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The 1COR Quarterly Medical Law Review

Updates and analysis of the latest legal developments

Spring 2021 | Issue 9

Welcome to the ninth issue of the Quarterly Medical Law Review, updating you on developments in Spring 2021:

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SUPREME COURT REVISITS WRONGFUL BIRTH CLAIMS

Owain Thomas QC and Robert Kellar QC

Khan v Meadows [2021] UKSC 21

In *Khan v Meadows* [2021] UKSC 21 the Supreme Court has revisited the principles to be applied in 'wrongful birth" claims: claims for the cost of bringing up a disabled child who would not have been born but for a doctor's negligent medical advice/treatment. However, the judgment has implications beyond the world of clinical negligence litigation. The Supreme Court has taken the opportunity to clarify the components or ingredients of the tort of negligence more generally. In particular, the court has affirmed the importance of the "scope of duty" principle: a principle which limits the recoverability of damages wherever it applies.

The facts

The Claimant mother was alerted to a risk that she may carry the haemophilia gene. Haemophilia is a genetic condition in which the ability of the blood to coagulate is severely reduced. She wished to avoid having a child with that condition. She therefore consulted her GP to advise her on her haemophilia risks. Her GP, the Defendant Dr Khan, failed to arrange for her to undergo genetic testing. Instead, it was arranged for her to have blood tests which could not establish whether she was a carrier. She was therefore falsely reassured that she would not have a child with haemophilia.

She subsequently gave birth to a child who suffered not only from haemophilia but also from severe autism. It was admitted by Dr Khan that she was liable to compensate Ms Meadows for the additional costs associated with her child's haemophilia. However, Dr Khan denied that she was liable to compensate the Claimant for the much more substantial costs of bringing up a child with autism.

The competing arguments

The High Court held that the Defendant was liable for the costs of both autism and haemophilia on the basis that the issue of the extent of recovery was a question of causation. After all, it had been accepted that "but for" the negligent advice, the child would not have been born and the Claimant would not have incurred any of the costs associated with bringing up a child with autism. That decision was reversed by the Court of Appeal.

The Defendant's argument, accepted by the Court of Appeal, was that the scope of the GP's duty was limited to advising about the risk of haemophilia. That was the only purpose of the consultation. It followed that Dr Khan owed no duty of care in relation to risks arising from having a child with autism.

On appeal to the Supreme Court, the Claimant argued that it was unjust to deprive her of compensation for autism related costs. Liability should be imposed because: a) her child's birth would not have happened but for the GP's error as Ms Meadows would have terminated the pregnancy on learning that her child carried the haemophilia gene; and b) it had been agreed between the parties that the possibility of having a child with autism was foreseeable.

The "scope of duty": 6 questions

The Supreme Court observed that the Claimant's submissions raised questions of (i) the role which factual "but for" causation, foreseeability and remoteness of damage performed in the analysis of a claim for clinical negligence and (ii) how the question of the scope of the Defendant's duty fitted into this analysis [23].

The court held that a helpful model for analysing the place of the scope of duty principle in the tort of negligence, and the role of other ingredients of the tort, consisted of asking the following questions in sequence [28] (emphasis added):

(1) *"Is the harm (loss, injury and damage) which is the subject matter of the claim actionable in negligence? (the actionability question)*

(2) What are the risks of harm to the claimant against which the law imposes on the defendant a duty to take care? (the scope of duty question)

(3) Did the defendant breach his or her duty by his or her act or omission? (the breach question);

(4) Is the loss for which the claimant seeks damages the consequence of the defendant's act or omission? (the factual causation question);

(5) Is there a sufficient nexus between a particular element of the harm for which the claimant seeks damages and the subject matter of the defendant's duty of care as analysed at stage 2 above? (the duty nexus question);

(6) Is a particular element of the harm for which the claimant seeks damages irrecoverable because it is too remote, or because there is a different effective cause (including novus actus interveniens) in relation to it or because the claimant has mitigated his or her loss or has failed to avoid loss which he or she could reasonably have been expected to avoid? (the legal responsibility question).

Application of this analysis gives the value of the claimant's claim for damages in accordance with the principle that the law in awarding damages seeks, so far as money can, to place the claimant in the position he or she would have been in absent the defendant's negligence."

The court held that this analysis shows that determining "but for" causation and "foreseeability" in favour of the Claimant did not circumvent the questions that must be asked in relation to the Defendant's duty [30]. The answer to this case turned upon the second, fourth and fifth questions (highlighted above). It followed that even if having a baby with autism was a foreseeable consequence of the breach and would have been avoided with reasonable care, the Claimant was nonetheless not entitled to damages for that "loss".

Scope of duty: an established principle

The court held that it was an "established principle" that the law addresses the nature and extent of the Defendant's duty in determining liability for damages. A defendant was not liable for damages in respect of losses which fell outside the scope of their duty of care. It was often helpful to ask the scope of duty question *before* turning to questions of breach of duty and causation.

The correct question was: "what, if any, risks of harm did the defendant owe a duty of care to protect the claimant against?". When the court asks the scope of duty question in the context of cases about the provision of advice or information, the court seeks to identify the purpose for which the advice was given. The court asks: "what was the risk which the advice or information was intended or reasonably understood to address?".

In the present case, the purpose of the consultation was to put Ms Meadows in a position to enable her to make an informed decision about having a child with haemophilia. Dr Khan owed a duty to take reasonable care to give accurate information or advice when advising her whether she was a carrier of that gene. Crucially, the service provided by Dr Khan was concerned with a very specific risk: the risk of giving birth to a child with haemophilia.

Factual "but for" causation insufficient

The Supreme Court emphasised that whilst proof of factual causation was an *element* of the tort of negligence it was not a "sufficient condition" for the imposition of liability. It was also necessary to establish "legal causation" [44-45]. The "but for" test was also open to criticism because it excluded the "common sense approach" favoured by the common law and because it implied (incorrectly) that value judgments should have no role in the assessment of causation [46].

The correct approach was to distinguish between what *"…as a matter of fact are consequences of a defendant's act or omission and what are the* ***legally relevant*** *consequences of the defendant's breach of duty. A defendant's act or omission may as a matter of fact have consequences which, because they are not within the scope of his or her duty of care, do not give rise to liability in negligence"* [58].

On the facts of the present case, Ms Meadows lost the opportunity to terminate her pregnancy. Thus there was a "but for" causal link between Dr Khan's mistake and the birth of the Claimant's child. However, that was not by itself sufficient to establish liability because it was "*not relevant to the scope of Dr Khan's duty*" [68].

The "duty nexus" question

The court observed that in many cases it would be obvious that there was a sufficient nexus between the harm for which damages were claimed and the scope of a defendant's duty. For example, where a car collides with a pedestrian, it was obvious that the car driver owed a duty to avoid inflicting physical injury and the economic loss consequent upon his injuries [47].

However, in the present case the answer to the scope of duty question pointed straightforwardly against liability. The law did not impose a duty upon Dr Khan in relation to risks unrelated to haemophilia, including autism, such as might arise in any pregnancy [68]. It followed that Dr Khan was liable only for costs associated with the child's haemophilia.

One way of testing whether there was a sufficient nexus between the duty of care and the claimant's loss was to ask the following question: what would the claimant's loss have been if the information which the defendant in fact gave had been correct? This question was referred to as the "SAAMCO counterfactual", having been posed by the House of Lords in the "SAAMCO" case: [1997] AC 101. If the same loss would have been suffered in any event, assuming the same decision by the recipient of the advice, then the loss was not attributable to the advice being wrong.

If one asked what the outcome would have been if Dr Khan's advice had been correct - and Ms Meadows had not been a carrier of the haemophilia gene - the answer was clear. Her child would have been born with autism in any event. Therefore, the child's autism could not be said to be attributable to Dr Khan's advice being wrong [68].

The court emphasised that it was not always necessary for the court to pose this question. In some circumstances the "scope of duty" question may identify the fair allocation of risk between the parties without using the counterfactual [53].

The views of the minority

There are two judgments from Lord Burrows and Lord Leggatt concurring in the result. Both make reference to the accompanying case of *Manchester Building Society v Grant Thornton UK LLP* [2021] UKSC 20. Both take a more conservative approach than Lords Hodge and Sales and prefer to limit the ruling to an application of the SAAMCO principle to the particular context of professional services and as a principle which limits the scope of a Defendant's liability for factually caused loss on the basis of whether it falls within the scope of the duty or not [71]. This moves away from the six questions as being a template for the law of negligence generally [78-9].

Lord Burrows decided the case on the basis that, while factual and legal causation were made out, the "autism losses" fell outside the scope of the duty of care because the Claimant had not sought (or received) any advice about autism, which was a general risk of pregnancy. Therefore the risk of the baby having autism cannot fairly be allocated to the doctor and the Claimant would have suffered the same loss even if the haemophilia advice (that she was not a carrier) had been correct [77].

Lord Leggatt also preferred to avoid an "excursus" on the law of negligence generally [96] and an analysis based on a "sufficient nexus" between the loss and the duty [97], instead deciding that the duty was to avoid losses connected with haemophilia [91-92] and because the autism was not caused by the haemophilia the autism damage was not caused by the breach of duty [93].

Comment

One preliminary point is that the Supreme Court affirmed that compensation is available in principle in cases of wrongful birth for the costs of bringing up a disabled child [74 (iv) and 86].

However, the court's decision has other important consequences for clinical negligence litigation and the law of tort generally. In cases about negligent medical advice or informed consent, it is not sufficient for a claimant to establish that – with competent advice - they would have made a different decision about their treatment or care. A claimant must also demonstrate that the particular harm that they have suffered fell within the scope of the defendant's duty of care. If the harm suffered was not one of the specific risks that was "*intended or reasonably understood*" to be addressed by the defendant's advice then the claim will fail.

In the authors' view there is likely to be a mixed response to this judgment. Some will welcome its contribution to coherence and consistency in the law of tort. The approach to the recovery of damages in clinical negligence has been brought firmly into line with that which applies in commercial cases about pure economic loss. Others might argue that a more flexible and open textured approach should have been permitted in clinical negligence litigation. Unlike the commercial context, negligent advice may vitiate a patient's informed consent to medical treatment. This has implications for a patient's autonomy and their right to make important choices about their body. The law of negligence has an important role in protecting that autonomy (see *Montgomery* [2015] UKSC 11). This feature has been used previously by the House of Lords to justify a different approach to causation in cases about informed consent, albeit in very limited circumstances: see *Chester v Afshar* [2004] UKHL 4. The latter decision did not feature in the Supreme Court's judgment although it featured prominently in the decisions of the courts below.

It might be wondered whether the rule in *Chester v Afshar* can stand with the analysis of the Supreme Court in this case[1]. In that case a claimant who was not warned of a particular risk of surgery (cauda equina syndrome) and would have had the surgery at a later date even if she had been warned of the risk, recovered damages on the footing that she would have postponed the surgery and thus would not have suffered the (very small) risk had she had the procedure at another time. This was on the basis that the court considered that even though the Defendant's conduct did not, overall, expose her to a greater risk of the damage than she would have been exposed to anyway, she should nonetheless be compensated because, the risk which eventuated was the very thing which she should have been told about.

Given that the defendant did not owe the claimant in *Chester* a duty to protect her from the risks of the procedure (only to tell her about them (question 2)) and that she would have had the procedure at a later date anyway it might be argued that damage arising from such risks was outwith the scope of the defendant's duty (Question 5). The relevant question, applying the SAAMCO counterfactual [see 53 and 94], was as follows: "*What would Ms Chester's loss have been if the information which she had been given about the risk of cauda equina had been correct*?". The answer is that Mrs Chester would have undergone the same surgery with precisely same risks in any event, albeit at a later date. Providing Mrs Chester with the correct information would not have diminished the risks in any way. Therefore, Mrs Chester's injuries were not attributable to the failure to advise her about the risks[2].

The alternative argument is that the specific nature of the risk of injury was not disclosed to Mrs Chester and the fact that that was the risk which eventuated, still serves as a basis for finding the loss to be within the "scope of the duty". How *Chester v Afshar* is to be reconciled with the Supreme Court's latest decision therefore remains to be seen.

More generally, the majority's decision strongly affirms the "scope of duty" principle as an anterior "*legal filter"* in all negligence claims. It applies at an early stage of the analysis being "*anchored in the question as to the defendant's duty of care*" [59]. It is also separate from principles of causation and remoteness which apply at a

[1] *Chester* has been distinguished in other areas of negligence including professional negligence on the footing that a special rule might be justified in cases of clinical negligence, but the refusal of the Supreme Court in *Meadows* to sanction any difference in principle between clinical negligence and other professional negligence cases in terms applying *SAAMCO* throws such reasoning into doubt.

[2] Proof of "but for" causation , without proof that the breach of duty increased the risk of injury is not sufficient to establish causation in law: see *Chester* and now *Khan* [44-46].

later stage in the analysis. In the authors' view the decision in *Khan* is likely to give rise to further litigation in which the limits of the "scope of duty" principle are mapped and clarified by the higher courts.

Philip Havers QC acted for the Appellant, Ms Meadows. He did not contribute to this article.

NECESSARY APPRECIATION OF THE ACCIDENT IN SECONDARY VICTIM CLAIMS

Jessica Elliott

Young v Downey [2020] EWHC 3457 (QB)

The court dismissed the Claimant's secondary victim claim arising out of the death of her father when she was four years old. Spencer J held that, where a secondary victim had witnessed the death, injury or imperilment of a loved one (or its immediate aftermath), it was necessary for them to show an appreciation that the primary victim was or might have been involved in the incident and was or might have been the person (or one of the persons) killed, injured or imperilled. The judge found that the four-year-old Claimant was unlikely to have had such an appreciation on the basis of what she had witnessed.

Facts

The Claimant's father had been a lance corporal in the Household Cavalry and was killed by a bomb explosion while on parade on 20 July 1982. On that day, the Claimant was in the barracks nursery. The judge accepted that she had watched her father leave that morning. When the bomb exploded, she heard a huge noise and felt the building shake. She then saw out of the window soldiers returning to the barracks covered in blood and embedded with nails, at which point she was taken to a different room. She remembered telling her mother that "*daddy should be coming home now*", but he never did.

