1 COR
1 CROWN OFFICE ROW

The 1COR Quarterly Medical Law Review

Updates and analysis of the latest legal developments

Winter 2020/21 | Issue 8

Editor-in-Chief
Rajkiran Barhey

Editorial Team
Jeremy Hyam QC
Shaheen Rahman QC
Suzanne Lambert
Matthew Flinn
Dominic Ruck Keene

Welcome to the eighth issue of the Quarterly Medical Law Review, updating you on developments in Winter 2020/21:

New QMLR website

Two years after Chambers began QMLR, we're launching a special archive website for you to find individual articles by issue number, author and practice area. Are you looking for all our articles on consent? Do you need one place with all our COVID-19 articles? Take a look at our new website by visiting www.1corqmlr.com, save us in your bookmarked websites and follow us on Twitter @1corqmlr.

Rajkiran Barhey provides a detailed look at the High Court's decision concerning puberty blockers on page 3, a decision concerning records and reliability on page 9 and on page 11 a decision concerning spinal surgery.

Jeremy Hyam QC considers two decisions exploring the principles relating to judicial assessment of the reliability of factual witness evidence on page 8 and three decisions relating to the Civil Procedure Rules on page 39.

Lizanne Gumbel QC discusses contested interim payments and how to avoid them on page 11.

Shaheen Rahman QC analyses a decision concerning whether the NHS owed a non-delegable duty of care to a patient when care was outsourced to a private provider on page 15.

Matthew Flinn analyses a decision on cauda equina and causation on page 16, and follows up on the Court of Appeal's decision concerning a challenge to changes in abortion regulations on page 36. He also considers a COP decision concerning an order requiring a caesarean section on page 38.

Richard Mumford highlights the Consumer Credit Act 1974 and the rights it gives to patients on page 18.

Suzanne Lambert considers a claim brought some 18 years late and exercise of the s.33 discretion on page 22.

Jessica Elliott explains further developments in secondary victim claims on page 25.

Robert Kellar QC considers wrongful life claims and the recent decision of *Toombes* on page 27.

Alasdair Henderson follows up on an appeal, considering when medical technology goes wrong on page 29.

Cara Guthrie also considers an appeal concerning the treatment of taking obvious risks in PI claims on page 31.

Matthew Donmall explains two quantum decisions concerning loss of earnings and income from businesses on page 33.

Thomas Beamont analyses a decision concerning pre-inquest admissions and recoverability of costs on page 35.

Angus McCullough QC revisits the issue of anonymity orders and provides a standard form anonymity order on page 41.

Owain Thomas QC explains the *Maughan* decision concerning the standard of proof for a conclusion of suicide in an inquest on page 45.

Dominic Ruck Keene considers a judicial review of a decision to not re-open an inquest on page 48 and a decision concerning hearing loss in the military context on page 50.

Finally, 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. Listen to hot topic discussions and interviews on the 1COR podcast Law Pod UK.

CHILDREN, INFORMED CONSENT AND PUBERTY BLOCKERS

Rajkiran Barhey

Bell & Anor v The Tavistock And Portman NHS Foundation Trust [2020] EWHC 3274 (Admin)

Introduction

This was a claim for judicial review of the practice of the Defendant's Gender Identity Development Service (GIDS) and two other Trusts joined as Interveners (University College London and Leeds Teaching Hospitals NHS Trusts) of prescribing puberty blockers ("PBs") to persons under the age of 18 experiencing gender dysphoria.

The issue at the heart of the claim was whether informed consent in the legal sense could be given by these children and young people. The court considered the issue in two parts: (1) whether, in principle, informed consent could be given by children or young persons and (2) if they could, whether the information provided by the Defendant and Trusts was adequate for providing informed consent.

The judgment was given by Dame Victoria Sharp (President of the Queen's Bench Division), Lewis LJ, and Lieven J.

Terminology

Gender dysphoria ("GD") was defined in the judgment at [3] as *"a condition where persons experience distress because of a mismatch between their perceived identity and their natal sex, that is, their sex at birth. Such persons have a strong desire to live according to their perceived identity rather than their natal sex."*

The judgment was concerned with a specific type of PB called gonadotropin-releasing hormone agonists (GnRHa) which suppress the physical developments that would otherwise occur during puberty.

As set out in [15] of the judgment, there are three stages of physical intervention for those with gender dysphoria: (1) administration of GnRHa, appropriate for either natal girls who have started developing breasts or natal boys whose testicles and scrotum have begun to get larger (2) administration of cross-sex hormones, prescribed from around the age of 16 and (3) gender re-assignment surgery, which is only available to those over age 18.

In this article, the term "children" describes persons under the age of 16, and "young person" describes those between the ages of 16 and 18.

GIDS and available data on its users

At [13] to [21] the court set out how GIDS operates. The key points were that:

1. GIDS takes referrals from a wide range of professionals [16].
2. Once a referral is made, the case is discussed with the relevant regional team and, if successful, will proceed to the GIDS waiting list [16].
3. The current waiting time for a first assessment is 22-26 months [17].
4. A child/young person will receive a number of assessment appointments, typically 3 to 6 over 6 months but there may be more [17].
5. During assessments the child/young person will be asked a range of questions about their GD [18].
6. At the end of this assessment period, a care plan is agreed with the child/young person and their family [21].
7. If the criteria are fulfilled, a child/young person will be referred by GIDS to the Intervener Trusts for assessment with endocrinologists with a view to being prescribed PBs. The Defendant's evidence was that, before any referral, GIDS clinicians discuss the treatment, including explaining side effects [21].

At [22] to [35] the court considered the available data on patients prescribed PBs. It noted that prior to 2011, PBs were only prescribed to those aged 16 or over. In 2011 PBs started to be prescribed for those aged 12-15 and in mid puberty as part of the Early Intervention Study. The court noted that the Study had not yet been published. Furthermore, the court noted with surprise that the Defendant had not collated data on the age distribution of those treated with PBs between 2011 and 2020 [27-28] although data for 2019/2020 was provided. It was noted [29] that for the year 2019/20, 26 of the 161 children referred by GIDS for PBs were 13 or younger (i.e. 16%) ; and 95 of the 161 were under the age of 16 (i.e. 59%).

The court also noted with surprise that the Defendant had carried out no analysis as to why referrals to GIDS had increased very significantly [31], or as to why the data suggested that an increasing proportion of natal females were being referred [32] and also had not collated any data on the proportion of patients referred for PBs with a diagnosis of autistic spectrum disorder (in circumstances where the Defendant's own Service Specification highlighted that a significant proportion of those presenting with GD have a diagnosis of autistic spectrum disorder) [33-35].

The consenting process

The court examined the evidence as to the consenting process at [36] to [47].

The Defendant's position was that:

> "*they will only refer a young person for PBs if they determine that person is competent to give consent, i.e. is Gillick competent within the meaning of competence identified in the decision of the House of Lords in Gillick v West Norfolk and Wisbech Health Authority [1986] AC 112."* [36].

It was explained that GIDs takes consent from patients to refer them to the Intervener Trusts but consent for the actual prescription of the PBs is taken separately by the clinicians working for the Trusts [37]. The Defendant's evidence was that GIDS clinicians make it very clear to children and young people that there are both known and unknown risks associated with GnRHa treatment [39]. Furthermore, it was noted that the consenting process undertaken by the Intervener Trusts was separate, and their evidence was that decisions did not automatically follow on from those made by GIDS [40].

The court asked for statistics as to how many people had been assessed as suitable for PBs but had been determined to not be *Gillick*-competent either by GIDS or the Trusts. No data could be provided. At [44] the court noted that:

> "*The court gained the strong impression from the evidence and from those submissions that it was extremely unusual for either GIDS or the Trusts to refuse to give PBs on the ground that the young person was not competent to give consent. The approach adopted appears to be to continue giving the child more information and to have more discussions until s/he is considered Gillick competent or is discharged."*

The court also noted evidence from a neuroscientist that, in her view, given their level of brain development:

> "*it is very possible for an adolescent to be unable to fully grasp the implications of puberty-blocking treatment. All the evidence we have suggests that the complex, emotionally charged decisions required to engage with this treatment are not yet acquired as a skill at this age, both in terms of brain maturation and in terms of behaviour."*[46]

As to the relevance of parental consent, the Defendant made it clear that they had a policy that a parent could not consent to PBs on behalf a child who was not *Gillick*-competent [47]. (Readers may be interested to know that a recent decision has considered this issue further and will be analysed in a future issue – (*AB v CD & Ors* [2021] EWHC 741 (Fam)).

The effect of PBs and their relationship with cross-sex hormones (CSHs)

The Defendant's case was that the purpose of PBs was to give the child/young person time to think about their gender identity [52]. However the court noted that there was a second purpose – to stop the development of the physical effects of puberty in order to make a later transition easier [55].

The other issue was the relationship between PBs and cross-sex hormones. The Defendant was clear that PBs and CSHs (Stage 1 and Stage 2, set out above) were completely separate. However the court's view was that the evidence showed that *"practically all children / young people who start PBs progress on to CSH."*

There was no data from GIDS showing the proportion of patients who move from PBs to CSHs [58]. A Dutch expert provided evidence that, of those who start PBs, only 1.9% did not proceed to CSH [57]. The court found at [59] that the language used in the witness statements of clinicians from GIDS and the Trusts suggests that a similarly high proportion of children and young people in the United Kingdom move from PBs onto CSH as in the Netherlands.

As to the effect of PBs, the court considered this issue at [60] to [68]. The Defendant's position was that PBs were reversible. The Claimant argued that:

> *"although most of the physical consequences of taking PBs may be reversible if such treatment is stopped, the child or young person will have missed a period, however long, of normal biological, psychological and social experience through adolescence; and that missed development and experience, during adolescence, can never be truly be recovered or 'reversed'."*[65].

The other issue was the connection between PBs and CSHs, as it was undisputed that CSHs have irreversible effects.

At [69] to [74] the court considered the evidence that PBs were an experimental treatment. At [71] it noted that "*the lack of a firm evidence base for their use is evident from the very limited published material as to the effectiveness of the treatment, however it is measured."*

At [75] to [77] the court considered the question of 'persistence' i.e. whether the prescription of PBs and/or affirmative treatment can lead to the persistence of GD in patients in circumstances where, without such treatment, their GD would resolve. At [77] the court stated: "*In short, the treatment may be supporting the persistence of GD in circumstances in which it is at least possible that without that treatment, the GD would resolve itself."*

At [78] to [89] the court considered a number of witness statements including from the Claimant (a natal female who de-transitioned) but also from patients who had successfully transitioned and were wholly supportive of their care.

The parties' submissions

At [90] to [104] the court set out the submissions of the parties.

As set out in [93], the Claimant submitted that: *"a child still going through puberty is not capable of properly understanding the nature and effect of PBs and weighing the consequences and side effects properly."* Furthermore, in their submission, PBs were properly described as an experimental treatment. Additionally, there was evidence that PBs have side effects, and evidence that children who start PBs will progress to irreversible CSHs. The information provided to patients was misleading as to the reversibility of PBs, their purpose and their benefits.

The Defendant and Intervener Trusts submitted that their process was fully compliant with the relevant regulatory frameworks, as well as *Montgomery v Lanarkshire Health Board [2015] AC 1430.* Counsel for the Intervener Trusts argued that the child or young person did not need to understand the impact of CSH on their fertility because that did not fall to be decided at the stage of prescribing PBs. The PBs provided the space for the person to think about further stages [100].

The Gillick decision

At [105] to [107] the court considered the decision which lay at the heart of this case – *Gillick v West Norfolk and Wisbech Health Authority* [1986] AC 112, a House of Lords decision considering the lawfulness of a policy by which children were given contraceptive advice without parental consent. The House of Lords held by a majority that a doctor could lawfully give contraceptive advice and treatment to a girl aged under 16 if she had sufficient maturity and intelligence to understand the nature and implications of the proposed treatment and provided that certain conditions were satisfied. The court also considered a number of decisions which applied the *Gillick* principle in the context of treatment for anorexia [109] to [113]; refusal of a blood transfusion [114] to [115] and putting up a baby for adoption [116] to [118]. At [119] to [124] the court also considered the parties' submissions as to *Montgomery v Lanarkshire Health Board* [2015] AC 1430, the well-known decision on informed consent.

At [126] to [132] the court set out its key conclusions:

1. Whether a person is *Gillick*-competent to make a decision will depend on the nature of the treatment proposed as well as that person's individual characteristics. The assessment is necessarily an individual one. Where the decision is significant and life changing then there is a greater onus to ensure that the child understands and is able to weigh the information.
2. However the court can draw some lines. It was undisputed that, for example, a 7 year old being treated for precocious puberty with PBs could not give informed consent.
3. Efforts should be made to allow the child or young person to achieve *Gillick* competency where that is possible.
4. Not every individual under 16 can achieve *Gillick* competence in relation to the treatment proposed. Depending on the treatment, it might be that *Gillick* competence can never be achieved.
5. The bar should not be set too high. It is not appropriate to equate the matters that a clinician needs to explain, as set out in *Montgomery*, to the matters that a child needs to understand to achieve *Gillick* competence. A person should be able to understand an explanation of that information in broad terms and simple language. The child or young person needs to be able to demonstrate sufficient understanding of the salient facts.
6. In deciding what facts are salient and what level of understanding is sufficient, it is necessary to have regard to matters which are those which objectively ought to be given weight in the future although the child might be unconcerned about them now e.g. the impact on fertility and on future sexual functioning.

Conclusions

At [133] to [150] the court set out its conclusions.

The court noted at [134] that PBs as a treatment are unusual because (1) they are experimental, in that there is uncertainty as to their consequences and limited evidence as to their efficacy (2) the purpose of PBs is unclear, i.e. whether they are prescribed to provide a patient with 'time to think' or to limit puberty such that a later transition is easier and (3) the consequences of the treatment are complex, can be lifelong, and are life changing.

Further as to the unique nature of PBs as a treatment, the court found at [135] that *"in other cases, medical treatment is used to remedy, or alleviate the symptoms of, a diagnosed physical or mental condition, and the effects of that treatment are direct and usually apparent. The position in relation to puberty blockers would not seem to reflect that description."*

The court also found that PBs and CSHs form "*one clinical pathway and once on that pathway it is extremely rare for a child to get off it*" [136] and that it was appropriate to see PBs as a *"stepping stone"* to CSHs [137], and therefore a child must understand the consequences of both treatments in order to be *Gillick* competent [138].

The information that a child would have to understand was: (i) the immediate consequences of the treatment in physical and psychological terms; (ii) the fact that the most patients taking PBs go on to CSH; (iii) the relationship between taking CSH and subsequent surgery; (iv) possible loss of fertility caused by CSHs; (v) the impact of CSH on sexual function; (vi) the impact that taking this step on this treatment pathway may have on future and life-long relationships; (vii) the unknown physical consequences of taking PBs; and (viii) the fact that the evidence base for this treatment is as yet highly uncertain [138].

The court observed at [139] to [141] that it was very difficult for a child to balance and weigh up this sort of information, and that many children treated by GIDS were especially vulnerable [142].

The court did not accept that simply providing more information to children would resolve the issue, finding at [144]:

> "*The issue in our view is that in many cases, however much information the child is given as to long-term consequences, s/he will not be able to weigh up the implications of the treatment to a sufficient degree. There is no age appropriate way to explain to many of these children what losing their fertility or full sexual function may mean to them in later years."*

Again at [150], the court found:

> *"The problem is not the information given, but the ability of the children and young people, to understand and most importantly weigh up that information. The approach of the defendant appears to have been to work on the assumption that if they give enough information and discuss it sufficiently often with the children, they will be able to achieve Gillick competency."*

As a consequence, in relation to children, the court found:

> *"… it is highly unlikely that a child aged 13 or under would ever be Gillick competent to give consent to being treated with PBs. In respect of children aged 14 and 15, we are also very doubtful that a child of this age could understand the long-term risks and consequences of treatment in such a way as to have sufficient understanding to give consent. However, plainly the increased maturity of the child means that there is more possibility of achieving competence at the older age."* [145].

As to young persons, i.e. those aged over 16:

> *"… so long as the young person has mental capacity and the clinicians consider the treatment is in his/her best interests, then absent a possible dispute with the parents, the court generally has no role...*
>
> *We do however recognise that in the light of the evidence that has emerged, and the terms of this judgment, clinicians may well consider that it is not appropriate to move to treatment, such as PBs or CSH, without the involvement of the court. We consider that it would be appropriate for clinicians to involve the court in any case where there may be any doubt as to whether the long-term best interests of a 16 or 17 year old would be served by the clinical interventions at issue in this case."* [146] to [147].

The court accepted that a balance must be struck between intrusion into the autonomy of a young person and protection of that person, but in this case the protective role of the court was appropriate.

Concluding thoughts

The practical upshot of this decision is that, in relation to children under the age of 16, an application to the High Court for a declaration that PBs are in the child's best interests will be required before they can be administered. In relation to young persons over the age of 16 it will not be necessary but may be appropriate if there is any doubt or a dispute with the person's parents.

In terms of wider implications, in the author's view, the decision as to *Gillick* competence is likely to be confined to the specific facts of the case. The court emphasised its view that puberty blockers were unusual, and even unique, as a course of medical treatment (see for example [134] and [135]) in terms of its experimental nature

(in the court's view), its purpose, and the fact that it is a treatment with very clear physical effects for a condition which has no physical manifestation. Furthermore, it remains disputed as to whether gender dysphoria is properly categorised as a medical condition.

Permission to appeal to the Court of Appeal has been granted and so this decision is unlikely to be the final word on this difficult and highly controversial issue.

Jeremy Hyam QC and Alasdair Henderson of chambers acted for the Claimant in this case. They did not contribute to this article.

ANOTHER TRIP DOWN MEMORY LANE

Jeremy Hyam QC

Ismail v Joyce [2020] EWHC 3453 (QB)

R (Dutta) v GMC [2020] EWHC 1974 (Admin)

We have previously in QMLR– see *CXB v North West Anglia NHS Foundation Trust* [2019] EWHC 2053 (QB) covered in Issue 3, November 2019 - considered the developing caselaw in respect of the judicial assessment of the reliability of factual witness evidence. These two further cases helpfully illuminate how, in the healthcare context, the court is likely to approach the assessment of factual evidence, particularly in cases where the facts in issue go back a number of years, and where there is a conflict between a Claimant's account and the medical records.

In *Dutta,* the Claimant, a cosmetic surgeon, brought a consolidated appeal and judicial review of an MPTS (GMC) decision to suspend him following a public hearing lasting some 17 days. The appeal was mainly concerned with MPTS's factual findings in respect of an allegation that Mr Dutta had inappropriately pressurised a patient to undergo breast augmentation surgery by offering her a £500 discount. This allegation dated back to 2009, some 10 years before the date of the hearing. The MPTS appeared to have accepted the complainant's account based on her demeanour saying in particular:

> "*The Tribunal assessed that Patient A's account of Dr Dutta offering her a discount was emphatic and assured, and whilst it may be expected that recollections of events could be inaccurate and evolved over time, it is less likely that an event would be contrived in its entirety as a result of the passage of time*".

Warby J identified at least three fundamental errors disclosed by this approach. First, the Tribunal approached the resolution of the central factual dispute by starting with an assessment of the credibility of a witness's uncorroborated evidence about events ten years earlier, only then going on to consider the significance of unchallenged contemporary documents. Second, the Tribunal's assessment of the witness's credibility was based largely, if not exclusively on her demeanour when giving evidence, and third, the way the Tribunal tested the witness evidence against the documents involved a mistaken approach to the burden of proof and the standard of proof.

The case is instructive because Warby J helpfully distils the key aspects of the judicial learning on the assessment of factual evidence and emphasises the points of particular relevance from *Gestmin*; *Lachaux*, and *Carmarthenshire County Council.* Perhaps the single important aspect of that learning is the summary taken from *Gestmin* that:-

> *"the best approach from a judge is to base factual findings on inferences drawn from documentary evidence and known or probable facts. This does not mean that oral testimony serves no useful purpose… But its value lies largely… in the opportunity which cross-examination affords to subject the documentary record to critical scrutiny* and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and

> events. *Above all, it is important to avoid the fallacy of supposing that, because a witness has confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth;"* (the italicising is Warby J's emphasis of matters relevant to the instant appeal).

