY's "*mother*".

Mr McConnell unsuccessfully attempted to judicially review this decision before the President of the Family Division sitting in the Administrative Court. Judgment was handed down on 25 September 2019. I explain the outcome of the judicial review in detail in Issue 3 and in this podcast.

The President held that the status of being a "*mother*" arises from the role that a person has undertaken in the biological process of conception, pregnancy and birth, a definition which was not necessarily gender specific. The relevant provisions of the Gender Recognition Act ("GRA") did not affect the status of a person as the father or mother of a child, such that Mr McConnell was to be registered as "*mother*". While the impact of the UK legislative scheme interfered with the Article 8 rights of both Mr McConnell and his son YY, this was justified, so there was no breach of Article 8 in relation to either parent or child (see by way of summary, [279]-[283] of the first instance decision).

On 29 April 2020, the Court of Appeal unanimously dismissed the Appellants' appeal, respecting what it described as the view taken by Parliament that "*every child should have a mother and should be able to discover who their mother was*", which took in to account the best interests of children "*as a primary consideration*" [86]. The legislative scheme of the GRA required Mr McConnell to be registered as the mother of YY, rather than the father, parent or gestational parent. That requirement did not violate his or YY's Article 8 rights and there was no incompatibility between the GRA and the Convention.

The Court of Appeal decision focuses on two key issues: (i) the correct interpretation of sections 9 and 12 of the GRA; (ii) whether this is compatible with the rights protected by the European Convention on Human Rights.

1) Statutory Interpretation

Sections 9 and 12 GRA read as follows:

> *"9 General*
>
> *(1) Where a full gender recognition certificate is issued to a person, the person's gender becomes for all purposes the acquired gender (so that, if the acquired gender is the male gender, the person's sex becomes that of a man and, if it is the female gender, the person's sex becomes that of a woman).*

> *(2) Subsection (1) does not affect things done, or events occurring, before the certificate is issued; but it does operate for the interpretation of enactments passed, and instruments and other documents made, before the certificate is issued (as well as those passed or made afterwards).*
>
> *[...]*
>
> *12 Parenthood*
>
> *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."*

The Appellants argued that section 12 could only have retrospective effect, such that the issue of a gender recognition certificate would not affect the status of a person as being either mother or father of a child only if that child was born before the certificate was issued. The Respondents argued that it could have both retrospective and prospective effect.

The Court of Appeal held that it was clearly correct that section 12 GRA had retrospective and prospective effect, as held by the High Court. The ordinary meaning on the face of the provision was not limited to events occurring before a certificate was issued; to hold otherwise would render section 9(2) of the GRA otiose; the wording of section 12 was similar to wording in other sections of the GRA which mark out exceptions to the effect of a gender recognition certificate; and where Parliament had wished a section to have only retrospective effect, it had made that express [28] – [33].

The Appellants endeavoured to persuade the court that it should interpret the legislation in line with contemporary moral and social norms. In response, the Court of Appeal held that the High Court had already made clear that "*mother*" meant a person who gives birth to a child, rather than it being a gender-specific word. Further, if the argument was that "*mother*" should be construed as "*father*", that would offend against statutory principles of construction. If the argument was that "mother" should be replaced by a new term such as *"gestational parent*", that would amount to judicial legislation. [35].

2) Convention Rights Analysis

The court recognised that this meant that the state required a trans person to declare in a formal document that their gender is not their current gender but that assigned at birth, which represents a significant interference with their sense of identity [54] – [55]. However, the court accepted that there was a legitimate aim, namely protecting the rights of others, including any children who are born to a transgender person, and the maintenance of a clear and coherent scheme of registration of births. As to proportionality, the key debate surrounded whether less intrusive means were available to achieve the objective, and whether a fair balance had been struck between the rights of the individual and the general interests of the community (i.e. limbs (iii) and (iv) of the proportionality test as set out in *Bank Mellatt v HM Treasury (no2)* [2012] UKSC 39 at [20] and [74].

The court stressed that *"there are many inter-linked pieces of legislation which may be affected if the word "mother" is no longer to be used to describe the person who gives birth to the child."* Importantly, that word is used in section 2(2)(a) of the Children Act 1989 which provides that a mother has automatic parental responsibility from the moment of birth.

The word "*parent*" also has a distinct statutory meaning. When addressing the status of a person who gives birth to a child but who is not genetically related to them, by virtue of a surrogacy arrangement or because there has been a method of conception such as *in vitro* fertilisation, the policy choice of Parliament was that the person who gives birth to a child is always described as the mother, even if, for example, it was not her egg which was fertilised [66]. Whereas a child can have more than one "*parent*", the law is clear that a child only ever has one mother - [67] in respect of IVF; [68] – [70] in respect of surrogacy, and [71] in relation to adoption.

Significantly, there is no decision of the Strasbourg Court which suggested the Appellants' interpretation was correct. The court noted that there was a case pending before the Strasbourg Court from Germany which

concerned similar facts. The German Federal High Court held that the legislative scheme required a registration of "*mother*", placing emphasis on the right of a child of a trans person to know their origins. In analysing Article 8, the Federal High Court emphasised the wide margin of appreciation left to contracting states relating to the legal recognition of trans identities and the absence of European consensus [73]-[77].

Interestingly, the Court of Appeal noted that whilst *"we cannot exclude the possibility that the Strasbourg court may disagree with the courts in Germany… we respectfully suggest that their reasoning is compelling. On any view, we should not pre-empt the Strasbourg decision."* [78].

Finally, the court held that in applying the Human Rights Act there is a "*margin of judgement*", analogous to the ECHR "*margin of appreciation*", whereby appropriate weight is to be given to the judgment of the executive or legislature depending upon the context [80]. A court has necessarily limited evidence with its focus limited to the parties before it. The Court highlighted that *"we have no idea, for example, whether all trans men object to the use of the word "mother"… it may be that some at least wish to have the automatic responsibility for the child to whom they have given birth which section 2 of the Children Act 1989 currently gives them… if there is to be reform of the complicated, inter-linked legislation in this context, it must be for Parliament and not for this Court."* This was further reinforced by the relative lack of democratic legitimacy of the courts by comparison to Parliament [81]-[82].

Next steps?

Mr McConnell has since indicated that he hopes to appeal to the Supreme Court. Given the movements at European level referred to in the Court of Appeal's judgment, there may well be significant developments in this field. Recent research suggests that many European countries presently assign parental status according to birth gender (see this paper at p 61, prepared for the European Network of Legal Experts in Gender Equality and Non-Discrimination in November 2018); however, it is clear that increasing pressure is being placed on such systems by the reality of transgender parenting. The concept of a "*margin of judgement*" employed by the Court of Appeal has compelling roots, but in the future, domestic courts may be empowered by developments at European level.

WASTED COSTS ARISING FROM EXPERT WITNESS' BREACH OF DUTY

Suzanne Lambert

Thimmaya v Lancashire NHS Foundation Trust [2020] PNLR 12

An expert witness had failed to fulfil his duty to the court under CPR 35 to provide competent expert evidence and therefore a wasted costs order was made against him for the Defendant Trust's costs from the date when the expert witness should have ceased to act, and the claim should have been abandoned.

Background

This claim for wasted costs arose from a clinical negligence case in which Mr Jamil (J), a consultant spinal surgeon, was instructed on behalf of the claimant (T). The clinical negligence claim proceeded to trial in the county court and J was called to give oral evidence in court in March 2019. During the course of cross-examination by counsel for the Trust, J "was wholly unable to articulate" the Bolam/Bolitho test for breach of duty to be applied in clinical negligence cases and admitted that he had only been involved in the type of surgery that gave rise to the index events on two occasions. Additionally, under cross-examination, it also emerged that J had been suffering from psychiatric difficulties which impaired his ability to give evidence and caused him to suspend his clinical practice from November 2017 before retiring completely in 2018. J had failed to give any notice of those matters to the court or the Claimant, however. T's claim was abandoned as a result of J's performance under cross examination, J being the only expert on whom she relied.

The Trust sought to recover its costs of defending the claim brought by T on the basis that J had breached his duty to the court under CPR 35 to provide competent expert evidence and pursuant to the GMC Guidance on Good Medical Practice.

Judgment

HHJ Evans held that J's inability to articulate the legal test for breach of duty was, on the balance of probabilities, because "*he did not know, was unable to recall, or could not apply the legal test, perhaps because of his general cognitive difficulties caused by his mental health problems*." Whether or not J knew the test, his psychiatric problems impaired his ability to perform as an expert and he should not have continued to act as an expert witness, whether in court or in writing or in conference, at a time when he was unable to work in his clinical practice as a result of his psychiatric difficulties. J should have taken sick-leave from his medico-legal practice at the same time as his clinical practice, but he failed to do so or even to inform T or her legal representatives of his condition.

J's failings amounted to *"improper, unreasonable or negligent conduct."* Therefore the jurisdiction to make a costs order against him was engaged and the test was the same as that which applied to wasted costs orders against legal representatives under s51(6) of the Senior Courts Act 1981.