Expert evidence and parties' arguments

The judge invited the Claimant's adult psychiatrist, Dr Cooling, to explain what a four-year-old might have experienced. Dr Cooling's evidence was that the Claimant would have understood that there was "*an interruption, a problem*" and that she would have appreciated she was seeing something "*unusual, frightening and challenging*". He interpreted the statement "*Daddy should be coming now*" as a child seeking reassurance which was not forthcoming.

The Claimant submitted that on the basis of Dr Cooling's evidence, the court could find that "*she did associate what she had heard (the bomb exploding) and what she saw (the soldiers wearing the same uniform as her father returning covered in blood and, in some cases, severely injured) with danger to, or fear for, her father."* She also submitted that she fell within the aftermath principle, albeit that she had not gone to the scene of the accident; rather, the aftermath came to her as the injured soldiers returned to the barracks.

The Claimant further submitted that while claims would normally entail actual sight of the injured person, "*sight of the accident once the victim has been removed from the scene may also be sufficient*".

The Defendant was not represented.

The judgment

At [26], Spencer J considered that the issue in the case was whether it is necessary for a secondary victim's shock to be "*materially connected to an appreciation that the primary victim is a loved one… and that a loved one has been or might have been involved in the accident witnessed (including its aftermath)".* He accepted that sight of an accident without the victim at the scene may be sufficient, but "*appreciation that a loved one has been or may have been involved is a necessary ingredient"* (at [27]).

Spencer J rejected the Claimant's submission that there was an association in her mind between what she had seen and heard, and the death of her father. He noted that "*although the Claimant gives evidence of having*

heard the bomb explode and having witnessed the aftermath of the event in terms of seeing the return to barracks of the injured soldiers, she does not say that she remembers associating what she saw and heard with her father or appreciating that her father was or might be involved." He rejected Dr Cooling's evidence that the Claimant was worried her father might not be coming home, instead interpreting her comment as meaning that she expected her father to return. He concluded "*my interpretation of the evidence is that it never occurred to this four-year-old's mind at all that her father might have been injured, or killed, or involved at all in what she had heard or seen"*. The claim therefore failed (at [32]).

Comment

What is it necessary to witness? The first point of interest is what is sufficient in terms of witnessing the 'aftermath' of an event. In this author's view, it must be right that the known involvement of a loved one is what distinguishes true secondary victims from bystander cases. On the facts, Spencer J dismissed that the known or even possible involvement of a loved one was present in this case. However, it is implicitly suggested that had the Claimant appreciated the potential involvement of her father in what she saw, it would have been possible for her claim to succeed (see [11], [26], [29], where '*might have been involved*' is used). This raises the broader question: if the victim is not present or identifiable in the accident/aftermath, can the claimant recover where the victim's involvement is possible (and transpires to have been correct)?

In this author's view, it would not have been straightforward for Ms Young to have succeeded even if it did occur to her that her father might have been involved. In *Alcock v CC South Yorkshire* [1992] 1 AC 310, Lord Oliver considered the position of those claimants who had seen television images and later realised that their loved ones had been killed. While this primarily turned on whether the images were sufficiently shocking, Lord Oliver also addressed the difficulty where the connection between the event and the loved one was not made in a short period of time (at [147] (emphasis added)):

> *"These images provided no doubt the matrix for imagined consequences giving rise to grave concern and worry, followed by a dawning consciousness over an extended period that the imagined consequence had occurred, finally confirmed by news of the death and, in some cases, subsequent visual identification of the victim. The trauma is created in part by such confirmation and in part by the linking in the mind of the plaintiff of that confirmation to the previously absorbed image. To extend the notion of proximity in cases of immediately created nervous shock to this more elongated and, to some extent, retrospective process may seem a logical analogical development. But… I cannot for my part see any pressing reason of policy for taking this further step along a road which must ultimately lead to virtually limitless liability."*

In line with Lord Oliver's observations, the claimant mother in *Young v MacVean* [2015] CSIH 70 failed to succeed where she had driven past the scene of an accident involving her son, but had not realised he was involved until sometime later that day. On the other hand, in dismissing an application for strike out brought by the Defendant Trust, the court in *Werb v Solent* (2017) WL 02978816 held that there were reasonable grounds for advancing a claim for psychiatric injury as a secondary victim brought by the second claimant, who was the father of a psychiatric inpatient who had killed himself while on leave from hospital. The second claimant had seen his son's body from a bridge before realising whose it was, and had returned to the scene after the first claimant told him in a phone call that their son was missing. He brought the claim on the basis that it was the composite of going to the bridge, then hearing from the first claimant and returning to the bridge that constituted the shocking event, which had all occurred within about 25 minutes. The court held that there was a good arguable case that the secondary victim had been in close proximity in space and time to the relevant event and that his psychiatric shock resulted from a sudden, unexpected and exceptional shock [24]. The court also rejected the contention that the second claimant had no reasonable grounds for advancing his claim for psychiatric injury as a secondary victim on the grounds that his shock had been caused by retrospective communication [25-28]. In this author's view, it is likely that any future claimants who do not physically see their loved one involved in the relevant accident must come to the realisation that they were involved with certainty and in a short space of time.

Cognitive impairment by age or otherwise: This judgment is also of interest for its implications for secondary victim claimants who were very young at the material time, or who are otherwise cognitively impaired. The strong suggestion is that it will be difficult for children of a very young age to show the necessary appreciation of horror, and this is supported by the case of *Tanner v Sarkar* [2016] 12 WLUK 259. In that case, where a child witnessed parts of the illness and death of her little brother, the judge found on the evidence of a child psychiatrist that a five-year-old "*would not have had sufficient comprehension of events to be able to process cognitively what was going on in a sense that permitted her to feel shocked by a realisation of Haydn's imminent death*" (at 75), much in line with Spencer J's comments in this case. On the other hand, in the context of slightly older children, Chamberlain J commented in *Paul v The Royal Wolverhampton NHS Trust* [2020] EWHC 1415 that the primary victim father's collapse "*would have been horrifying … and especially so to children of 12 and 9*", suggesting that the immaturity of slightly older children would amplify the shock experienced.

The key message is that a secondary victim claim which involves young children or a cognitively impaired adult should be firmly shored up with evidence from an appropriately qualified psychiatrist. Neither *Young* nor *Tanner* have purported to set a rule about recovery at a young age, and each case will depend on the facts and evidence; nonetheless, there is clearly a measure of judicial caution about assuming the necessary understanding for *Alcock* shock in very young children.

View our secondary victims archive on our website here.

NON-DELEGABLE DUTY: DIFFERENT DENTIST, SAME DRILL

Jim Duffy

Around this time last year, Dominic Ruck Keene examined the County Court decision in *Ramdhean v Agedo and The Forum Dental Practice Limited* 2020 WL 00620352. HHJ Belcher concluded that a dental practice owed a non-delegable duty of care with respect to treatment carried out by a dentist working there.

Another Circuit Judge has now reached the same conclusion on the same preliminary issue. In *Breakingbury v Croad* (Cardiff County Court, 19 April 2021), a dentist who retired in 2000 found himself being sued 19 years later for treatment carried out at FDC, a Merthyr Tydfil dental practice. Mr Croad had continued to own the practice until 2012, which covered the period material for the purposes of the claim.

Background

Mr Croad entered into contracts with the local health board to provide dental services. He met his contractual obligations by engaging self-employed dentists to treat patients – a fairly common business model.

A claim was issued in October 2019, which HHJ Harrison considered to have been within the 3-year limitation period beginning with the date when the Claimant had acquired the requisite knowledge for the purposes of s.14 of the Limitation Act 1980.

The allegations of negligence concerned various attendances between 2008 and 2012. The events that triggered the investigation of a claim were evidenced by an internal email from a separate practice the Claimant had attended:

> "*I will write an x ray report and send to you over the weekend… the bridge is crap and has been since it was placed [.] [I]f I was her and wanted implants, she should sue the dentist who did the bridge… give her [the] number for Dental Law Partnership when you see her… but you can't have the work done until the case is settled.*"

In his defence, Mr Croad averred that the associate dentists at FDC were all self-employed and individually insured. He denied the existence of a non-delegable duty and the relevance of the Claimant's arguments as to vicarious liability.

Those issues, and the question of limitation, were hived off for a preliminary issues trial.

Non-delegable duty

As in *Ramdhean*, the judge applied the approach set out by Lord Sumption in *Woodland v Swimming Teachers Association* (2014) AC 537:

(1) Is the claimant a patient or a child or for some other reason especially vulnerable or dependent on the protection of the defendant against the risk of injury? "*On any sensible construction of the meaning of the word… yes."* The judge considered that it was not possible to distinguish the nature of a doctor-patient relationship from the relationship that existed between a dental surgeon and his patient.

(2) Is there an antecedent relationship between the claimant and defendant, independent of the negligent act or omission itself, (i) which places the claimant in the actual custody, charge or care of the defendant, and (ii) from which it is possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm, and not just a duty to refrain from conduct which will foreseeably damage the claimant? This Claimant regarded herself as a patient of "*the practice*". She had registered with it. They provided her with dental care. The practice regarded her as "*belonging*" to it. The contract between the associate dentist and the practice made it clear that the patient was not to be poached if an associate moved on. The contractual obligation with the health board lay with the practice. The practice was paid for the service. The Claimant did not choose which dentist would see her.

(3) Did the claimant lack control over how the defendant chose to perform its obligations, i.e. whether personally or through third parties? The Claimant had no control over how dental care was provided to her. It was up to the practice who did the work. It did not matter whether the patient could be viewed as having "*elected*" to accept treatment from the practice; "*… what is at the heart of this characteristic is the Claimant's lack of control over how the service she elects to receive is provided… they could provide the service in whatever way they choose. It was not open to her to insist on how they did so."*

(4) Had the defendant delegated to the third party some function which was an integral part of the positive duty he had assumed towards the claimant? Was the third party exercising, for the purpose so delegated, the defendant's custody or care of the claimant and the element of control that goes with it? As far as HHJ Harrison was concerned, the associate dentists provide the care provided to the Claimant within the ambit of the local Health Board contract. They did so, effectively, on behalf of FDC. This aspect was made out.

(5) Did the alleged negligence relate to the performance of the very function assumed by the Defendant? Yes, said the judge: "*The pleaded allegations of negligence relate to the central function of the practice, namely the provision of dental services."*

HHJ Harrison acknowledged that the assessment of whether there was a non-delegable duty was not limited to a tick-box exercise. Applying Lady Hale's approach in *Woodland*, he applied a broader sense check: "*… if one stands back and asks if a practice… should owe a duty to a patient for whose care they are paid by the local health board, then the answer must in my judgment be, yes."*

Vicarious liability

The Claimant's case had also been put on the alternative basis of vicarious liability, which the judge went on to deal with obiter. The associate dentists were not employed by the practice, but the latter was held to be vicariously liable for the following reasons:

(1) Mr Croad had accepted that he was the "provider" of dental care and that the practice had an overarching obligation to ensure that the services provided were safe and met the expected standard set by the health board.

(2) The associate dentists were given targets to meet. The practice was telling the associates what to do without telling them how to do it. The relationship between the two was "akin to employment".

(3) The associates' work was undertaken on behalf of the practice; they provided dental care, which was the defendant's business. The defendant received a direct financial benefit from the work the associates undertook. The practice brought the patients in. *"Having considered the various factors in this case I am unable to conclude that the associates were engaged in their own separate business."*

(4) Judge Harrison noted that his findings were consistent with those of HHJ Belcher in *Ramdhean*, a decision that did not bind him but that he plainly considered to be persuasive.

Limitation

On the question of date of knowledge, the judge reached a fact-specific determination in favour of the Claimant.

But he went on to deal nonetheless with what he would have made of the Claimant's section 33 argument. On the face of it, the delay in this case might have been expected to pose some difficulties: there were no records available, and the index consultations took place many years earlier.

However, HHJ Harrison concluded that the issue of liability would not be a matter of the Claimant's recollection, but *"an analysis of the treatment provided and recorded by appropriate experts."* He found that the effect of the passage of time on that exercise would be limited. He did not specifically address the total lack of contemporaneous documentation.

But all of this was academic given his determination that the limitation period was still current at the point of issue.

Conclusions

How the higher courts might resolve issues such as those presented in *Ramdhean* and *Breakingbury* remains to be seen. But this further Circuit Judge decision chips further at any tenable distinction between how dental service providers and private hospitals ought to be treated when it comes to the question of the non-delegability or otherwise of the common law duty of care.

THE IMPORTANCE OF CONTEMPORANEOUS MEDICAL RECORDS

Dominic Ruck Keene

HXC (by her litigation friend) JXS vs Hind, Craze [2020] 10 WLUK 603

The facts

On 8 June 2016, the then 24-year-old Claimant suffered a catastrophic subarachnoid haemorrhage arising from the rupture of a 10-11mm left internal carotid artery aneurysm. As a result of the haemorrhage she had a dense hemiplegia. Quantum was agreed with a capitalised value of £7 million.

On 19 and 27 May 2016 the Claimant had suffered from sentinel headaches which preceded the haemorrhage. On 19 May she was seen by the First Defendant (a nurse practitioner). The Claimant claimed that the First Defendant negligently failed to ask about the onset of her headache and that, if she had done so, the Claimant would have reported that it had been of sudden onset which would have mandated immediate referral to hospital. There was no reference in the records about onset. The First Defendant's case was that, as per her invariable practice, she had asked the Claimant about onset and that the response must have been that it had been gradual. It was not necessary to make a note of this aspect of the history as it was, in terms of a "red flag", a negative finding.

On 27 May 2016, the Claimant was reviewed over the telephone and then in person by the Second Defendant (a GP). The Claimant alleged that (again) the Second Defendant negligently failed to ask her about the onset of the headaches and that, if he had done so, she would have reported that it had been of sudden onset which would have mandated immediate referral to hospital. The Second Defendant's case was that he did ask about onset and the response was that it had been gradual. The Second Defendant accepted that his note of the consultation was inadequate as it did not contain any detail of examination or a diagnosis. He said that this was, in part, because of the time pressure because he had devoted so much time to the Claimant. The amount of time spent with the Claimant was an issue between the parties.