Ismail v Joyce [2020] EWHC 3453 (QB), is a decision of HHJ Freedman sitting as a deputy High Court Judge in a clinical negligence case. The key issue on liability turned on what symptoms the Claimant was suffering at, and in the days preceding, a GP consultation with Dr Joyce. The Claimant subsequently went on to be diagnosed with TB and suffered brain damage which prompt intervention by Dr Joyce might have avoided. The Defendant's case was essentially that the Claimant's account of events could not be relied upon and Dr Joyce's recollection (supported as it was by clinical notes) should be preferred. Once again *Gestmin* is cited as the '*locus classicus*' for judicial guidance on the fallibility of human memory, and reference is made to Stewart J's decision in *Kimathi,* and *Dutta,* above. The judge observed how such cases are of particular application in the medical context where the medical records do not bear out what is recalled by the Claimant. Indeed it is notable that HHJ Freedman started from the proposition that: "*the inherent fallibility of human memory"* means that *" it is fair and proper to test the accuracy of recollections of medical consultations against what is documented in the records*".

The judge also made one further observation which turned out to be critical to his overall findings, namely that:

> "*it seems to me to be perfectly legitimate to find that, in some instances,* [the Claimant and her sister's] *memories may be unreliable but, in other instances, their recollections of what was said or done can be relied upon. The latter will be particularly be the case if there is support in the medical records for what is said by them in their written and oral evidence. The central point is that just because in some instances, it is not possible to accept their evidence as to what happened or as to what was said, it does not render them unreliable witnesses, in the sense that the totality of their evidence falls to be rejected*."

Thus while the judge held that the Claimant's memory was unreliable in some respects, including whether she had told Dr Joyce that she coughed up spots of blood in her saliva at her appointment, on a critical issue - whether the Claimant was suffering '*drenching night sweats'* shortly before the Claimant saw Dr Joyce – the Claimant's evidence was accepted. The superficial inconsistency in rejecting part of the Claimant's recollection as unreliable but accepting another part as reliable, was explained by the judge as owing to the partial corroboration of her account of a history of drenching night sweats preceding the appointment, in the contemporaneous note made by Dr Joyce that she was '*sweaty at night*'.

Comment

The real point to make about this recent flurry of cases in which the judicial learning on the fallibility of human memory is condensed into a series of general propositions is that that they should be seen as the court seeking to explain the proper process of judicial-decision making rather than establishing any new legal principle. As Warby J explains, much of the current thinking on this issue is not 'new' and much of it can be traced back at least to Robert Goff LJ's decision in *Armagas Ltd v Mundogas SA* [1985] 1 Lloyds Rep 1, 57 if not before. Lord Bingham's paper on "*The Judge as juror*" in chapter 1 of "*The Business of Judging*" describes the judicial fact-finding process in much the same vein. One thing is certainly clear: reliance on a witness's confident demeanour is now a discredited method of judicial decision-making. It will be a brave Claimant who seeks to argue for factual findings against medical professionals that find no support in contemporaneous documentation, or which are inconsistent with them, when the starting point for the Court will be "*the inherent fallibility of human memory*".

Readers may also be interested in the piece by Rajkiran Barhey (below) and Dominic Ruck Keene on page 50.

MEDICAL RECORDS AND RELIABILITY

Rajkiran Barhey

Failes v Oxford University Hospitals NHS Trust [2020] EWHC 3333 (QB)

Along with *Ismail* and *Dutta* considered by Jeremy Hyam QC, this decision of HHJ Cotter QC also provides a good example of the approach courts will take to the reliability of medical records and witness testimony.

On 9 June 2015, the Claimant underwent surgery to remove a tumour from within his spinal cord. By 15 June 2015 the Claimant had deteriorated such that he was paralysed from the waist down. The Claimant's case was that by 11 June he had deteriorated such that he should have received emergency surgery and, if he had, he would have avoided the injury. The Defendant's case was that the Claimant was in fact progressively improving but suffered a sudden deterioration on 15 June.

As noted at [12], there was a single factual issue at the heart of the case: when did the Claimant's condition deteriorate?

As a result, the factual evidence was key in this case. At [28] HHJ Cotter QC set out his approach to factual findings, noting his previous comments in *Busby v Berkshire Bed Company Limited* [2018] EWHC 2976 (QB) that ultimately the court has to stand back and consider whether the suggested explanation is more likely than the alternative explanations and that the court has to approach the exercise of fact finding as fitting together a sufficient number of jigsaw pieces to allow the full picture to be seen (even if all the jigsaw pieces cannot be fitted together).

The Claimant relied on neurological observations recorded in a chart entitled 'laminectomy observations.' These observations showed a deterioration in the afternoon of 11 June 2015 which was not brought to the attention of any doctor and, the Claimant argued, should have been.

The Defendant did not call any of the 24 nurses who made the entries in the laminectomy chart. The Claimant asked the judge to draw an adverse inference on that basis [31] and, as a result, the Defendant's solicitor had to put in a witness statement to explain why no such evidence had been obtained. Ultimately the judge did not draw an adverse inference, noting at [33] that:

> *"I did not approach the relevant entries in the laminectomy chart as I may other entries in documents in different contexts. Rather I took as a starting point a presumption that they accurately recorded the belief of the relevant nurse after some form of investigation or assessment."*

The judge then undertook a detailed analysis of the medical records, the Root Cause Analysis, factual and expert evidence pertaining to the Claimant's presentation in the days after his surgery. Ultimately, the experts agreed [120] that apart from the laminectomy chart, all of the other evidence suggested that the Claimant was making reasonable progress following the surgery on 9 June before an acute deterioration on the 15 June. The judge also attached significant weight to the Claimant's own account of his condition, noting at [122]:

> *"So often over 35 years of involvement in clinical negligence work I have seen complaints from Claimants that the nursing or clinical staff did not take sufficient notice of what they were saying about issues with their bodies ; that judgments were made or not made without adequate weight being attached to the history or issues raised by the person actually experiencing the relevant symptoms... What a person says about what they think of pain, discomfort etc is vitally important as they can usually put it into a context or normality or relevant recent history whereas a clinician (absent objective testing) cannot do so. Indeed even with objective testing it will often still be the case that what a patient says, and/or can actually do, that should usually have primacy within a clinical assessment."*

The judge also considered the limitations of the laminectomy chart in terms of the way in which observations were recorded (e.g. the legs and arms were treated as a whole, and there was no scoring system, only the categories of normal power, mild weakness and severe weakness). Overall, he found that the presumption of accuracy of the laminectomy chart had been displaced.

Overall, the judge concluded that, in fact, the Claimant was improving until 15 June when he deteriorated catastrophically. As a result, had he been reviewed by the consultant on 11 June, subsequent detailed neurological examination would not have found any material deterioration in the lower limbs and the Claimant would not have been returned to surgery. The Claimant's claim therefore failed.

Comment

Ultimately, the claim appeared to hinge on the laminectomy chart. The Defendant was able to successfully argue that it was unreliable and to displace the presumption of accuracy that generally attaches to medical records.

SPINAL SURGERY

Rajkiran Barhey

Henry v Oxford University Hospitals NHS Foundation Trust [2020] EWHC 3306 (QB)

This claim concerned posterior instrumental fusion surgery which took place on 22 July 2010. The Claimant alleged that there was failure to recognise misplacement of the L5 pedicle screw, either intra-operatively, in the immediate post-operative period or longer term. No issue was taken with the placement of the pedicle screw. The Claimant's case was that he suffered impingement or irritation of the L5 nerve root caused by the pedicle screw from July 2010 until its removal in 2015. The Claimant ultimately underwent removal of the screw. Whilst initially this brought relief, his pain levels slowly increased to pre-surgery levels.

Ultimately, Master Cook found against the Claimant. He found that whilst the pedicle screw was misplaced, the misplacement was minor and was not a breach of duty. He further found that AP imaging and a radiolucent table were used during the procedure, and therefore no breach was made out on that ground. Furthermore, and crucially, he found that, following the procedure, the Claimant did not develop new pain or neurological deficit, rather he was reporting the same pain as pre-surgery albeit at different intensities. Furthermore, he found that the misplaced pedicle screw was not touching the nerve root at any point. Additionally, the pedicle screw was not the cause of the Claimant's symptoms and, despite its removal, the Claimant's pain returned.

Of particular interest may be Master Cook assessment of the Claimant's experts – he noted that the radiology expert "*only considered the issue from his own point of view"* [51] and the spinal surgery expert's approach was "*partisan, rather than taking an objective view of the evidence contained in the medical records, he has attempted to select medical records which fitted in with his view of the case"* [53]. In contrast, he found both treating clinicians, and the Defendant's experts, to be more reliable. Furthermore, Master Cook commented that, whilst the Claimant tried his best to give honest evidence, he was a poor historian which he found unsurprising, given the level of painkillers the Claimant had been taking for a significant period of time.

CONTESTED INTERIM PAYMENT APPLICATIONS AND WHY TO AVOID THEM

Lizanne Gumbel QC

Carl Duffy v Centraal Beheer Achmea [2020] EWHC 3341

Interim payment applications in clinical negligence and other personal injury cases are a prolific area of contested litigation. It is surprising how often an interim payment cannot be agreed. It is probably partly because applications need to be made urgently to meet the claimant's injured needs but the evidence in support is not available in a disclosable form (or at all) in a time scale that meets these needs. The defendant is often met with an application when it has very limited expert evidence, (if any at all) and very little detail of the claimant's prognosis and needs. At the stage the application is made the defendant will want to test the evidence unless it is really clear cut and carefully prepared. The case of *Duffy v Central Beheer Achmea* is another example of this situation. Significant work is required on the part of the claimant to provide schedules and supporting evidence for the items that make up the calculations for the interim payment. The more detail and support that can be provided the more likely an interim payment can be agreed or will be ordered by the judge. However the urgency of applications to meet the claimant's needs always has to be balanced against the delay and costs that obtaining

detailed evidence and a fully detailed schedule will involve. Negotiation with the defendant as to what they require in order to be able to agree interim payments should always be the starting point and compromise is usually better for both parties than a contested application.

The decision of HHJ Coe QC sitting as a High Court Judge does not set out any new approach but is a good practical example of the detail that is required to be provided to the court when making such applications. Although the case was heard after the Court of Appeal decision in *Swift v Carpenter* it does not include a claim for future accommodation. Therefore unfortunately it does not assist with how a court will make a conservative assessment of future accommodation costs where the accommodation claim is calculated on the basis set out by the Court of Appeal in *Swift v Carpenter.*

Further, although in the *Duffy* case there was a jurisdiction issue, as the Defendant was a Dutch motor insurer , this was only of limited relevance to the application. The judge explained the position in [8]:

> "*In terms of the applicable law there is little if any dispute between the parties and so I can take this shortly. The claim is brought in the English Court against a Dutch motor insurer and it is agreed that the law of the Netherlands applies to this claim in tort. The claimant, as a result of Dutch law has a direct right of action against the insurer and, following the decision in FBTO v Odenbreit [2007] C 463-06 , the jurisdiction of the English Court is not an issue. The law of the Netherlands applies (pursuant to Article 41(1) of the Rome II Regulation on applicable law in tort (Regulation 864/2007)). Dutch law will govern limitation, breach of duty and causation as well as the existence of, the nature of and the assessment of damages to which the claimant might be entitled. Matters of procedure and evidence are nonetheless reserved to the forum court (see Article 15(c) of the Rome II Regulation and Article 1(3)). This is an application for an interim payment which is a procedural application and thus governed by English law. However, when it comes to any assessment of the damages to which the claimant might be entitled on which to base the interim payment decision, Dutch law has to be applied."*

The starting point for calculating the appropriate amount to be awarded by way of interim payment remains the principles set out by the Court of Appeal in *Cobham Hire Services Ltd v Eeles* [2009] EWCA Civ 204*.* The Court of Appeal described how there are two possible criteria for making an interim payment. However the ordering of any interim payment at all remains within the discretion of the court.

Eeles – Limb 1

The first basis – referred to in subsequent cases as Limb 1 of *Eeles* is:

That on a conservative estimate the likely award of a lump sum at trial for general damages, past losses with interest and accommodation (including running costs) will exceed the total sum sought by way of interim payments. That is, that at trial these items cumulatively will exceed any sums already obtained by way of interim payment and the further sum requested at the application after any deduction is made for contributory negligence or liability compromise.

The interim payment can be a high proportion of the likely award of the lump sum provided the estimate is made on a conservative basis. For the purposes of making an award on this basis the Court need not have regard to how the lump sum is to be spent, that is a matter for the claimant. In the case of *TTT v Kingston Hospital NHS Trust* (25/11/2011) Mr Justice Owen confirmed that a proportion calculated at 90% of the likely capital to be awarded at trial was a reasonable approach. Subsequently in the case of *FP v Taunton and Somerset NHS Trust* (16/12/2011), Mr Justice Higginbottom awarded a further interim payment of £500,000 to a Claimant making total interim payments of £2.2 million in a case where he assessed the lump sum likely to be awarded at trial would be £2.3 million. This represents over 95% of the assessed lump sum. In the case of *Duffy*, HHJ Coe QC calculated the interim award on the basis of 90% of a conservative calculation.

Eeles – Limb 2

The second basis – referred to in subsequent cases as Limb 2 of *Eeles* is:

If the claimant cannot satisfy the test in limb 1 of *Eeles 1* that the lump sum is likely to exceed interim payment sought together with any interim payments already received when damages that might be made by periodical payments are excluded, then the claimant must show that the trial judge is likely to need to capitalise other heads of loss to provide a lump sum to meet the claimant's needs. That is the claimant will need to satisfy the test set out in the case of *Braithwaite v Homerton University Hospitals NHS Foundation Trust* [2008] EWHC 353 (QB) and endorsed by the Court of Appeal in the *Eeles* case.

In the *Braithwaite* case Stanley Burnton J (as he then was) summarised the position as follows:

> *"Indubitably on the basis of the interpretation I have arrived at on Part 25, there is a degree, perhaps a high degree, of prediction involved. I accept the submission that at this stage the court should not make a decision which is liable to close the door on decisions which may be made by the trial judge. However, the crucial words in 25.7(4) are ''the likely amount of the final judgment'' and it seems to me that if the court now is able to say that it is likely or indeed more than likely that a capital award will be made at trial significantly in excess of £850,000 there is jurisdiction to make an interim payment.*
>
> *Should or can the court so predict? Were the discretion available to me it is one I should unhesitatingly exercise. The need of the claimant for professional care and for suitable accommodation is evident on the evidence before me. It is not suggested, as I understand it, that the accommodation that is presently occupied by the claimant, her mother and her sister, is in any way suitable. The object of the jurisdiction to award an interim payment is in part so that a claimant who is in such need may have those needs satisfied out of monies she is likely to receive in due course. The need is enhanced in the present case because the ability of the claimant to access professional care is itself limited by her present accommodation. It is only if she can obtain suitable accommodation that there will be any possibility of her accessing professional care.*
>
> *Is the court at this stage, therefore, able to say that it is likely that there will be at trial an award of a capital sum of the kind of figure which is necessary for this interim payment to be made? If the court cannot say what is likely to occur then there is no jurisdiction under Part 25.7(4). If, on the other hand, the court is in a position to make a reliable prediction as to what the judge at trial will do then the position is different.*
>
> *Again, in my judgment, even on the evidence presently available I can confidently predict that at trial the judge will make an order for a capital payment significantly in excess of £850,000. I say that because unless such an award is made the claimant's needs simply cannot adequately be satisfied, as I have already indicated the accommodation is unsuitable and she cannot access professional care. If that means there will have to be some discount to or postponement of periodical payments, in my judgment, the judge is bound so to order."*

In the case of *Duffy,* HHJ Coe QC set out the principles to be applied with reference to the summary by Popplewell J in *Smith v Bailey* [2014] EWHC 2569:

> *"19. It is convenient to set out the principles which I take to be established by Eeles and the previous authorities which it sought to summarise:*
>
> *(1) CPR r. 25.7(4) places a cap on the maximum amount which it is open to the Court to order by way of interim payment, being no more than a reasonable proportion of the likely amount of the final judgment (para 30).*
>
> *(2) In determining the likely amount of the final judgment, the Court should make its assessment on a conservative basis; having done so, the reasonable proportion awarded may be a high proportion of that figure (paras 37, 43).*
>
> *(3) This reflects the objective of an award of an interim payment, which is to ensure that the claimant is not kept out of money to which he is entitled, whilst avoiding any risk of an overpayment (para 43).*

(4) The likely amount of a final judgment is that which will be awarded as a capital sum, not the capitalised value of a periodical payment order ("PPO") (para 31).

(5) The Court must be careful not to fetter the discretion of the trial judge to deal with future losses by way of periodical payments rather than a capital award (para 32).

(6) The Court must also be careful not to establish a status quo in the claimant's way of life which might have the effect of inhibiting the trial judge's freedom of decision, a danger described in Campbell v Mylchreest as creating "an unlevel playing field" (paras 4, 39).

(7) Accordingly the first stage is to make the assessment in relation to heads of loss which the trial judge is bound to award as a capital sum (para 36, 43), leaving out of account heads of future loss which the trial judge might wish to deal with by a PPO. These are, strictly speaking (para 43):

general damages for pain, suffering and loss of amenity;

past losses (taken at the predicted date of the trial rather than the interim payment hearing);

interest on these sums.

(8) For this part of the process the Court need not normally have regard to what the claimant intends to do with the money. If he is of full age and capacity, he may spend it as he will; if not, expenditure will be controlled by the Court of Protection (para 44). Nevertheless, if the use to which the interim payment is to be put would or might have the effect of inhibiting the trial judge's freedom of decision by creating an unlevel playing field, that remains a relevant consideration (para 4). It is not, however, a conclusive consideration: it is a factor in the discretion, and may be outweighed by the consideration that the Claimant is free to spend his damages awarded at trial as he wishes, and the amount here being considered is simply payment at the earliest reasonable opportunity of damages to which the Claimant is entitled: Campbell v Mylchreest [1999] PIQR Q17.

(9) The Court may in addition include elements of future loss in its assessment of the likely amount of the final judgment if but only if it has a high degree of confidence that the trial judge will award them by way of a capital sum, and (b) there is a real need for the interim payment requested in advance of trial (para 38, 45).

(10) Accommodation costs are "usually" to be included within the assessment at stage one because it is "very common indeed" for accommodation costs to be awarded as a lump sum, even including those elements which relate to future running costs (paras 36, 43)."

In looking at reasonable proportion the cases now consistently allow a high proportion and between 90 and 95% is not unusual. HHJ Coe QC allowed 90% on the *Eeles 1* calculation.

The case of *Duffy* emphasises how important it is to provide detailed and up to date figures to the judge when making an interim payment application. If the trial is still some years ahead then details of all the likely expenditure to trial need to be provided with expert support where possible. In respect of the position as to the losses to trial in the case of *CR v West Hertfordshire NHS Trust* [2015] EWHC 1123 Spencer J explained how the anticipated losses in the 18 months between the application in that case and the trial should be added to the past losses when making the *Eeles* calculation. He set out in [6] how:

"It is important to emphasise as Popplewell J made clear in Smith v Bailey that "past losses" means losses taken at the predicted date of trial, rather than the interim payment hearing."

HHJ Coe QC pointed out in the *Duffy* case that:

"*A particular difficulty in this case is that the defendants' figures set out in the written submissions are formulated in the context of the 2019 schedule to which I have already referred. The claimant's submissions are based on the Immediate Needs Assessment of Elizabeth Edwards which is not currently*

> *incorporated into an updated schedule. The figures and the methods of calculation are by no means the same. Therefore, any meaningful valuation table in accordance with the practice recommended in Grainger v Cooper [2015] EWHC 1132 is not properly achievable given that one would not be comparing like with like."*

A detailed up to date schedule setting out all the costs to date and projected costs to trial is ideally needed to support such applications. However this is not always feasible at this stage in the litigation and there is a balance to be struck as to what can be achieved by way of detail and the urgency of the application. In the event the judge went through each figure suggested by the Claimant and each figure offered by the Defendant and arrived at her own conservative valuation. The Claimant obtained significantly less than requested, a sum of £400,000 was sought and £116,000 awarded.