Notwithstanding HHJ Evans's view that J was not a very good expert (his reports were neither well written nor well argued) and that he did not have a great deal of expertise in carrying out the particular operation, she did not go on to find that J's conduct and engagement were improper, unreasonable or negligent from the very outset of the case in order to justify making an order for costs against J on the basis that he should never have accepted the role of expert witness in the first place. She observed that there were "*plenty of not very good experts around*" and plenty of cases where experts give an opinion and they are not particularly experienced in the operation concerned. Those were not exceptional failings and the jurisdiction to make wasted costs orders is one to exercised exceptionally.

In contrast, the fact that J continued to act as an expert witness after November 2017 (when his psychiatric difficulties caused him to suspend his clinical practice) was an exceptional failing. HHJ Evans rejected the submission on behalf of J that if J had ceased to act for T from that date another expert would have been instructed and the Trust would have been no better off. Whilst accepting that it was not her role to try the claim on its merits, HHJ Evans held that on the balance of probabilities T's claim would be unlikely to succeed, no other expert would have supported the claim and the claim most likely would have been abandoned.

Therefore, all of the Trust's costs incurred after November 2017 had been incurred as a result of J's breach of duty and would have been avoided. J was ordered to pay the Trust's costs from November 2017 in the sum of £88,801.68 plus the Trust's costs of the application.

Comment

Although HHJ Evans described this as an "*unusual*" case and acknowledged that there were many experts who were not very good, the 21 paragraphs of this brief judgment may make for some uncomfortable reading for expert witnesses. Experts owe clearly prescribed duties to the court under CPR Part 35. As HHJ Evans pointed out, these are important and significant duties and experts must all understand the importance of their duties to the court and the potential consequences if they fail in them. The "*gateway*" to the line of cross-examination as to J's competence to give expert evidence in this case was the use of the phrase "*best practice"* in his joint statement with the Defendant's expert witness. Whereas in some cases the use of such a phrase might simply be sloppy language, in J's case it indicated a lack of understanding of the relevant test for breach of duty in clinical negligence claims, which may or may not have been caused by his psychiatric difficulties.

Whilst HHJ Evans had sympathy for J and acknowledged that the jurisdiction to make wasted costs orders is not intended to be punitive or to mark the court's displeasure at J's conduct, a considerable amount of court time had been wasted and the balance came down firmly in favour of the Defendant Trust, a public body which had

incurred significant unnecessary costs. J's liability to pay costs would have significantly outweighed any fee that he would have received for his role as an expert witness in T's case.

More generally, legal representatives will no doubt also regard this judgment with interest and consider even more carefully the competence and suitability of medico-legal experts not only before instructing them but throughout the litigation process. HHJ Evans noted that, at various stages, counsel and solicitors for T were concerned as to whether J was a suitable expert and had gone so far as to ask him to confirm in 2017 that he was suitable to provide expert evidence. J did not inform them of his psychiatric difficulties, however. It is not entirely inconceivable that an application for wasted costs may also have been made against the legal representatives if they had not sought such confirmation or, having been told that J was no longer in clinical practice, continued to use him as an expert.

Giles Colin from 1 Crown Office Row acted for the Defendant in this case. He did not contribute to this article.

CAUSATION – NO NEED TO PROVE A SPECIFIC MECHANISM?

Dominic Ruck Keene

Schembri v Marshall [2020] EWCA Civ 358

Somewhat surprisingly, the Court of Appeal has upheld the controversial judgment of Stewart J (covered in Issue 3) that the Claimant's wife would not have died if she had been referred to hospital, despite having made a specific finding that the Claimant had not proved the precise train of events by which her death would have been prevented.

The facts

The Defendant GP admitted that he had negligently failed to refer the Deceased to hospital when she attended his surgery with chest pain and breathlessness. It was common ground that, had the Deceased been referred to hospital at the proper time, she would have been diagnosed as having a pulmonary embolism. However, causation was denied.

As noted in our consideration of the High Court judgment in Issue 3, 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. The key parts of Stewart J's judgment were his comments that "*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 hold that 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*." However, 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."

The Court of Appeal

The Claimant argued in the Court of Appeal that where a claimant establishes a breach of duty of care and shows that the injury that follows is of a kind likely to have resulted from a breach of that kind, that is usually enough to enable the court to find that the injury has resulted from the breach. Here the Defendant admitted a breach of duty in failing to refer the Deceased to hospital on 25 April 2014 in respect of what he should have seen as the signs of the pulmonary embolism, which in fact she had. The likely result of that breach was that she would die from the embolism, in the absence of specialist treatment. She did die and it was submitted that was enough to sustain the finding that the death was caused by the breach. It was not necessary for the Claimant to show on the balance of probability, the precise mechanism, or route of treatment, that would have led to the Deceased's survival.

The Defendant argued that where a judge found that the Claimant had failed to establish to the necessary standard that the Deceased would have survived by the receipt of either or both of the only possible treatments for her condition, then the claim must fail. The judge should not have posed a separate overriding question based on general survival rates of patients with pulmonary embolisms in hospital and/or a general analysis that most people do not die from pulmonary embolisms in hospital.

Judgment

McCombe LJ at [44] cited with approval Clerk and Lindsell to the effect that "*If the evidence is that, say, 80 per cent of patients survive with prompt treatment, but 20 per cent die even with prompt treatment, the fact that the patient died following delayed treatment does not establish that he probably fell into the 20 per cent category at the outset and therefore the delay did not contribute to the death. The assessment of causation would turn upon the detailed medical evidence, both as to the overall statistical chances of survival and the particular condition and circumstances of the patient…. Proof of causation is almost inevitably about a burden of persuasion and sometimes statistics can be highly persuasive."*

McCombe LJ at [53] held that Stewart J had not fallen into error by asking the question "*Looking at the evidence as a whole, is it nevertheless more likely than not that the Claimant would have survived had she been referred to Southend Hospital?"* McCombe LJ held that Stewart J was right to take the *"common sense and pragmatic view"* of "*the evidence as a whole*". He concluded at [56] that:

"…without being able to prove the precise mechanism of survival to the requisite standard, after exhaustive consideration of all the material, the Respondent did satisfy the judge "clearly" that the result that occurred was caused by the breach of duty. In my judgment, he was entitled to be so satisfied. This was not a case in which statistics were used to transpose a strong case in the Appellant's favour into a decision in favour of the Respondent. I also reject the argument for the Appellant that to uphold the judge's judgment would be to say that statistics are determinative of causation issues such as the present. The judge's decision was heavily focused upon the Deceased's condition and likely presentation at hospital. As the Appellant's own case on the pleadings and the authorities showed, there is a legitimate place for statistical evidence in cases of this type. The employment of that evidence by the judge in this case was closely linked by him to his assessment of the evidence as to the Deceased's own particular condition, in which her prospects of survival (on hypothetical admission to hospital) were very good indeed. I remind myself that, on the judge's assessment (at paragraph 146) this was not simply a 50/50 case on the statistics. That will not be so in every case. Each case (like this one) will be intensely "fact-specific"."

Comment

Any decision involving causation, clinical negligence, and statistics is likely to be highly fact sensitive. However, this case will potentially be of some assistance to claimants faced with complex counter factual scenarios where there are a number of different causal hoops to jump through on the way to establishing a clear causal chain. Not least because of the Court of Appeal's specific endorsement of the authority of *Drake v Harbour* [2008] EWCA Civ 25, where Toulson LJ held at [28]:

"In the absence of any positive evidence of breach of duty, merely to show that a claimant's loss was consistent with breach of duty by the defendant would not prove breach of duty if it would also be consistent with a credible non-negligent explanation. But where a claimant proves both that a defendant was negligent and that loss ensued which was of a kind likely to have resulted from such negligence, this will ordinarily be enough to enable a court to infer that it was probably so caused, even if the claimant is unable to prove positively the precise mechanism. That is not a principle of law nor does it involve an alteration in the burden of proof; rather, it is a matter of applying common sense. The court must consider any alternative theories of causation advanced by the defendant before reaching its conclusion about where the probability lies. If it concludes that the only alternative suggestions put forward by the defendant are on balance improbable, that is likely to fortify the court's conclusion that it is legitimate to infer that the loss was caused by the proven negligence.

WHEN SIDESTEPPING THE AGREED CONTRACTUAL DISCIPLINARY PROCEDURE WILL BE IN BREACH OF CONTRACT

Jeremy Hyam QC

Smo v Hywel Dda University Health Board [2020] EWHC 727

The Claimant, a consultant colorectal surgeon, was subject to disciplinary proceedings in respect of conduct and his approach to clinical practice pursuant to "Upholding Professional Standards in Wales" (UPSW) closely modelled on the similar provisions in England under 'Maintaining High Professional Standards' ("MHPS"). He was suspended pursuant to the UPSW procedure but there then followed delays with that process. During the currency of such delay, the Defendant then sought to launch an additional inquiry by way of a "*working relationship investigation"* into his relationships with his colleagues to determine whether they had irretrievably broken down (which can be "*some other substantial reason*" for termination of the employment contract) thus "*side-stepping*" the contractual disciplinary process to which the Claimant was entitled. The Claimant sought final injunctive relief (an interim injunction already having been granted by Roger Ter Haar sitting as a Deputy High Court Judge - *Smo v Hywel Dda University Health Board* [2019] EWHC 1973 (QB), covered in Issue 3 by Shaheen Rahman QC) for breach of contract to prevent the Defendant side-stepping the agreed contractual procedure.