The Claimant was seen by paramedics on 29 May 2016, who noted that she reported a gradual onset of her headache. She was also seen later that day at the walk-in centre, where no express reference was made in the notes to onset. HHJ Cotter QC noted that the Claimant had not brought any claim against the ambulance service, despite alleging that their note was inaccurate, nor against the walk-in centre doctor. Similarly, she had not brought a claim against a GP who saw her on 7 June 2016, who again made no reference to onset. The Defendant argued that if the Claimant had not brought a claim against the paramedics for negligence then the court as a matter of law should assume that the document was accurate as to what the Claimant's response had been when asked about her headaches.

Factual assessment

The judge noted that it was not disputed that it was mandatory for both Defendants to ask the Claimant direct questions about onset of her headache. The fundamental issue was whether or not they had done so. The Claimant was unable to give evidence, but on her behalf reliance was placed on the inferences that could be drawn from the notes as to the thought processes of the writer, the circumstances of each consultation and the conclusions reached by the Defendants, the poor quality of the notes indicating poor clinical practice, and the expert neurosurgical evidence that it was likely that the headaches had been sudden onset.

With regards to the issue of the accuracy of the paramedic records, the judge reviewed the relevant factors under the Civil Evidence Act 1995 concerning hearsay evidence, and identified that there was a question as to whether *"the starting point as regards the weight to be attached be that a contemporaneous record produced by a medical professional is likely to be accurate?"* The Claimant referred to medical professionals being taught the mantra that "*it if is not there, it did not happen*" in order to encourage them to make full and accurate medical records. The judge held at [137] to [138] that:

> *"…a court can and often will taking* [sic] *a starting point, but no more than a starting point, that a contemporaneous entry made by a medical professional is likely to be a correct and accurate record of what was said and done at a consultation/examination.*
>
> *There is a clear evidential difference between the position where a Claimant (or another witness of fact) gives evidence in relation to an entry in a record that it is not correct (and the court is faced with a clear factual dispute) and the position where no such evidence is adduced. In the latter case, as here, the attack can only be through indirect evidence and inference, but not speculation."*

The judge held that, while there was some evidence that could suggest the record was inaccurate, nevertheless the paramedics had clearly been focussed on the onset of the headache and had otherwise conducted an appropriate and comprehensive review, and on balance accepted the record as accurate.

The judge went on to hold that both Defendants had asked about onset. When reviewing the expert evidence, the judge stated that the Claimant's expert neurosurgeon had departed from his role as an expert through speculating as to why the paramedics had made a mistake on 29 May 2016 in recording that the Claimant's headache had been of gradual onset, rather than acknowledging that this was evidence that did not fit his theory of the Claimant having the classic presentation of a sentinel headache. He commented that "*an expert trying to mould the facts to fit a theory is not an edifying sight."* The judge concluded that he was not satisfied on the expert and factual evidence that the Claimant's headaches on either the 19 or 27 May 2016 were more likely

than not to have been of sudden onset. Accordingly, the Claimant had responded to the Defendants' questions by telling them they were of gradual onset.

Comment

The judgment was subsequently cited by HHJ Cotter in his later judgment in *Failes v Oxford University Hospitals NHS Trust* [2020] EWHC 3333 (analysed in Issue 8) concerning the likely accuracy of medical records. He also referred in *Failes* to *Synclair v East Lancashire Hospitals NHS Trust* [2015] EWCA Civ 1283, where Tomlinson LJ held that:

> *"Clinical records are made pursuant to a clear professional duty, serious failure in which could put at risk a practitioner's registration. Moreover, they are not compiled simply as a historical record, they fulfil an essential and ongoing purpose in informing the care and treatment of a patient. Contemporaneous records are for these reasons alone inherently likely to be accurate."*

In *Ismail v Joyce* [2020] EWHC 3453 (QB) (analysed in Issue 8) the court also had to consider the conflict between witness evidence and the GP's record. Having referred to the various dicta concerning the unreliability of memory, HHJ Freedman held that:

> *"In evaluating the lay evidence in this case, in particular that of the Claimant and her sister, I have found all these dicta to be of considerable assistance. They are of particular application in circumstances where medical records do not necessarily bear out of what is recalled by the Claimant and her sister. The inherent unreliability of memory does mean that it is fair and proper to test the accuracy of recollections of medical consultations against what is documented in the records.*
>
> *On the other hand, it does not necessarily follow that just because the complaint of a particular symptom does not feature in the record of a consultation, it was not, in fact, mentioned by the patient. Sometimes a doctor will obtain an extensive history and make a very detailed record. Sometimes, because of pressure of work or for whatever other reason, a doctor may take a less extensive history and will make a somewhat briefer note.*
>
> *I must also bear in mind that it is human nature for a patient not always to give precisely the same account of his or her symptoms to every doctor who examines him or her. Much may depend upon the questions which are asked by the doctor. Equally, the patient is likely to emphasise and stress the symptoms which are troubling them the most at the particular time of the examination. The medical records need to be scrutinised, with these matters in mind."*

Jeremy Hyam QC represented the Defendants in HXC v Hind but had no part in the writing of this article. Readers can find other articles analysing recent decisions commenting on witness evidence on our website here.

INTERIM PAYMENTS AND EELES

Matthew Flinn

PAL (A Child) v Davison & Ors [2021] EWHC 1108 (QB)

This clear and digestible judgment from Yip J provides an excellent example of the court's approach to applications for substantial interim payments in cases where periodical payments are likely, applying the methodology outlined by the Court of Appeal in *Eeles v Cobham Hire Services Ltd* [2009] EWCA Civ 204.

The claim underlying the application is tragic. The Claimant was a 13-year-old girl who was struck by the First Defendant's car as she was out walking with her family. She suffered catastrophic injuries, including a severe brain injury. She was unable to walk and needed assistance with all aspects of daily living. Her life expectancy

was reduced, but it was not possible to quantify the reduction. The available evidence suggested a confident prognosis would not be possible until at least five years post-accident.

Interim payments had already been received in the sum of £1,025,000 to deal with her immediate care and equipment needs. The present application was for a further £2,000,000 to enable the purchase and adaptation of a suitable property for her and her family. The Defendants had offered a payment of £1,250,000. The Claimant had obtained various expert medical reports but the Defendants had not yet done so, although both parties had managed to obtain accommodation reports for the purposes of the application. The Claimant's accommodation expert identified one suitable property and, with adaptation costs, identified a need for £1,802,000. The Defendants' expert had found a small range of properties, at a total cost (including adaptation costs) of around £1,300,000.

Eeles stage 1

Noting that this was plainly a case where a Periodical Payments Order was likely, Yip J set out the key passage from the judgment of Smith LJ in *Eeles*, setting out the first stage of the assessment the court needed to carry out [43] to [44]:

> *"The judge's first task is to assess the likely amount of the final judgment, leaving out of account the heads of future loss which the trial judge might wish to deal with by PPO. Strictly speaking, the assessment should comprise only special damages to date and damages for pain, suffering and loss of amenity, with interest on both. However, we consider that the practice of awarding accommodation costs (including future running costs) as a lump sum is sufficiently well established that it will usually be appropriate to include accommodation costs in the expected capital award. The assessment should be carried out on a conservative basis. Save in the circumstances discussed below, the interim payment will be a reasonable proportion of that assessment. A reasonable proportion may well be a high proportion, provided that the assessment has been conservative. The objective is not to keep the claimant out of his money but to avoid any risk of over-payment.*
>
> *For this part of the process, the judge need have no regard as 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."*

A question arose as to whether special damages "to date" in the passage above meant to the date of the application or to a predicted date of trial. Yip J dealt with this issue as follows at [26]-[27]:

> *"It seems to me that the starting point remains as stated by Smith LJ that strictly speaking the court looks at special damages "to date". However, there will be many instances where it is entirely appropriate in making the conservative assessment at the first stage to bring in special damages which have not yet accrued but will do so before trial. I consider this a question of fact which inevitably depends on the context of the application. What is essential, is to keep in mind the clear principles which underpin the approach at stage 1 of Eeles. The court's task is to estimate the likely amount of the lump sum element of the final judgment. The objective is not to keep the claimant out of his or her money but to avoid the risk of overpayment. The court must avoid fettering the trial judge's freedom to make an appropriate PPO.*
>
> *It is easy to think of examples where the court can be confident that special damages yet to accrue will form part of the likely amount of the lump sum. In the case of an adult claimant, an ongoing claim for loss of earnings might fall into that category. The provision of gratuitous care on a basis which is expected to continue to trial might be another example. Even then, any advance payments in respect of special damages yet to accrue can give rise to some risk of over-payment. The longer the estimated period to trial, the greater the uncertainty and so the greater the risk."*

On that basis, it was open to the court to consider working into its assessment the likely damages for e.g. care and therapy to the date of a likely trial. Doing so would mean that the £2,000,000 sum sought in the application

would certainly not be more than a reasonable proportion of the likely lump sum of damages. However, Yip J identified a need for caution, particularly where there was likely to be a need for further interim payments [31] to [32]:

> *"If the court brings in the likely cost of care and other needs to trial when addressing Eeles stage 1 in relation to an interim payment which is expressly sought to meet the claimant's accommodation needs, difficult issues may then arise further down the line. I accept the point made by Mr O'Sullivan QC on behalf of the defendants that the court must guard against allocating large elements of other pre-trial expenditure into an interim payment for accommodation. That is not to ignore the guidance at paragraph 44 of Eeles that the judge need have no regard to what the claimant intends to do with the money when addressing the first stage of Eeles. Rather, it is a case of acknowledging that the same sums cannot be spent twice. If they are brought in at this stage and relied upon to found an interim payment which is then used to fund accommodation they will not later be available to fund care and other needs.*
>
> *In those circumstances, it seems to me that I must leave out of account the special damages which are likely to accrue in relation to the claimant's other needs when considering this application. Doing so, will avoid prejudicing future interim payment applications and/or the availability of funds to meet the claimant's ongoing care and rehabilitation. The monies the claimant has already received are to be applied in that direction. It is envisaged that a further interim payment will be required around the end of this year or early next year. Taking out of the 'pot' required to be allocated for those needs in order to fund accommodation now would serve only to defer the problem. For that reason, on the facts of this application, I am unable to include all the anticipated special damages to trial in the Eeles stage 1 calculation.*

What this meant is that the court was only able to take into account PSLA damages, special damages accrued to the date of the application, and the likely accommodation damages. However, adopting the cautious approach required by the authorities meant acknowledging (though not accepting) that the Defendant's figures were markedly lower and there was a possibility they might be accepted at trial. If they were, then the £2,000,000 sought in the application was more than a reasonable proportion of the likely lump sum damages which could be taken into account in the application.

Eeles stage 2

However, this was not to be the end of the story, as Yip J went on to consider the second stage of the *Eeles* approach, in which Smith LJ addressed the circumstances where the court could build into its assessment of the likely final lump sum additional elements of future loss [45].

> *"We turn to the circumstances in which the judge will be entitled to include in his assessment of the likely amount of the final judgment additional elements of future loss. That can be done when the judge can confidently predict that the trial judge will wish to award a larger capital sum than that covered by general and special damages, interest and accommodation costs alone. We endorse the approach of Stanley Burnton J in the Braithwaite case [2008] LS Law Medical 261. Before taking such a course, the judge must be satisfied by evidence that there is a real need for the interim payment requested. For example, where the request is for money to buy a house, he must be satisfied that there is a real need for accommodation now (as opposed to after the trial) and that the amount of money requested is reasonable. He does not need to decide whether the particular house proposed is suitable; that is a matter for the Court of Protection. But the judge must not make an interim payment order without first deciding whether expenditure of approximately the amount he proposes to award is reasonably necessary. If the judge is satisfied of that, to a high degree of confidence, then he will be justified in predicting that the trial judge would take that course and he will be justified in assessing the likely amount of the final award at such a level as will permit the making of the necessary interim award."*

Applying that approach, Yip J said it was evident that it was necessary for the Claimant to purchase another property, and that on the evidence available to her, she was satisfied that the only property which was

realistically available to the Claimant was that identified in her application (at a higher cost than those options proposed by the Defendants). Accordingly, the higher degree of expenditure was "reasonably necessary" at the present time. This did not mean, however, that the court was definitively deciding that the house was suitable – that would remain a live issue to be determined when the claim was resolved.

Having determined that it was "reasonably necessary" to expend the sum sought by the Claimant in purchasing a property, Yip J went on to say that it was sensible and necessary to ensure that the identified adaptions to the proposed property were covered by the interim payment. Accordingly, she concluded that the £2,000,000 sum sought by the Claimant was reasonably necessary, applying the second stage of the *Eeles* approach, and granted the application.

This case provides a useful example of a step-by-step approach to consideration of large interim payment applications in cases of catastrophic injury. The court will first consider "Eeles stage 1", which involves a traditional consideration of a reasonable proportion of the likely final lump sum award, taking into account general and special damages to the date of the application, along with some very likely special damages to the date of trial where appropriate. If the sum sought is greater than a reasonable portion of the likely lump sum (adopting a conservative approach) the court may then go on to apply "Eeles Stage 2", and consider whether, in any event, the expenditure is reasonably necessary such that a judge at trial would be likely to allocate some of the future damages to an immediate lump (as opposed to future periodical payments) sum to facilitate needed capital expenditure.

Find Lizanne Gumbel QC's recent article on interim payment applications and more on our website here.

ADVICE AND AORTIC VALVES

Dominic Ruck Keene

Negus v Guy's and St Thomas's NHS Foundation Trust [2021] EWHC 643 (QB)

The facts

The claim was brought by the executors on behalf of the estate of Mrs Tracy Neill. On 4 March 2014 the Deceased underwent the implantation of a 19mm mechanical aortic valve. The Claimants alleged that a larger size valve should have been used (albeit that would have required an Aortic Root Enlargement or ARE), and that there was a failure to advise the Deceased properly as to the risks arising from the implantation of a smaller valve. The Deceased had subsequently undergone a re-do valve replacement on 18 March 2015, which required an ARE and the insertion of a 23mm valve. The Deceased ultimately developed progressive heart failure and died in January 2020.