These applications when contested are never straightforward. As suggested above, negotiation with the defendant and even a round table meeting to discuss an application for an interim payment should always be the starting point. If the defendant requires expert evidence before being prepared to make such payments then the costs need to be taken into consideration. Striking a balance between what is reasonably required and what is reasonably necessary and proportionate should be a matter of negotiation rather than driving the parties to contested litigation. It is almost inconceivable that the defendant will pay more than the final capitalised award by way of interim payments but the need for the defendant to understand the basis of the application is also understandable. As with most aspects of litigation the interests of both parties are usually best met by sensible negotiation and compromise. Too often the result of such contested litigation is that the claimant obtains less then they hope from the application and the defendant pays more than they hope and pays the costs of the application.

NON DELEGABLE DUTIES

Shaheen Rahman QC

Hopkins v (1) Akramy (2) Badger Group (3) NHS Commissioning Board [2020] EWHC 3445 (QB)

A preliminary issue was determined by HHJ Melissa Clarke on the issue of whether the NHS owed a non-delegable duty of care to a patient when care was outsourced to a private provider.

The Claimant was an unwell 2-year-old child whose grandmother sought out-of-hours care for her on 28 December 2008. The child had become unwell on Boxing Day, was not interested in her presents, eating and drinking very little, moaning and unable to talk and had become unsteady on her legs.

The GP practice's automated message directed patients to an out-of-hours medical centre where the Claimant was assessed by a nurse practitioner. The advice given was to encourage the child to drink and take paracetamol and to consult her GP If she did not improve. The child deteriorated and was admitted to hospital a few days later where an MRI scan revealed hydrocephalus and brain abnormalities requiring urgent surgery. The child has been left with severe and permanent neurological injuries. It is alleged that the nurse practitioner's assessment was negligent.

The First Defendant was the nurse practitioner, the Second Defendant a private company with whom the NHS had contracted to operate the out-of-hours medical centre (which had in turn contracted with the nurse to provide care) and the third defendant was the Primary Care Trust, whose liabilities have since been assumed by the NHS Commissioning Board.

The Second Defendant had no insurance for the purposes of any liability to the Claimant, notwithstanding the requirement to hold adequate insurance arising from the negligent performance of the services that was part of its contract with the PCT. It required those they engaged to provide care to hold their own insurance cover. However, the cover obtained by the First Defendant in this case is unlikely to be sufficient to satisfy the claim at full value.

Against this background, the Claimant argued that as the Claimant was an NHS patient the Third Defendant owed a non-delegable duty of care to her and should also be liable to her for any damages arising from the nurse practitioner's negligence.

The judgment considered the provisions of the NHS Act 2006 ("the Act") which provides at section 83 that each PCT must provide primary medical services within its area or secure their provision within its area and that it can either provide those services itself or make arrangements for such provision including entering into contractual relationships with other providers. The Claimant argued that the statutory duty went beyond merely arranging provision of services, but extended to the performance of those services and this could not be delegated.

However, the judge accepted the Defendant's contrary argument that the duty in this case did not extend further than making arrangements for services to be provided, similar to the arrangement of foster care by councils as considered in *Armes v Nottinghamshire County Council* [2017] UKSC 60. Whilst the statutory duty under section 83 is mandatory, It may be discharged either by the PCT providing primary medical services or securing the provision of those services by a third party (see [68] to [74] of the judgment).

Comment

Of note:

1. The Second Defendant did not contest that it owed a non-delegable duty to the Claimant and/or was vicariously liable for the actions of the First Defendant. (Para 24-5)

2. The matter was considered only on the basis of whether a non-delegable duty arose under statute rather than any common law duty, such as that considered in *Woodland v Swimming Teachers Association and Os* [2013] UKSC 66. A common law duty did not fall for consideration in this case as it could not override the explicit statutory provision within the Act. (Para 73-4)

3. The Claimant sought at first to rely on the NHS Constitution, principle 5 of which notes that the NHS is committed to working with a number of organisations including private organisations in the interests of patients. At the hearing it was accepted by the Claimant that the NHS Constitution was not in place at the date of the negligence. However, it appears that such an argument could be deployed in a future case. (Para 58)

The quadriplegic Claimant in this case was an NHS patient, but the NHS will not cover her claim. Should she succeed, the insurance taken by the nurse practitioner is likely to fall well short of meeting her needs, as may the value of the nurse's own assets and those of the uninsured Second Defendant, a position that is unfortunate to say the least, for all involved.

Angus McCullough QC appeared for the Third Defendant. He did not contribute to this article.

CAUDA EQUINA AND CAUSATION

Matthew Flinn

Hewes v West Hertfordshire Acute Hospitals NHS Trust and 2 Others [2020] EWCA Civ 1523

The Court of Appeal dismissed a challenge to a first instance decision of the High Court that two NHS Trusts and an out-of-hours GP were not liable to the Claimant for alleged failings in the identification and treatment of Cauda Equina Syndrome.

Cauda Equina Syndrome ("CES") is a devastating condition, and where it arises due to negligence, it frequently leads to large and complicated claims for compensation. Accordingly, it is of note that this was said by Davis LJ to be, so far as is known, *"the first case directly relating to the treatment of CES which has come before the Court of Appeal".* That may be so, but the Court of Appeal was also at pains to emphasise that, having regard to the

issues in the case and the nature of the grounds of appeal, it was not a case of wider public significance (albeit of course very important to the Claimant); rather, it was a case which turned on its own facts.

The crucial issues in the case related to: (1) the urgency with which the Claimant's suspected CES was dealt with by the out-of-hours GP he spoke to on the phone and the Trusts involved in his care thereafter, and (2) the point at which the Claimant's condition progressed from CES "Incomplete" ("CESI") to "Retention" CES ("CESR"). This involved the judge at first instance considering evidence from factual witnesses relating to matters such as the process for arranging MRI scans at a District Hospital and thereafter making arrangements for surgery, and resolving disputes between experts as to the significance of (1) the Claimant not feeling like urinating for a specified period of time and (2) not being able to urinate when advised to try a period of hours later.

At first instance, the judge concluded that the Claimant had been managed reasonably (save for a delay in transporting him to hospital, of de minimis causal impact) and that, in any event, his condition had progressed to CESR (and was therefore largely irreversible) at a point in the chronology that was much earlier than that contended for by the Claimant. That meant that the alleged breaches of duty would have had no impact in any event.

On appeal, the Claimant advanced a "detailed attack" on the reasoning and conclusions of the first instance judge. Attempting to summarise the key points in the first instance judgment, the submissions of the parties on that judgment, and the conclusions of the Court of Appeal would risk misleading the reader (or making this article far too long). Suffice it to say that the appeal was heavily focussed on the detailed reasoning of the first instance judge and whether, in light of the evidence that had been heard, that reasoning was permissible.

Ultimately, the Court of Appeal rejected the Claimant's grounds of appeal, and in fact rather went out of its way to praise the judgment of Anne Whyte QC, sitting as a Deputy Judge in the High Court. It emphasised that first instance judges are the primary assessors of the evidence, the primary finders of fact, and they have the primary role of deciding the issues between the parties. In those roles, the appellate courts will not lightly interfere - see e.g. the decision of the Supreme Court in *Perry v Raleys Solicitors* [2019] UKSC 5, in which the key issue was whether the judge at first instance had gone wrong in his decision on the facts to an extent which enabled the Court of Appeal to intervene. At [52], Lord Briggs said that the test is whether there is no evidence to support a challenged finding of fact, or that the finding was one which no reasonable trial judge could reach.

In setting out the challenges to the judge's assessment of the evidence, her findings and her conclusions, Laing LJ said:

> *[62] The trial in this case lasted six days. There were pages of pleadings, witness statements, experts' reports and academic literature for the Judge to absorb before the trial, and to reflect on after she had reserved judgment. This appeal is not a wholesale opportunity to revisit, in detail, her findings of fact, her evaluative assessments, or her mixed findings of fact and law. To use Lewison LJ's vivid metaphor in Fage UK Limited v Chobani UK Limited [2014] ETMR 26 , at paragraph 114, 'In making [her] decisions the trial judge will have regard to the whole sea of evidence presented to him, whereas an appellate court will only be island hopping'…*
>
> *[66] The Judge was given many building blocks for her judgment, that is, all the evidence, lay and expert, and the parties' submissions. The agreed issues were the framework of the judgment. But they did not dictate its overall structure, or its details. Those were for the Judge to decide, as a result of a cumulative series of assessments which it was for her to make; not for this court. I consider that the Judge is to be commended for having grappled with the details of the evidence and submissions, and for having distilled the essence of those materials into a judgment which deals economically and persuasively with what, the parties had agreed, were the significant issues. The tight structure of the judgment, and its succinctness, are signs that the Judge had carefully navigated the sea of evidence and analysed its essential components into a coherent whole.*

Accordingly, it seems that the most important part of this case is not the articulation of any legal principle of specific relevance to CES cases, but as a reminder of the proper scope of an appeal generally: to deal with points

of law and broad public significance, and only to interfere with evidential assessments and findings of fact at first instance where they were impermissible on the evidence that had been presented.

Richard Booth QC acted for the Appellant in this case. He did not contribute to this article.

MEDICAL TREATMENT CLAIMS UNDER SECTION 75 OF THE CONSUMER CREDIT ACT 1974

Richard Mumford

Introduction

Where medical treatment has been paid for on a credit card, a dissatisfied patient may have recourse against the credit card provider under section 75 of the Consumer Credit Act 1974 ("CCA").[1] This provision gives consumers who have been the victim of a misrepresentation or breach of contract by the supplier of goods or services paid for on a credit card the option of seeking redress against the supplier, the credit card company or both.

Where healthcare is increasingly being sought on a private basis, in particular by those who 'self-fund', claims arising from such treatment are likely to increase in frequency. A LaingBusson report in November 2019[2] noted a doubling in the sum spent on self-funded private healthcare in the UK in the 5 years between 2013 and 2018, from £527 million to £1.1 billion p.a.; one in four private patients was self-funded. The growth in patients choosing to self-fund private hospital treatment was said to be present across all specialties, particularly orthopaedics, ophthalmology, gastroenterology, gynaecology and urology with growth in demand for diagnostic services such as MRI scans, CT scans and endoscopy. It seems likely that this trend towards self-funded private healthcare will have been accelerated by the Covid-19 crisis and the increasing pressures on NHS waiting lists. In addition, self-funding is the norm in elective cosmetic procedures, which seem likely to increase in number once pandemic restrictions are eased.

What then are the options for the self-funded patient who receives treatment that was not what he or she bargained for? A patient may of course pursue a claim against the clinician or organisation providing the treatment, usually both under common law negligence and breach of contract and less commonly under the tort of misrepresentation. There may however be challenges to that approach; the defendant may be insolvent, inadequately insured or difficult to trace (particularly if abroad). If however the treatment was paid for using a UK credit card, an additional route to compensation may exist. Section 75(1) CCA provides:

> *"If the debtor under a debtor-creditor-supplier agreement falling within section 12(b) or (c) has, in relation to a transaction financed by the agreement, any claim against the supplier in respect of a misrepresentation or breach of contract, he shall have a like claim against the creditor, who, with the supplier, shall accordingly be jointly and severally liable to the debtor."*

For these purposes, a "debtor under a debtor-creditor-supplier agreement falling within section 12(b) or (c)" means someone who has paid for goods or services on his or her credit card. The "supplier" is the person or company who sold the goods or services and the "creditor" is the credit card company. It is important to remember that the debtor's claim against the creditor is no different in substance from that against the supplier – it is "a like claim". It is no wider, in that it still requires a misrepresentation or breach of contract by the supplier to be shown, but on the other hand no narrower in that it replicates in scope and remedy the claim against the "supplier" (in our example, the provider of private medical treatment).

[1] The same may also apply where the medical treatment has been paid for under a specific loan agreement or finance scheme. For simplicity this article will focus on the credit card situation.
[2] Private Healthcare: Self-Pay UK Market Report (2019, LaingBusson)

How then could s75 CCA be of application to claims relating to medical treatment? I have attempted below to identify and where possible answer the key questions that clients and practitioners in this field are likely to have.

Does s75 CCA apply to medical procedures?

Yes. The section applies to "a transaction financed by" a credit agreement, without any restriction as to the subject matter of the transaction. The provision (though surprisingly rarely litigated for something which has been on the statute books for approaching half a century) has been held in a reported case to apply to a privately-funded medical procedure in the form of a "treatment for baldness which went disastrously wrong".[3] Significantly, the section was relied on by around 600 claimants in the widely-reported PIP breast implant litigation to secure a settlement against their credit card provider Lloyds TSB[4] (albeit that this did not require the court to consider the scope of the section). Other reported claims under the section have been as varied as for purchase of land,[5] a conservatory,[6] a DVD recorder[7] and a personalised number plate.[8] The Financial Services Ombudsman (discussed further below) has determined a number of complaints under s75 in relation to medical treatment paid for with a credit card or finance scheme.

What is a "misrepresentation"?

A 'misrepresentation' is an untrue statement of fact (which can be made by words or conduct) that causes someone to enter into a contract. Misrepresentations can be categorised as fraudulent, negligent or innocent. In the medical context, a fraudulent misrepresentation might include a surgeon stating that a proposed procedure had a 100% success rate when in fact the surgeon knew the success rate was much lower; the same statement might be negligent if the surgeon, though believing it to be true, ought with proper care to have been aware of literature which contradicted it; the statement might be an "innocent misrepresentation" if the literature disproving it had not yet been published. A claimant who has been induced to enter into a contract by means of a fraudulent or negligent misrepresentation is entitled to be put in the position which he or she would have occupied if the misrepresentation had not been made .[9] This can include not only the return of the money paid under the contract but also compensation for consequential losses arising from having entered into the contract, including damages for personal injury (though the cases on this are limited).[10] It should be noted that an action in negligent misrepresentation can be founded on common law as well as section 2(1) of the Misrepresentation Act 1967 and that there is an interface between the statute and Pt 4A of the Consumer Protection from Unfair Trading Regulations 2008 which prohibit certain aggressive or unfair trading practices. In respect of innocent misrepresentation, the primary remedy is rescission i.e. unwinding the contract to return the parties to the position they occupied before it was entered into (which, in the medical context, seems unlikely to be possible in the majority of cases); where rescission is impossible, the court has a discretion to award damages in lieu but those damages are not likely to include compensation for consequential losses including personal injury. In reality therefore claims in this area are likely to be limited to fraudulent or negligent misrepresentations.

What is a "breach of contract"?

At its most straightforward, a supplier of goods or services (in our contemplated example, a medical professional providing treatment) will be liable for any loss (including consequential losses) caused by a failure to comply with the terms of the agreement reached with the customer. The common law has long held that in most

[3] *Bond v Livingstone & Co* [2001] 3 WLUK 739; [2001] PNLR 30
[4] https://www.bbc.co.uk/news/health-20935107
[5] *Mal'ouf v MBNA Europe Bank Ltd (t/a Abbey Cards)* [2014] 1 WLUK
[6] *MBNA v Ankers* [2013] 8 WLUK 294
[7] *Grant v Electro Centre Ltd* [2006] 6 WLUK
[8] *Lampon v Midland Registration Ltd* [2000] 5 WLUK 821
[9] I.e. the tortious measure of damages – see McGregor on Damages, 20th Ed, Chapter 49.
[10] McGregor cites the "strange case" of *Burrow v Rhodes* [1899] 1 QB 816 where the claimant was induced to join an invasion of the South African Republic by various fraudulent misrepresentations; he successfully claimed damages arising from the loss of his leg, his kit and his pay.

circumstances a contract for the performance of a service will include an 'implied term' that the service will be carried out using reasonable care and skill. Section 49 of the Consumer Rights Act 2015 replicates the implied term of reasonable care and skill; section 50 goes further in providing that "anything that is said or written to the consumer" by the trader "about the trader or about the service" may become a term of the contract if (a) it is taken into account by the consumer when deciding to enter into the contract, or (b) it is taken into account by the consumer when making any decision about the service after entering into the contract. This formulation widens the scope of statements or representations which, though not forming part of the written agreement, may nonetheless be actionable as contract terms.

Are there financial limits on the cost of the treatment?

To qualify for protection, the cash price of the goods or services must be more than £100 and not more than £30,000 – s75(2). In certain circumstances where the cash price is over £30,000, a credit provider under a "linked credit agreement" might still be liable under s75A; an important feature of s75A is that (unlike s75) it requires at least "reasonable steps" to be taken to pursue the claim against the supplier first, before seeking redress from the creditor.

Does the whole cost of the treatment/procedure have to be paid for on a credit card?

No. Under section 189 CCA "finance" means to finance wholly or partly, and "financed" in s75 is construed accordingly. In essence, this means that only part payment (such as a deposit) is required to be made by credit card in order for the section to apply. Importantly, whilst a £100 threshold exists for the item which is the subject of the transaction, if any part of that single item (even less than £100) is paid for on a credit card, s75 is engaged.

Is the debtor/patient limited to a refund of the price paid or can he/she get damages for consequential loss?

Although reported cases interpreting the section are surprisingly sparse, there appears to be a consensus[11] that damages for consequential losses are recoverable pursuant to s75, an important consideration in medical treatment cases where the injury, loss and damage inflicted by inadequate treatment may outstrip the treatment cost many times over. This is consistent with the structure of s75, which replicates as against the creditor the debtor's causes of action in misrepresentation and breach of contract against the supplier. As discussed above, damages for consequential loss may be claimed under misrepresentation (fraudulent or negligent) or breach of contract against the supplier[12] and there is no express wording in the statute to limit the scope of the remedies available to the debtor in the parallel action against the creditor.

What if the treatment took place outside the UK?

Section 75 will still apply, so long as the credit agreement is with a creditor carrying on business in the UK. An argument that s75 should be limited to transactions in the UK was roundly rejected by the House of Lords in *Office of Fair Trading v Lloyds TSB Bank plc and others*.[13] This wider approach is clearly beneficial to patients who seek treatment abroad, paid for on a UK credit card, who may otherwise face an uphill struggle in obtaining compensation for deficiencies in that treatment.

Who is the creditor?

Section 189 CCA defines "creditor" as "the person providing credit under a consumer credit agreement or the person to whom his rights and duties under the agreement have passed by assignment or operation of law". Essentially, this means the company (usually a bank or building society) that has provided the credit card under

[11] See *Bond* (supra) where no point is raised as to the legitimacy of a claim in general damages against the credit card company for the failed treatment.

[12] Though the approach to the measure of loss differs between the tort of misrepresentation (where the Claimant's "reliance interest" is protected i.e. the claimant is to be put in the position he or she would have occupied had the misrepresentation never been made) and breach of contract where the "expectation interest" is protected i.e. the claimant is to be put in the position he or she would have occupied had the contract term been fulfilled.

[13] [2007] UKHL 48

an agreement with the debtor rather than the payment processing network (such as Visa and Mastercard). American Express is both a credit card provider and a payment processing network.

What if the debtor was in breach of his or her credit agreement?

Section 75(4) CCA provides that "This section applies notwithstanding that the debtor, in entering into the transaction, exceeded the credit limit or otherwise contravened any term of the agreement."

What is the limitation period for bringing a claim?

Where the transaction concerned is one involving medical treatment, any claim for damages arising from inadequate treatment is likely to include a claim for damages "in respect of personal injuries"[14] within the meaning of section 11(4) of the Limitation Act 1980. In those circumstances a 3 year limitation period will apply, measured from the date the cause of action arose or the claimant's date of knowledge within section 14 of the 1980 Act. In *Bond* (see above), the claimant's representatives erroneously believed that a claim against two credit card companies could be brought as of right up to 6 years from the date of the alleged breach; the court found otherwise, declined to extend time pursuant to section 33 of the Act and dismissed the claimant's claim; the claimant then obtained summary judgment against his solicitors for negligently failing to bring the claim against the credit card companies in time.

Does the debtor have to sue the supplier first / at all?