Linden J held at [203] that the Defendant could not continue to accuse the Claimant of serious misconduct under UPSW on the basis that it believed that he was at fault whilst, at the same time, sidestepping the procedural safeguards under UPSW by hiving off one of the aspects of the case which continues to be investigated under the Procedure. This is particularly so given that, if the parallel process leads to the dismissal of the practitioner, the practitioner will be denied the opportunity to address the allegations against him and to be vindicated.

Comment

The case is of interest for three principal reasons. First, it is a very helpful clarification of the law on "sidestepping". The Court reviewed the trilogy of cases: *Lauffer v Barking Havering and Redbridge University Hospitals NHS Trust* [2009] EWHC 2360 (QB); *Kerslake v North West London Hospitals NHS Trust* [2012] EWHC 1999 (QB) and *Jain v Manchester University NHS Foundation Trust* [2018] EWHC 3016 where similar "side-stepping" issues had arisen i.e. an employer who, rather than proceed with the contractual disciplinary process under MHPS or its equivalent, seeks to terminate employment on "*some other substantial reason*" grounds, usually, irretrievable breakdown of relations. Distinguishing *Jain* (where a similar situation arose) from the present facts, Linden J held that UPWS was directly incorporated into Dr Smo's contract of employment, and that the relevant contractual clause (clause 9.2) expressly required the Defendant "*to handle… any issues relating to conduct, competence and behaviour… in accordance with UPSW*". This express stipulation precluded the Defendant's attempt at sidestepping. Linden J also observed that any working relationships investigation entailed, both in principle and practice, consideration of the reasons why relationships between the Claimant and his colleagues had broken down and whether, in the light of those reasons, the situation was irretrievable.

It was therefore plainly impermissible to sidestep the agreed procedure which provided specific protections to the Claimant (legal representation etc.) and had been agreed at a national and local level.

The second reason the case is of interest because the judge held that if he was wrong about the effect of the express term 9.2, then the Defendant was in breach of the implied term of mutual trust and confidence to embark on the working relationships investigation in the circumstances in which it did so. Again, distinguishing *Jain* because in that case, in contrast to the present, MHPS was not directly incorporated into the contract, the judge explained that the premise on which the question of breach of mutual trust and confidence or rationality arose was that although the relationships investigation was not one which the Defendant was required to consider under UPWS, it was very closely related to it. Thus concerns or issues were being investigated under that procedure and the state of working relationships had been a relevant consideration at all stages of the UPWS procedure up to that point.

The third reason the case is of interest, which is dealt with in an appendix to the judgment, is that the Claimant, although seeking to rely on his written witness evidence prepared for the interim injunction application, did not propose to give oral evidence at the final injunction hearing. His stated justification was that he did not want to be drawn into debate about the merits of the underlying allegations against him given that those allegations are currently under consideration in the UPSW disciplinary process. The Defendant objected arguing that if the Claimant maintained his position his evidence should be disregarded and the claim dismissed "*by reason the that there cannot be a fair trial and the claim is an abuse*". The judge rejected the Defendant's application considering it to be disproportionate, but did in the event, require the Claimant to give oral evidence on certain limited paragraphs of his witness statement. In the event the cross examination of him on those issues went nowhere.

Overall, the case very helpful because Linden J (a very experienced employment barrister when at the Bar) distils many of the key principles at play in such cases, and explains how, on particular facts and circumstances, an employer will be in breach of both express and implied terms by seeking to sidestep an agreed contractual procedure in respect of dealing with conduct and performance issues.

PROFESSIONAL REGULATION

Shaheen Rahman QC

(1) General Medical Council (2) Professional Standards Authority for Health & Social Care v Asef Zafar [2020] EWHC 846

The Divisional Court substituted a sanction of erasure for a 12 month suspension in this appeal by the GMC and PSA arising from the GMC's own error. At a hearing before the Medical Practitioners Tribunal ("MPT") the GMC relied upon the fact that the doctor had been sentenced to prison for 6 months, suspended for 2 years, as a result of contempt of court in a case concerning the making of false statements as an expert witness. However that sentence had subsequently been found to be too lenient by the Court of Appeal, albeit that a declaration to that effect was deemed sufficient rather than actually increasing the sentence. The GMC agreed to withhold that fact from the MPT, for reasons that are unclear: *"At first sight and indeed at second sight that seems extraordinary"* [39]. The Divisional Court agreed that an inappropriate concession had been made by the GMC. Given the purpose of the proceedings were to protect the public, the Court of Appeal's judgment could be admitted as fresh evidence on appeal and the PSA were not in any event bound by the GMC's concession. There was no benefit in remitting the matter – on the facts of the case the only sanction was erasure, with or without the Court of Appeal's judgment, given the findings of dishonesty and recklessness and the sanctions guidance available to the panel. Accordingly, the outcome in the regulatory proceedings reflected the fact that in the criminal proceedings the doctor had been afforded undue lenience for his wrongdoing.

ARTICLE 2 INQUESTS AND COMMUNITY-BASED PSYCHIATRIC PATIENTS

Jim Duffy

R (Lee) v HM Assistant Coroner for the City of Sunderland [2019] EWHC 3227 (Admin)

It is now eight years since the Supreme Court found that the death of a voluntary mental health patient whilst on leave could engage the state's Article 2 investigative duty. *Rabone v Pennine Care NHS Trust* [2012] UKSC 2 opened up the prospect of *Middleton* inquests being held in connection with an expanded variety of mental health cases.

Identifying the reach of *Rabone* has been a regular focus of inquests ever since, as has seeking to delineate the scope of the State's 'systemic' duty to protect life.

In *R (Lee) v HM Assistant Coroner for the City of Sunderland* [2019] EWHC 3227 (Admin) the High Court considered the case of a young patient living in the community, and a coroner's refusal to accept that Article 2 was engaged on either the operational or systemic basis. Deciphering the outcome is no easy task given the astonishing number of errors in the transcript of this *ex tempore* judgment. But the case is a further demonstration of the challenges involved in seeking to extend the scope of *Rabone* into the community mental health context.

Background

Melissa Lee had suffered from mental health problems since her teenage years. She had been under a community care regime since December 2012 and was subject to a series of care plans. Melissa had overdosed on a number of occasions and had been admitted in the past, both voluntarily and under section.

In February 2016, Melissa's psychiatrist diagnosed her with an emotionally unstable personality disorder and arranged medication. On 8 March 2016, Melissa contacted her care worker and the crisis service carried out an assessment at her home the following day.

On 13 March, Melissa attended Accident and Emergency as a result of an overdose, but self-discharged.

The following day, the crisis team carried out a further assessment and considered Melissa to have a moderate risk of self-harm which did not justify re-admission to hospital, which was what she had wanted. The team's decision was affirmed by a consultant psychiatrist.

On 17 March 2016 Melissa was again treated at A&E having suffered a further overdose. She was allowed to self-discharge that evening. Her father visited her in the early hours of 18 March but left having felt reassured that Melissa was safe. She was found dead later that morning.

The inquest

At a pre-inquest review, Melissa's family argued that Article 2 was engaged on both the operational and systemic bases. They contended that an arguable breach of the '*Osman'* operational duty had taken place, based on an analysis of the factors identified in respect of non-detained mental health patients by Lord Dyson in *Rabone*: extreme vulnerability, a real and immediate risk to the individual, and the degree of responsibility and control exercised by the State.

The family also cited an arguable breach of the systemic duty, referring to alleged failures or inadequacies in care planning and discharge planning.

The coroner decided that Article 2 was not engaged on either ground. On the operational duty, she said "*I believe I am being urged to extend Rabone v Pennine Care NHS Trust to mental health patients in the community; I do not find that the operational duty arises in those circumstances; the Trust has not assumed control or responsibility in that regard of the word, and therefore there can be no breach."*

On the systemic duty, she concluded that there had been no evidence before her to suggest that adequate provision had not been made for securing high professional standards among health professionals and the protection of the lives of patients. She reminded herself – in line with *Powell v United Kingdom* (2000) 30 EHRR CD 362 – that mere errors of judgment by/negligent cooperation between health professionals were not sufficient to amount to an Article 2 violation.

The High Court's judgment

HHJ Raeside QC remitted the operational duty question for the Coroner to reconsider on the facts, having found that she had not taken into account anything other than the degree of control exercised in Melissa's case; she had failed to deal with the extent to which Melissa had been vulnerable, or the question of exceptional risk.