At the relevant consultation with a consultant cardiothoracic surgeon, Mr Sabetai, the Deceased was advised as to the risks and benefits of the surgery. She agreed to proceed with an aortic valve replacement. Eady J summarised the expert evidence that the size of valve that can be implanted depended on the size of the annulus (the aperture at the root of the aorta). However, it was possible to enlarge the aortic root and implant a larger valve. Nevertheless, ARE was a very rare procedure, which was undertaken in less than 1% of aortic valve replacements. It was common ground that the size of valve to be used could not be determined prior to surgery once the aortic root had been decalcified. It was also common ground that the standard practice was to insert the largest size of valve that could be safely implanted. In any event, prior to the operation, Mr Sabetai did not discuss with the Deceased the size, particular brand or design of the valve to be implanted. He explained to the court that he would not do so as the decision as to the particular size and make of valve would have to be determined intra-operatively. Mr Sabetai further agreed that, prior to surgery, he did not discuss with the Deceased the possibility of undertaking an ARE to permit the insertion of a larger prosthetic valve. The judge accepted his evidence that this was not because he was incapable of performing such a procedure but because,

whilst he had in mind the possibility that he might need to undertake an ARE, this would only be something he would do if he found it was necessary intra-operatively.

The Deceased subsequently signed a consent form with Mr Sabetai's registrar, which included the statement that *"I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health*." Mr Sabetai's evidence was that he would have considered intra-operatively during the subsequent surgery whether it was appropriate to perform an ARE – if it had been so, he would considered it as a procedure falling within that description. His evidence was that, in light of his operational findings concerning the Deceased's heart, ARE was not appropriate.

Assessment

The judge commented in respect of the expert cardiothoracic evidence that the Claimants' case was founded on a number of allegations of negligence that in cross examination of the Claimants' expert were "*demonstrated to be based upon a particular opinion as to how things should be done, rather than allowing for possible alternative views that might still be recognised as proper by a competent, reasonable body of opinion. Whilst experts should, of course, make concessions where it is appropriate to do so, the concern in this case is that so many of the allegations levied against Mr Sabetai appear to have been based on the application of the wrong test*."

The judge's first conclusion was that it was not negligent to implant a 19mm valve rather than to undertake an ARE and implant a larger valve – it was in accordance with a reasonable body of surgeons, and was also logical.

Her second conclusion was that, while there was a negligent failure to warn the Deceased of the potential risk that an ARE might have to be undertaken (which would double the risks), there was no requirement to have informed her that ARE was an alternative procedure. She held that Mr Sabetai's duty to warn did not extend to:

> "*presenting TN with the various possible choices that might arise intra-operatively and could only properly be determined by the surgeon at that stage. The decision that Mr Sabetai had to make during surgery was not simply whether to implant a 19mm valve without undertaking an ARE, or to perform an ARE and then implant a larger valve; he had to exercise judgement at various stages of the surgery to determine what choices were open to him to achieve the best outcome for TN (what size of valve he could fit once he had de-calcified the root; what make and design of valve he should use; what outcome that could achieve; whether he could be assured of achieving a better outcome if he could insert a different, larger valve; whether any risks involved in doing so (in particular, if that involved undertaking an ARE) were justified; and so on). This involved highly technical decision-making, requiring a specialist-level of understanding and experience; it would be false to represent this as a simple or bilinear choice of treatment*."

She also held that, even if the Deceased had been informed of the possible risk of ARE, she would have still consented to surgery. Further, had she been advised that ARE was an alternative form of procedure, there was no evidential basis for thinking the Deceased would have done anything other than leave it to Mr Sabetai to exercise his professional judgment as required during the operation.

Comment

The judgment is an illustration of the problem of experts failing to appreciate the Bolam test (or potentially of their instructing solicitors failing to ensure that they understood it properly). It also is an interesting and relatively rare consideration of the circumstances in which informed consent does not require discussing highly technical matters that most patients could not reasonably be expected to grasp.

Matthew Barnes acted for the Defendant. He did not contribute to this article.

THE STANDARD OF CARE AND HEALTH VISITORS

Rajkiran Barhey

XM (By His Father and Litigation Friend FM) v Leicestershire Partnership NHS Trust [2020] EWHC 3102 (QB)

This article focuses on one interesting aspect of this detailed decision – its consideration of the standard of care to be expected from health visitors.

There were a range of allegations but much of the judgment focused, (and the Claimant ultimately succeeded) on the allegation that at the 6 week check on 8 August 2012 the health visitor, Mrs Furmage, failed to appreciate that the growth of the Claimant's head from the 25th centile at age 2 weeks to the 50th centile at age 6 weeks was abnormal.

It was agreed that had referral been made on 8 August 2012, the outcome would have been remeasurement, diagnosis and successful treatment. Unfortunately, the Claimant did not receive treatment for his rare benign tumour, the growth of which caused an overproduction and accumulation of cerebrospinal fluid which led to permanent catastrophic brain damage.

Relevant authorities

From [27] Stewart J set out the legal framework. He set out a number of well-known authorities relevant to clinical negligence claims generally. At [34] he noted:

> *"The parties did not take me to any case specifically on the standard of care of health visitors/nursery nurses. In this context:*
>
> *Mr Todd QC cited this passage from Clerk & Lindsell 23rd edn. at 9-98:*
>
> *"…Liability of other medical and quasi-medical professionals*
>
> *Nursing staff, as well as medical practitioners, owe a duty of care to the patients in their care, though there are few decided cases on the matter. Nevertheless, the principle relating to the liability of doctors applies equally to nurses. The nurse must thus attain the standard of competence and skill to be expected from a person holding their post. The more skilled the job undertaken by the nurse, the higher the standard of care expected."*
>
> *Miss Gollop QC cited passages from two authorities:*
>
> *In Wilsher v Essex AHA [1987] QB 730 @ 751, Mustill LJ said:*
>
> *"For my part, I prefer the third of the propositions which have been canvassed. This relates the duty of care not to the individual, but to the post which he occupies. I would differentiate "post" from "rank" or "status." In a case such as the present, the standard is not just that of the averagely competent and well-informed junior houseman (or whatever the position of the doctor) but of such a person who fills a post in a unit offering a highly specialised service. But, even so, it must be recognised that different posts make different demands. If it is borne in mind that the structure of hospital medicine envisages that the lower ranks will be occupied by those of whom it would be wrong to expect too much, the risk of abuse by litigious patients can be mitigated, if not entirely eliminated"*
>
> *In Darnley v Croydon Health Services NHS Trust [2018] UKSC 50, Baroness Hale said:*
>
> *"25. The particular role performed by the individual concerned will be likely to have an important bearing on the question of breach of the duty of care. As Mustill LJ explained in Wilsher v Essex Area Health Authority [1987] QB 730 , 750–751, the legitimate expectation of the patient is that he will receive from each person concerned with his care a degree of skill appropriate to the task which he or she undertakes. A receptionist in an A & E department cannot, of course, be expected to give medical*

> *advice or information but he or she can be expected to take reasonable care not to provide misleading advice as to the availability of medical assistance. The standard required is that of an averagely competent and well-informed person performing the function of a receptionist at a department providing emergency medical care."*

He then went on to consider a number of documents relevant to the 6 week check, including the Department of Health's Healthy Child Programme (HCP), the UK-World Health Organisation 0-4 years growth charts, the Defendant's Standard Operating Procedure (SOP), the 'Red Book', and the standard textbook of Hall & Elliman: Health For All Children [35] to [49].

There was also a range of expert evidence before the court, from experts in nursing and health visitors and experts in general practice.

Standard of care – health visitors

At [354] Stewart J considered the standard of care for a health visitor. He stated that he took into account the various documents set out above (the HCP, the WHO document, the SOP and the NIPE), as well as the evidence of the experts in nursing and health visitors, the experts in general practice, and the evidence of the factual health visitor witnesses.

The NIPE described standards for clinical care and professional competences required for health care professionals who undertake physical examination of newborn babies and the 6-8 week infant examination. It stated that all health care professionals should ensure that if they do not have the appropriate competency for a particular aspect of care, they make an appropriate referral. It also stated that regardless of the healthcare professional's qualifications, background and experience, the standard, quality and content of the examination should be consistent throughout the UK.

The Standard Operating Procedure said that the 6 week check may only be delegated between the health visitor and the GP. This led to Stewart J's finding at [358] to [360] that:

> *"It is clear from the SOP that the health visitor was required, in the context of this case, to obtain a head circumference measurement at the initial contact and at the 6 week contact. Further, she was required to plot the head circumference on the centile chart, to interpret the head circumference size so as to ensure that its growth was along expected centile lines, considering future growth potential and earlier growth measurements and, if she was concerned about rapid head growth, to consider hydrocephalus and urgently refer to the GP.*
>
> *I accept that one must be aware of the different level of qualification, training and experience between a health visitor and a GP. Some of the allegations made against the Defendant are matters exclusively within the domain of health visitor expertise.* ***However, Mrs Furmage, when doing the initial contact and the 6 week check, had to perform her tasks to the standard of the competent health care professional charged with those duties. She was not required to make a diagnosis.*** *She was required to be aware of, follow, and competently interpret the guidance which is crystallised in the textbook and the SOP.*
>
> *Page 18 of the SOP requires urgent liaison with the GP if there are concerns about hydrocephalus. After that point, i.e. considering potential diagnosis and referring to a specialist, the expertise becomes that of the general practitioner.* ***Up to that point the same standard is required of whichever health care professional measures the head and does the initial interpretation of the results.*** *All this flows from the fact that the documentation provides for: (i) one standard of care to that point, (ii) the possibility that it is not just general practitioners who will carry out those elements and (iii) in this case, the Defendant's SOP envisaged those material parts of the general physical examination being carried out by the health visitor and to be her responsibility."* [emphasis added]

He therefore concluded at [363] that: *"I therefore accept Miss Gollop QC's submissions that there is one standard of care, regardless of the qualification or post held by the health professional responsible for the task. It follows*

that on this particular point the evidence of both the health visitors/nurses and the general practitioners is material as to whether or not there was a breach of duty."

Comment

This judgment of Stewart J as to the standard of care of health visitors is useful as it demonstrates a practical application of the principles established in *Wilsher* and *Darnley,* namely that the role carried out by a professional is the important consideration, and not the qualifications of the individual in question. This explains why, in assessing the standard of care, Stewart J took into account the expert evidence of 4 experts – the 2 experts in nursing and health visitors, but also the 2 experts in general practice. This was notwithstanding the fact that the directions limited the GP evidence to causation only. At trial, the evidence of both GP experts as to breach of duty was explored and Stewart J considered it appropriate to take it into account (see [363]). This is a useful practice point for those who may be unsure how to approach expert evidence in a similar case in future.

PROVING THE DREAM – EVIDENCING CLAIMS FOR FUTURE LOSS OF EARNINGS AS A PROFESSIONAL FOOTBALLER

Richard Smith

TVZ v Manchester City Football Club Ltd [2021] EWHC 1179 (QB)

Swansea City AFC v Owen [2021] EWHC 1539 (QB)

Introduction

Two recent cases highlight contrasting approaches by claimants to proving the level of earnings they could have expected to receive as professional footballers, but a generous approach by the court to admitting such evidence in each case.

Mere weeks before contesting two of the most prestigious/lucrative matches in world football, two professional clubs found themselves in the altogether grittier battles of High Court case management. On 22 April 2021, Swansea City AFC succeeded in persuading Bourne J to permit expert evidence from an agent as to the Claimant's potential earnings – sadly they could not repeat their success in the Championship playoff final, losing against Brentford. Just over two weeks later, on 6 May 2021, Manchester City FC failed to persuade Cavanagh J to exclude as inadmissible, among other things, factual witness statements on players' earnings – their losing streak continued in the Champions League Final against Chelsea (albeit with the Premier League title to console themselves).

The nature of the issues before the respective judges demonstrates the uncertainty of litigants as to how best to present evidence of potential earnings in sports (and other) cases. The answer is little clearer as a result of these decisions.

TVZ v Manchester City Football Club Ltd [2021] EWHC 1179 (QB)

This is a claim brought by a group of former youth players against Man City, alleging that the club is vicariously liable for acts of child abuse committed against them by one of the club's scouts/coaches, Barry Bennell. Two investigations into Bennell's actions (one statutory and one commissioned by the club) have concluded that Bennell abused the Claimants and others. A redress scheme was set up by the club to compensate victims, in which the Claimants declined to take part in favour of bringing the instant proceedings.

The court considered a number of applications brought by the parties, including the one considered here, namely that the evidence from two witnesses, Nick Harris and Keith Carter, *"is factual evidence and is to take the form of witness statements already served."* The alternative analysis, advanced by the club, was that the documents were expert reports, for which the Claimants did not have permission.

The judge's ultimate conclusion was that this was an issue which should be left for the trial judge to determine at the PTR, but as he expressed a very clear view that the evidence was admissible factual evidence, it is instructive to consider the details. The disputed evidence was as follows:

- Mr Harris is described in the judgment as a sportswriter, researcher and analyst, specialising in the business and finance of sport. His statement referred to and exhibited several documents in which research on footballers' wages in various periods was set out.
- Mr Carter is an employment consultant. His statement provided information about the two pension schemes that existed in the relevant period for professional footballers.

Man City submitted that the statements were, in reality, expert reports, and, as such, could not be relied upon by the Claimants as leave had not been sought to adduce the evidence as expert evidence. The club pointed out that the witnesses held themselves out as having special expertise in football finance and employment matters. They were being paid for their evidence. Man City also pointed out that in otherwise very similar statements filed in other proceedings, these witnesses used language which was much more apt for an expert report. For example, Mr Harris referred to his statement as a "*report*" and referred to his "*professional opinion*". The club suggested that these statements had been "*tidied up*" for the purposes of these proceedings so that they looked more like statements of fact, and so that they could avoid the need to seek leave to rely upon them as expert reports.