No. There is no requirement that the supplier (such as the operating surgeon or treatment clinic) be sued in preference to the credit card provider. Indeed, the Financial Ombudsman Service (which has jurisdiction in relation to complaints against consumer credit providers) has awarded compensation to a customer for inconvenience caused by a credit card company "repeatedly, and incorrectly, telling him that it was only required to meet his claim if he first obtained a court judgment against the supplier." That having been said, it would seem prudent to heed the words of Master Ungley in *Bond*, remarking on "the desirability of joining all Defendants potentially at risk in the original action. It would not have greatly increased costs. There would have been three defences rather than one and they may well have served contribution notices against each other. Since proceedings were commenced it is difficult to see why it was not done in 1994. Had this been done, Mr Bond would have recovered the damages to which he seems undoubtedly entitled and there is some doubt whether the costs of the second proceedings being brought out of time would ever have been incurred."

Does QOCS apply to a s75 claim against a credit card company in relation to medical treatment?

CPR 44.13(1) provides that section II of Part 44 which deals with Qualified One-Way Costs Shifting "applies to proceedings which include a claim for damages – (a) for personal injuries…". Provided that the s75 claim does indeed include a claim for personal injuries, whether for general damages or losses arising (or more likely both), the QOCS provisions would seem to apply. This would also be consistent with the reasoning in relation to the application of the 3 year limitation period discussed in *Bond* (see point 0 above).

Can a claim be brought under s75 by the estate or dependents of a patient who has died following / as a consequence of medical treatment paid for on a credit card?

Subject to certain exceptions, all causes of action vested in (i.e. maintainable by) a person who dies will survive for the benefit of his or her estate (section 1 Law Reform (Miscellaneous Provisions) Act 1934). This would appear to include a s75 claim against the credit card company. However, the position is different in respect of a (usually more valuable) dependants' claim where the deceased's death is alleged to have been caused by the deficient medical treatment. The claim for the benefit of the dependants under the Fatal Accidents Act 1976 is purely statutory and the cause of action does not arise until the death of the deceased. In so far as a s75 claim

[14] One might however have a claim for e.g. last minute cancellation of an elective procedure where the patient/debtor is seeking refund of the sum paid and consequential losses such as travel or accommodation expenses, which might not involve a claim for "personal injuries".

requires the person bringing the claim to be both (in our scenario) the injured patient (who contracted with the supplier) and the credit card holder, this appears to preclude its being deployed by the surviving dependant(s).

What if the treatment was paid for on someone else's credit card?

Section 75 applies if the "debtor" has a claim against the supplier. In the context of credit cards, the question arises whether the term "debtor" only covers the person who enters into the agreement with the card issuer or whether it extends to any "additional card-holders" which the account-holder nominates to receive additional cards for use on the account. The definition of "debtor" in s.189(1) (as "the individual receiving credit under a consumer credit agreement") suggests that only the account-holder is the "debtor". The additional holders have been given authority by the account-holder to obtain goods or services to be paid for, in the first instance, by the card issuer, with reimbursement to be made by the card-holder. This arrangement does not render them "debtors" to whom the card issuer has provided "credit" in the sense of enabling them to defer payment. On the other hand, it may be arguable (at least in some fact situations) that when they use the card, the additional holders act as agents for the account-holder and therefore any claims arising against the supplier are the claims of their principal: the debtor. Moreover, the Financial Ombudsman Service has upheld a claim made by an additional cardholder where that person purchased goods for the benefit also of the principal cardholder.[15] By contrast however, the Ombudsman has rejected a number of claims where cosmetic surgery was paid for by the patient's spouse on credit, on the basis that the patient and the debtor were two different people.[16] Absent a successful argument that the patient in undergoing the procedure was acting as agent for the account holder and/or that the medical procedure was to the benefit of the patient and account holder jointly, a s75 claim in this situation appears unlikely to succeed.

Do I have to go to court?

Part XVI of the Financial Services and Markets Act 2000 created an ombudsman scheme "under which certain disputes may be resolved quickly and with minimum formality by an independent person". The Financial Services Ombudsman has jurisdiction to determine complaints in relation to the provision of credit to consumers as a regulated activity under FSMA 2000. The outcome of complaints "is to be determined by reference to what is, in the opinion of the ombudsman, fair and reasonable in all the circumstances of the case." The overall approach of the FSO of providing a swift, free resolution of disputes without a hearing may on its face appear attractive. However, the absence of a hearing and of cross-examination to test evidence may limit the appropriateness of the scheme to only the most straightforward and modest of medical claims. The FSO rules allow for the referral of a complaint to another complaints scheme or the court, which may occur where the Ombudsman considers the matter too complex for the informal scheme to be appropriate or if the limit in the sum which he has jurisdiction to award may be insufficient.[17] The level of compensation which the FOS can award is subject to limits depending on the date of the acts complained of and the date on which a complaint is referred. The current cap is £355,000 (excluding interest) for complaints referred on or after 1 April 2020 about acts or omissions by firms on or after 1 April 2019.

WHEN IS A CLAIM TOO STALE?

Suzanne Lambert

Azam v University Hospital Birmingham NHS Foundation Trust [2020] EWHC 3384 (QB)

[15] See https://www.financial-ombudsman.org.uk/files/105848/DRN4115539.pdf;

[16] See https://www.financial-ombudsman.org.uk/files/64133/DRN2215933.pdf; https://www.financial-ombudsman.org.uk/files/106003/DRN4121740.pdf and https://www.financial-ombudsman.org.uk/files/240966/DRN7944294.pdf

[17] See for example https://www.financial-ombudsman.org.uk/files/43870/DRN1246765.pdf

In this very useful judgment, the Saini J restated the relevant legal principles in relation to the exercise of discretion under section 33 of the Limitation Act 1980 ("the Act") and held that there was error of law on the part of the first instance judge (following a preliminary issue as to limitation) in concluding that it was equitable to allow the Claimant to pursue his clinical negligence claim even though it had been issued more than 18 years out of time and the Defendant's operating surgeon had died.

Background

The Claimant alleged that the gynaecomastia surgery performed in March 1996 by a consultant surgeon, for whom the Defendant Trust had assumed responsibility, was negligently performed and that as a result he had suffered severe pain as well as chest wall distortion and significant scarring. It was also alleged that there was a lack of informed consent in carrying out the procedure. The claim was issued in July 2017, more than 21 years after the procedure had been carried out and thus 18 years after primary limitation had expired. The Trust had submitted only an outline Defence, relying primarily on a limitation argument. By the time that proceedings had been issued, the operating surgeon was no longer alive, having died in April 2014.

At the trial of a preliminary issue as to limitation, the judge held that the primary limitation had expired in March 1999 because the Claimant had the requisite knowledge (as to the significance of his injury) for the purposes of section 14 of the Act almost immediately after the operation, thus preferring the Defendant's evidence as to date of knowledge. There was evidence that at least two years post-operatively the Claimant was dissatisfied with the results of the operation but that the Claimant did not act promptly after he raised the possibility of having revision surgery in 1998. The judge also held that there was no concealment on the part of the Trust for the purposes of section 32 of the Act and that there was no disability or excuse as to why the Claimant had not brought proceedings promptly. As to the informed consent claim, the judge concluded that it would not be equitable to allow the Claimant to pursue that claim out of time as there might well be significant prejudice to the Trust if that claim were to proceed. However, the judge concluded that it was equitable on the facts before him to give the Claimant permission to pursue his negligence claim out of time, applying section 33 of the Act, as he was not satisfied that there was significant real prejudice to the Trust in terms of its ability to defend the claim as a result of the passage of time beyond the limitation period.

In the appeal, the Trust sought to challenge the judge's exercise of discretion in favour of the Claimant in relation to the negligence claim on the basis that his conclusion was "manifestly wrong". The Trust advanced two separate grounds, although Saini J considered that "essentially the same point" was being raised. First, it was contended that the judge erred in his assessment of "forensic prejudice" and failed to give due weight to the forensic prejudice suffered by the Trust as a result of the death of the operating surgeon and the "staling" of the evidence. Secondly, it was contended that the judge failed to perform the necessary balancing exercise under section 33: had he done so, he would have reached a different conclusion.

Judgment

The nature of an appeal challenging the exercise of judicial discretion

Saini J helpfully restated the basic principles as to appellate challenges to the exercise of a discretion by a judge at first instance at [48] – [52] and explained that the hurdle for an appellant is a high one as an appellate court is exercising a CPR 52.21(1) "review" power and will only interfere where an appellant can identify one or more errors as follows:

(i) A misdirection in law;
(ii) Some procedural unfairness or irregularity;
(iii) That the judge took into account irrelevant matters;
(iv) That the judge failed to take account of relevant matters; or
(v) That the judge made a decision which was "plainly wrong".

In relation to error type (v), he explained that this meant "a decision which has exceeded the generous ambit within which reasonable disagreement is possible". The role of the appellate court is "to police a very wide

perimeter and it will be rare that a judge who has exercised a discretion having regard to relevant considerations will have come to a conclusion outside that perimeter".

Saini J held that it was clear that there was no misdirection in law by the judge below. The judge had correctly identified that the burden was on the Claimant to satisfy him that the section 33 discretion should be exercised in his favour. However, he also identified that there was an evidential burden on the Trust in relation to the prejudice that was said to have been caused by the delay i.e. that the evidence adduced or likely to be adduced would be less cogent. The judge also properly directed himself in accordance with the leading case of *Cain v Francis* [2008] EWCA Civ 1451 as to the exercise of discretion under section 33. The judge's directions in relation to the approach to the legal test upon which the discretion rested were impeccable.

Satisfying the evidential burden as to prejudice

Saini J rejected the first ground of appeal, finding that it was essentially a thinly disguised attack on the exercise of the judge's discretion.

In considering the relevant circumstances of the case and factors section 33 factors, the judge accepted that the operating surgeon's evidence was no longer available to the Trust because of his death, and also that there may be difficulty in tracing witnesses or, if witnesses could be traced, the witnesses' recollection of the events in question. The judge also accepted that the Claimant had not acted promptly and had no excuse or reason for not acting promptly. Nor was there any conduct on the part of the Trust that could be relied upon by the Claimant for the purpose of section 33(c).

However, as to whether the evidence adduced or likely to be adduced by the Claimant or Defendant is likely to be less cogent, there needed to be at least some evidential or sound inferential basis upon which to make findings about what evidence was likely to be less cogent. Such finding could not be made on the basis of bare assertion as was the case in this appeal. Apart from the operating surgeon's absence resulting from his death, the Trust had not adduced any evidence at all of any steps it had taken to try to trace any other witnesses, let alone any issues regarding the recall of those witnesses of relevant witnesses. Such matters mandated evidence in order to satisfy the evidential burden on the Trust as to evidential prejudice. Otherwise, the Trust's assertions were pure speculation in the absence of evidence and the judge would have been entitled to exclude those assertions entirely from consideration or weigh them against the Trust.

Further, the finding against the Claimant in relation to the requisite knowledge for the purposes of section 14 of the Act did not mean that the quality of the Claimant's evidence was bound to have gone stale with the passage of time.

The judge had noted that the contemporaneous medical records appeared on their face to be relatively comprehensive and would be available to the court at the trial. Saini J made clear that it would be wrong in principle as well as odd for the Trust to be able to rely on any shortcomings in its own clinician's record keeping as a ground of prejudice in its favour. To do so "would encourage poor practice and make it forensically advantageous" to keep poor records, which would be "perverse".

Importantly, Saini J made clear that death of the clinician would not mean that in every such case the section 33 discretion would be automatically exercised in favour of the defendant. Whilst it was clearly an important factor and may be given substantial weight in some cases, it was not determinative in clinical negligence cases, and even in abuse cases death was not a trump card.

The judge concluded that the issue in relation to negligence turned on the expert evidence and the Trust's assertions as to what assistance the operating surgeon's evidence would have provided to any expert on behalf of the Trust was a matter of speculation. The Trust had called no evidence and could not make out the evidential burden. The judge was entitled to attach weight to the fact that the Claimant had produced expert evidence as to the Claimant's injuries and the way in which the procedure had been performed. The Defendant's expert would be able to examine the Claimant. Even if a "full blown" responsive expert report was not called for at the preliminary issues limitation trial on the grounds of proportionality, a report (even if in outline terms) was

required in response to the Claimant's expert evidence to explain how the evidence of the deceased surgeon would be relevant to the claim. As it was, the Claimant's expert evidence was uncontradicted. In the absence of such evidence, there was no error in the judge resolving the balancing act against the Trust.

The nature of the s33 balancing exercise

In the same way that the judge had performed the balancing exercise appropriately in relation to the informed consent issue when he decided in favour of the Trust, he had done so in relation to the negligence claim when he decided against the Trust. The judge had correctly stated and applied the appropriate legal principles in relation to the informed consent claim. "The suggestion that he had forgotten and failed to apply those principles when considering the negligence claim is fanciful".

Saini J rejected this ground on the basis that it was simply an attempt to reargue the case on discretion. It was not a case where the factors went all one way. Even if "the balance sheet was heavily weighed against [the Claimant]", the judge did not err in law in giving the lack of prejudice to the Defendant significant weight.

Comment

Section 33 requires the court to balance the prejudice the claimant would face in not bringing a claim as a consequence of the provisions of sections 11, 11A or 12 of the LA (expiry of the primary limitation period) against the prejudice the defence would face as a result of the delay in bringing the claim when deciding whether it would be equitable to allow the claim to proceed out of time. Although there is a burden on the claimant to satisfy the judge that the section 33 discretion should be exercised, there is an evidential burden on the party asserting prejudice to prove that there is likely to be prejudice as a result of the passage of time.

Although Saini J was careful to emphasise that there would be no form of "floodgates" problem as a result of his judgment (and that of the judge below) as it did not set "some precedent that stale claims are permissible, even when the treating physician has died" and each case depends on its own facts, both claimants and defendants will no doubt take careful note of the judgment.

Claimants are likely to be encouraged that the death of the relevant clinician is not a trump card and that the passage of almost two decades without excuse before bringing a claim would not automatically mean that a court would refuse to exercise the section 33 discretion in a claimant's favour. However, considerations may be different where the issues relate to informed consent, as opposed to negligence where the contemporaneous records and expert evidence may be more determinative.

Defendants will be reminded that if they are to pursue a limitation defence it would be risky to do so half-heartedly and without advancing any evidence (whether factual or expert evidence) as to the prejudice likely to be suffered.

FURTHER DEVELOPMENTS IN SECONDARY VICTIM CLAIMS

Jessica Elliott

Polmear v Royal Cornwall Hospitals NHS Trust [2021] EWHC 2914 (QB)

The High Court dismissed the Defendant Trust's strike-out application in a secondary victim claim where the primary victim had '*clearly suffered actionable damage*' prior to the shocking collapse. Master Cook held that it was not necessary to identify a '*stopping point*' for liability prior to the shocking event, and that preceding actionable damage was no bar to recovery. An appeal is outstanding.

Facts and Admissions

The Claimants' daughter, Esmee, was investigated for intermittent cardiorespiratory symptoms between December 2014 and February 2015. No diagnosis was reached. The symptomatic episodes continued and

worsened. Significant parental anxiety was noted by the GP on 21 April 2015 (at [10]-[11]). Esmee collapsed and died in front of her parents on 1 July 2015. Her parents claimed damages for psychiatric injury caused by witnessing her death.

The hospital admitted that Esmee's condition should have been diagnosed and managed by mid-January 2015.

The parties' arguments

The Trust argued that there was actionable and '*manifest*' damage in Esmee's case prior to the shocking event itself ([32]-[33]). According to the recent judgment of *Paul v Wolverhampton NHS Trust* [2020] EWHC 1415 (see Issue 6), liability was precluded because the '*stopping point*' was '*the point when damage to the primary victim first becomes manifest*' (at [79] of *Paul*). Counsel relied on the GP record showing significant and concerning symptoms in April 2015.

The Claimants submitted (at [35]) that Esmee's symptoms were '*transient and non-horrifying*', and accordingly could not be described as 'manifest' within the meaning of *Paul.* The Claimants added that there was no policy reason why earlier symptoms should prevent recovery, nor would there have been in *Paul* had there been a prior episode of angina. The baby in *Walters v North Glamorgan NHS Trust* [2002] EWCA 1792 had hepatitis for a number of weeks prior to the fit, and recovery was permitted.

The judgment

Master Cook first found that Esmee's pre-collapse symptoms were not '*transient and non-horrifying*', and were capable of founding a claim on her behalf (at [38] – and therefore that they constituted actionable damage, see also at [52]). However, he noted that the same could be said of the baby in *Walters*.

Standing back, Master Cook found that the failure to diagnose Esmee's condition meant that the consequences of her illness continued, causing '*not unnatural*' concern for her parents (at [42]). The event itself was sudden, external to the secondary victims, and rapidly caused death; it would have been horrifying, and could appropriately be described as the '*fact and consequence of the Defendant's negligence*'. Master Cook asked himself '*why should the fact that Esmee had suffered non-fatal episodes on previous occasions rule out the secondary victim claims of her parents*' (at [43]).

After revisiting *Paul* at [78] – [79], Master Cook found that it was not necessary to identify a stopping point in this case, '*as it is possible to identify a qualifying shocking event and that shocking event need not coincide with or immediately precede the first actionable damage to the primary victim*' (at [46]). He therefore found that the claim was not bound to fail.

Comment

In the author's view, this judgment is correct in its conclusion, but light on reasoning. The finding that '*the shocking event need not coincide with or immediately precede the first actionable damage*' is clearly supportable (and welcome for claimants) following *Paul.* However, the difficulties presented by *Taylor v A Novo* [2014] QB 150 – which did introduce a proximity-based 'stopping point' into secondary victim jurisprudence, and one that has been interpreted very restrictively in clinical negligence claims – were somewhat sidestepped. *Paul* did not completely eliminate the need to consider whether there should be a 'stopping point', and further reasoning on why one did not arise here would have been helpful for future claims.

Relevant Background in the Case-Law. In *Taylor* in 2014, the Court of Appeal held that one could not have an accident caused by the Defendant's negligence, and then have a shocking event as a later consequence of that accident. The court based its reasoning on proximity. In the author's view, this amounted to an additional hurdle for Claimants over and above the criteria set out in *Alcock.* The latter judgment did not set out a free-standing limb of proximity beyond the criteria themselves; in particular, it did not envisage any proximity-based 'stopping point' following the breach of duty after which a shocking event would no longer qualify.

Matters got worse for claimants as the years progressed. Defendants took the *Taylor* proximity criterion further, arguing repeatedly (and successfully) in the county courts that the first actionable damage caused to the primary

victim was the relevant proximate event caused by the Defendant's breach of duty. Anything after that was a *Taylor*-style 'later consequence' and insufficiently proximate to the negligence. The 'first actionable damage' stopping point has proved fatal in clinical negligence cases, where there is almost invariably a period of actionable symptoms or deterioration before a fatal or life-threatening collapse.

In *Paul*, Chamberlain J addressed this development. First, he clarified that the question of proximity in *Alcock* claims was answered by applying the control mechanisms (at [61]-[62]). He then clarified that the ratio of *Taylor* was that '*where the defendant's negligence results in an "event" giving rise to injury in a primary victim, a secondary victim can claim for psychiatric injury only where it is caused by witnessing* that event *rather than any subsequent, discrete event which is the consequence of it'* (at [73]). Against this background, he tackled whether '*actionable damage*' had to be taken as the proximity-based stopping point after which all else would fail [76ff]. He noted that there was '*nothing that could naturally be described as an event*' in Mr Paul's case. If one had to identify a stopping point, it would be '*the point when damage to the primary victim becomes manifest*' or '*evident'* (at [79]). While he does not say this expressly at para [79], it is tolerably clear from his comments at [73], [77], [78] and throughout the judgment that '*manifest*' means something approaching an event. It must, in the author's view, mean more than simply 'apparent' or 'concerning'.

This judgment. It was plainly right to hold that Esmee's pre-collapse symptoms were capable of founding a cause of action, and that such a finding was not a bar to the claim following *Paul*. It also appears (more than) arguable that Esmee's symptoms did not reach Chamberlain J's 'manifest/could naturally be described as an event' threshold. The wording of [46] could be interpreted as a finding to this extent, but it would have been helpful to have more detailed reasoning - particularly as [42]-[43] reads as a first-principles assessment, which is a difficult route in this area of law. As foreshadowed by Gideon Barth in Issue 6, what counts as 'manifest' is likely to prompt further debate (unless *Paul* is reversed in its upcoming appeal) and commentary on this point would have been illuminating. It is likely that these issues will receive detailed attention in the upcoming appeals; in the meantime, this judgment adds weight to the abandonment of the 'first actionable damage test' as the proximity limit in secondary victim claims.