On the other hand, there was no basis on which it could be argued that there had been a systemic breach. Indeed, when the family had been asked to identify arguable evidence as to a failure of the system itself, none was provided, and it was agreed that "*there was no such information".*

Consequently, the judge did not have to address the significant hurdles now facing any systemic breach argument in a medical negligence context. In *R (Parkinson) v HM Senior Coroner for Kent* [2018] EWHC 1501, Lord Justice Singh noted the importance of *Lopes de Sousa Fernandes v Portugal* (app. no. 56080/13). In *Lopes* the Grand Chamber of the European Court of Human Rights emphasised that, in the context of alleged medical negligence, a State's substantive positive obligations "*are limited to a duty to regulate, that is to say, a duty to put in place an effective regulatory framework compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patient's lives."* There were two exceptional circumstances, described at [191] and [192] of *Lopes*. The first:

"*concerns a specific situation where an individual's life is knowingly put in danger by denial of access to life-saving emergency treatment… It does not extend to circumstances where a patient is considered to have received deficient, incorrect or delayed treatment."*

The second:

"*arises where a systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving emergency treatment and the authorities knew about or ought to have known about that risk and failed to undertake the necessary measures to prevent that risk from materialising, thus putting the patients' lives, including the life of the particular patient concerned, in danger…".*

Clearly, no court was likely to be satisfied that deficiencies in individual care or discharge plans amounted to such exceptional circumstances.

On the remitted question relating to the operational duty, the coroner has since decided afresh that Article 2 does not apply. She determined that Melissa's case did not involve an assumption of the level of responsibility found in Article 2 cases. There was no close supervision or control, or responsibility for overseeing Melissa's daily life. The state did not create any danger for her.

On vulnerability, Melissa "*did not demonstrate the kind of helpless or acute vulnerability which Lord Dyson instances at para. 23 of the Rabone case (there, a child known to be at risk of abuse)."* Her risk was a long-term and chronic one.

In any event, the coroner found that there was no apparent basis for saying that admission (compulsory or otherwise) had been a required reasonable step at any stage.

The High Court's decision to remit that factual determination to the coroner means that arguments as to whether Article 2 applies in specific mental health inquests are likely to rage on.

A BLOW AGAINST BIG PHARMA

Sarabjit Singh QC

Bayer Plc & Anor v NHS Darlington CCG & Ors [2020] EWCA Civ 449

In the interesting case of *Bayer Plc v NHS Darlington Clinical Commissioning Group* [2020] EWCA Civ 449 in the Court of Appeal, two pharmaceutical companies, Bayer Plc ("Bayer") and Novartis Pharmaceuticals UK Ltd ("Novartis"), appealed against the dismissal by Whipple J of their judicial review challenge to a policy adopted by a number of Clinical Commissioning Groups ("CCGs") in North Cumbria and the North East. Under this policy the CCGs, in effect, recommended to NHS Trusts that the preferred treatment option for an eye disease, generally referred to as wet age-related macular degeneration ("WAMD"), was a drug that happened not to be marketed by either Bayer or Novartis.

WAMD is generally treated by the injection into the eye of so-called 'anti-VEGF agents', which inhibit the over-production of the protein which causes WAMD. There are three anti-VEGF agents that are equally effective and safe in treating WAMD. Two of them, Lucentis and Eylea, were marketed in Europe by Novartis and Bayer respectively and had been licensed specifically for ophthalmic use. The third, Avastin, produced by a different pharmaceutical company, was licensed for the treatment of certain cancers but had never been licensed for ophthalmic use. Moreover, unlike Lucentis and Eylea, a dose of Avastin had to be divided into smaller doses in a process known as 'compounding' before it was suitable for ophthalmic use.

Nevertheless, the CCGs adopted a policy in which Avastin, rather than Lucentis or Eylea, would be offered to patients with WAMD as the preferred treatment option. This was solely on cost grounds, as it was enormously more expensive to use Lucentis or Eylea as compared to Avastin. Per injection, Lucentis cost about £550 and Eylea cost about £800, whereas Avastin cost only about £28.

Because the pharmaceutical company that produced Avastin did not hold a marketing authorisation for ophthalmic use, Bayer and Novartis judicially reviewed the legality of the CCGs' policy. They claimed that the implementation of the CCGs' policy would lead to breaches by NHS Trusts of the EU and domestic legislation regulating the marketing and manufacture of medicines. It was accordingly necessary for the Court of Appeal, like Whipple J before them, to consider EU legislation and caselaw in some detail.

In giving the main judgment in the Court of Appeal, Underhill LJ noted that the CJEU caselaw *did* permit Member States to adopt measures which were aimed at saving costs, in order to ensure the financial stability of their domestic healthcare system.

Further, although Article 6 of the Medicines Directive (Directive 2001/83/EC) stated in terms that no medicinal product could be placed on the market of a Member State unless a marketing authorisation had been issued, there had already been caselaw that considered whether the use of unlicensed Avastin fell foul of that provision. That was because health providers in other countries in Europe were just as anxious as the CCGs to take advantage of the lower cost of Avastin as a treatment for WAMD.

The key decision of the CJEU was *Novartis Pharma GmbH v Apozyt GmbH*, C-535/11, ECLI:EU:C:2013:226 ("*Apozyt*"). The principal effect of the decision in *Apozyt* was that the supply of Avastin by a compounder to a clinician did not constitute a 'placing on the market' within the meaning of Article 6 of the Medicines Directive, and so did not require a marketing authorisation, but only if the compounding process did not result in a modification of the medicinal product and was carried out solely on the basis of individual prescriptions.

The appellants, Bayer and Novartis, argued that Avastin in its compounded form should be treated as modified, because of the risk of contamination or other changes to its substance as a consequence of poor quality control during compounding. Underhill LJ had no hesitation in rejecting this argument, because on analysis of the decision in *Apozyt*, what mattered was whether there was a change to the physical, chemical or biological properties of Avastin that was necessarily inherent in the fact of compounding, and there was no evidence that the compounding process involved any such change.

The Appellants also claimed that the systematic use of Avastin undermined or evaded the legislative scheme because it eroded the primacy given by the Medicines Directive to the promotion of patient safety. They emphasised the importance of maintaining control over the distribution chain and avoiding the risk of contamination and other quality failures during the compounding process. Again, Underhill LJ had no hesitation in rejecting this argument. As he put it, following the CJEU's decision in *Apozyt*, "*that boat has sailed*" [183]. The unspoken premise of the Appellants' complaint was that the requirements of the Medicines Directive, particularly Article 6, were intended to apply to the compounding of Avastin, but the CJEU had held just the opposite in *Apozyt*. There was accordingly no question of the preparation and supply of Avastin in its compounded form undermining or evading the legislative scheme.

The Court of Appeal's decision in this case is worth reading in full because there are many other interesting aspects of the decision, including a discussion of whether guidance issued by the GMC prohibited clinicians from taking account of cost when considering whether to prescribe an unlicensed medicine. The default position in the GMC's guidance was that doctors should 'usually' prescribe licensed medicines in accordance with the terms of their licence, which would have precluded the prescription of Avastin for the treatment of WAMD because Avastin was not licensed for ophthalmic use. Certain exceptions to that default position were spelt out in the guidance but none of them referred to cost as a possible justification for prescribing an unlicensed medicine.

Whipple J held that the guidance was not exhaustive and that there could be other exceptions to the usual position not expressly referred to in the guidance, and moreover she decided that the present case was far outside the category of 'usual' cases envisaged by the guidance in any event, given the extensive material that showed that unlicensed Avastin was of equivalent clinical effectiveness and safety for the treatment of WAMD as the licenced alternatives. Accordingly, she decided that the GMC's guidance did not prohibit the prescription of Avastin for the treatment of WAMD on the grounds of cost, and the Court of Appeal upheld her reasoning.

The Court of Appeal's decision is of particular interest in the current climate, where efforts are ongoing to find drugs that may treat or even cure Covid-19. Cases may arise where relatively cheap drugs developed for wholly different purposes are shown on an experimental basis to have some effect against the virus, but their unlicensed use against the virus may conflict with the financial interests of pharmaceutical companies developing their own drugs to treat the virus which they may seek to supply to desperate public health authorities at relatively great cost. The decisions of Whipple J and the Court of Appeal indicate that the courts will not kowtow to the commercial needs of 'Big Pharma' and will uphold the right of public health authorities to make prescription decisions aimed at protecting the public purse, wherever legally permissible to do so.

APPLICATIONS RELATING TO MEDICAL TREATMENT - GUIDANCE FROM THE VICE PRESIDENT OF THE COURT OF PROTECTION

Matthew Flinn

Applications Relating to Medical Treatment: Guidance Authorised by Justice Hayden, Vice President of the Court of Protection [2020] EWCOP 2

On 17 January 2020 the Vice President of the Court of Protection authorised the promulgation of guidance about when those involved in serious decisions about medical treatment should consider making an application to that court.

As practitioners in the field of clinical negligence will know, providing medical treatment without properly informed consent is a serious issue, and a major source of litigation in recent years. The issues become particularly acute, however, where a patient lacks the capacity to consent, and the medical treatment proposed involves consequences such as a major infringement of one's human rights, or the risk of serious harm or death.