The reasons why the Claimants were chary of seeking permission to rely on the content of these statements as expert evidence was not discussed.

Having determined that the matter should be left to the trial judge, Cavanagh J said this [129]:

> *"I should add, however, that if it had been necessary finally to determine the issue today, I would not have made an order which had the effect of preventing the Claimants from relying on these statements at trial. The starting point is that, if the Claimants succeed in their claims and succeed in establishing that they lost the chance of becoming a professional footballer, the judge will need to have some information about pay and pensions for professional footballers in the relevant period in order to assess damages. The material contained in the Harris and Carter statements is potentially very useful. In my judgment, for what it is worth, Mr Carter's statement is not an expert report. It is simply a means of identifying the specialist pension schemes that were available for professional footballers at the relevant time, and a peg upon which to hang the inclusion in the trial bundle of documentation relating to these specialist pension schemes. The vast majority of Mr Harris's statement is also factual, simply identifying and summarising the surveys which provide some information about footballers' salaries. It makes some observations about the surveys, but most of these observations are ones which do not require specialist expertise. Rather, they are apparent on the face of the documents themselves. If and in so far as the statement sometimes strays into inappropriate expert comment, the judge will be well able to disregard such comment, if she considers it appropriate to do so."*

The PTR is scheduled for early August 2021 in advance of an 8-week trial beginning on 25 October 2021. The prejudice to the Claimants of being prevented from relying on this evidence at that stage would appear significant (albeit I am not aware of what other evidence of potential earnings will be before the court). The Claimants may be counting on this being a point in their favour at that stage. Notwithstanding that, the uncertainty appears to the outside observer to be somewhat unsatisfactory. This is all the more so if the matter could have been put on a different footing by gaining the court's permission to rely on Messrs Harris and Carter as expert witnesses (and thereby gaining a mechanism to recover the fees that they had been paid). However, the Claimants' approach is understandable given the risk of failing to get such permission; the chance of then being able to argue successfully that what had been advanced as experts' reports are, in fact, witness statements would be slim.

They may, however, have been encouraged down that path had the following case been decided earlier.

Swansea City AFC v Owen [2021] EWHC 1539 (QB)

This is a claim by the club's former player for a negligent failure properly to treat an injury. It is alleged that his career as a goalkeeper was ended as a result, whereas but for the injury he would have had a lengthy career in leagues up to and including the Championship.

At the CCMC before Master Eastman the Claimant argued that he should be permitted to rely on quantum expert evidence from an accountant. This was permitted. Swansea argued that further expert evidence should be permitted from an expert in "*football playing ability*" and, rather than an accountant, a sports agent who could speak more accurately to the level of earnings that could be negotiated for particular players. The Master permitted the "ability" expert but denied permission for the agent. One issue was his fees (£30,000), but, colourfully, the Master went on to say:

> *"I am not sure whether that* [sports agency] *is frankly a proper area of expertise in any event. Their expertise is in disrupting football players and making them move around so that they can make more fees. ... The idea that the judge can have a benefit from some wise old bird who has been involved in professional football on both sides, who can talk about the chances of people doing as well as they would hope to do in the professional world which, as we know, is as cut-throat as it comes, is I think of some value. I think that would help put the prospects of this gentleman in context."*

Swansea appealed and by the time of the hearing the Claimant had disclosed his accountancy report and the factual evidence on which it relied, which happened to be a witness statement from a sports agent, discussing the wages which he had negotiated for goalkeepers in the lower leagues. The club's submission was that this was inferior to the expert evidence that it was proposing, which would come from an expert who had personal knowledge of the contract terms of 18 relevant goalkeepers.

Bourne J allowed the appeal, stating [30] to [33]:

> *"…there will remain the question of how various ability levels would translate into salary levels. That question is one of fact, but that does not mean that expert opinion will not help to answer it. The variations in salary identified by Mr Letheren no doubt exist for various reasons. As was seen in the case of Smith v. Collett [2008] EWHC 1962 (QB), different clubs in each division will pay different salaries and different players within each club will earn more or less.*
>
> *…I have concluded that expert evidence is reasonably required. That is on the basis that a sports agent from professional experience - perhaps aided by research - will be able to provide insight into more precise salary expectations. With knowledge of what factors affect salary and what effect those factors have had in practice, the trial judge may be able to make better use of his or her findings about what factors actually apply to the claimant.*
>
> *…The way in which the master expressed his conclusion also was not entirely satisfactory. Whilst his disparaging remark about their expertise being in causing disruption was probably just a flippant way of saying that their relevant area of expertise had not been clearly identified, it gave the wrong impression. It is true that sports agents sometimes get a bad press, but then so do judges."*

In making his decision, the learned judge had referred to guidance in the White Book and, in particular, the three-stage test in *British Airways plc v Spencer* [2015] EWHC 2477 (Ch), namely:

(1) Is expert evidence necessary to decide an issue rather than merely helpful? If yes, it should be allowed;

(2) If it is not necessary, will it assist the judge in determining an issue? If it would assist but is not necessary, then the court should consider;

(3) If expert evidence on that issue was reasonably required to determine the proceedings, taking into account proportionality, the effect of a judgment either way on the parties and who will pay for it.

Taking into account that last factor, and at Swansea's invitation, the Judge capped the sports agent's fees at £12,500.

Discussion

Should litigants in claims such as this have greater confidence that specialist expert evidence on football earnings will be permitted? The issue is similar to employment consultants in the broader sweep of personal injury and clinical negligence cases, permission for which is seldom granted. However, there are particular issues which arise in football/sports cases which are not of general application, namely commercial sensitivity and secrecy around wages.

The Supreme Court formulated a test for the admissibility of expert evidence in *Kennedy v Cordia (Services)* [2016] UKSC 6 (§44) (a Scottish case, and so only of persuasive force to applications under the CPR):

> *"a skilled person can give factual evidence either by itself or in combination with opinion evidence. There are in our view four considerations which govern the admissibility of skilled evidence:*
>
> *(i) whether the proposed skilled evidence will assist the court in its task;*
>
> *(ii) whether the witness has the necessary knowledge and experience;*
>
> *(iii) whether the witness is impartial in his or her presentation and assessment of the evidence; and*
>
> *(iv) whether there is a reliable body of knowledge or experience to underpin the expert's evidence.*
>
> *All four considerations apply to opinion evidence, although, as we state below, when the first consideration is applied to opinion evidence the threshold is the necessity of such evidence. The four considerations also apply to skilled evidence of fact, where the skilled witness draws on the knowledge and experience of others rather than or in addition to personal observation or its equivalent."*

Consideration (iv) does not appear in the test applied by Bourne J and it must be open to question whether evidence from a sports agent is based on a reliable body of knowledge or experience in the way that underpins that of a medical or engineering expert (even without going so far as to ascribe to the view of the Master). The evidence being advanced in the *Manchester City* case appeared to have that quality, but whether experience of 18 goalkeeper's contracts, as in the *Swansea* case, rises above the anecdotal may be doubted.

While Cavanagh J's description of the nature of the evidence contained in the statements disputed before him as factual seems correct, it is also right that it would fall into the category of "*skilled evidence of fact*" described in *Kennedy.*

Notwithstanding doubts about the body of knowledge on which it is based, it seems clear that evidence of potential earnings is essential in claims such as this. That being the case it would seem better for that evidence to be provided by experts to whom the duties imposed by CPR Part 35 apply. Approaching matters in that way would offer certainty as to the body of evidence to be considered by the court at an appropriately early stage, rather than leaving it in doubt until the PTR. However, parties may need to be steered clearly in that direction by judicial guidance if they are to be relieved of the dilemma of whether to seek permission to rely on such evidence under Part 35.

Rory Badenoch acted for the Claimant in Swansea City AFC v Owen. He did not contribute to this article.

SECTION 40 APPEALS AND DEFERENCE TO THE MPT

Andrew Kennedy QC

(1) Sastry (2) Okpara v General Medical Council [2021] EWCA Civ 623

The Court of Appeal heard two second appeals challenging orders made by the Administrative Court dismissing their appeals under section 40 of the Medical Act 1983 ('the 1983 Act'). In each case permission to appeal was granted by Leggatt LJ (as he then was) on similar grounds namely, the correct approach to be adopted to the question of the deference to be afforded by the appeal court to the views expressed by the Medical Practitioners Tribunal ('MPT').

Background

The case against Dr Sastry arose from treatment of a female patient whilst he was working as a medical oncologist in a hospital in Mumbai. The MPT found that Dr Sastry recommended that his patient undergo high dose chemotherapy and autologous stem cell transplantation (harvesting and freezing of the patient's own blood stem cells prior to chemotherapy) when he knew this to be inappropriate as the harvested cells did not contain a sufficiently high proportion of CD34 positive cells. The patient underwent cell harvesting followed by high dose chemotherapy and reinfusion of the harvested cells. She later died.

The MPT found Dr Sastry's fitness to practice impaired on the basis that he had not remediated his misconduct, lacked insight and had sought to mislead it during his oral evidence. The MPT determined that Dr Sastry's misconduct was fundamentally incompatible with continued registration and erased his name from the medical register.

The MPT found proved a number of allegations of sexual misconduct against Dr Okpara. It also concluded that his conduct was sexually motivated. It described his conduct as "*persistent and predatory"*, targeted at a victim who was timid in nature and that it had taken place in a "*hierarchical institutional context*". The MPT noted that there was no evidence of remediation, reflection, or expressions of regret or remorse and concluded that erasing Dr Okpara's name from the medical register was the only proportionate sanction.

Approach of the High Court at the first appeals

The Court of Appeal noted in Dr Sastry's appeal May J's reliance on *General Medical Council v Jagjivan and Another* [2017] 1 WLR 4438 (an appeal by the GMC pursuant to section 40A of the 1983 Act) and *Bawa-Garba v General Medical Council* [2019] 1 WLR 1929 (a section 40 appeal). At [66] and [67] May J stated:

> *"The observations in Bawa-Garba, set out above, are of particular relevance here. Where it comes to an evaluation of clinical behaviour and the treatment of patients, particularly in connection with a sophisticated procedure like autologous cell transfer, a court is totally ill-equipped to arrive at a view of what public protection and reputation of the profession requires. It would be wrong to substitute its own untutored view for that of a panel drawn from the profession in question.*
>
> *The MPT here was not obliged to apply the sanction sought by the GMC. For the reasons which it gave, it came to the view that proper protection of the public and the profession required the more serious sanction. I can see no proper reason for interfering with that decision."*

In Dr Okpara's first appeal Julian Knowles J also referred to the Court of Appeal's decision in *Bawa-Garba*. At [44] he stated:

> *"At [67] of Bawa-Garba the Court said that this general caution applies with particular force in the case of a specialist adjudicative body, such as the Medical Practitioners Tribunal, which (depending on the matter in issue) usually has greater experience in the field in which it operates than the courts: see Smech Properties Ltd v Runnymede Borough Council [2016] EWCA Civ 42, [30]; Khan v General Pharmaceutical Council [2017] 1 WLR 169 at [36]; Meadow at [197]; and Raschid v General Medical*

> *Council [2007] 1 WLR 1460, [18]-[20]. It therefore said that an appeal court should only interfere with such an evaluative decision on sanction if (a) there was an error of principle in carrying out the evaluation, or (b) for any other reason, the evaluation was wrong, that is to say it was an evaluative decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide (citations omitted)."*

And at [100]:

> *"The starting point is, as I have said, that the Tribunal is the body best equipped to determine the sanction to be imposed. The assessment of the seriousness of the misconduct is essentially a matter for the Tribunal in the light of its experience. It is the body best qualified to judge what measures are required to maintain the standards and reputation of the profession: Bawa-Garba, supra, [67] and [94]. I remind myself that I can only intervene if (a) there was an error of principle in carrying out the evaluation, or (b) for any other reason, the evaluation was wrong, that is to say it was an evaluative decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide."*

The challenge before the Court of Appeal

In each case the essence of the challenge was that the judge at the first appeal had conducted a judicial review-type review of the sanction decision despite the wording of CPR52.21(1)(a) expressly providing that the appeal be by way of rehearing and not by way of review. Furthermore, it was said that each judge had impermissibly or inappropriately deferred to the decision of the MPT.

Furthermore, Counsel for Dr Okpara sought to identify a tension between sexual misconduct cases such as *Jagjivan* where the court was willing to decide issues of weight without deferring to the expertise of the MPT and cases such as *Bawa-Garba* where the court was prepared to defer to the expertise of the MPT.

The decision in the Court of Appeal

The Court reviewed the cases of *Ghosh v General Medical Council* [2001] 1 WLR 1915, *Preiss v General Dental Council* [2001] 1 WLR 1926, *Meadow v General Medical Council* [2007] QB 462, *Rashid and Fatnani v General Medical Council* [2007] 1 WLR 1460, *Cheatle v General Medical Council* [2009] EWHC 645 (Admin), *Khan v General Pharmaceutical Council* [2017] 1 WLR 169, *Jagjivan* and *Bawa-Garba*. On the basis of these authorities the Court of Appeal identified the following principles:

(1) The test on a section 40 appeal is whether the sanction was "*wrong*", the approach of the court is appellate in nature, not supervisory and is unqualified and the question for the court is whether the sanction imposed "*was appropriate and necessary in the public interest or was excessive and disproportionate"* [105].

(2) By contrast on a section 40A appeal (i.e. an appeal by the GMC) although the task of the court is to determine whether the decision of MPT was "wrong", the approach of the appellate court is supervisory in nature and "*in particular in respect of an evaluative decision, whether it fell 'outside the bounds of what the adjudicative body could properly and reasonably decide'*" [107].

It followed that the judge in *Sastry* was wrong to conclude "*a court is totally ill-equipped to arrive at a view of what public protection and reputation of the profession requires*" (see passage at [66] cited above) and that she was required to exercise her own judgment as to whether the sanction imposed was excessive and disproportionate [110].