"WRONGFUL LIFE" REVISITED

Robert Kellar QC

Toombes v Mitchell [2020] EWHC 3506 (QB)

In *Evie Toombes v Dr Philip Mitchell* [2020] EWHC 3506 the High Court has given renewed consideration to claims for, so called, "wrongful life". Can a disabled person ever claim damages on the basis that they would not have been born but for the defendant's negligence? The court answered that question with a resounding "yes".

The issue

Where a disabled child would not have been born but for the Defendant's negligence, it is well established that their parent has a claim for the reasonable costs associated with the child's disability . That is a "wrongful birth" claim: see *Parkinson* [2001] EWCA Civ 530. However, the child cannot bring a claim for personal injury on the basis that, with competent advice, their mother would have chosen a termination. *In McKay v Essex Area Health Authority* [1982] 2 All ER 771 the Court of Appeal affirmed the principle that a disabled claimant cannot sue for "wrongful life". In *Toombes* the Court reconsidered the scope of that prohibition. Did it apply only to termination cases? Or did it extend to claims that, absent the negligence, a disabled person would never have been conceived?

The facts

Evie Toombes was born with a congenital developmental defect causing spinal cord tethering. Her mother had attended her GP for family planning advice. In breach of duty, her GP had failed to prescribe or give advice about

folic acid. The Claimant was conceived shortly after this consultation at time when her mother was not taking folic acid. She alleged that with competent care her mother would not have conceived when she did. A different child would have been conceived at a later date after her mother had been increasing her intake of folic acid. This child have been a "genetically different person" to the Claimant. The disabled Claimant would not have come into existence.

The Defendant resisted liability on the basis that this was, in essence, a "wrongful life" case. It raised the same legal and policy objections which vexed the court in *McKay*. It was, argued the Defendant, "repugnant to the law" to allow the Claimant to recover where the correct advice would have led to the conception of a different individual.

The principles

Lambert J held that the issue was essentially one of statutory interpretation. In relation to "occurrences" which "affected either parent of the child in his or her ability to have normal, healthy child" the relevant provision was section 1 (2) (a) of the Congenital Disabilities (Civil Liability) Act 1976. The Act had to be construed in the light of the recommendations of the Law Commission from which the legislation had arisen.

The judge held that a cause of action under section 1(2)(a) involved three components:

1. A wrongful act; and
2. An "occurrence" as defined in the Act; and
3. A child born with disabilities.

There was no question that components 1 and 3 were made out. The crucial question was whether there had been an "occurrence". The Defendant submitted that nothing had happened. There had been no change in the mother's physiological state. However, the court held that the Act did not require any change or alteration in the mother's physiological state for there to be an "occurrence". This was reflected in the provision in section 1 (3) that there was no need for the mother to have suffered an actionable injury for a lawful claim by a child for pre-natal injury. On the facts of the present case it was sufficient that in reliance upon negligent advice the claimant's mother had sexual intercourse without the benefit of folic acid supplementation.

McKay distinguished

Lambert J held that she was not bound by the Court of Appeal's decision in *McKay*. The court emphasised that post-conception cases engaged important issues of principle and policy that were not engaged in pre-conception cases. As Stephenson LJ put it in *McKay*, in post-conception cases: "*the only duty which either Defendant can owe the unborn child … is a duty to abort or kill her, or deprive her of that opportunity*". The court observed that: *"to impose such a duty towards the child, would … make a further inroad on the sanctity of human life which would be contrary to public policy*". Lambert J observed that a negligent failure to prevent a birth of an already conceived child engaged a "*range of social and moral policy issues, not least the imposition upon the medical profession of a duty to advise abortion in possibly dubious circumstances*". However, claims based upon a wrongful act before conception raised no such difficulties.

Moreover, there was an important distinction between the relevant statutory provisions in pre- and post-conception cases. Post-conception cases fell under section 1(2)(b), which were subject to an explicit rider that but for the index negligence the "*child is born with disabilities which would not otherwise have been present".* The Law Commission had recommended including such a rider in post-conception cases to import the assumption that but for the negligence the child would have been born healthy (not that it would not have been born at all). However, no such rider applied in pre-conception cases (covered by section 1 (2) (a)). Lambert J held that this was a deliberate statutory distinction reflecting the different social and moral policy considerations in pre- and post-conception cases.

Causation

How does causation work in pre-conception cases? Is it sufficient that but for the Defendant's negligence the Claimant's parents would not have had sexual intercourse and the Claimant would not have been conceived with disabilities?

Not according to Lambert J. There must be a sufficient causal link between the *"circumstances of the sexual intercourse and the disability*". This test would not be satisfied where, for example, a child is born with a disability as a result of negligent but reassuring advice concerning their parents' genetic status. In that situation the child's disability has nothing to do with the "*circumstances affecting intercourse*": the disability arises from the parents' genetic status which is unaffected by the index negligence. In contrast, Evie Toombes' disability resulted from the circumstances of her conception which took place in her mother's folic acid deficient state.

Comment

Following *Toombes*, there is no longer any bar to "wrongful life" claims where it is alleged that but for the index negligence the disabled claimant would never have been conceived. The only real hurdle is the causation test affirmed by the court. But in the author's view this is no more than a reflection of the statutory requirement that the negligence must "*affect either parent … in his or her ability to have a normal healthy child*". If that ability has not been affected by the index negligence no claim will arise under the Act.

In practical terms, such claimants will no longer need to rely upon their parents bringing claims for "wrongful birth". The central difference between such claims and "wrongful life" claims is that the mother's claim is limited to her life expectation rather than that of the (much younger) claimant.

Whether this development is right in principle is likely to divide opinion. Detractors might object that Lambert J's decision gives rise to an inconsistency. The bar on "wrongful life" claims may be justified on policy grounds. The equal sanctity of all human lives (including disabled lives) means that there should be no actionable "right to remain unborn". That objection might be said to apply equally to pre-conception and post-conception claims for wrongful life. On the other hand, the value of disabled lives is not an attractive basis upon which to deprive disabled people of the right to compensation. Lambert J's decision also has the merit of ensuring greater consistency between wrongful birth and wrongful life claims (at least in pre-conception cases). Whether the case goes further, and whether the appellate courts take the same view, remains to be seen.

This article originally appeared in the UK Human Rights Blog.

WHEN MEDICAL TECHNOLOGY GOES WRONG (UPDATE)

Alasdair Henderson

Hastings v Finsbury Orthopaedics Ltd and Stryker UK Ltd [2021] CSIH 6

Back in QMLR Issue 4 we covered *Hastings v Finsbury Orthopaedics Ltd* in the Outer House of the Scottish Court of Session. That case dealt with the question of what happens when medical technology goes wrong and the standard which patients are entitled to expect from medical devices. The unsuccessful Claimant subsequently appealed and the original judgment has now been upheld by the Inner House of the Court of Session in a decision handed down on 16 January 2021.

The facts

A former forestry worker brought a claim against the manufacturers of a metal-on-metal total hip replacement ("MoM THR") prosthesis. The device consisted of a Mitch/Stryker Howmedica uncemented acetabular cup, manufactured by the First Defendant, and an Accolade V40 uncemented femoral stem, manufactured by the Second Defendant. The Claimant had a history of arthritis and underwent hip replacement surgery to both hips in 2009, using the Mitch/Accolade device. There was no suggestion that the hip replacement surgery was carried

out negligently, nor that the particular prostheses themselves were made in a negligent or faulty manner. However, the MoM THR shed metal debris which meant the Claimant suffered an adverse reaction and had to have revision surgery on his left hip some three years later.

The claim was brought under the provisions of the Consumer Protection Act 1987, section 2 of which imposes no-fault liability on a manufacturer for damage caused wholly or partly by a defect in a product. Section 3 defines a product as defective if its safety is not such as persons generally are entitled to expect. The trial was therefore to resolve the preliminary issue of whether the Mitch/Accolade device was defective within the meaning of section 3.

At first instance Lord Tyre held that it was not defective, despite the fact that the manufacturers accepted there was an inherent propensity of MoM THR devices of this type to shed metal debris with a risk that some patients may suffer an adverse reaction, and that the devices had been recalled in 2012 and not used since then. The main reason for Lord Tyre's conclusion was that he considered the revision rate for MoM THRs and the prospects of success of revision surgery compared with other prostheses, which were the two most important 'safety' criteria, and was not persuaded that these were worse for MoM THRs at the relevant time.

Appeal outcome

The Claimant's appeal had two main strands. First, that Lord Tyre in the Outer House had failed to take adequate account of the strict liability nature of the 1987 Act and its purpose in strengthening consumer protection. He thus applied an inappropriately high threshold on the question of whether the device was defective and placed incorrect emphasis on the fact that the Claimant bore the burden or onus of proof and had not discharged it. The Claimant suggested that in a consumer protection claim such as this there should be a degree of 'claimant benevolence' by the court. Second, that Lord Tyre's decision that the device was not defective was contrary to the *prima facie* evidence of defectiveness – the concerns, notices and warnings which had been raised, leading to its recall – without adequate basis for departing from it.

The Inner House rejected these arguments. In relation to the first strand of the appeal, it noted that strict liability was a well-known concept in Scots Law (and the same is true of English law). It accepted that the 1987 Act was a measure intended to improve consumer protection (even though the underlying EU Directive had a wider set of aims). It also made the following observation about the imbalance of power in such cases (at [68]):

> *"There is considerable force in the contention that the court should not impose excessively exacting standards on pursuers, whatever the nature of the case or the defender. It should not expect the ordinary citizen to be able to mount an in depth challenge which requires a detailed examination of a defender's manufacturing processes and subsequent product safety analysis of the type which might be seen in a commercial litigation between multinationals. The pursuer must be able to access the courts and have his claim adjudicated upon in a proportionate manner. Insurmountable or excessive obstacles should not be placed in the way."*

However, the court held that whilst the 1987 Act imposes strict liability for a defective product, the Claimant still has to prove the existence of a defect as defined by the Act, and in practice the Claimant was able to secure appropriate expert witnesses and data to pursue his claim. In terms of the burden of proof, the court agreed that a determination based on a party's failure to discharge the burden can leave a first instance judge open to criticism, because usually a judge should be able to reach a concluded view on the facts and decide where the balance lies. But it held that determining a case on the basis of the burden of proof is nevertheless a course open to a judge, and is not a problem if it is properly reasoned. As for the suggestion that there should be a degree of 'claimant benevolence' in this type of case, this was roundly rejected.

That led to the Inner House's consideration of the second strand of the appeal, and it determined that Lord Tyre's conclusion had been properly reasoned. He had recognised the power of the *prima facie* evidence of defect. Whilst his conclusion that the devices were not defective for the purposes of section 3 at the relevant time was perhaps "*an unexpected outcome*" ([71]) it was clear the judge had carefully considered all the data and it was not an unreasonable decision given the comparison with other similar devices and the fact that they too had a tendency to shed debris.

Comment

The first instance judgment in this case was a lengthy, detailed analysis of some very complex evidence, and was always going to be difficult to challenge. The outcome was, as the Inner House acknowledged, perhaps a bit surprising given the devices had been recalled after several safety alerts and concerns were raised. However, Lord Tyre's conclusion was based so much on a careful sifting of the specific facts that it would have been difficult for it to be overturned on appeal. What the Inner House decision does make clear is that defective product claims can be successfully defended, even where there is *prima facie* evidence of problems. It also affirms that there is no tilting of the scales towards claimants and that the burden of proof remains relevant even in strict liability claims.

RUNNING OBVIOUS RISKS

Cara Guthrie

Mrs James v The White Lion Hotel [2021] EWCA Civ 31

In Issue 4 the first instance decision was covered. In this article, the appeal is considered.

The facts

The Deceased fell out of the sash window of a second-floor hotel room in the middle of the night and died. The sill of the window was much lower than normal. The sash was also defective as the window would close under its own weight unless held open. There were no witnesses to the fall and the Defendant contended that the Deceased had been smoking a cigarette at the time. The judge found that the Deceased had chose to sit on the windowsill and that he must have appreciated that there was the risk, if he sat on the sill or leaned out of the window, that he might fall.

The Defendant had pleaded guilty to an offence under section 3 of the Health and Safety at Work Act 1974. The basis of the plea was that the Defendant accepted that the window posed a (low) risk to an adult occupying the room and that a risk assessment would have resulted in a recommendation that window restrictors be fitted. At the civil trial no attempt was made to go behind the guilty plea.

The first instance decision

The first instance judge found that: (i) the Defendant owed the Deceased a duty; (ii) there was a foreseeable risk of injury; (iii) any injury would inevitably be very serious; (iv) there was no social value to failing to restrict the window opening; and (v) the cost of a restrictor was minimal.

The judge considered whether, given the Deceased had been willing to run the risk of an obvious danger, the Defendant was liable under section 2 of the Occupiers' Liability Act 1957. When deciding whether there was a breach of statutory duty, the judge noted that sections 2(2) and 2(3) required occupiers to conduct a risk assessment taking into account that visitors may not be careful. He decided that the criminal conviction resolved the question of whether or not a risk assessment was required and that such a risk assessment would have required steps to be taken to reduce the risk. Given that there was an obligation to act and that the steps taken in response would have avoided the Deceased's death, he held that the obligation to take such steps could not be avoided on the basis that the risk was obvious and a person would have to voluntarily run the risk before injury could occur.

The judge considered whether the Deceased's decision to lean out of the window was an intervening event which broke the chain of causation. By a narrow margin, he found that the Deceased's act in sitting on the windowsill did not break the chain of causation; the accident was still the result of the Defendant's failure to apply window restrictors to a very low window.

The judge found that the Deceased had been 60 per cent contributorily negligent.

The basis of the appeal

The first instance judge gave the Defendant permission to appeal. There were three grounds of appeal:

1. Whether the judge, having found that the Deceased had chosen to sit on the windowsill, part out of the window, and had recognised and accepted the risk of falling from the window due to leaning too far out or losing his balance, erred in law in failing to apply the principle that a person of full age and capacity who chooses to run an obvious risk cannot found an action against a defendant on the basis that the latter has permitted him to do so, or not prevented him from so doing.

2. Whether section 2(5) of the 1957 Act applied such that the Defendant had no obligation to the Deceased in respect of falling from the window.

3. Whether an occupier who is in breach of his statutory duty under section 3(i) of the Health and Safety at Work Act 1974 was *ispo facto* in breach of his duty to a visitor under the Occupiers' Liability Act 1957.

The judge's findings of fact and his determination of the level of contributory negligence were not challenged.

Issue 1

Nicola Davies LJ reviewed the authorities[18] relied on by the Appellant and found that they did not provide unequivocal support for the proposition that a person of full age and capacity who chooses to run an obvious risk cannot found an action against a Defendant on the basis that the latter has permitted him to do so, or not prevented him from so doing. She expressly found that there was no such absolute principle. The issue of a what a Claimant knew or should have appreciated about any risk he is running is relevant to the analysis of whether there is a breach of duty which may or may not outweigh other factors. Relevant factors to be taken into account included the type of activity being undertaken and the fact he was a guest in a hotel.

She supported the approach of the first instance judge saying that the judge's conclusions as to the existence of the Defendant's duty to the deceased, a lawful visitor, the foreseeable risk of serious injury due to the state of the premises, the absence of social value of the activity leading to the risk and the minimal cost of preventative measures were unassailable. She held that these were findings which provided a sound factual basis for a determination that the Defendant breached its section 2 common duty of care to the deceased.

Issue 2

Nicola Davies LJ considered whether there was a section 2(5) defence, which is the statutory equivalent of the defence of *volenti non fit injuria*. She recognised that the test is a high one and for the defence to succeed it must be shown that the Deceased was fully aware of the relevant danger and consequent risk. She did not consider that the findings of the judge as to the general risk which the Deceased faced went sufficiently far to meet the requirements of section 2(5). That would require a finding that the Deceased was aware of, and expressly or impliedly accepted, that the risk had been created by the Defendant's breach of duty and by his actions he was deliberately absolving or forgiving the Defendant for creating the risk. She thought it pertinent to observe that the Defendant had not appreciated the risk prior to the accident.

Issue 3

Given the clear wording of section 41(1)(a) of the HSWA 1974, Nicola Davies LJ was unable to accept the conclusion of the judge that unless the conviction is challenged on its facts civil liability does axiomatically follow. Whilst she accepted the need for coherence and consistency between the civil and criminal law which apply to the same set of facts, she said that those facts need to have been explored in order to decide whether, and if so, how, a criminal conviction relates to civil liability. However, account could and should be taken of the conviction and the basis on which the plea was entered. The weight to be attached to the conviction and any basis of plea will depend on the facts of each case. In this case, the risk which formed the basis of the criminal

[18] *Tomlinson v Congleton Borough Council* [2004] 1 AC 46, *Edwards v Sutton London Borough Council* [2016] EWCA Civ 1005 and *Geary v JD Weatherspoon* [2011] EWHC 1506 (QB)

conviction was directly relevant to the to the tragic events which materialised and so the chain of causation was made out.

Comment

This decision is authority for the following propositions:

1. There is no absolute principle that a person of full age and capacity who chooses to run an obvious risk cannot found an action against a Defendant on the basis that the latter has permitted him to do so, or not prevented him from so doing.

2. The section 2(5) defence is equivalent to the *volenti* defence and the test is a high one. For the defence to succeed it must be shown that the Deceased was aware of, and expressly or impliedly accepted, that the risk had been created by the Defendant's breach of duty and by his actions he was deliberately absolving or forgiving the Defendant for creating the risk.

3. Whilst civil liability does not axiomatically follow a criminal conviction, account can and should be taken of the conviction and the basis on which the plea was entered. The weight to be attached to the conviction and any basis of plea will depend on the facts of each case.

QUANTUM: FUTURE LOSS OF EARNINGS / DEPENDENCY IN FAMILY BUSINESS CASES

Matthew Domnall

Rix v Paramount Shopfitting Co Ltd [2020] EWHC 2398 (QB)

Head v Culver Heating Co Ltd [2021] EWCA Civ 34

These two recent cases illustrate the complexities that can arise in a situation where the injured (or deceased) person has (or had) his or her own business, with income both from a salary and from a shareholding. If the income from the shareholding will endure after the death, what does that mean for a FAA financial dependency claim, or a claim for lost years of earnings? Especially in the light of the Court of Appeal's judgment in the later case, *Head*, which cited and approved the approach in *Rix,* the applicable principles are now somewhat clearer.

Rix

In a judgment of September 2020, Cavanagh J considered the financial dependency aspect of Mrs Rix's FAA claim. Her late husband had built up a profitable company in construction and joinery. At the time of his death, he owned 40% of the shares in that company, and Mrs Rix owned 40%, with their sons 10% each. Mr Rix also drew a salary, as did Mrs Rix, although that salary did not reflect her contribution to the business, but was a tax-efficient way of taking money out of it. He found that she was, at the point of his death, financially dependent upon him. After his death, his eldest son took over as managing director of the business, and the business became more profitable. As Mrs Rix now had an 80% shareholding, the defendant argued that she had not suffered any financial loss at all as a result of her husband's death, as in purely financial terms, her income was greater than when he was alive.

The court considered that there was some logic in both parties' positions, but that the answer lay in three leading Court of Appeal authorities, *Wood v Bentall Simplex Ltd* [1992] PIQR P332 (CA); *Cape Distribution Ltd v O'Loughlin* [2001] EWCA Civ 178; and *Williams v Welsh Ambulance Services NHS Trust* [2008] EWCA Civ 81. The core principles he identified included the following.

First, and critically, there is a difference between an income-producing asset, such as a rental property or an investment, on the one hand, and a business which was benefiting from the labour, work, and skill of the deceased, on the other. Where the value of an income-producing asset is unaffected by the deceased's death, there is no financial loss or injury as a result of the death, and so there is no claim for loss of financial dependency

in relation to it. Where, however, the deceased worked in a business that benefited from his or her hard work, the dependants will have lost the value of that hard work as a result of the deceased's death and so will have a financial dependency claim.