Section 5 of the Mental Capacity Act 2005 ("MCA 2005") provides some protection for medical practitioners in these difficult circumstances, by providing a defence from liability where reasonable steps have been taken to establish whether or not the patient has capacity, and where, having taken those steps, it is reasonably believed that the patient does lack capacity and that proposed treatment is in their best interests (although this protection does not exclude liability for loss and damage arising from negligence in the actual provision of the treatment).

The purpose of the guidance on *Applications relating to medical treatment* ("the Guidance") is to assist clinicians and practitioners in understanding where a defence under section 5 will not or may not be available, so that, as an alternative means of acquiring legal protection, an application to the Court of Protection should be made.

As a starting point, the Guidance confirms that if the provisions of the MCA 2005 and its Code of Practice are followed, then if there is agreement as to the decision-making capacity and best interests of the patient in question, the proposed course of medical treatment (including e.g. withdrawal of treatment) can be pursued without an application to the Court of Protection, in reliance on the section 5 defence.

However, the Guidance also highlights the types of situation where an application is necessary or advisable.

An application is recommended in situations where, at the end of the medical decision-making process (carried out in accordance with the relevant procedures, guidance and Code of Practice), any of the following circumstances arise:

(a) It is felt that the merits of the best way forward are finely balanced;
(b) There is a difference in medical opinion;
(c) There is disagreement over the way forward amongst those with an interest in the patient's welfare (e.g. a disagreement between clinicians and family members); or
(d) There is a potential conflict of interest in those involved in the decision-making process.

The Guidance explains that in such circumstances, it is "*highly probable*" that an application to the Court of Protection is appropriate. However, where any of those circumstances arise and in addition the decision relates to life-sustaining treatment (including the provision of nutrition and hydration), an application **must** be made (in order to be compliant with Article 2 of the European Convention on Human Rights ("ECHR")).

Where the case is not about life-sustaining treatment but involves some other serious interference with the patient's human rights under the ECHR, it is "*highly probable*" that an application is appropriate, even where everyone concerned is in agreement as to the best way forward. The Guidance provides examples of treatment which entails this kind of interference, such as sterilisation, organ donation, or where the treatment is experimental or controversial.

Finally, the Guidance suggests that an application may be required if the proposed treatment entails the application of some force or restraint, which may go beyond the parameters set out in sections 5 and 6 of the MCA 2005. It also goes on to set out some practical and procedural points relating to the mechanics of urgent applications and the involvement of the Official Solicitor.

It is important to note that the procedure for bringing applications to the Court of Protection is currently being reviewed within the revised MCA Code of Practice, which will soon be subjected to public consultation and parliamentary scrutiny – the Guidance will therefore only apply until superseded by the revised Code.

APPLICATIONS RELATING TO MEDICAL TREATMENT – A PRACTICAL APPLICATION

Matthew Flinn

Sherwood Forest Hospitals NHS Foundation Trust [2020] EWCOP 5

"Mrs H" was a 71-year-old lady with a history of Bipolar Affective Disorder. She was also suffering from squamous cell carcinoma on her face, but for an extended period of time, she refused to accept the diagnosis or undergo any treatment.

She had been assessed as lacking capacity to make decisions in relation to her medical treatment in May 2019, but the Trust providing her with care did not make an application to the Court of Protection to confirm the way forward until December. That is because the clinicians involved were "perplexed as to whether it was appropriate and if so in what circumstances for Mrs H effectively to be forced, physically and by coercion if necessary, to attend for her treatment and, if so, how that might be achieved".

Hayden J expressed some criticism of this delay, querying why an application had not been made sooner. He reiterated his view, as expressed in a number of his previous judgments, that although an avoidance of delay was not explicitly incorporated into the scheme of the Mental Capacity Act 2005, it was to be read into that scheme by virtue of Articles 6 and 8 of the European Convention on Human Rights ("ECHR"), particularly because in many cases delay would be inimical to the best interests of the patient concerned. He also referred to the Guidance recently promulgated by the court, which confirmed that applications were appropriate where e.g. the merits of the case were finely balanced, or there was a difference of medical opinion. At [32] of his judgment he said:

"The Mental Capacity Act creates what can both conveniently and accurately be described as a presumption of capacity and, where it is absent, imposes upon those best placed to do so, an obligation to deploy all reasonable options available to them in order to promote a return to capacity. A reasonable period before making an application might have been a week, two weeks, three weeks, but it was certainly not 6 months."

The merits of the application before him make for utterly tragic reading. During the period when Mrs H refused to accept the diagnosis or engage with treatment, the lesion on her face grew significantly, to a point where it was causing significant pain and discomfort. Without any treatment, she was likely to face an agonising decline and death within a period of months. The lesion had become so extensive that curative radiotherapy was no longer a viable option, and there were even risks that surgical excision, which offered the best hope of curative treatment, would fail – particularly if the tumour had become attached to the eyeball. Palliative options were also limited.

A particular feature of the case was that, by the time of the hearing, Mrs H had met and reposed her trust in a particular clinician – this engagement had led her to become, to an extent, acquiescent to treatment, although as the court noted, she was still not consenting "*in any capacitous way*". However, the new circumstances meant that the proposed care plan did not propose the use of force to bring about treatment (e.g. through restraint and sedation). Rather, the care plan which was ultimately approved by Hayden J (unfortunately not detailed in the judgment) appears to have involved securing Mrs H's agreement and compliance without explaining the significance of what she was to undergo. Initially, the judge was concerned that she would be "*inveigled into serious treatment that she did not understand, in circumstances where there is no longer any plan to try and explain it to her"*. However, after considering all the evidence, he concluded that in fact the plan, although unusual, was "*intensely sensitive*", and that it was "*the appropriate and kindly way forward and one that respects, in different ways, Mrs H's dignity, her autonomy and the very grave circumstances that she finds herself in".*

He concluded that the proposal was in Mrs H's best interests.

CONTINGENT DECLARATIONS AND CAESAREAN SECTIONS

Matthew Flinn

Guys and St Thomas' NHS Foundation Trust v R [2020] EWCOP 4

The Court of Protection made a contingent declaration allowing for a caesarean section to take place in the event of a patient losing capacity in the midst of labour.

"R" was a detained psychiatric patient in the late stages of her pregnancy. Although she had Bipolar Affective Disorder which was characterised by psychotic episodes, it was agreed between the clinicians providing her with psychiatric and obstetric treatment that she had capacity to make decisions as to her antenatal and obstetric care. However, it was also agreed that there was a substantial risk of her (a) suffering a deterioration in her mental health and so losing that capacity in the course of labour and (b) requiring an emergency caesarean section, which it was anticipated she might resist (it was something which she had previously described as "*the last thing she wanted*").

The application (which was brought by the Trusts involved in her care) required the Court of Protection to consider its power to make a declaration authorising a possible future course of treatment in respect of a patient who had relevant capacity at the time of the hearing. In a detailed judgment, Hayden J decided that section 15(1)(c) of the Mental Capacity Act 2005 ("MCA 2005") provided the court with the relevant jurisdiction. That provision provides that the court has the power to make declarations as to "the lawfulness or otherwise of any act done, *or yet to be done*" (emphasis added) in relation to the relevant patient. In reaching that conclusion, he also confirmed that the jurisdiction did *not* arise under section 16, as had been contemplated in some previous cases.

It was held that the wording of section 15(1)(c) (in particular the words "*any act…yet to be done*") contemplated a factual scenario occurring at some future point, and thus could logically encompass not just future acts based upon current circumstances, but also future acts based on *potential* future circumstances. Accordingly, the court had the power to make a declaration which made lawful a future course of medical treatment *when and only when* the patient became incapacitous.

A further issue, however, was that the course of treatment proposed potentially involved a deprivation of liberty, because the declaration sought provided for the "*transport and treatment*" of R, which could involve moving her against her will. The advocates involved in the case submitted that the MCA 2005 only permitted orders entailing a deprivation of liberty in carefully circumscribed circumstances explicitly laid out in the statute (e.g. under section 16, section 4A, 4B and Schedule A1). The court agreed. The answer to this problem was to be found in the court's inherent jurisdiction. Whilst Hayden J acknowledged that such jurisdiction was to be deployed sparingly, he explained at [44]:

"…Having concluded that Section 15(1)(c) is apt to authorise contingent declarations, it would be rendered nugatory if there were no mechanism to authorise the contemplated intervention as being lawful. This is, to my mind, a paradigmatic situation for recourse to the inherent jurisdiction."

The court recognised that such contingent orders ought to be exceptional, but ultimately decided to make a declaration confirming that *if* R lost capacity in the course of labour, she could be transferred from her psychiatric unit (against her will if necessary) for the purpose of being provided with obstetric care. This was on the basis that, if those circumstances arose, that course of action would be in her best interests.