Similarly, the judge in *Okpara* who followed *Bawa-Garba* (i.e. the test appropriate to a section 40A appeal but not a section 40 appeal) was wrong as he did not assess whether the sanction imposed by the MPT was appropriate and necessary in the public interest or was excessive and disproportionate [113]. The Court of

Appeal added "*We agree that in matters such as dishonesty or sexual misconduct, the court is well placed to assess what is needed to protect the public or maintain the reputation of the profession and is less dependent upon the expertise of the Tribunal*".

Comment

This was something of a pyrrhic victory for both doctors. The Court of Appeal went on to undertake the task that the judges at the first instance had failed to undertake and was in no doubt that the sanction of erasure was necessary and appropriate, substantially for the reasons given by the MPT in each case.

This is an important and helpful clarification and confirmation of the approach that should be taken by the appellate court in section 40 and section 40A appeals. The Court of Appeal explained the rationale for the difference in approach as:

(1) The right of appeal conferred by section 40 is without limit. By contrast the GMC may only bring an appeal pursuant to section 40A on the limited basis that "*they consider that the decision is not sufficient (whether as to a finding or a penalty or both)*" – see section 40A(3) of the 1983 Act.

(2) CPR52.21(1) provides that "*Every appeal will be limited to a review of the decision of the lower court unless (a) a practice direction makes different provision for a particular category of appeal*" and 52DPD.22 §19.1(2) that "*Every appeal to which this paragraph applies … will be by way of re-hearing*". The list of appeals to which the paragraph applies includes appeals brought under section 40 of the 1983 Act but not appeals brought under section 40A.

A Review of Recent Regulatory Decisions

Marina Wheeler QC

R (on the application of Young) v General Medical Council [2021] EWHC 534 (Admin)

Haris v General Medical Council [2021] EWCA Civ 763

Bux v General Medical Council [2021] EWHC 762 (Admin)

Gupta v Northampton Hospital Trust [2021] EWHC 965 (QB)

During the pandemic, the public's gratitude to the medical profession has been palpable. But rightly, practitioners continue to be regulated, supervised by the courts. Here we report a clutch of their decisions highlighting some common themes: the importance of transparency and maintaining public confidence in the profession; managing conflicts of interest; and making and handling findings of dishonesty.

R (on the application of Young) v General Medical Council [2021] EWHC 534 (Admin)

In *R (on the application of Young) v General Medical Council* [2021] EWHC 534 (Admin), the Administrative Court upheld the decision of a GMC Assistant Registrar (AR) to proceed with charges against the Claimant notwithstanding a previous Assistant Registrar had taken a contrary view.

The events giving rise to the case were tragic. In October 1996 Claire Roberts, age 9, was admitted to the Royal Belfast Hospital for Sick Children with vomiting, lethargy and slurred speech. An initial blood test showed her sodium levels were low, but monitoring was inadequate and over the next two days her condition declined. She suffered seizures, cerebral oedema and ultimately died. Her death was not referred to the Coroner and the certificate failed to record hyponatraemia, (a condition where sodium in the blood falls dangerously low, leading to cerebral oedema) despite it being the only confirmed diagnosis at the time.

In October 2004, Ulster TV aired a documentary about the deaths of three other children from hyponatraemia and the following month a public inquiry was set up, under the chairmanship of John O'Hara QC (as he was

then). Claire's parents saw the documentary and contacted the hospital. In order to respond to questions they raised (over fluid management in particular), the Claimant - Professor of Medicine at Queen's University, Belfast - was asked to review the notes of Claire's treating consultants. In December 2004 he met with Mr and Mrs Roberts and in January 2005 contributed to an "explanatory" letter to them. In May 2006 he gave evidence at the inquest convened to investigate Claire's death.

In January 2018 the Inquiry's report into hyponatraemia-related deaths was published. Claire's treating consultants, Dr Steen and Dr Webb, were heavily criticised and accused of covering-up failures in treatment. The Claimant also faced criticism. At the December 2004 meeting he was said to have failed to acknowledge "*the very many failings in care"* despite having formed the view that monitoring had not been sufficiently frequent given the severity of Claire's condition. This "lack of openness" was reflected in the January 2005 letter (authored largely by Dr Steen) which was described in the Report as *"inaccurate, evasive, and unreliable."* The letter contained the "*misleading*" assertion that the "*normal procedure*" in 1996 was to monitor sodium levels every 24 hours. The Claimant gave substantially the same evidence to the Coroner leading the report to conclude that the Claimant had *"shifted from his initial independent role … to one of protecting the hospital and its doctors".*

These criticisms led to two charges of professional misconduct relating to the "highly questionable" content of the January 2005 letter and "misleading evidence" given to the May 2006 inquest.

In November 2018, an Assistant Registrar (AR1) considered the five-year limitation period in Rule 4(5) of the GMC (Fitness to Practise) Rules 2004 and decided that the public interest in investigating "*these concerns*" was insufficient to justify waiving the 5-year rule. Other countervailing considerations included the large lapse of time, and the low risk to the public given the absence of any "*fitness to practice history*" (i.e. prior misconduct) and the Claimant's skills, knowledge and professional achievements.

On being informed of the GMC's decision to take no further action, Mr Roberts sought its review.

On review, the second Assistant Registrar (AR2) found the decision of AR1 to be materially flawed within the meaning of Rule 12(2)(a). She took a fresh decision, "*waiving*" the 5-year limitation period and adding an additional charge relating to the Claimant's communications with Mr and Mrs Roberts at the December 2004 meeting.

The Claimant challenged this decision by way of judicial review, but applying *Wednesbury* principles, the court upheld AR2's assessment and decisions. AR1's decision *was* materially flawed: the most fundamental error being his assessment of the gravity of the allegations and his approach to public interest factors. Simply put, AR1 had misread the O'Hara Report and misunderstood the nature and gravity of the criticisms levelled against the Claimant.

He wrongly thought the Inquiry's main criticism was a failure to review the accuracy of sections of the January 2005 letter to which Dr Steen contributed but which fell outside the Claimant's specialist expertise. He failed to address criticisms levelled directly against the Claimant of *omissions* in the letter and in the December 2004 meeting which preceded it.

As the court put it "*the Inquiry's findings were significantly more serious than AR1 had appreciated*." In particular, AR1's decision gave no proper consideration or evaluation of the key point: the Claimant's absence of candour in circumstances where the duty had special importance, namely when providing information to the family of a patient who has died while undergoing treatment in a hospital and to a Coroner investigating that death. The allegation the Claimant faced was *"of deliberately misleading the family of a deceased child and a Coroner in relation to cause of death".*

Granted, said the court, the purpose of the 2004 Rules is to protect doctors. But regard must also be had to the overarching objectives of the GMC: to protect the public, ensure proper professional standards, and *promote and maintain public confidence in the medical profession* (emphasis added). These were, the court found, very serious matters going to heart of public's confidence in the profession. AR1 had *"failed to appreciate the*

significance of the alleged lack of candour in dealings with Mr and Mrs Roberts and the Coroner, and if substantiated, its effect on maintaining public confidence in the profession".

AR1's reasoning on the issue of delay was also materially flawed. It was agreed that the complaint could not sensibly be raised until the Inquiry had reported which created significant delay. Irrationally however, AR1 considered this weighed *against* waiver of the 5- year rule, whereas logically it was a factor pointing *in favour* of waiver. Further, the absence of a transcript of the inquest proceedings should not have weighed heavily against waiver. AR2 recognised some prejudice but noted that AR1 had found that the absence *could* prevent a fair and just inquiry but not that it *would*. If at the next stage Case Examiners did not think a fair trial possible, they would not refer an allegation to a Tribunal.

The court also dismissed the irrationality claims directed against AR2's decision. She was correct to note that while criticisms of the Claimant's conduct had been aired ("*prior ventilation*"), the Inquiry's investigation did not address how any lack of candour might affect fitness to practice, which was a matter for the GMC alone. Similarly, there was no error in her approach to the Claimant's regulatory history and she reminded herself that such matters, going to personal mitigation, have less significance than the maintenance of public confidence in the profession.

The court's final conclusion was strongly expressed: notwithstanding the forensic skill deployed by Rob Kellar QC (of these Chambers), *"there was no legal basis upon which the court could possibly interfere with the decisions of AR2".*

Haris v General Medical Council [2021] EWCA Civ 763

In *Haris v General Medical Council* [2021] EWCA Civ 763, the Court of Appeal upheld a decision that a sexual motivation was the only rational conclusion to draw from a Medical Practitioners Tribunal (MPT)'s finding that a GP had performed non-clinically indicated, intimate examinations without consent.

Before the MPT, Dr Haris denied that incidents described by two female patients had occurred, but the MPT found they did. They took place a couple of weeks apart, one in Lancashire and one in the minor injuries unit of a Yorkshire Hospital and collusion between complainants was ruled out. The "examinations", performed without gloves, bore a striking similarity. Although the MPT found that they could "*reasonably be perceived as overtly sexual*" it went on to conclude that the GMC had not proved that the conduct was sexually motivated. In doing so, it appeared to rely on evidence that Dr Haris suffered from Asperger's syndrome and had no interest in sexual matters, despite an acceptance in cross-examination that the diagnosis was not inconsistent with having sexual urges or feelings and did not mean he was *incapable* of having a sexual motivation for behaving as he did.

Having found the Claimant's fitness to practice impaired, the MPT imposed conditions on his registration for 12 months.

The GMC appealed successfully to the High Court under s.40A of the Medical Act 1983. The GP in turn appealed, unsuccessfully. Before dismissing the appeal, the Court confirmed Foster J had correctly identified the following principles:

(1) The appellate court may interfere with an evaluative decision (as here) if there is an error of principle or if the decision fell outside the bounds of what an adjudicative body could properly and reasonably decide: *Bawa-Garba v GMC* [2019]; and

(2) The court will be especially cautious about upsetting conclusions of primary fact which depend on an assessment of the credibility of witnesses, but it is under less of a disadvantage when the question is what inferences are to be drawn from specific facts (as here): *GMC v Jagjivan* [2017].

The Court of Appeal upheld Foster J's finding that the reasoning of the MPT was flawed. It had become muddled about the burden of proof. "*This was not a case*", the court observed, *"which turned on who bore the burden of proof. The only question was whether it was more likely than not that that the doctor's actions were sexually motivated"*. It explained, *"[T]he best evidence as to motivation was the behaviour itself: it was not just capable*

of being perceived as overtly sexual it was overtly sexual, and there is no other way in which it could have been perceived".

Dr Haris' claimed asexuality "did not begin to explain why he groped a patient's buttocks and breasts and performed physical examinations of her vagina and (on another occasion) that of another patient, in each case without any clinical justification, without warning or obtaining prior consent, without giving or recording any reason for it at the time and without using gloves. In the absence of a plausible explanation for what he did, the facts spoke for themselves. A sexual motive was plainly more likely than not." In fact, the court concluded *"that that inference was overwhelming."*

But even beyond the GP's behaviour, the court noted, there were additional relevant factors from which inferences could properly have been drawn, which the MPT failed to consider. The GP's defence, it said, was of "*obvious significance*". He had not claimed to have touched the women believing it to have been clinically justified, or that any touching was accidental. He denied any intimate touching and said they had made up the allegations. The MPT's determination failed to consider how accusing these women of lying might affect the question of motive and the GP's professed lack of interest in sex. The "*obvious inference"* from false denial was that he knew there was no innocent explanation for what he had done.

Bux v General Medical Council [2021] EWHC 762 (Admin)

In *Bux v General Medical Council* [2021] EWHC 762 (Admin) Mostyn J upheld the decision of a MPT to direct the Appellant's erasure from the medical register after finding he had written sub-standard, non-CPR-complaint medico-legal reports for a solicitors' firm where his wife was a salaried partner and, when challenged, gave answers which were deliberately false.

The scheme in issue had "*all the hallmarks of a corrupt practice*", said the judge. A claimant would instruct AMS Solicitors to bring a claim against a travel company on a conditional fee basis alleging they had suffered food poisoning on holiday. In support the Claimant wrote medico-legal reports described by the court as *"superficial, unanalytical, devoid of differential diagnoses"* and *"invariably supportive of the claim".* They were also produced "*on an industrial scale*": between 2016 and 2017 he wrote 684 reports, for which he was paid £123,120 plus VAT. The defendant would pass the claim to its insurers who generally paid out the small level of damages claimed.

Eventually complaints reached the GMC about the Claimant's failure to disclose a connection with AMC Solicitors and the lack of evidential base or reasoning in his reports, which led in turn to his erasure.

The central ground of appeal alleged there was no conflict of interest, the issue having been decided by a preliminary-issue judgment of HHJ Gregory in the County Court in a claim where the Appellant acted as an expert witness. Consequently, it was argued, there was no duty to disclose and the findings on dishonesty and financial motive could not stand.

In dismissing the claim, the court noted the duties of an expert witness in civil proceedings to give an objective, unbiased opinion which carries with it an obligation to disclose any actual or potential conflicts of interest. A conflict, said the court, will arise when an expert witness's opinions are either (1) actually influenced, or (2) capable of being influenced, by his personal interests. The existence of a conflict doesn't necessarily disqualify an expert or render his evidence inadmissible or of no weight. But the court must be made aware of the conflict as soon as possible, to enable it and the other parties to assess its implications. In this regard, there is a high duty of candid disclosure on an expert witness, as justice must not only be done but be seen to be done.

A "*linchpin*" of the appeal was the preliminary issue judgment. The MPT, after considering all the evidence before it, including judgment of HHJ Gregory had found there was an actual conflict of interest. The Appellant argued it was a serious procedural irregularity not to adopt HHJ Gregory's ruling which, it was said, did not find an actual conflict of interest.

The court upheld the MPT's decision. The preliminary issue judgment was *admissible* in inquisitorial regulatory proceedings pursuant to r.34(1) of the 2004 Rules, said the court, but plainly it was not *binding*. Furthermore,

whilst perhaps the finding on conflict was not a model of clarity, the judge had clearly found a real risk of a conflict of interest and ruled the report inadmissible as not being CPR-compliant. Critically however, the MPT had additional evidence before it which the judge hadn't seen.