Second, following *O'Loughlin* and *Williams,* a loss of financial dependency is fixed at death, and so the value of the loss, is not assessed by reference to how well the business has been doing since the deceased's death.

Third, the courts should look at the practical reality in relation to financial dependence, not at the corporate, financial or tax structures that were used in family arrangements. This was a reference to the fact that although she had received a salary, she had not herself worked at all, and it was an arrangement for tax reasons.

As a result, Cavanagh J rejected the defendant's contentions, that Mr and Mrs Rix's shareholding in the family business was an income-generating asset, independent of the work and labour of Mr Rix himself. He found that Mrs Rix had suffered a loss of financial dependency, notwithstanding that the business was more profitable after his death than it was before. Finally, he also went behind the ostensible fact of Mrs Rix herself receiving a salary and income, because the practical reality was that such income arose by virtue of Mr Rix's labour, rather than her own.

Head

This case concerned a mesothelioma claim brought by the injured Mr Head, who subsequently died after trial. The issue which subsequently went to the Court of Appeal was that of the 'lost years' claim. On this, the parties had been "very far apart indeed": the Claimant had contended for an award of over £4 million, whereas the Defendant argued there should be no award at all.

Mr Head had established a profitable business. His wife worked for the business in an administrative role for two days a week, and took a salary, but HHJ Melissa Clarke found that it was essentially Mr Head's business, and concluded, as a fact, that Mr Head's future earning capacity was at 90% of his business' profits, subject to a deduction equal to the value of Mrs Head's work for the business. However, she then considered whether this notional loss was diminished by the dividend income from his shares in the business which was likely to survive his death, and concluded that it was, to such an extent that there was no residual loss at all. She reached that conclusion on the basis of her reading of an earlier High Court decision in *Adsett v West* [1983] QB 826, understanding that to mean that where earnings enjoyed in life survive and continue to be earned after death, those earnings have not been lost and cannot form part of a 'lost years' claim.

Giving the only judgment of the Court of Appeal, Bean LJ concluded that this conclusion at first instance was wrong in law. He considered all that had been determined in *Adsett* was that there was a critical distinction between loss of earnings from work, and loss of income from investments. As an example of the latter, he took someone who, after a few years in the insulation industry, won the National Lottery and then lived off investments before being diagnosed: he would have no claim for loss of earnings in the lost years. By contrast, Mr Head was not someone who was not working, and merely passively received an income from his shareholding. Rather, he was the driving force of the company. So his future loss of earnings was not restricted to the "very modest" salary which he took – the level of which was fixed "for reasons of tax efficiency" and did not reflect the value of his work. Rather, the full extent of his earnings included all the income which he and his wife received from the company, save for the small deduction in respect of Mrs Head's work.

Summary observations

The two decisions in *Rix* and *Head* are complementary. Although the former is a FAA claim, and the later was a claim personal to Mr Head (and thereafter his estate), the core principles appear the same. Indeed, in coming to his conclusion, Bean LJ cited *Rix,* and expressly analogized the position with that case (*"As Cavanagh J did in the Rix case…"*). A conceptual flaw in the defendants' position in both cases was assuming a dichotomous treatment of salary as earnings on the one hand, and dividend income as analogous to a passive investment income on the other. These decisions show the courts looking behind the arrangements that might be made cases for tax efficiency, and to the underlying reality of what income each man was generating by his work.

Given how far apart the parties were on the law in both cases, the clarification in *Rix* and *Head* appears to have been much needed, albeit applying these principles to the facts of any particular case may yet prove difficult.

EQUIVOCAL ADMISSIONS AND INQUEST COSTS

Thomas Beamont

Greater Manchester Fire and Rescue Service v Veevers [2020] EWHC 2550 (Comm)

An admission of liability before an inquest can have a substantial effect on the recoverability of the family's inquest costs. An early and full admission may extinguish them entirely.

But in the cautionary case of *Veevers*, the High Court held that the costs of an inquest were in principle recoverable. That was so notwithstanding that Greater Manchester FRS had stated, in pre-inquest correspondence, that the estate would be compensated for any losses arising from the death of the Deceased.

The 'admission'

Stephen Hunt was a firefighter, employed by the Appellant and who tragically died in the course of his employment. The family of Mr Hunt pursued a civil claim. In doing so, the family's solicitors incurred substantial costs in investigating the facts of the claim, and the family were represented at the well-publicised inquest.

In pre-action correspondence and prior to the inquest, the Claimant's solicitors invited Greater Manchester FRS to admit liability. The response was in terms that, while they were *"not in a position to consider an admission of liability"*, they were willing to *"compensate the estate and dependents of Stephen Hunt…for any loss which they may prove to be attributable to the incident."*

Judgment

Upholding the decision of the Deputy District Judge, HHJ Pearce set out the classical inquest costs cases of *Ross v The Owners of the Ship 'Bowbelle'* [1997] 2 Lloyd's Rep 196, and *Roach v Home Office* [2010] QB 256.

He set out the following summary of the principles to be applied, at [55]:

1. Inquest costs may be recoverable in so far as reasonable and proportionate, so long as they can properly be said to be incidental to the civil claim;
2. Such costs will not be recoverable if liability is no longer in issue between the parties, since the costs are simply not incidental to something in issue in the civil claim;
3. In determining whether liability is in issue, the court must look at all the circumstances of the case, but the central issue is likely to be whether the prospective defendant has admitted liability or otherwise indicated a willingness to satisfy the claim;
4. Liability will not be in issue if it has been admitted since such an admission is binding unless the court subsequently permits it to be withdrawn pursuant to CPR 14.1A.
5. However, the Costs Judge is entitled to look with care at anything less than an unqualified admission to see whether the prospective defendant's position is one from which it may resile or which leaves matter in issue between the parties.
6. In particular, if the defendant's position is not one of unqualified admission in circumstances where such an admission could have been made, the Costs Judge may be entitled to find that the failure to make an unqualified admission justified the conclusion that the defendant might exercise its right to resile from the admission and that therefore the costs of the inquest could properly be said to be incidental to the civil claim.

7. If the costs can be justified upon these principles, the mere fact that there are other reasons why the family of the deceased should wish to be represented at an inquest, most obviously to avoid the inequality of arms between unrepresented family members and a represented public body does not mean that the costs are not recoverable. It is enough that the attendance to secure relevant evidence in relation to matters in issues was a material purpose for the attendance.

Applying those principles, the judge considered that that the inquest costs were recoverable in principle. In particular, there had been no unqualified admission. Accordingly, the Claimant solicitors had been entitled to treat the statement as capable of withdrawal.

Discussion

For those representing the family, the threat of a substantial inquest costs bill is a powerful tool in encouraging early settlement, particularly where those costs may be comparable to the eventual damages claim. For those on behalf of an institutional Interested Person, is a delicate balance, and is difficult to strike in circumstances where the factual and expert evidence will not yet have been fully explored.

When considering the terms, though, of an admission received or to be made, a two-stage test is suggested as a practical approach.

> First, compare the wording of the admission to the procedural rules. Does it satisfy the clear procedure set out in CPR 14?
>
> The second is to consider the scope of the admission in the circumstances of the case. Are there potential aspects of a claim on which the admission is silent, or ambiguous? Consider an admission of liability *"for the death of"* the Deceased. In that case, the extent of liability for pain, suffering, and loss of amenity on the part of the Deceased, or in particular its duration, may remain a matter of dispute and therefore incidental to the claim. Costs expended in exploring that issue may remain recoverable.

Overall, once the decision to satisfy a claim is made, it is clear from *Veevers* that to do so by equivocal admission runs a risk of negating a significant benefit of that approach.

MEDICAL TERMINATION OF PREGNANCY AND THE HOME OF A PREGNANT WOMAN

Matthew Flinn

R (on the application of Christian Concern) v Secretary of State for Health and Social Care [2020] EWCA Civ 1239

The Court of Appeal has determined that the Divisional Court was right to refuse permission to bring judicial review proceedings challenging a ministerial decision to approve "the home of a pregnant woman" as a "place" where early medical termination of pregnancy (i.e. via medication) could occur under the Abortion Act 1967.

Pursuant to the exigencies of the COVID-19 pandemic, the Secretary of State for Health and Social Care utilised powers under sections 1(3) and 1(3A) of the Abortion Act 1967 (as amended in 1990) to permit women to take both of the two drugs necessary to effect an early medical abortion at home. Prior to the change, since 2018, only the second of the two drugs could be self-administered by the pregnant woman at home. The first had to be taken in the clinic providing access to the treatment.

In a previous Special Issue, QMLR covered the decision of the Divisional Court ([2020] EWHC 1546 (Admin)), which refused permission to challenge the decision on all eight proposed grounds of review, namely:

1. The decision was ultra vires s.1 of the Abortion Act 1967;
2. The decision was contrary to the legislative purpose of the Act;
3. The decision was irrational;

4. The decision was tainted by constitutional impropriety;
5. The decision was in breach of both substantive and procedural legitimate expectations;
6. There was a failure to take into account irrelevant considerations and/or conduct sufficient enquiries;
7. There was a failure to carry out a public consultation; and
8. The decision entailed human rights breaches under s.6 of the Human Rights Act 1998.

Permission to appeal was granted in respect of two aspects of the Divisional Court's decision:

1. The court had erred in refusing permission to challenge the SS's decision on the basis that it was ultra vires the Abortion Act 1967; and
2. It had erred in refusing permission to challenge the decision on the basis that it was contrary to the legislative purpose of that Act.

Ultra vires

The vires argument was based on phraseology in s.1 of the Abortion Act 1967 which required that termination was carried out "*by* a registered medical practitioner" (emphasis added). It was argued for Christian Concern that the approval of a pregnant woman's home for the purpose of both starting and completing medical termination (through the taking of the first and then the second drug), when she may not have had a consultation with a doctor, meant that this requirement was bypassed; the termination was not carried out "by" a registered medical practitioner in such circumstances.

The Court of Appeal disagreed. Case law had already established that the words required the practitioner to be in charge of (and to have responsibility for) the process, but not to be personally involved for carrying it out (see *Royal College of Nursing of the United Kingdom v Department of Health and Social Security* [1981] AC 800 and *SPUC Pro-Life Scotland Ltd v Scottish Ministers* 2019 SC 588).

It was also important to consider the way in which medical science and prevailing conditions had changed – the enabling provision under s.1(3A) of the Act permitted the SS to be responsive to such changes. Medical science now meant that an early medical abortion could be effected entirely via medication safely, and societal conditions had also moved in that (a) it was now possible to have detailed consultations digitally (the court referred to this as "tele-medicine") and (b) there was a pressing need for processes which were responsive to the pandemic.

Finally, it noted that there had been no challenge to the change in 2018 which permitted the second of the two drugs to be taken at home. It followed that the principle of approving a pregnant woman's home for the self-administration of such medication had been accepted as intra vires the Act. There was no evidential basis for distinguishing between the two medications.

Legislative purpose

The Claimant had advanced the classic public law argument (based on *Padfield v Minister of Agriculture, Fisheries and Food* [1968] AC 997) that no statutory power is unfettered: it must be exercised so as to promote the purpose of the statute conferring it and not to frustrate that purpose. It was argued that the purpose of the Act was to ensure that abortion treatment was provided with proper care and skill, in places which were safe and hygienic, and where women would not be exposed to pressure. Enabling women to both begin and complete abortion treatment at home – an unregulated environment – thwarted that legislative purpose.

At [40] of her judgment, Nicola Davies LJ described the purpose of the Abortion Act as follows:

> *"The purpose of the 1967 Act was to broaden the access of a woman to a legal termination of pregnancy, approved on a specified ground(s) by an RMP and provided in a place which was deemed safe for the relevant medical process."*

In this case, thanks to the development of medical science and technology, the relevant medical process was simply the consumption of medication. A woman's home was a safe environment for that process. Moreover, the Court of Appeal agreed with the Divisional Court that the approval – which was specifically time-limited and

tied to the pandemic – was implemented in order to address the risk of women not having access to abortion treatment during lockdown, and thus seeking treatment in environments which were wholly unsafe.

Comment

When litigation turns on the interpretation of a statutory provision, its significance is very often confined to the specific issue or context which the particular case is addressing. After all, the meaning of statutory words will always depend on their statutory context and the kinds of situations in which they are intended to apply.

That may be the case here, but it will be interesting to see if this case is cited or applied in the future in other medical contexts. After all, it does address issues such as the meaning of "treatment", what it means for such treatment to be administered "by" a registered medical practitioner, and when and why a medical practitioner remains "in charge of" or "responsible" for medical treatment, although it is not carried out directly by him/her. Those are all issues which could easily come up in any number of clinical negligence cases. What this space, or more specifically, keep checking back in with QMLR!

COURT OF PROTECTION DECISIONS ON CAESAREAN SECTIONS

Matthew Flinn

A London NHS Trust v KB [2020] EWCOP 59

The Court of Protection granted an order to an NHS Trust permitting it to require KB to undergo a caesarean section prior to spontaneous labour in her own best interests, using proportionate restraint if necessary. As Poole J noted, although the order was agreed by all parties, it involved the court *"giving consent to a significant intervention and it comes to court against a background of some disturbing circumstances".*

KB had suffered a hypoxic brain injury at birth, leaving her with moderate to severe learning disabilities, and some physical disability. Her communication was limited to a few words and was mostly non-verbal, and she was not capable of independent living. In July 2020 she visited her GP with her mother as she was feeling unwell, and found to be 22 weeks pregnant.

There was clear evidence from KB's allocated social worker, midwife, obstetrician and anaesthetist, which led the court to conclude that KB could not understand that she was pregnant, or the implications of that. In November 2020 an order was made that she lacked capacity to make decisions as to her antenatal care, the delivery of her baby, contraception and engagement in sexual relations.

The Trust's present application was necessary because it involved issues relating to contraception and the potential need for restraint, applying the *Guidance on Applications in Relation to Medical Treatment*, authorised by the Vice President of the Court of Protection, Mr Justice Hayden, at [2020] EWCOP 2.

In considering the order sought by the Trust and applying the best interests test set out in section 4 of the Mental Capacity Act 2005, Poole J noted that due to KB's lack of understanding, she would find labour and vaginal delivery extraordinarily distressing. In contrast, an elective caesarean section would result in the birth of a healthy baby, and avoid the traumatic experience that labour would entail for her. In other words, it would reduce the risks to her and the baby. Poole J also formed the view that if KB had had capacity, she would have wished to do what was best for her unborn child, which in this case was to undergo a caesarean section.

He also found that it was necessary and proportionate to authorise restraint if required in order to effect that treatment plan – see [27]:

> *"The authorisation of restraint is not lightly given. KB is a very vulnerable woman who would not comprehend why she was being taken to hospital. The evidence to date is that KB has been entirely compliant with visiting hospital, and examinations, save for recoiling when palpated during one*

> *examination. Nevertheless, authorisation is sought as set out above in the event that she is not compliant in the future. KB has human rights under Art 5 and Art 8 of the European Convention on Human Rights and it is troubling to be asked to authorise the deprivation of her liberty and the use of restraint if necessary, but the far more alarming prospect is of her not receiving the obstetric treatment that she will obviously need in the days ahead of this hearing. I am quite satisfied that the proposed deprivations of liberty, including the provision for the use of restraint, are necessary, proportionate and in her best interests."*

Poole J also passed comment on various aspects of delay in the case, including delays in medical appointments and decision-making which meant that the opportunity for termination (if found to be in KB's best interests) was lost. Also, there had been delay in making the present application (KB was almost at full term). However, the role of the Court of Protection was to look forwards. In that regard, as well as granting the order sought in relation to delivery, it noted that decisions about contraception and sterilisation would need to be taken, but that this would happen after the identification of the father and the circumstances in which KB had fallen pregnant. Given that KB was incapable of consenting to sexual intercourse, that individual was in fact the perpetrator of a sexual assault, and the court made orders to permit samples being taken from KB to assist in identifying him, as well as police disclosure orders so that any relevant information about the police investigations could be used in assessing KB's care and best interests moving forwards.

Happily, there is a short postscript appended to the judgment confirming that KB gave birth by caesarean section later in November 2020, and that both mother and baby were doing well.

SOME PROCEDURAL ISSUES IN BRIEF

Jeremy Hyam QC

Jarman v Brighton and Sussex University Hospitals NHS Trust [2021] EWHC 323 (QB)

Cherian v Cambridge University Hospitals NHS Foundation Trust [2020] EWHC 3601 (QB)

Taleb (A Child Proceeding by His Litigation Friend M) v Imperial College Healthcare NHS Trust [2020] EWHC 1147 (QB)

When can an expert in one set of proceedings be used in another?

This issue came up before Lambert J in *Jarman v Brighton and Sussex University Hospitals NHS Trust* [2020] EWHC 3238 (QB). The Claimant, a primary school teacher suffered a lifting injury at work in February 2015. She went to her GP and then to a physio who was sufficiently concerned about her symptoms that on 3 March 2015 she was told to go to A and E. She duly did and was assessed by a junior doctor who said there was no evidence of a cauda equina lesion and that an MRI would be performed in the next few days. It was eventually performed on 18 March, two weeks later. It showed a huge central right sided disc protrusion. Urgent decompressive surgery was performed but unfortunately too late. The Claimant had been left with significant and disabling Cauda Equina Syndrome.

She issued one set of proceedings against her employer, the Council, and then a separate set of proceedings against the Trust for culpable delay in undertaking decompression surgery. The Council itself then brought Part 20 proceedings against the Trust in respect of the alleged delay. The actions were not consolidated but Master Yoxall directed they be tried together. Under these directions there was a joint meeting of experts including the experts instructed by the Council in its Part 20 claim against the Trust. That joint statement contained some seemingly favourable opinions from the Council's instructed experts. However, in September 2020 the claim against the Council was compromised and, unless she obtained permission to do so, the Claimant would not be entitled to rely on the evidence of the Council's experts as they were experts in a separate set of proceedings.

The experts were Mr Maurice-Williams (neurosurgeon) and Dr Cockerill (neurologist). The Claimant duly made the application and relied on an analogy with the position under CPR 35.11 (the rule which permits any party to use an expert's report disclosed in the proceedings by another party as evidence at the trial) and the overriding objective. The application was resisted by the Defendant who considered allowing oral evidence from the additional experts would result in increased complexity and length to the trial. In her succinct and lucid judgment Lambert J explained that the applicable provision was CPR 35.1; that the overriding objective applied; and that expert evidence should be restricted to that which was reasonably required to resolve the proceedings. No one was suggesting the views of Mr Maurice-Williams and Dr Cockerill should be redacted from the joint statements. To do so might give a distorted impression of the joint statement as a whole. Thus both reports would be admitted. The real question was whether oral evidence of Dr Cockerill and Mr Maurice-Williams should be permitted. She answered that question in the affirmative saying that in the absence of oral evidence from the two experts the difficult job for the trial judge would be all the more difficult. Further, if the evidence of Dr Cockerill and Mr Maurice-Williams was in some respects inconsistent with the other experts to be called by the Claimant then this seemed to militate in favour rather than against their evidence being explored in cross examination rather than being dealt with by submissions only. In terms of additional cost and time, the financial cost was estimated at £22,000 and the extra trial time, one day. In the context of the amount of money involved in the claim, the importance of the case; the complexity of the issues and the financial position of the parties, it was proportionate to admit the evidence.

In the event (and perhaps as may have been anticipated by Lambert J if the evidence was tested under cross examination) calling the additional experts did not avail the Claimant. The experts were duly cross examined and the views of the Defendant's experts preferred, see the final judgment before Jason Coppel QC sitting as a deputy [2021] EWHC 323 QB, who found against the Claimant on breach of duty and explained he would also have found against the Claimant on causation.

Is Reconstruction evidence: "opinion" or "factual" evidence?