It is clear from the judgment that Hayden J considered this to be an exceptional outcome, not least because the clear wishes of R, as a capacitous individual, were that she did not want to undergo a caesarean section. That was to be considered against powerful legal authority which underscored the right of a pregnant woman's

autonomy to refuse medical intervention, even when the life of her unborn child depended on it (see *St George's Health Care NHS Trust v S* [1998] 3 All ER 673). At [33] he explained:

"…I am not being asked to authorise medical intervention in relation to a capacitous adult. I am being invited to determine whether, if the adult in question loses capacity, a medical intervention can be authorised which is contrary to her expressed wishes, whilst capacitous. In virtually every application that comes before this Court, relating to medical treatment, the answer to the question posed here would be a resounding 'no'. There is now a raft of case law, including many of my own judgments, which illustrate the efforts the Court of Protection will go to in order to identify what the likely wishes of P would be, in circumstances where P has lost the capacity for the relevant decision making (see e.g.: Cumbria NHS Clinical Commissioning Group v Ms S & Ors [2016] EWCOP 32 ; Briggs v Briggs [2016] EWCOP 53 ; Salford Royal NHS Foundation Trust v Mrs P [2017] EWCOP 23 ; PL v Sutton Commissioning Group [2017] EWCOP 22). Whilst the identified wishes of P will not in and of themselves be determinative, they will always be given substantial weight and are highly likely to be reflected in the order or declaration the Court makes…"

However, Hayden J was also concerned to reflect that a hypothetical capacitous R in the midst of labour might well change her mind, and he wanted to give weight to that aspect of her autonomy. The conundrum is encapsulated at [57] of the judgment:

"The particular challenge presented by the facts of this case…is that unlike her capacitous coeval, the mother, upon losing capacity, would lose the opportunity to express a changed decision. The birth process is, self-evidently, highly dynamic. It will frequently require obstetric re-evaluation. With considerable diffidence, I suspect that many birth plans are changed, when confronted with the painful realities of a complicated labour. Many expectant mothers who may have vociferously disavowed epidurals re-evaluate this choice in labour. This is true of the whole gamut of obstetric options, including both induction and caesarean section. Accordingly, the strength and consistency of previously expressed views must be considered with intense subtlety and sensitivity in this highly uncertain and emotionally charged obstetric context. Thus, it seems to me, that I must balance my instinctive inclination to protect the autonomy of a woman's control over the invasion of her own body, with my obligation to try to ensure that her options on losing capacity are not diminished."

It was also relevant in this case that R's expressed opposition to a caesarean section appeared to be based upon a belief that it was best for both her and her baby i.e. it was not based upon religious grounds in full knowledge that it might lead to the death of her child, see [63]:

"…It is important that respect for P's autonomy remains in focus but it will rarely be the case, in my judgement, that P's best interests will be promoted by permitting the death of, or brain injury to, an otherwise viable and healthy foetus. In this case it may be that R's instincts and intuitive understanding of her own body (which it must be emphasised were entirely correct) led to her strenuous insistence on a natural birth. Notwithstanding the paucity of information available, I note that there is nothing at all to suggest that R was motivated by anything other than an honest belief that this was best for both her and her baby. It is to be distinguished, for example, from those circumstances where intervention is resisted on religious or ethical grounds. In the circumstances therefore, it seems reasonable to conclude that R would wish for a safe birth and a healthy baby."

He concluded as follows at [66] – [67]:

"I do not think that I have previously delivered a judgment relating to serious medical intervention, in which I have decided the issue contrary to the identifiable wishes and feelings of P. These views are often articulated with clarity, colour and, with remarkable frequency, humour by P's family and close friends, at a time when P has lost the capacity for reasoned expression. The Court of Protection has, for example, recognised P's right to refuse lifesaving dialysis. It has declined applications to authorise amputations which would have, at least, significantly extended life. In extreme cases the Court has respected the refusal of nutrition by those with chronic eating disorders. The case law emphasises the importance of individual autonomy.

Caesarean sections however, present particular challenges even weighed against all these parlous circumstances. The inviolability of a woman's body is a facet of her fundamental freedom but so too is her right

to take decisions relating to her unborn child based on access, at all stages, to the complete range of options available to her. Loss of capacity in the process of labour may crucially inhibit a woman's entitlement to make choices. At this stage the Court is required to step in to protect her, recognising that this will always require a complex, delicate and sensitive evaluation of a range of her competing rights and interests. The outcome will always depend on the particular circumstances of the individual case."

PERMISSION REFUSED FOR A REVIEW OF CONTACT ARRANGEMENTS

Matthew Flinn

A v B and Ors [2020] EWCOP 1

A mother was refused permission to apply for a full review of the arrangements for contact with her severely autistic son, on the basis that she could not show a "good arguable case" that a review was likely to lead to the arrangements being changed.

This case concerned the level of a mother's contact with her severely autistic son, "D". Aged 20 at the time of the hearing, D had been in the care of his father and the father's partner since he was 3 years old, and his contact with his mother was very limited. Over the course of the next 17 years, the mother had brought a number of substantive applications for a review of the contact arrangements, each time involving in-depth investigations by various combinations of psychiatrists, the Tavistock Centre, the Guardian ad Litem and Cafcass. At the time of the hearing, the extant contact regime permitted four supervised 2-hour visits per year. It had been confirmed by the court two years previously.

The mother faced two permission hurdles in order to bring about a substantive review. First, she was subject to a civil restraint order – but she was granted leave to proceed under the terms of that order in July 2019. Secondly, she had to acquire permission from the Court of Protection to apply to have the contact arrangements reviewed in full. That is because section 50 of the Mental Capacity Act 2005 provides that, subject to a limited list of exceptions set out in subsections 50(1) and (2), permission is required for such applications to that court.

Mostyn J referred to section 50(3), which sets out the factors the court is to have particular regard to when considering an application for permission, namely (a) the applicant's connection with the person to whom the application relates, (b) the reasons for the application, (c) the benefit to the person to whom the application relates of a proposed order or directions, and (d) whether the benefit can be achieved in any other way. He also noted, however, that there is no authority which sets the merits "*threshold*" for permission to be granted. In those circumstances, the judge was inclined to follow the test for permission to proceed with judicial review proceedings i.e. the applicant had to demonstrate a "*good arguable case*" that at a substantive hearing, she could show that it was in D's best interests for the present contact arrangements to be altered.

It had been argued by the mother that the fact that D had recently passed the age of majority was a relevant factor, but this was rejected by the court as an "*arbitrary chronological threshold*" in the context of an individual with a mental age of seven years. Rather, Mostyn J took into account the evidence which showed that, although D derived some pleasure from visits with his mother, he also exhibited distressed behaviour prior to and after such visits. In those circumstances it was difficult to envisage the benefit to D in having the level of contact increased. He also accepted a submission from the father that nothing had materially changed since the current regime had been confirmed by the court following a previous review two years ago.

In the circumstances, the mother did not cross the second hurdle for permission, and her application was rejected. The decision provides a useful steer on the threshold requirement for permission under section 50 of the MHA 2005, and demonstrates the relevance of a change in circumstances where the application seeks a change in extant contact arrangements.

CAPACITY ASSESSMENT AND HUNGER STRIKE

Matthew Flinn

QJ v A Local Authority [2020] EWCOP 3

The court decided that a further assessment of capacity was needed when an elderly man who was detained in a care home under Schedule A1 of the Mental Capacity Act 2005 expressed conflicting desires regarding his food intake.

"QJ" was an 87-year-old male with vascular dementia and substantial care needs. He had been the subject of a standard authorisation under Schedule A1 of the Mental Capacity Act 2005 ("MHA 2005") from mid-November 2019 which had the effect of depriving him of his liberty and requiring him to live and be cared for in a care home. On 10 January 2020 an application was made under section 21A of the MHA 2005 to consider his best interests, after he had seemed to commence a hunger strike in December 2019. This arose in the context of a clearly expressed desire not to be living in a care home, and in circumstances where he was being investigated by police in relation to allegations of historic child sex abuse.

The key issue for the court was whether QJ had capacity to make decisions about his nutrition and hydration (as opposed to decisions about his residence and daily care). As is not unusual in such cases, events intervened, and shortly before the application was to be heard QJ suffered a bleed. The hearing was adjourned for 45 minutes so that he could be seen by his GP, who reported that the bleed was not huge, although he was likely to die within weeks if he continued to refuse food. Although QJ had been assessed as lacking capacity to make decisions about his residence and daily care, his GP felt that he did have sufficient capacity to make decisions about his food and medical treatment, and that he ought to be able to die as he appeared to wish. However, subsequent to the GP assessment, when speaking to his Litigation Friend in the presence of his legal representatives, QJ appeared to say that he would like medical treatment to keep him alive, and did not want to die. When asked if he would like to start eating, he said that if was presented with something he liked he would eat it. When asked if he wanted to be put on a drip to receive nourishment, he nodded.

In light of the position that QJ had been assessed as lacking capacity in relation to residence and daily care, and having regard to the conflicting signals he was sending in relation to food and medical treatment, the court endorsed a proposal that he should be assessed by a psychiatrist to consider questions of capacity in relation to food and medical treatment more generally. The court also indicated that even if the report concluded that he did have capacity, the matter should come back to court for a final determination, in light of the extant application.