In one of the complaints before the MPT, the Defendant insurers had challenged the Appellant's report and raised questions about the Appellant's connection to AMS Solicitors. In response the Appellant asserted that the MDU had assured him he was following regulatory guidelines. This was a "*seriously inaccurate answer*": the MDU had in fact advised him to declare his connection as a failure to do so might be considered a conflict of interest and a breach of his professional obligations. This dishonesty, said the court, irrespective of the decisions on other charges, would have justified the sanction of erasure. As it was, in light of all the evidence, the court considered that it would have been "*perverse and wrong for the MPT to have decided anything other than that the appellant had an actual, serious, conflict of interest"* [83].

As to the other charges, the MPT was correct to find the reports were improperly written and failed to comply with CPR requirements: the diagnoses lacked sufficient evidence, they failed to acknowledge contemporaneous consultations, and gave no reasoning other than reciting information provided by the claimant. Similarly, its conclusion that the conduct complained of was dishonest and financially motivated, was sound. In *"a throwback to the old law*", i.e. before the Supreme Court's decision in *Ivey v Genting Casinos (UK) Ltd (t/a Crockfords)* [2017], the MPT ruled that the Appellant knew what he was doing was dishonest. This was not required. The findings that he knew what he was doing and that ordinary decent people would consider his conduct dishonest (the objective standard) was sufficient. In the light of these findings, impairment and erasure were inevitable.

Gupta v Northampton Hospital Trust [2021] EWHC 965 (QB)

In *Gupta v Northampton Hospital Trust* [2021] EWHC 965 (QB) the High Court dismissed a consultant oncologist's challenge to his suspension pending the outcome of investigations into misconduct allegations, applying the three-limb *American Cyanamid* test for granting interim injunctions.

The Claimant's speciality was urological cancer. He treated patients at Northampton General Hospital where he was employed, and in the private sector. In early 2020, concerns were raised that he was promoting private services to patients attending his NHS clinic and later that he had received large sums for additional duty hours that were not authorised. When alerted, the Local Counter Fraud Services requested his suspension but instead, and without bringing the investigation to the Claimant's attention, measures were put in place to prevent him signing off his own hours.

At the end of 2020, the wife of a seriously unwell patient (GG) disclosed to a nurse that the Claimant had been billing her husband privately for short, weekly telephone calls. In response, the Defendant's Medical Director, Mr Metcalfe, initiated an investigation under the Trust's Medical Staff Concerns Policy.

In January 2021 the Claimant was informed that he was under investigation but was not, at that time, suspended. Mr Metcalfe gave evidence that, by the end of March, he was aware of evidence from GG's family that the billed calls were when the patient was on an end of life pathway and had no clinical value. There were concerns about other patients. Mr Metcalfe also became aware that the Claimant may have been seeking to interfere with the investigation by contacting GG's wife and asking if they had put in a complaint against him.

In accordance with the Trust's disciplinary and capability procedures, Mr Metcalfe took advice from the Practitioner Performance Advice service (PPA), then exercised his discretionary power to "*exclude*" the Claimant. This prompted the Claimant's application for an interim injunction with an order directing his reinstatement. A further order was sought to prevent the Defendant from contacting or sharing information with the Claimant's private work providers, alleging this would breach his rights under Article 1 of the First Protocol to the European Convention on Human Rights (AP1).

The legal framework was mostly agreed:

i. To succeed C had to show the decision to suspend was unreasonable or irrational: *Jahangiri v St George's University Hospitals NHS Foundation Trust* [2018];

ii. Suspension without reasonable grounds may amount to a breach of contract or breach of the implied term of trust and confidence: *Braganza v BP Shipping Ltd* [2015].

It was also common ground that damages would not provide an adequate remedy in the event the Claimant succeeded given the impact of exclusion on his professional reputation.

As to the AP1 claim, the court accepted the Defendant's submission that it added nothing to the contractual position following *Braganza*: an unjustified interference with the Claimant's private practice would be a breach of the implied term of trust and confidence.

In the event, the claim fell at the first hurdle. The court was not satisfied that there was serious issue to be tried that the exclusion was unlawful. The allegations against the Claimant were very serious and the available evidence was cogent. It was not just a dispute about charges and potentially defrauding the Defendant. There were safeguarding concerns which, put bluntly, amounted to an allegation of financially abusing a terminally ill patient.

The decision to exclude was taken cautiously and in a considered way. Although the Defendant should have given fuller reasons at the time, on the evidence the court considered the Defendant entitled to exclude the Claimant in order to safeguard patients and guard against the risk of the Claimant impeding the investigation. The Defendant was required to keep the exclusion under review and given the approach of Mr Metcalfe to date, in the court's view there was no reason to think this wouldn't be done.

Finally, as to the claimed prohibition on informing other organisations, the court rejected this too. It noted Mr Metcalfe's evidence that although the Trust's policy did not address this specifically, requirements to notify others had strengthened after the Paterson Inquiry and he felt under an obligation to do so. In the event, a private hospital where the Claimant practiced contacted the Defendant to say concerns had been raised there. Further, the terms of the Claimant's practising privileges required him to notify his exclusion by his NHS Trust. Finally, the court accepted the proposition that "*transparency is important in the medical context and the sharing of information, provided it is done in good faith, is to be encouraged*." The Defendant acted rationally and in good faith so again there was no serious issue to be tried. Accordingly the claim was refused.

Robert Kellar QC acted for the Claimant in Young. He did not contribute to this article.

DISHONESTY AND DENIAL

Richard Smith

Towuaghantse v GMC [2021] EWHC 681 (Admin)

Al Nageim v General Medical Council [2021] EWHC 877 (Admin)

The steady stream of appeals to the High Court from the Medical Practitioners Tribunal ("MPT") against findings of dishonesty shows no sign of abating. Two recent cases have produced and illustrated guidance suggesting a more nuanced approach to unsuccessful denials of dishonesty than had hitherto been the case.

Dishonesty

The test for dishonesty in professional regulatory tribunals is now settled as that laid down in *Ivey v Genting Casinos* [2017] UKSC 17. This requires the fact-finding tribunal to ascertain (subjectively) the actual state of knowledge or belief on the part of the accused registrant and then to ask the question whether their conduct was honest or dishonest. The latter question is assessed according to the objective standards of ordinary decent people. The view of the person accused of dishonesty as to whether their conduct was dishonest is irrelevant (which had not previously been the case prior to *Ivey* under the prevailing test in *R v Ghosh (Deb Baran)* [1982]

QB 1053). Thus, the standard to be applied when assessing dishonesty is not subjective and should be the same in every case.

This might also mean that the accused person might genuinely not have understood that what they did would be considered dishonest by the standards of ordinary decent people, but that rarely reflects well on them.

The issue

A question that frequently arises in regulatory tribunals is what the consequence should be for a registrant who denies the charge, but whose evidence is rejected. Should the fact that the charge was denied, and the version of events which was disbelieved persisted with, count against the registrant when considering whether their fitness to practice is impaired and, if so, what the appropriate sanction should be?

This is a question of particular importance given the weight that regulators tend to place on the registrant's insight into what brought them before the Tribunal. If they have denied a central and fundamental aspect of the case against them then must this lack of insight into their wrongdoing be held against them over and above the wrongdoing itself?

It is essential to bear in mind when considering this question that regulatory proceedings are not a binary process of establishing guilt or its lack, and going on to sentence in the former case. A regulatory tribunal such as the MPT will make findings of fact, before going on to consider whether those findings amount to serious fault on the part of the registrant and whether that in turn translates to a current impairment of fitness to practice. There are shades of grey within a finding of impairment, depending on the gravity of the wrongdoing, and the record of the registrant. These shades of grey find their expression within the tribunal's determination on sanction, which will also consider any remediation undertaken, and which might encompass erasure from the register, suspension or practising under conditions.

Findings of dishonesty are always serious and will usually result in a finding of impairment, but the variety of factual scenarios underpinning such findings mean that tribunals will not find themselves obliged to order erasure in every case. There is a recognition that some dishonesty is worse than others.

What has been less clear is when or if the tribunal should ever show any degree of understanding for a registrant who has unsuccessfully maintained a denial of the facts charged. This is especially so when, e.g. in the MPT, the tribunal are enjoined by their Sanctions Guidance to see failures to accept their mistakes, or tell the truth during the hearing, as aggravating features.

The recent case law suggests the approach in the Sanctions Guidance is not of universal application and should not be taken at face value.

The recent cases

In *Towuaghantse v GMC* [2021] EWHC 681 (Admin), the registrant Consultant Paediatric Surgeon was accused of serious errors in the delivery of a baby suffering an exomphalos, resulting in death. He was an experienced surgeon with an otherwise blemish-free career. He disputed findings made at the inquest, he disputed the opinion of the GMC expert and disputed the witness evidence of colleagues present at the time of the underlying events. The MPT rejected his evidence and found that Mr Towuaghantse's care for the baby fell seriously below the standard required.

When considering whether this failing impaired Mr Towuaghantse's fitness to practice, the MPT noted the following as relevant features:

> *"In particular, Mr Towuaghantse failed to accept any of the Coroner's findings"* [14]
>
> *"[The MPT] could not ignore the fact that, particularly at the first stage of the hearing when the Tribunal was considering the facts, Mr Towuaghantse had tried to attribute to others at least some of the responsibility for what had happened to Patient A. In the judgment of the Tribunal, that was a particularly regrettable feature of the case."* [60]

The MPT did not find that Mr Towuaghantse had been dishonest but did reject his evidence on the central facts of the case. In this regard, Mostyn J said at [61] and [63]:

> *"It is clear to me that a significant component in the decision-making process, both as to determination of impairment of fitness to practise, and in the imposition of the sanction of erasure, was the conclusion that the appellant was to be seriously faulted for (a) having contested the allegations against him at the inquest, and not having accepted the Coroner's findings, and (b) having contested the allegations against him at the MPT. The pleas of not guilty (in effect) in both courts were clearly regarded by the MPT as evidence of an incapacity to remediate and therefore of a risk to the public, as well as an aggravating feature contributing to the award of the ultimate penalty.*
>
> *…*
>
> *In my judgment it is not procedurally fair for a registrant to face the risk of enhanced sanctions by virtue of having robustly defended allegations made against him before the MPT, or before another court."*

This built on the approach that the same judge took to the case of General Medical Council v Awan [2020] EWHC 1553 (Admin), where he said at [37]:

> *"I think it is too much to expect of an accused member of a profession who has doughtily defended an allegation on the ground that he did not do it suddenly to undergo a Damascene conversion in the impairment phase following a factual finding that he did do it. Indeed, it seems to me that to expect this of a registrant would be seriously to compromise his right of appeal against the factual finding, and add very little, if anything, to the principal allegations of culpability to be determined."*

Mostyn J went on, in *Awan*, to say that an accused professional has the right to advance any defence he or she wishes and is entitled to a fair trial of that defence without facing the jeopardy, if the defence is disbelieved, of further charges or enhanced sanctions.

In *Towuaghantse*, Mostyn J acknowledged that paragraph 52 of the Sanctions Guidance provides that *"a doctor is likely to lack insight if they … failed to tell the truth during the hearing (this includes being dishonest or misleading)",* that this had been approved in previous cases before the High Court (e.g. by Yip J in *Yussuff v GMC* [2018] EWHC 13 (Admin)) and conceded that this was hard to square with his analysis. This brought His Lordship to the following conclusion at [71] to [72]:

> *"I can see, were a defence to be rejected as blatantly dishonest, then that would say something about impairment and fitness to practise in the future.* ***But there would surely need to be a clear finding of blatant dishonesty for that to be allowed****. Absent such a finding it would, in my judgment, be a clear encroachment of the right to a fair trial for the forensic stance of a registrant in the first phase to be used against him in later phases.*
>
> ***In my judgment a distinction should be drawn between a defence of an allegation of primary concrete fact and a defence of a proposed evaluation (or exercise of a discretion) deriving from primary concrete facts. The former is a binary yes/no question. The latter requires a nuanced analysis by the decision-maker with a strong subjective component.*** *If a registrant defends an allegation of primary concrete fact by giving dishonest evidence and by deliberately seeking to mislead the MPT then that forensic conduct would certainly say something about impairment and fitness to practice in the future. But if, at the other end of the scale, the registrant does no more than put the GMC to proof then I cannot see how that stance could be held against him in the impairment or sanctions phases. Equally, if the registrant admits the primary facts but defends a proposed evaluation of those facts in the impairment phase then it would be Kafkaesque … if his defence were used to prove that very proposed evaluation. It would amount to saying that your fitness to practise is currently impaired because you have disputed that your fitness to practise is currently impaired."* [emphasis added].

Thus, the judge constructed a spectrum between defending a case on the basis of a blatant lie at one end and putting the GMC to proof at the other; there are clearly myriad positions in between, but the judgment could

be read as saying that the defence should only be held against the registrant if their evidence was blatantly dishonest. Had the judge intended that any dishonesty could be held against the registrant then (a) he would not have needed to use the adjective 'blatant' to qualify it (several times) and (b) he would have said so in terms. Does this require the MPT to ignore the line taken in response to the facts when they consider impairment and sanction in cases where the dishonesty is not 'blatant'? If so, the boundaries of this concept will need to be tested.

A more extreme argument might be that the approach allows different positions for different sorts of dishonesty. As noted above, the test for dishonesty involves applying objective standards to the registrant's subjective state of knowledge; the judge here appears to be advocating a further subjective consideration as long as the dishonesty does not relate to a primary concrete fact (however that is defined). For instance, a dishonest explanation of an uncontested primary fact. This would be surprising, but the approach in the judgment would arguably allow for it.

Mostyn J's application of his approach to the facts of the case before him lead to the conclusion that Mr Towuaghantse's denial of the charge should not have been used as a basis for a finding that he lacked insight or was incapable of remediation because there was no finding of blatant dishonesty on his part, only that the evidence of the other witnesses was preferred. This is, as the judge emphasised, perfectly normal in a forensic process and does not require a condemnation as a liar of the witness whose evidence has been rejected.