This issue was considered in *Cherian v Cambridge University Hospitals NHS Foundation Trust* [2020] EWHC 3601 (QB) by Robin Knowles J [2020] EWHC 3601 on appeal from a decision of Recorder Gallagher. The Claimant was a nurse who suffered an injury at work when she tried to sit on one of a new stock of wheeled stools in the recovery unit at the Defendant hospital. As she tried to sit down on the stool, it rolled way from under her and she fell suffering a flexion compression injury to her back. The recorder had refused the Claimant permission to rely on the evidence of the Claimant's husband and some videos he had taken of stools at the hospital. His reasons had a certain attractive simplicity about them:

> "*The evidence sought to be put in, in my judgment is not proper evidence of fact. The witness was not there. He is seeking to give opinion evidence which he is not entitled to give of a reconstructive nature. That type of evidence has already been refused. It is clearly not expert evidence. …He is trying to say that the stool was essentially unsafe and it must be inherently unsafe. That is expert evidence in my judgment*".

Yet the Judge overturned the Recorder's decision who had, it appears, not been referred to key authority, *Blair-Ford v CRS Adventures Ltd* [2012] EWHC 1886 (a case about a catastrophic injury in a wellie-wanging contest when expert engineering evidence about the forces deployed in wellie wanging generally was refused, but factual evidence was admitted from those experts so long as it was confined to the accounts of the experiments (presumably example wellie-wangs) which they carried out.

The judge summarised the effect of that authority to be that factual reconstructive evidence need not be evidence from an expert and can be admitted through a lay witness and overturned the decision of the Recorder but only to the extent that the evidence allowed was only that relevant to factual reconstruction and therefore some aspects of the videos and written evidence.

Comment: In some senses a surprising result. How much evidential value would the court in this (or any case) be likely to place on the husband's (non-expert) accident reconstruction videos? Perhaps the right approach in reconstruction cases is to ask sequentially: is the evidence (or relevant part of the evidence e.g. a video) sought

to be admitted evidence of fact or an opinion? If expert evidence, then permission is required for it under Part 35, if fact then its admissibility turns on relevance and probative value not the identity or qualifications of the maker.

When will a late application for a joint single expert be allowed?

This issue is considered by Stewart J in *Taleb (A Child Proceeding by His Litigation Friend M) v Imperial College Healthcare NHS Trust* [2020] EWHC 1147 (QB). This case concerned an application by the Defendant for a single joint expert in genetics in a brain injury case. The issue arose because in the course of a conference which took place after exchange of witness statements with the Defendant's factual and expert witnesses it was suggested by the Defendant's paediatric neurologist that the cause of the Claimants injuries could be genetic rather than iatrogenic. The Defendant therefore applied for a single joint geneticist to be instructed to investigate this issue. The Claimant resisted on grounds that the Defendant had already admitted, and not resiled from, its admission that the Claimant had suffered a chronic partial hypoxic ischaemic insult in utero, that the medical evidence available (and such genetic investigations as had been carried out on the child) had not identified any genetic abnormality; and that the application was both late, unnecessary and inappropriate and would jeopardise the trial date. The Court reviewed the relevant authorities and notably refused to follow the decision of Karen Steyn QC (now Steyn J) in *SJ Moore Jeweller v Squibb Group Ltd* [2018] EWHC to the effect that there was an implied sanction in CPR 35.4, and held that there was no express or implied sanction and that the applicable principles were either (a) the overriding objective or, if it was a "very late application"(b) whether there was a good reason for the late application; the significance of the new material; consideration of prejudice to each party; and the need to do justice to all the parties – see *Heiser v The Islamic Republic of Iran and Anor* [2019] EWHC 2073.

After analysing the chronology of the application and the time to trial, the Court concluded that if the application were granted it was inevitable the trial date would be lost and it was therefore a "very late application". The Court then applied the *Heiser* principles to the facts, the Court and refused the application by reference to the relevant discretionary factors.

Matthew Barnes of 1COR appeared for the Defendant in Taleb. He did not contribute to this article.

ANONYMITY ORDERS: AN APPROVED TEMPLATE

Angus McCullough QC

Anonymity orders are a routine part of the working life of those practising in the field of personal injury and clinical negligence. In 2015 the Court of Appeal in *JXMX v Dartford & Gravesham NHS Trust* [2015] EWCA Civ 96 clarified the basis on which anonymity was justified in cases involving the approval of a settlement on behalf of a protected party (i.e. a child or someone who lacks capacity to conduct the proceedings: CPR r.21.1). Since then it has been generally recognised that the principles identified in *JXMX* extend beyond approval hearings, to all stages of proceedings involving a protected party. Anonymity orders are routinely sought and granted in such cases: *GB v Home Office* is an early example in which Coulson J referred to the requirement for consistency that had been highlighted in JXMX.

Given that such orders are so frequently obtained, it is perhaps surprising that no standard form of order has emerged. More concerningly, some forms of order have been found either to lack clarity, or be remarkably burdensome to comply with; indeed, unnecessarily burdensome for the purposes of achieving proper protection of the identify of a vulnerable party.

Further detail as to the background to anonymity orders, and some of the difficulties with their operation in practice, can be found in a two part article published on the UK Human Rights Blog in 2019: Straining the Alphabet Soup, Part 1 and Part 2. In a recent QMLR article (QMLR Issue 6) William Edis QC reviewed recent cases in which anonymity had been considered where the person seeking anonymity was not a protected party, to which reference may be made for the trickier cases beyond the paradigm.

In an attempt to address the issues that have been experienced even in standard cases in which anonymity will ordinarily be granted, I have been involved, with William Latimer-Sayer QC and Helen Mulholland, in developing a template for an order for use in personal injury and clinical negligence proceedings. This is with a view to producing a form of order that is effective in its purpose, makes only such incursions into the principle of open justice as are strictly justified, and is practical to operate.

The full membership of both the Personal Injury Bar Association (PIBA) and the Professional Negligence Bar Association (PNBA) have been consulted on the form of order. That exercise established that there was strong support for such an order and yielded some useful suggestions from senior practitioners for improvement of the template on which views were sought. The product of that exercise has now been endorsed by both Associations, and the template is set out below, with some commentary. The next stage, which may lead to further refinement of this template, is to seek the views of the judiciary and others working in the field. If you have any comments or suggestions in relation to this template, I would welcome hearing from you.

If you would like access to an electronic version of the template, it may be found at the following link: https://ukhumanrightsblog.com/2019/05/02/straining-the-alphabet-soup-part-2-drafting-anonymity-orders/

TEMPLATE FOR ANONYMITY ORDER

FOR USE IN PERSONAL INJURY / CLINICAL NEGLIGENCE CASES

[HEADING]

The heading should be anonymised, as the general provision in the Practice Guidance: Publication of Privacy and Anonymity Orders dated 16 April 2019 is for the orders to be published on the website of the Judiciary of England and Wales.

[WWW]

For the HMCTS computer system, the anonymised name of the Claimant should be three letters.

(a child / protected party by his/her Litigation Friend, XXX)

Claimant

and

[DEFENDANT]

Usually, D's name will not be anonymised; however sometimes it may be necessary to anonymise D's name if there is a risk of identifying C by a 'jigsaw' effect.

Defendant

ANONYMITY ORDER

BEFORE [*Judge*] sitting at [*Court*] on [*date*].

UPON HEARING [*Counsel / Solicitor*].

AND UPON:

In cases that fall outside the scope of the procedure identified by the CA in JXMX, an application notice and evidence will be required, and should be referred to in the recital.

(1) Consideration of the Article 8 rights of the Claimant to respect for private and family life, and the Article 10 right to freedom of expression.

In a case under the FAA which involves child dependants, the references to the Claimant in the order will require to be adjusted as appropriate.

(2) It appearing that non-disclosure of the identity of the Claimant is necessary in order to protect the interests of the Claimant and that there is no sufficient countervailing public interest in disclosure.

(3) The Defendant indicating its neutrality[19] to the making of the order and there being no representations from the press or any other interested party.

Generally, the NHS, other health body defendants, institutional defendants, and insurers express neutrality in relation to the making of an anonymity order to protect the identity of a vulnerable claimant. However, it is advisable for defendants to ensure that the form of the order sought does not impose more extensive burdens than may be necessary, as all parties are likely to be affected by the terms of the order.

AND PURSUANT to section 6 of the Human Rights Act 1998; section 11 of the Contempt of Court Act 1981; and CPR rules 5.4C, 5.4D and 39.2(4).

WHEREAS:

(1) For the purposes of this order:

i) 'Publication' includes any speech, writing, broadcast, or other communication in whatever form (including internet and social media), which is addressed to the public at large or any section of the public.

This non-exhaustive indication of what constitutes 'publication' is broadly based on that in s.2(1) of the Contempt of Court Act 1981

ii) Publication for the purpose of this Order includes any further publication (as defined in subparagraph (i) above) from the date of this Order, even if such information has derived from a previous stage or stages of these proceedings.

2) For the avoidance of doubt, set out below is a non-exhaustive list of examples of communications and records which do not constitute publication within the meaning of this order (providing always that proper steps are taken to protect the confidentiality of information from being made public). In this list references to 'the anonymised party' include that party's appointed representatives and advisers, such as solicitor, Litigation Friend, attorney, trustee and deputy.

Arguably this lengthy recital is unnecessary once the scope of 'publication' at (1) has been appreciated. On balance, based on consultation thus far, it has been felt worth including this reassurance (including bearing in mind that individuals considering the order may not be lawyers) despite its length.

[19] Generally, the NHS, other health body defendants, institutional defendants, and insurers express neutrality in relation to the making of an anonymity order to protect the identity of a vulnerable claimant. However, it is advisable for defendants to ensure that the form of the order sought does not impose more extensive burdens than may be necessary, as all parties are likely to be affected by the terms of the order.

(i) Communications between the Court Funds Office and the anonymised party in relation to the payment of money into the Court Funds Office for the benefit of the anonymised party or the investment or treatment of payment out of such money.

(ii) Communications between the Court Funds Office, the anonymised party, and any financial institution concerned as to the receipt or investment of such money.

(iii) Records kept by the Court Funds Office, the anonymised party, and any financial institution concerned as to the receipt or investment of the Claimant's money.

(iv) Retention by all parties to the claim, their representatives, and their advisers of their unredacted files for the purposes of their continuing functions and obligations in relation to the proceedings.

(v) Communications between the Defendant(s), their insurers, or their successors in title and their legal and professional advisers, reinsurers, HM Revenue and Customs (or its successor), the Compensation Recovery Unit or any other person required by law.

(vi) Communications between the anonymised party's representatives and advisers in managing that party's affairs.

(vii) Communications for the purpose of obtaining medical care, advice or treatment for the anonymised party.

IT IS ORDERED [BY CONSENT] THAT:

1. The identity of the Claimant as a party to these proceedings is protected and shall not be published.

2. Pursuant to CPR Rule 39.2(4), there shall not be disclosed in any report of these proceedings or other publication the name or address of the Claimant, the Claimant's Litigation Friend or other immediate family members, or any details (including other names, addresses, or a specific combination of facts) that could lead to the identification of WWW as the Claimant in these proceedings. The Claimant and the Litigation Friend shall be referred to as set out at paragraph 3 of this Order.

The wording of this paragraph reflects that in the Order of the CA in JXMX at para 3, slightly adapted.

3. In any judgment or report of these proceedings, or other publication (by whatever medium) in relation thereto:

Aside from any judgment, this form of order does not require anonymisation of other Court documents – neither those documents that have been filed or served prior to the date of the order - nor those that will be thereafter. This is deliberate. Such provisions (e.g. "For all purposes of this case …") may be unduly onerous, and may be considered unnecessary in most personal injury or clinical negligence cases, given the terms of the order providing for (a) a prohibition on publication of identifying details in paras 1 to 3; and (b) the restriction on access to the Court file at paras 4 and 5.

Such broader provisions were not adopted by the CA in the order made in JXMX - although do appear in High Court form PF10.

(i) The Claimant shall be referred to as "[WWW]".

(ii) The Litigation Friend shall be referred to as "[XXX]".

(iii) Any other details liable to lead to the identification of the Claimant (including any names of other immediate family members or their addresses) shall be redacted before publication.

4. Pursuant to CPR Rules 5.4C and 5.4D:

i) A person who is not a party to the proceedings may not obtain a copy of a statement of case, judgment or order from the Court records unless the statement of case, judgment or order has been anonymised in accordance with subparagraphs 3(i) to (iii) above.

The substance of this wording is taken from the Order made by the CA in JXMX at para 4.

ii) If a person who is not a party to the proceedings applies (pursuant to CPR r.5.4C(1B) or (2)) for permission to inspect or obtain a copy of any other document or communication, such application shall be on at least 7 days' notice to the Claimant's solicitor, trustee or deputy.

CPR r.5.4D(2) provides that generally (and with some specified exceptions) applications made under r.5.4C do not require to be made on notice, "but the court may direct notice to be given …". The wording of para 4(ii) accordingly prevents an application being made without notice.

5. The Court file shall be clearly marked with the words "An anonymity order was made in this case on [date of this Order] and any application by a non-party to inspect or obtain a copy document from this file must be dealt with in accordance with the terms of that Order."

6. Any interested party, whether or not a party to the proceedings, may apply to the Court to vary or discharge this Order, provided that any such application is made on notice to the Claimant's solicitor, trustee or deputy, and that 7 days' prior notice of the intention to make such an application is given.

7. Pursuant to the 'Practice Guidance: Publication of Privacy and Anonymity Orders' issued by the Master of the Rolls dated 16 April 2019 a copy of this Order shall be published on the Judicial Website of the High Court of Justice (www.judiciary.uk). For that purpose, a court officer will send a copy of the order by email to the Judicial Office at judicialwebupdates@judiciary.uk.

8. The costs of obtaining this order be costs in the [case / claim / assessment].

MAUGHAN: SUICIDE AND UNLAWFUL KILLING CONCLUSIONS IN INQUESTS

Owain Thomas QC

R (Maughan) v Her Majesty's Senior Coroner for Oxfordshire [2020] UKSC 46

The Supreme Court has now issued its judgment in this important case for Coroners and inquests dealing with the standard of proof to be applied where the death might have been caused by suicide or unlawful killing.

Everyone who has done an inquest where these conclusions were realistic on the evidence has traditionally gone along with the idea that in order to be satisfied that either conclusion should be returned the criminal standard of proof was required.

This is often seen in practice, particularly where suicide is concerned, as being a way for Coroners to return an open verdict where there is no positive and direct evidence that the deceased intended to take his or her life, even if the surrounding circumstances point clearly in that direction. Such an approach can be welcome to families grieving the loss of a family member.

However, that all changed with the judgment of the Divisional Court and then the Court of Appeal in this case (see my coverage on the UKHRB here). This long held practice was held to be devoid of a sound legal basis and that given that the inquest was not itself a criminal proceeding then the civil standard ought to be applied. The Supreme Court has now confirmed that that is right, albeit by a majority of 3 to 2.

The result is that all forms of conclusion in the coroner's court whether narrative or short form are to be rendered on the balance of probabilities. This includes suicide and unlawful killing.

Background

The appeal arises out of the death on 11 July 2016 of James Maughan, at HMP Bullingdon. At the inquest, the Senior Coroner for Oxfordshire decided that the jury could not safely reach a short form conclusion of suicide. This was because the jury could not be sure beyond reasonable doubt that James Maughan had intended to kill himself. The Senior Coroner put questions to the jury and asked them to make a narrative statement of the circumstances of James Maughan's death on a balance of probabilities. The jury answered the questions put to them by saying that he had a history of mental health issues and that on a balance of probabilities he intended fatally to hang himself and that increased vigilance would not have prevented his death. Thus, the same conclusion was effectively reached by different means.

The judgment

Did the form issued under the Coroners Rules specify the criminal standard of proof?

There was first a dispute based on whether there was effectively a statutorily prescribed standard of proof for short form verdicts based on the Coroners (Inquests) Rules 2013 which prescribes a form for recording conclusions. Note (iii) states that the standard of proof "required" for short form conclusions of suicide and unlawful killing is the criminal standard and that for other conclusions including narrative conclusions, the civil standard applies.

In many ways the outcome of this issue depended on what the members of the Supreme Court held was meant by the word "required" in Note (iii). The majority held that this formulation was not a distinct endorsement of the criminal standard as a rule independent of the common law position on that question. The dissent, as I note below, takes a more literal approach and holds that the Note is itself a binding statement of the correct standard.

The majority refused to see the note as the specification of a standard of proof but instead a reflection of what was then understood to be the position. They relied on the fact while this is mentioned in the note there is in fact no rule which specifies the standard of proof and (except Lord Carnwath) on the provisions of the public consultation leading to adoption of the Rules.

It is easy to see why this note was not seen as having the decisive impact which was being urged on the Court. While it is possible in some contexts for provisions contained in forms adopted with rules to have this effect, and for all elements of statutory instruments including footnotes to change the law and adopt new rules in place of the old, for a provision in the context of a form to change or specify the standard of proof would require clear contextual evidence to signal that this was the case. While the use of mandatory language "required" arguably does so, for this to appear in a Note amongst provisions intended as a reminder of the law for those filling in the form would seem odd.

What is the standard of proof as a matter of legal principle?

On the main question of principle, namely whether the common law recognized a different standard of proof for suicide and unlawful killing, Lady Arden concluded that the civil stand proof applied to short form conclusions of suicide. To apply different standards of proof for short form and narrative conclusions would lead to an internally inconsistent system of fact-finding [71]. While the judgment is mainly concerned with the legal principles underlying the identification of the standard of proof it also refers to the fact that the higher the standard of proof the less likely it is that the prevalence of suicide will be accurately recorded [73-74]. Furthermore, the appeal for special treatment for suicide could not be seen as a compelling one since societal attitudes to suicide have changed and the role of inquests has developed to be concerned with the investigation of deaths, not criminal justice [75-81]. In particular, Lady Arden pointed out that suicide, while originally a crime, is not any longer and has not been since 1961.

Lady Arden held that the civil standard of proof also applied to determinations of unlawful killing [93],[96]. There is then consistency between the determinations made at an inquest [96]. This is something which was raised as a likely outcome in my previous UKHRRB blog post. The Court of Appeal was bound to find that the criminal standard applied because there was binding authority to that effect. However, Lady Arden took the approach

that to allow inconsistent and confusing dual approaches to be applied in the same inquest depending on whether a short form verdict of unlawful killing was being entertained, as opposed to a narrative, was unsatisfactory and that the same principle should apply as to all other civil proceedings. She also rejected the idea that section 10(2) of the Coroner's Act 2009 which states *"may not be framed in such a way as to appear to determine any question of criminal … liability on the part of a named person …*" had the effect of specifying the criminal standard.

The judgment on unlawful killing is particularly sensitive because it will lead to determinations that someone was unlawfully killed being made on the civil standard of proof and in a context where the procedural protections available in a criminal court are not available to someone effectively accused of the killing. The privilege against self-incrimination survives of course but it is questionable at least whether the coroner's system is effectively equipped to protect the legitimate interests of those accused of being responsible for killing someone else.

The dissent

The dissent was to the effect that short form verdicts of suicide and unlawful killing should be treated separately and that there was nothing wrong in doing so. They were treated separately because there was case law supporting a different standard of proof and that that case law had been reflected in Note (iii) to the form for recording inquest conclusions. Given that this was introduced as part of the Coroners Rules there was therefore a statutory basis for holding that the standard of proof was the criminal standard and unless and until changed by Parliament that remained the position.

Comment

From a practical perspective inquest practitioners are perhaps unlikely to be persuaded that there is much of a difference between a narrative verdict which says suicide in long form and one which says simply "*suicide*". The dissent was, of course, constrained to accept that different standards applied because Note (iii) is clear in stating that the standard is the civil standard for narrative verdicts.

Assigning special significance to short form verdicts as opposed to narratives seems an artificial exercise and one which would have laid special stress on the decision whether to render a short form verdict or a narrative, itself a question of discretion. It was the sophistry of finding that the deceased probably deliberately killed himself but that this was not "suicide" that led the Divisional Court to take the approach that it did and fostering that sort of dual approach does not seem a satisfactory way forward.

The majority judgment does, in my view, reach a result which is more coherent with the considerable body of case law over recent years to hold that, as a matter of common law principle, the criminal standard applies in criminal proceedings but not otherwise. The Supreme Court (and before that the House of Lords) has held in a string of cases that one civil standard applies in all proceedings even where the issues could be cast in terms of the criminal law (see Lord Carnwath's judgment at [99]). That would be the case for example in professional disciplinary proceedings based on allegations of assault or theft, or in family proceedings where cruelty and neglect are alleged sometimes involving injuries which would easily amount to grievous bodily harm or in plain old civil proceedings which allege fraud. That body of case law would call for the same standard to be applied across the different conclusions to be returned by the Court.