APPLICATION TO DISCHARGE A NURSING HOME RESIDENT

Matthew Flinn

AG v AM [2020] EWCOP 59

The court considered an application by the wife of a man with substantial and complex care needs to for him to be discharged from a specialist nursing facility in order to live and receive care at home.

In 2008, "AM" suffered a devastating stroke. He maintained movement in his limbs but this was non-functional. He suffered from cognitive impairment and significant communication difficulties (severe expressive dysphasia and moderate receptive dysphasia). He was doubly incontinent and required 24-hour care. He received nutrition and hydration via PEG. He had insulin type-II diabetes and cortical blindness.

At the time of the hearing, he was compulsorily residing at a nursing home under the terms of a "standard authorisation" under Schedule A1 of the Mental Capacity Act 2005 ("MCA 2005"). The nursing home specialised

in accommodating residents with profound and complex disabilities. It offered 24-hour nursing care, and had access to on-site GP and SALT services. It was located around 8 miles from the family home.

After 28 years of marriage, AG (AM's wife) made an application under section 21A of the MCA 2005 for a determination of AM's best interests such as would permit him to be discharged from the nursing facility to reside at home with his family. The application was opposed as not being in AM's best interests by the Official Solicitor (acting on AM's behalf), by the local authority, and by one of AM's sons (from a previous marriage).

Reading the judgment of District Judge Eldergill provides a helpful introduction for those unfamiliar with, but interested in, this branch of the law. Careful and detailed, it sets out a useful summary of the relevant legal principles on capacity and best interests under the MCA 2005, and their interaction with human rights considerations (which, helpfully, were not disputed in the case). It also provides an excellent example of the careful way the court will seek to give voice and weight to the many sensitive interests involved in such a case. In particular, there is a very useful expression of the way in which the court should determine and have regard to the wishes of the person whose best interests are to be determined:

"The fact that the individual's past and present wishes, feelings, beliefs and values must be considered tells us that this is not a sterile objective test of best interests. It is not a case of trying to determine what some hypothetical objective or rational person would decide in this situation when presented with these choices. Nor are we seeking to do nothing more sophisticated than impose on the individual an objective and rational analysis based on professional expertise of what they ought sensibly to do in that situation.

The law requires objective analysis of a subject not an object. The incapacitated person is the subject. Therefore, it is their welfare in the context of their wishes, feelings, beliefs and values that is important. This is the principle of beneficence which asserts an obligation to help others further their important and legitimate interests, not one's own. In this important sense, the judge no less than the public authorities is AM's servant, not his master."

The court concluded that the evidence showed that AM wished to live at home and be cared for by his wife if at all possible, although this was tempered with an acknowledgement that he perhaps did not appreciate all the risks entailed with living at home. The court also gave weight to the fact that great efforts had been made by his family and the local Clinical Commissioning Group ("CCG") to propose a viable, funded package of care which would meet his daily needs.

However, there ultimately proved to be a decisive consideration militating in the other direction, that being that if he was cared for at home, AM would not have access to the proactive and highly responsive medical services which were available to him in the nursing home context (the CCG was not willing to fund enhanced GP care at home – a decision which could not be interfered with by the court absent a successful public law challenge). A number of GPs in the area had made it clear that they would not wish to register him as a patient, and the judge concluded that the medical care provided to him would not go beyond that required by the general contracts under which the GPs operated.

This meant that there could be delays in accessing medical care, and yet there was evidence to show that AM did not always manifest typical symptoms when he had a health problem, and further, he could deteriorate very rapidly. In turn, this meant that there was a risk of more admissions to hospital, serious illness and death. Added to this were the considerations that the nursing home (which had many advantages not to be found elsewhere) was not able to hold his place for more than 14 days after he left, and a trial was not an available option. In the round, despite the many factors in favour of the application, it was not one that the judge felt able to accede to. In this sad case, it was in AM's best interests to remain in the nursing home, notwithstanding that this involved a deprivation of his liberty and went against the wishes of himself and his family.

BEST INTERESTS ASSESSMENT AND CLINICALLY ASSISTED NUTRITION AND HYDRATION

Matthew Flinn

A Clinical Commissioning Group v AF [2020] EWCOP 16

Following a hearing that took place via Skype due to the COVID-19 medical emergency, the court decided it was not in the best interests of a stroke patient to have his Clinically Assisted Nutrition and Hydration ("CANH") withdrawn.

"AF" was an elderly man who suffered a severe stroke May 2016, which caused him to lose capacity for the purposes of the Mental Capacity Act 2005 ("MCA 2005"). A decision was taken to commence the provision of nutrition through via PEG. In this case the court was called upon to consider whether it was in his best interests for that to continue. If it was withdrawn, AF was likely to die in a short period of time. That outcome was supported by AF's daughter – although she did not want her father to die, she fought passionately for what she considered to be his right to die.

The judgment provides another useful example of the way the court will consider the wishes of the protected party and those involved in their care when assessing best interests, pursuant to section 4(6) and 4(7). Section 4(6) confirms that the court must consider not just the actual current wishes of the protected party (so far as ascertainable), but also what their wishes were prior to their incapacity, and what their wishes would be likely to be now if they had capacity.

Mostyn J noted that AF's autonomy was important, and the wishes of the past capacitous AF were to be given weight as to what was to happen with the present incapacitous AF. However, of equal importance was the preservation of life, and the principle that all life had intrinsic value.

An important principle that was eloquently articulated in the case is the idea that assessing the actual wishes and feelings of an incapacitated person had to done cautiously, because it is difficult to know the extent to which they have an appreciation of their plight. As Mostyn J explained at [16]:

"A very important consideration when judging AF's present quality of life is to keep at the forefront of one's thinking that it would be fallacious to seek to judge the processes of his mind by the standards of a capacitous mind. All the expert witnesses agreed with me that the workings of a grossly incapacitated mind is a largely undiscovered country. It would be a grave mistake to assume that AF repines and that he makes relativistic judgments about the plight in which he finds himself. As Dr G rightly stated: 'it is very difficult to know his subjective views since the stroke.' What is known is that he derives simple physical and emotional pleasures from his quotidian existence."

There was clear evidence before the court that, prior to his stroke, AF was very keen on maintaining his dignity and not being a "*body in a bed*". However, he did not record any advance decisions as to the sort of treatment he would wish to refuse in circumstances like the present, under section 24 of the MCA 2005. After the stroke, he expressed a wish to die on multiple occasions, but as a matter of fact those expressions came after he had lost capacity.

The judge gave weight to the fact that AF had meaningful functionality in various respects (i.e. he was not in a vegetative state) and that there was evidence that he was able to take pleasure from life e.g. visits from animals and children, and musicians. He also felt that AF's past expression of views could not be taken as clearly applying to his current situation. He concluded at [32]:

"I have reached the very clear conclusion that it would be categorically contrary to AF's interests for him to be set on the path that will lead to his inevitable death from starvation. This may be a diminished life, but it is a life nonetheless which has, as I have said, intrinsic quality and from which AF derives pleasure and satisfaction."

PSLA IN ST HELENA

Rajkiran Barhey

Attorney General of St Helena v AB and others (St Helena) [2020] UKPC 1

This case arose out of two actions for damages for personal injury brought against a doctor employed on the island of St Helena (in the South Atlantic Ocean). The trial judge had awarded the claimants significant damages for PSLA, calculated using the Judicial College Guidelines for the Assessment of General Damages in Personal Injury Cases ("JC Guidelines") published in England and Wales. The issue in these proceedings was whether the trial judge should have discounted the amounts awarded by one third to reflect the differences in average earnings between those in St Helena and those in England and Wales.

It was agreed that quantification of PSLA damages in St Helena was a matter governed by the common law of England. The issue was whether local circumstances made adaptation to the common law necessary.

At [22] the Board started by setting out the purpose of PSLA damages, namely to compensate the Claimant for non-pecuniary injury. At [23] the Board noted that: *"An important part of the purpose of PSLA damages is that they should reflect what society as a whole considers to be fair and reasonable compensation for the victim…"* noting that in difference societies, the amount that is fair may differ.

At [29] to [30] the Board emphasised the principle that the identity of the Defendant must be irrelevant to the assessment of PSLA. The Board noted at [32] the suggestion by the Attorney General's counsel that *"the Board should have regard to the fact that a rise in the level of PSLA damages awarded against the Government of St Helena might lead to a corresponding scarcity in its resources for provision of its other services and activities on the island."*

This argument was given short shrift and at [33] it was noted that: *"In the Board's view this particular contest misses the point. Fairness or justice to defendants is not about an individual defendant, but about defendants as a whole. They may be governmental, they may be multinational corporations or private individuals, insured or uninsured, rich or poor, solvent or insolvent. The cost to society of a fault-based system of defendant liability for causing pain and suffering may well have a bearing upon the level of compensation for PSLA which society may regard as fair, just and reasonable, but the concept of fairness to defendants does not require a form of equitable balancing of the type contended for by the Attorney General in his written submissions. This is an aspect of pure common law, in which equity plays no part."*

The Board went on to consider a further argument as to whether there was sufficient evidence before the lower court to come to its conclusions. The Board dismissed this ground of appeal too.