But the narrower point at issue in this case was that it appears that everyone accepts that a narrative verdict touching on the same issues must be reached on the basis of the balance of probabilities. I cannot think of a reason why such a concession should not mean that, for the sake of logic and real world practicality, the same standard should apply regardless of which format of conclusion is under consideration.

It must be better surely to have one consistent standard of proof in a case involving potential unlawful killing regardless of whether the Coroner or jury is being invited to return a short form or narrative verdict. The facts of Maughan itself illustrate the strained position of adopting two different standards of proof for reaching effectively the same conclusion in a different linguistic format. The jury had been directed that they could not consider suicide because the evidence could not at its highest justify such a conclusion bearing in mind the standard of proof. Instead, they were asked to answer a number of questions on the civil standard which

resulted in the same overall conclusion. That sort of system would be difficult to explain to lay people and makes little sense. The majority judgment seems to me to provide a logical and consistent approach.

This article originally appeared on the UK Human Rights Blog.

ARTICLE 2 INQUESTS AND PREVIOUS CRIMINAL PROCEEDINGS

Dominic Ruck Keene

R (on the application of Grice) v HM Senior Coroner of Brighton and Hove [2020] EWHC 3581 (Admin)

The Facts

Garnham J considered a judicial review of a refusal to resume an inquest into the death of Shana Grice, who had been murdered by her former boyfriend at her home in Brighton. There had been a criminal investigation culminating in a conviction. There had also been a statutory Domestic Homicide Review, an investigation by the Independent Office for Police Conduct, an inspection by HMP Inspectorate of Constabulary and Fire & Rescue services into Sussex Police and its response to cases of stalking, and police disciplinary proceedings concluding with findings of gross misconduct against one officer and misconduct against two others.

The primary ground on which the refusal was challenged was that it was a breach of the Article 2 ECHR investigative duty. The family argued that investigations on the part of the state to date were inadequate because they were not sufficiently independent, were ineffective, provided insufficient scrutiny and permitted insufficient involvement of Ms Grice's family. Further, the inquest would enable the determination of whether a prevention of future deaths report was appropriate.

The requirements of Article 2

Garnham J set out at [55-6] the familiar general principles governing inquests, including that Article 2 imposes on the state negative obligations not to take life without proper cause and carefully defined positive obligations to protect life. It also imposes:

> "*procedural obligations, including both (i) a general obligation to have in place proper systems for investigating all deaths; and (ii) in respect of certain deaths, a specific obligation to establish one or more independent investigations which satisfy Convention standards*."
>
> *"…Where the Article 2 procedural obligation to establish a Convention-compliant investigation is engaged in relation to a death and has not been discharged by procedures other than an inquest, the statutory provisions governing inquest conclusions are modified so that the question "how" the deceased came by his/her death is read as "by what means and in what circumstances" the deceased came to die. In practice, this can open up scope for conclusions addressing wider circumstances of death and underlying causes, and it may require a somewhat expanded form of narrative conclusion*."

The Article 2 procedural obligation is engaged automatically in some situations (such as suicides in prison or deliberate killings by state agents), or if there is an arguable case that the state or its agents breached one or more of the substantive Article 2 duties in relation to the death.

Further, he set out at [63-4] that the precise requirements of an Article 2 compliant investigation vary according to the circumstances of the case under consideration, but there are minimum *Jordan* requirements:

> *"a) the authorities must act of their own motion; b) the investigation must be independent; c) the investigation must be effective in the sense that it must be conducted in a manner that does not undermine its ability to establish the relevant facts; this is, as it was described in Jordan "an obligation of means rather than results"; d) the investigation must be reasonably prompt; e) there must be a "sufficient element of public scrutiny of the investigation or its results to secure accountability in practice*

> *as well as in theory; the degree of public scrutiny required may well vary from case to case'': and f) there must be involvement of the next of kin ''to the extent necessary to safeguard his or her legitimate interests.''*

He held at [61] to [62] that in answering the question as to whether the investigations other than the coronial investigation satisfied the Article 2 procedural obligation "*in a manner which adequately served the public interest*" the Coroner was obliged to "*consider whether all the other investigative procedures of the state have collectively satisfied the requirements of the procedural obligation … It is necessary for the Coroner to consider "the totality of available procedures", including public investigations and any potential for a civil claim*."

Garnham J also emphasised at [84] to [85] that it was important to note what was not required in an Article 2 compliant investigation:

> *"(i) It is not a requirement of the ECHR that any particular procedure be adopted to fulfil the Jordan requirements. The form of the investigation may vary according to the circumstances and those requirements can be satisfied by a set of separate investigations, rather than by a single, unified procedure..*
>
> *(ii) The requirement for the family of the deceased to be involved in an investigation to the extent necessary to safeguard their interests does not mean that the investigating authorities must satisfy every request for a particular step to be taken in the investigation…*
>
> *(iii) The requirement of public scrutiny does not invariably require a public hearing… And neither requirement means that the family of the deceased must be able directly to test evidence:*
>
> *85. Furthermore, in my view, there is no requirement that each element of the State's investigative procedure meets each one of those tests; the question is whether, viewed in its totality, the investigations meet the minimum requirements identified in Jordan . So, the fact that next of kin of the victim ordinarily play no active part in a criminal trial does not mean that the criminal trial falls out of account in assessing whether the totality meets the state's investigative obligation. Similarly, the fact that there is limited public scrutiny of one part of the process or limited involvement of the next of kin, will not necessarily invalidate the whole."*

He also noted at [58] that in all inquests, the coroner is accorded a broad range of judgment as to the scope of the inquiry. Further, a decision that the Article 2 procedural obligation is engaged will have little, if any, effect on the scope of inquiry or conduct of the hearing because any properly conducted inquest will consider the circumstances surrounding and events leading to death. The key effect of Article 2 engagement is upon conclusions at the inquest.

The effect of the criminal proceedings

Garnham J held at [59-60] that a coronial investigation has to be suspended following notification that a person has been charged with a homicide offence in relation to the death in question, unless the prosecuting authority indicates that it has no objection to the coronial investigation continuing or there is exceptional reason for not suspending the investigation (para 2 of Schedule 1 to the CJA 2009). No such indication or other exceptional reason had been relevant here, and accordingly, the Coroner had no choice but to suspend the inquest in 2017. A coronial investigation may not be resumed unless, but must be resumed if, the coroner thinks there is sufficient reason to resume it after the conclusion of the criminal proceedings (para. 8(1) of Schedule 1). He held that "*it follows from that statutory language that the decision on whether or not to resume an inquest is one for the coroner's judgment and is one 'of a highly discretionary character'*."

At [87] he held that a murder trial alone will usually meet the state's Article 2 obligations in respect of the death, and an inquest thereafter will not be necessary, and indeed be the exception "*in most cases a criminal trial will involve a sufficient exploration of the circumstances surrounding the death.*"

Conclusion

Garnham J reviewed the various investigations and the extent to which they investigated the circumstances of Ms Grice's death, had involved the family and had led to failings being identified. He held at [86] to [87] that the criminal trial would not be sufficient in itself in the circumstances of this particular death to satisfy Article 2 as it had become apparent that there were serious failings by the police that contributed to Ms Grice's death. However, he held it was "significant in Article 2 terms" that the sentencing judge's remarks had prompted an investigation by the IOPC.

In respect of the IOPC investigation he again held at [89] that it had been 'Article 2 effective' through being "*conducted in a manner consistent with an ability to establish the relevant facts*". He noted at [90] to [91] that the HMICFRS report had given further oversight of Sussex police and identified further and persisting areas of concern. Further, the disciplinary proceedings had ensured that the officers directly concerned were held to account for their actions. He concluded at [92] to [93] that:

> *"92. In my judgment, there were here prompt, independent enquiries initiated by the state of its own motion, which were effective, both in the manner in which they established the relevant facts and in the results they achieved, which provided a sufficient element of public scrutiny of the investigation or its results to secure proper accountability and which involved the family to the extent necessary to safeguard their legitimate interests. In my judgment the Coroner was not only entitled to find that these enquiries satisfied article 2; she was right to do so.*
>
> *93. It is apparent that what the Claimant seeks is a much more detailed enquiry than any of those that have taken place hitherto with a much fuller analysis being produced in consequence. In my judgment, as Mr Hough submits, a fully Article 2-compliant inquest would not produce such an outcome. The Courts have repeatedly made clear that in Article 2 inquests determinations should be relatively succinct… While it may be appropriate for conclusions to address underlying causes of death, they should not usually address matters of policy and resourcing."*

Comment

This case is a useful and authoritative summary of the relevant principles concerning the purpose, scope and limits on the Article 2 investigative duty in the context of inquests, as well as of the more niche considerations applying where there has been a previous criminal homicide investigation and trial.

PERSONAL INJURY - MOD

Dominic Ruck Keene

Constance v (1) MOD (2) Portsmouth Hospitals University NHS Trust [2020] EWHC 3029 (QB)

The Facts

Mr David Lock QC sitting as a deputy Judge of the High Court held the Ministry of Defence and an NHS Trust to be liable to a former soldier whose hearing loss had been negligently diagnosed as being noise-induced hearing loss, which was not treatable, rather than otosclerosis, which was largely curable by surgery. If he had been appropriately treated earlier, he would not have been medically discharged. The court calculated his damages for hearing loss, psychiatric injury, loss of congenial employment, and loss of earnings, pension and other benefits.

Conductive Hearing Loss

Unusually for MOD hearing loss claims, the Claimant suffered from conductive loss caused by otosclerosis, rather than sensorineural loss caused by exposure to loud noise (NIHL). The Claimant was left with the impression by the military clinician who initially treated him that he suffered from NIHL, and that subsequently formed the

basis of his medical discharge. However, he had in fact correctly been diagnosed with conductive hearing loss, albeit negligently not informed that there was a surgical treatment option. The Medical Board discharged the Claimant on the mistaken basis that he suffered from NIHL and therefore should not be exposed to further loud noise as it could cause further hearing loss. A clinician employed by the Defendant Trust also negligently failed to inform the Claimant that there was a surgical option. The judge concluded at [71] that damages against the MOD had to be assessed on the basis of what would have happened had he been initially told that there was a surgical option. Damages against the Trust had to be assessed on the basis of the events that would have happened if he had been properly advised by the Trust clinician Mr Ahmed. Damages against the MOD could also arise on the basis of the events that would have happened if the Medical Boards from January 2006 onwards had appreciated that the Claimant suffered from conductive hearing loss as opposed to suffering from NIHL. The MOD and the Trust were held jointly liable for the damages suffered from the point after which the Trust's negligence could have affected the Claimant's prospects of remaining in the Army.

Evidential Assessment

The judge noted in respect of his evidential findings that he was required to consider events of 10 or even 15 years prior. He noted at [3] "*I am conscious of the need to adopt a proper approach to the balance between the evidence of accounts of events as set out in the documents and an individual's recollections of things that happened a long time ago. That is an even greater problem where witnesses are attempting to give evidence about what would have happened in projected scenarios, relating to things which ought to have happened but, in the event, did not happen*." He referred to the comments of Leggatt J in *Gestmin SGPS SA v Credit Suisse (UK) Ltd* [2013] EWHC 3560 :

> *"16…Two common (and related) errors are to suppose: (1) that the stronger and more vivid is our feeling or experience of recollection, the more likely the recollection is to be accurate; and (2) that the more confident another person is in their recollection, the more likely their recollection is to be accurate."*
>
> *19. The process of civil litigation itself subjects the memories of witnesses to powerful biases. The nature of litigation is such that witnesses often have a stake in a particular version of events. This is obvious where the witness is a party or has a tie of loyalty (such as an employment relationship) to a party to the proceedings. Other, more subtle influences include allegiances created by the process of preparing a witness statement and of coming to court to give evidence to one side of the dispute. A desire to assist, or at least not prejudice, the party who called the witness or that party's lawyers, as well as a natural desire to give a good impression in a public forum, can be significant motivating forces.*
>
> *20. Considerable interference with memory is also introduced in civil litigation by the procedure of preparing for trial. A witness is asked to make a statement, often (as in the present case) when a long time has already elapsed since the relevant events. The statement is usually drafted for the witness by a lawyer who is inevitably conscious of the significance for the issues in the case of what the witness does or does not say. The statement is made after the witness's memory has been "refreshed" by reading documents. The documents considered often include statements of case and other argumentative material as well as documents which the witness did not see at the time or which came into existence after the events which he or she is being asked to record. The statement may go through several iterations before it is finalised. Then, usually, months later, the witness will be asked to re-read his or her statement and review documents again before giving evidence in court. The effect of this process is to establish in the mind of the witness the matters recorded in his or her own statement and other written material, whether they be true or false, and to cause the witness's memory of events to be based increasingly on this material and later interpretations of it rather than on the original experience of the events."*

The need for caution was particularly relevant with regards to resolving any conflicts as how decisions were in practice made, and what ought to have happened according to relevant policies. He concluded at [9] that "*evidence from a person who attempts to argue that the same decision would have been made even if a mistake had not been made should be looked at carefully and assessed within the context of all the surrounding evidence,*

including the evidence in contemporaneous documents, before it is accepted." This was particularly relevant when considering evidence given by a retired Army occupational health physician as to whether or not the Claimant would have been discharged in any event following successful surgery. The judge rejected his evidence on the basis that: he had retired 8 years ago and was giving evidence on how the Army approached the relevant decisions 12 years ago; there was no documentary evidence to support his alleged approach to soldiers in the same position as the Claimant; was reluctant to accept there had been any errors made by the Medical Boards in question; and there was no published medical evidence to support his point of view.

Special Damages

As is usual in MOD personal injury claims, the judge considered employment expert evidence as to the Claimant's likely career length and promotion trajectory, and awarded damages for loss of earnings and also for loss of congenial employment. Interestingly, the Defendants sought to argue that they should not have to pay damages based on 'lifestyle choices' if the Claimant's residual earnings were lower by choosing to work as a transport manager rather than as a postman. This submission was based on a combination of *South Australia Asset Management Corporation v York* [1997] AC 191 and *Khan v Meadows* [2019] 4 WLR 26 - i.e. that a tortfeasor is only liable in damages for a type of loss which falls within the scope of the appellant's duty. The judge held at [146] that

> *"the "type of loss claimed" is loss of earnings following an early discharge from the Army where that early discharge arose as a consequence of the negligent advice Mr Constance was given by Mr Caldera and Mr Ahmed. That, in my judgment, is a "type of loss" where there is an adequate link between the breach of duty and the loss. In simple terms, if Mr Caldera or Mr Ahmed had provided Mr Constance with the advice that he should have received, it is likely that he would have had the stapedectomy operation by September 2006 and then been able to continue his military career and serve as a soldier until January 2017 as opposed to being medically discharged in August 2011. Thus his loss of earnings in the period between August 2011 and January 2017 arise directly as a result of the negligence and within the scope of the type of losses for which the Defendants are liable."*

The judge further considered the context of the Claimant's initial career choice after his discharge from the MOD and held that it was reasonable to take an initially low stress job as a postman. However, the Defendants were not liable for any losses resulting from his subsequent 'lifestyle' decision to move to Padstow.

Comment

The judgment is currently subject to a pending appeal application on grounds including that the judge reversed the burden of proof in his assessment of the evidence of what would have happened in the counter factual scenario and made findings infringing the principle in *Edwards (Inspector of Taxes) v Bairstow* [1956] AC 14.

EVENTS & NEWS

News & Events

RSVP to our **upcoming webinars** on *Healthcare Inquests & COVID-19* at 2pm on 13th May and *Public Law Lessons From COVID-19* at 2pm on 10th June by emailing Olivia (events@1cor.com).

Podcast

On **Law Pod UK** Alasdair Henderson joins Rosalind English to discuss Uber, Ola and the Gig Economy. Further news, events, webinars and previous QMLR issues 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.

Lizanne Gumbel QC (Call: 1974, QC: 1999) - Contributor

Elizabeth-Anne Gumbel QC is a leading practitioner in clinical negligence and personal injury claims. Lizanne has a distinguished reputation for representing Claimants with highly complex claims for catastrophic injury. In clinical negligence she has particular expertise and experience in birth damage and neo-natal claims but acts in claims arising in a wide range of circumstances. In personal injury she acts for Claimants with head injuries, spinal injuries and other complex multiple injuries.

Angus McCullough QC (Call: 1990, QC: 2010) – Contributor

Angus conducts medical claims of the highest value and complexity for both claimants and defendants. He won the Chambers and Partners award for personal injury and clinical negligence barrister of the year 2009, took silk in 2010, and medical law remains a major specialism. Angus is available to act as a mediator in personal injury and clinical negligence disputes, bringing his extensive experience acting for both sides in the field to facilitate resolution. He also advises and appears in regulatory and disciplinary matters.

Owain Thomas QC (Call: 1995, QC: 2016) – Contributor

Owain has wide experience acting for both Claimants and Defendants (NHS and MoD) in clinical negligence, particularly high value claims resulting from birth injury or other catastrophic injuries. He has experience of a wide variety public law challenges against Mental Health Trusts in the Administrative Court and emergency injunctions and best interests cases in the Family Division. He regularly appears for public authorities (hospitals, mental health Trusts and prisons) in complex inquests.

Robert Kellar QC (Call: 1999, QC: 2019) - Contributor

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

Cara Guthrie (Call: 2000) - Contributor

Cara specialises in clinical negligence, and has done so since she started in practice. She also acts in personal injury cases, inquests, lawyers' negligence cases and Court of Protection cases and regularly represents claimants and defendants in High Court trials. She is instructed by many of the leading firms of clinical negligence solicitors. Cara has been highly ranked as a leading junior (Band 1) in clinical negligence in both Chambers & Partners and Legal 500 since 2011.

Richard Mumford (Call: 2004) - Contributor

Richard is a specialist healthcare and personal injury barrister, providing timely and focused advocacy and advice to injured individuals and to clinical practitioners and organisations, amongst others. Richard's healthcare work is focused on claims relating to medical accidents of all descriptions but also encompasses regulatory proceedings and contractual claims relating to the provision of healthcare and related services.

In addition, Richard regularly deals with personal injury claims ranging from serious road traffic injury and industrial injuries to physical and sexual abuse. Richard also advises and represents clients in relation to costs arising from litigation.

Matthew Domnall (Call: 2006) – Contributor

The son of two doctors, Matt has medicine in the family. His expertise in clinical negligence spans both liability and quantum issues, and the difficult points of causation that can intersect them. He acts for both claimants and defendants, and finds doing so helps to give insight into how opponents may act. Matt has extensive experience in clinical negligence claims representing claimants and defendants across a wide range of medical areas. These include obstetric / perinatal injury; gastroenterology; delayed cancer diagnosis; orthopaedic and other surgery; general practice and dentistry.

Alasdair Henderson (Call: 2009) - Contributor

Alasdair has a broad practice with a particular interest in public law and human rights, employment and equality, clinical negligence and environmental law. He appears regularly before a wide variety of courts and tribunals, and also has considerable experience of inquests and public inquiries. ” He is a member of the Attorney General’s B Panel and a Commissioner of the Equality and Human Rights Commission.

Jessica Elliott (Call: 2013) – Contributor

Jessica acts for both claimants and defendants in clinical negligence claims. She has significant experience advising and drafting pleadings across the entire spectrum of medical law, and has a particular interest in the law of material contribution, psychiatric injury and secondary victims.

She is co-author of the chapter on breach of duty in Kennedy and Grubb’s Principles of Medical Law, and gives regular talks on current developments in the law.

Thomas Beamont (Call: 2019) – Contributor

Tom accepts instructions in all areas of Chambers’ work and is developing a broad practice. He appears in courts and tribunals on behalf of both Claimants and Defendants in a range of hearings. Tom is regularly instructed in cases of clinical negligence. He appears at a range of hearings, advises on liability and quantum, and settles pleadings, for claimants and defendants. Tom is keenly developing his inquest practice. While seconded to a leading inquest firm on a six-month placement, he gained significant experience appearing regularly in Coroner’s Courts.