Overall, this short judgement of the Judicial Committee of the Privy Council is a helpful reminder of the purpose of PSLA damages and the basic principles upon which they are founded.

IN BRIEF

M (Declaration of Death of Child) [2020] EWCA Civ 164 – Issue was whether the child, Midrar, was legally dead and therefore no best interests assessment was required in deciding whether to withdraw ventilation. CA found that Midrar was dead, either on the definition of brain stem death or whole brain death, and therefore there was no basis for a best interests assessment.

R (on the application of British Pregnancy Advisory Service) v Secretary of State for Health and Social Care [2020] EWCA Civ 355 - Matt Flinn covered the High Court decision in Issue 2, which was upheld by the Court of Appeal.

Agoe v General Medical Council [2020] EWHC 39 (Admin) – Practice's registration with CQC suspended, doctors continued working despite the suspension, Interim Orders Tribunal suspended doctors' registration for 12 months, decision by IOT challenged, found that IOT had given sufficient reasons for suspension.

BXB v Watch Tower & Bible Tract Society of Pennsylvania & Ors [2020] EWHC 656 (Admin) – costs point - The Defendants breached Court direction to serve a statement explaining refusal to engage in ADR. Claimant was awarded indemnity costs from the date of refusal.

Carroll v Taylor [2020] EWHC 153 (QB) – Claimant was robbed by a taxi driver on his way home – was abandoned in the street by taxi driver and fell off a motorway bridge, suffering catastrophic injuries – claim brought against the taxi insurer for damages – did the Claimant's injuries arise out of the use of a taxi – answer was no.

Dowson v Lane [2020] EWHC 642 (QB) – Clinical negligence claim, issue was whether GP had been negligent in failing to refer the diabetic Claimant to a foot clinic, whether the GP had done an examination of the foot, judge found proper examination had been done.

Haider v DSM Demolition Ltd [2019] EWHC 2712 (QB) – Appeal against a decision that a claim (concerning a road traffic accident and credit hire) was not fundamentally dishonest – Defendant partially successful.

Jagger v Holland [2020] EWHC 46 (QB) – Claimant, a pedestrian, was hit by a lorry whilst attending a funfair – Occupier's Liability claim – judgment for the Claimant.

King v South Tees NHS Hospital Foundation Trust [2020] EWHC 416 (QB) – C brought a claim on behalf of her deceased husband, alleging there had been a delay in diagnosis of cancer. Only issue was how advanced the Deceased's cancer was in June 2016. Conclusion – Claimant would have been N0 in June 2016.

Morrison v Liverpool Women's NHS Foundation Trust [2020] EWHC 91 (QB) – appeal against Recorder's decision in favour of Claimant in obstetric case – Turner J found that it was not relevant that the Recorder had failed to refer to *Bolam/Bolitho* test in original judgment as he had applied the correct test.

Morrow v Shrewsbury Rugby Union Football Club Ltd [2020] EWHC 379 (QB) – Judgment considers the use of intermediaries for vulnerable witnesses in civil proceedings - context of quantum only proceedings, C (adult) alleged he had a brain injury. The judge found intermediary to be of limited use, see [49].

Paula Mackintosh v Sheffield Teaching Hospitals NHS Foundation Trust [2020] EWHC 683 (QB) – case management decision by Master Cook in vaginal mesh litigation – whether case management should be co-ordinated – Master Cook found further delay was not desirable.

Professional Standards Authority for Health and Social Care v Health and Care Professions Council [2020] 3 WLUK 95 – only summary available on Westlaw. Paramedic made an isolated racist comment. Health and Care Professions Council's Committee found fitness to practice not impaired. Decision challenged. Committee had not erred. Test of impairment was in the present tense - "*Isolated incidents could show a momentary lapse which was not reflective of a deep-seated attitude. It was an exercise of judgment.*"

Rotherham MBC v ZZ [2020] EWHC 185 (Fam) – whether it was in Baby X's best interests that he should be resuscitated or receive life-saving treatment – decided that it was not.

Smith, R (On the Application Of) v Assistant Coroner for North West Wales [2020] EWHC 781 (Admin) – judicial review of Coroner's decision to find that a number of failings in mental health care of Deceased did not contribute to her death. Coroner's decision upheld – she had properly considered *Tainton and Chidlow.*

Witham v Steve Hill Ltd [2020] EWHC 299 (QB) – C brought a claim following the death of her husband from mesothelioma. C and her husband had fostered two children and the husband had given up work to look after the children so C could continue working. She successfully claimed a dependency for loss of husband's domestic and childcare services. D unsuccessfully argued that the claim was an attempt to bypass the rule in the Fatal Accidents Act prohibiting recovery by the foster children.

EVENTS & NEWS

News

Following amendment to the Fatal Accidents Act 1976, s. 1A, **bereavement damages** have been increased to **£15,120** from £12,980. The change applies to deaths occurring after 1 May 2020.

In a written answer to the House of Lords, the Government has provided a range of data regarding **clinical negligence claims** brought against the NHS.

In February, the Supreme Court heard an appeal brought by two carers about whether they were entitled to the **minimum wage** for time spent working as a **sleeping night carer**. The result is awaited.

Podcast

In Episode 109, Editor-in-Chief Rajkiran Barhey discusses highlights from QMLR Issue 4.

Readers may also be interested in Episode 110 in which William Edis QC talks about Whittingdon v XX, and Episode 106 in which Robert Kellar QC and Isabel McArdle discuss vicarious liability.

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. Follow us on Twitter @1corQMLR.

CONTRIBUTORS & EDITORIAL TEAM

Rajkiran Barhey (Call: 2017) – Editor-in-Chief

Rajkiran (Kiran) accepts instructions in all areas of Chambers' work and is developing a broad practice, particularly in clinical negligence, personal injury, inquests, tax, environmental and planning law, immigration, public law and human rights. Kiran joined Chambers as a tenant in September 2018 following successful completion of a 12-month pupillage. She has a wide range of advocacy experience, both led and unled**.**

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.

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.

William Edis QC (Call: 1985, QC: 2008) - Contributor

Recognised as a leading Silk in his field, William Edis QC has a wide practice covering healthcare law, clinical negligence, disciplinary and regulatory inquiries, inquests, employment, healthcare-related public law and personal injury. He regularly acts in cases of the highest value, importance and complexity. He has appeared before the Supreme Court, the House of Lords, the Court of Appeal and all courts and tribunals relevant to his practice areas.

He has acted as a mediator.

Sarabjit Singh QC (Call: 2001, QC: 2018) - Contributor

Sarabjit Singh QC has long been recognised as a leading and versatile practitioner in various areas of law including tax, public law, clinical negligence and historic abuse cases. He acts for claimants and defendants and, being public access qualified, is happy to accept instructions directly from members of the public.

Sarabjit is known for his calm, cool and persuasive manner in court. In Chambers and Partners 2019 his clients state: "When handling our case, he remained incredibly cool under heavy fire from Supreme Court judges". Chambers and Partners 2020 concludes that Sarabjit's "drafting is fantastic and he's a very compelling advocate".

Judith Rogerson (Call: 2003) – Contributor

Judith Rogerson has a civil practice with a particular focus on cases involving healthcare professionals. She is recognised as a leading junior in clinical negligence.

She has extensive experience of acting on behalf of patients, NHSR and individual medical practitioners in a wide range of cases arising out of allegations of clinical negligence. She also has a good knowledge of professional disciplinary tribunals having been involved in cases in a number of healthcare tribunals. She has represented NHS Trusts in judicial review proceedings and Judith frequently appears in the Coroner's Court where she represents families, clinicians and other interested parties.

Jim Duffy (Call: 2012) – Contributor

Jim Duffy's practice spans clinical negligence, inquests and inquiries, personal injury, human rights and employment.

He is a member of the Attorney General's 'C' Panel of Counsel and has particular experience of prison law claims, acting on both sides. He regularly advises in cases involving parole board decisions, security categorisations, and personal injury claims brought in a prison context. He is currently acting for the applicant in a case recently filed at the European Court of Human Rights relating to joint enterprise murder.

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, Inquests, and Public Law and Human Rights. Charlotte joined Chambers as a tenant in March 2018 following successful completion of pupillage.

She regularly acts for both claimants and defendants in complex clinical negligence matters, advising on liability and quantum, settling a variety of pleadings and advising in conference. She has appeared in court in a variety of civil hearings on behalf of both claimants and defendants.

Thomas Beamont (Call: 2019) – Contributor

Thomas Beamont has joined chambers as a tenant following the completion of his pupillage and accepts instruction in all areas of chambers work.

During his legal studies Thomas volunteered with the School Exclusions Project and worked with the death penalty abolitionist charity Reprieve on preparation for strategic litigation in Pakistan. He also worked as a paralegal at an immigration law firm. Thomas has written for the UK Human Rights Blog, and Free Movement. Thomas studied with a Scholarship for an undergraduate degree in History and Modern Languages from Pembroke College, Oxford.