Nevertheless, this conclusion is directly contrary to the MPT's standard approach as set out in paragraph 52 of the Sanctions Guidance.

As he had in *Awan,* Mostyn J said that the position was most acute where the decisions on impairment and sanction had followed on directly from the fact-finding stage [77]:

> *"it is unrealistic to expect a registrant who has unsuccessfully defended the fact-finding phase then almost immediately in the impairment phase to demonstrate full remediation by fully accepting in a genuinely sincere manner everything found against him. In my opinion the capacity of the registrant to remediate sincerely should be judged by reference to evidence unconnected to his forensic stance in the fact-finding stage (unless the fact-finding decision included findings of blatant dishonesty by the registrant)."*

In practical terms, this approach is likely to be problematic since insight is integral to remediation. The demonstration of insight in the eyes of the MPT involves a registrant accepting that they should have behaved differently, showing empathy and understanding (Sanctions Guidance para 46). In the absence of this, the MPT will rarely if ever find that a registrant has adequately remedied, or be capable of remedying, the issues which led to the charges (which would be unsurprising if there is no recognition of a problem).

Al Nageim v General Medical Council [2021] EWHC 877 (Admin)

The opportunity for consideration of the approach adumbrated by Mostyn J arose very soon in *Al Nageim v General Medical Council* [2021] EWHC 877 (Admin). In that case the doctor was found to have been dishonest (i) in continuing to use staff accommodation at Wrexham Maelor Hospital after ceasing to work there as a locum and (more strikingly) (ii) continuing to receive payments from the Liverpool Victoria Hospital for over 27 months after ceasing work there (obtaining in excess of £41,000 in the process). Dr Al Nageim admitted the facts but denied that he had been dishonest. This was rejected by the MPT in strong terms.

On appeal, it was argued that the MPT should not have taken into account Dr Al Nageim's stance at the fact-finding stage when concluding that he lacked insight into his wrongdoing and would be incapable of remedying it. The judgment in *Towuaghantse* was handed down after the hearing in this case and both parties made written supplemental submissions, with Dr Al Nageim's representatives contending that it bolstered their case. The GMC, by contrast, argued that the MPT is entitled to take into account dishonest evidence given on oath when considering impairment and sanction on the basis of the law before and after *Towuaghantse*. Interestingly, the

GMC did not seek to argue for the wider point made in paragraph 52 of the Sanctions Guidance (that any contradicted evidence can be seen as indicating a lack of insight), but in this case they did not need to.

After a detailed consideration of the judgment in *Towuaghantse,* Julian Knowles J applied the approach set out in that case, concluding that, even though the MPT did not use the phrase 'blatantly dishonest', that was an apt description for Dr Al Nageim's evidence. Fitting the facts to the terms of Mostyn J's test, he had dishonestly denied primary concrete facts as the MPT found that he did not genuinely believe either that he was entitled to use staff accommodation or to continue to receive payments after he had ceased his employment (which the judge described as egregious dishonesty).

The judge's ultimate conclusion is not surprising. The interesting point in this case is that Julian Knowles J could have doubted Mostyn J's approach in *Towuaghantse* and reverted to the approach taken in earlier cases such as *Yusuff,* endorsing the Sanctions Guidance. He did not do so, albeit it does not appear that the GMC argued strongly that he should. That argument may yet be made on another day – alternatively, the GMC may decide (yet again) to amend the Sanctions Guidance and incorporate the *Towuaghantse* approach.

As matters stand, there would seem to be a good basis to deploy this approach in the MPT and in any regulatory tribunals operating in a comparable way to the MPT.

TESTING THE BOUNDARIES OF CAUSATION IN MESOTHELIOMA DEATHS

Caroline Cross

Wandsworth BC v HMC for Inner West London [2021] EWHC 801 (Admin)

Mesothelioma deaths arising from asbestos regularly come before coroners. This case, though, is of particular interest because it tests the boundaries of causation in relation to mesothelioma deaths – what evidence is needed to show that asbestos exposure led to that specific death?

The issue before the court was whether the coroner was entitled to conclude that it was probable, as opposed to merely possible, that the deceased had developed the mesothelioma that caused and led to her death as a result of exposure to asbestos while living in the council's property.

It was concluded that in the circumstances, the evidence had been insufficient and the relevant findings in the Record of Inquest were altered.

Facts

Mrs Johns and her daughter moved into the council's flat at 8 Eliot Court in July 1996. Twelve years previously, in 1984, asbestos had been detected in the flat. In October 2003 the council instructed contractors to remove the asbestos. While the work was being done, Mrs Johns and her daughter moved out. However, during the works a vacuum cleaner used by the contractors 'exploded', soaking a number of pieces of furniture, the carpet and personal possessions with a polymeric substance. On their return to the flat, they discovered the scene, as described by her daughter: "It looked as if something had happened whereby what [the vacuum] was meant to do was to vacuum dust up but what it had in fact done is blown it out…". She could not recall whether her mother cleaned up the mess, but assumed she had. The contractors and council settled her claim for the damage to her possessions.

Mrs Johns lived at 8 Eliot Court until June 2017 before moving to a new address. In June 2018 she attended her GP, complaining of backache. Her condition deteriorated rapidly, and in July 2018 she was diagnosed with metastatic adenocarcinoma. She died on 27 August 2018 aged 51. The consultant pathologist concluded that she had died of bronchopneumonia, which had resulted from malignant mesothelioma, a form of cancer that affects the lining of the lungs.

An inquest was opened into her death because she had lived for many years in a council-owned property that had contained asbestos. The pathologist, Dr Coumbe, was called to give evidence at the pre-inquest review hearing – itself "*an irregular way of proceeding*", given that the Chief Coroner's Guidance on pre-inquest reviews states that no evidence should be called or witness asked to attend [15].[3] He gave evidence that there was "*an extremely strong association" between asbestos dust exposure and malignant mesothelioma*". Further, he was "*entirely satisfied on the balance of probabilities*" that exposure to asbestos while Mrs Johns was living at 8 Eliot Court had led to and caused the malignant mesothelioma from which she had died [20]-[21]. However, he did not consider that the vacuum cleaner dust explosion could have caused or contributed to the death.

The coroner found that Mrs Johns had, on the balance of probabilities, been exposed to asbestos at her flat. She also stated that "*I am also entirely satisfied that malignant mesothelioma virtually never arises without exposure to asbestos and therefore Linda's malignant mesothelioma was caused by exposure to asbestos and that this occurred whilst she was resident at number 8 Eliot Court and that this exposure to asbestos has led to and caused her death by causing her to develop malignant mesothelioma*." [25]. She recorded a short narrative conclusion that Mrs Johns had died from "*exposure to asbestos whilst resident at 8 Eliot Court, causing malignant mesothelioma*".

The Claimant council did not raise concerns at the time, but challenged the coroner's findings and conclusions after the inquest. They argued that the totality of the evidence was not sufficient to justify a conclusion on the balance of probabilities that Mrs Johns had developed malignant mesothelioma as a result of exposure to asbestos at 8 Eliot Court. The council gave six reasons in support of their position [35]:

> *"(i) as a matter of generality, living in a property that contains asbestos does not constitute exposure to asbestos;*
>
> *(ii) there was no positive evidence that Mrs Johns had ever been exposed to freely circulating asbestos fibres at any time during her tenancy at 8 Eliot Court;*
>
> *(iii) although malignant mesothelioma is often caused by exposure to asbestos, there are other possible causes which the evidence did not adequately exclude or address;*
>
> *(iv) even if Mrs Johns had developed malignant mesothelioma as a result of such exposure, it could have occurred elsewhere than at 8 Eliot Court;*
>
> *(v) the coroner was wrong to rely upon Dr Coumbe's evidence that it was "reasonable to assume" that exposure to asbestos at 8 Eliot Court had caused Mrs Johns's malignant mesothelioma, because that was not a matter on which Dr Coumbe was qualified or entitled to express an opinion; and*
>
> *(vi) the coroner failed to apply the 'Galbraith plus' test by asking herself, first, whether there was sufficient evidence upon which to conclude that Mrs Johns developed malignant mesothelioma as a result of exposure to asbestos at 8 Eliot Court and, second, whether such a finding or conclusion was safe."*

The Claimant also argued that the totality of the evidence was not sufficient to justify a conclusion on the balance of probabilities that Mrs Johns had developed malignant mesothelioma as a result of exposure to asbestos at 8 Eliot Court.

The court unanimously agreed with the Claimant council. In the judgment of the Chief Coroner, HHJ Teague QC (with whom Popplewell LJ and Cavanagh J agreed), the Tainton test for causation in the coroner's court was initially cited, namely *"… whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to death*": *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin), at [41].

[3] Chief Coroner's Guidance No. 22, 18 January 2016, [16].

Notably, the test in civil proceedings is different: it is not necessary to establish that a particular exposure to asbestos was responsible for causing mesothelioma: liability "*falls on anyone who has materially increased the risk of the victim contracting the disease*": *Fairchild v Glenhaven Funeral Services Ltd and Others* [2003] 1 AC 32.

However, the court emphasised that that principle has no application in coronial investigations, where it is clear that the relevant event "*must make an actual and material contribution to the death of the deceased*": *R (Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] EWHC 1396 (Admin), at [62]." [33].

The court posed two questions: first, whether there was evidence upon which the coroner could properly find, on the balance of probabilities, that the mesothelioma from which Mrs Johns died had resulted from exposure to asbestos fibres; and second, if so, whether there was evidence upon which the coroner could properly find, on the balance of probabilities, that such exposure had taken place while Mrs Johns was living at 8 Eliot Court [38].

The court concluded that it could not be inferred that Mrs Johns' malignant mesothelioma was caused by exposure to asbestos fibres. Even though there is a statistical association, it is not absolute: specific evidence is required in each case. Further, living in close proximity to products or materials that happen to contain asbestos does not necessarily entail exposure to asbestos fibres. Mrs Johns and her daughter were not present when work was carried out to remove the asbestos. In addition, the pathologist ruled out that the vacuum cleaner dust explosion could have caused or contributed to her death. As such, the coroner rightly concluded that Mrs John's exposure to asbestos whilst living in the flat was no more than a possibility. However, she erred in finding that Mrs Johns must have been exposed to free circulating asbestos fibres at some point during her occupancy of the flat [39]-[41].

The court went on to say [42]:

> *"Mrs Johns' illness was certainly consistent with exposure to asbestos fibres. The time interval between 2003 and the diagnosis of metastatic adenocarcinoma in 2018 was consistent with the long latency period associated with such exposure. By reference to the fact that Mrs Johns had no history of paid employment, it was possible to exclude an industrial origin for her illness. But those factors, even taken together, could establish no more than a possibility that Mrs Johns' mesothelioma was the result of exposure to asbestos fibres at 8 Eliot Court. They could not support a finding on the balance of probabilities that such exposure had in fact taken place or, if it had, that it had caused her malignant mesothelioma."*

In addition, even if she had been exposed to freely circulating asbestos fibres in October 2003, it was not safe to assume that Mrs Johns had never been exposed to another source of such a commonplace material between 2003 and her diagnosis. As such, the evidence did not support a conclusion that Mrs Johns had contracted malignant mesothelioma as a result of exposure to asbestos fibres while she was living at 8 Eliot Court.

Therefore, the court quashed the findings and the finding in box 3 was substituted with the words "*Linda was diagnosed with malignant mesothelioma in July 2018 and despite treatment this led to and caused her death on 27 August 2018 at St George's Hospital".*

Comment

Two points are relevant. First, it is interesting to note the difference in the causation tests between civil and coronial proceedings. In a civil claim in relation to mesothelioma, it is only necessary to show that the defendant materially increased the risk of the victim contracting the disease, whereas the test is stricter in coronial proceedings: it must be shown on the balance of probabilities that the event made an actual and material contribution to the death.

Second, the court stated that it was not necessary for the coroners' court to carry out an "exhaustive forensic enquiry" [29] that would be undertaken during adversarial litigation. It is not the coroner's role to look at all issues – nor indeed do they have the time or resources. That should be left to civil proceedings. But this case

does highlight the limitations of a coronial investigation, in particular that conclusions must be supported by the evidence.

Peter Skelton QC appeared for the Claimant at the High Court in this matter. He was not involved in the writing of this article.

THE JUSTICE COMMITTEE REPORT INTO THE CORONER SERVICE – IS A LONG OVERDUE OVERHAUL IN THE OFFING?

Rory Badenoch

The House of Commons Justice Committee – The Coroner Service – First Report of Session 2021-2022

On 27 May 2021, following an inquiry into the effectiveness and capacity of the Coroner Service in England and Wales, the House of Commons Justice Committee published a report calling for a number of "*fundamental*" reforms to be made to the service, most notably that there should be a legal "*equality of arms"* during inquests, with bereaved people having an automatic right to public funding for legal representation. Some of the key findings and recommendations relevant to medical law practitioners are addressed below.

Background

There are 85 local Coroners' services throughout England and Wales, all of which are administered and funded by local authorities. There have been continued calls for more than 20 years for a national Coroners' service, including from Dame Janet Smith after the Harold Shipman inquiry and the Luce Review.

The Coroners and Justice Act 2009 ["CJA 2009"], implemented in 2013, provided for the appointment of a Chief Coroner to give national leadership to coroners but not a national service. The CJA 2009 also contained provisions for the Coroner Service to be inspected by the Inspectorate of Courts Administration (excluding inspection of judicial decisions) and for a system of appeals to the Chief Coroner from coroners' judicial decisions. Neither was implemented, each has since been repealed, and the Inspectorate of Courts Administration was abolished in 2011. The Ministry of Justice reviewed the effectiveness of the CJA 2009 in 2015 but has not published the results or conclusions of that review.

The findings

The Committee found that there have been substantial improvements to the Coroner Service since the 2009 Act was implemented in 2013, including guidance and mandatory training for all coroners and coroners' officers, appraisals for Assistant Coroners, and improved consistency by amalgamation of smaller areas. The Committee also highlighted that the Coroner Service had responded well to Covid-19.

However they made a number of critical findings which included, inter alia, the following:

- Help and support for bereaved people is variable between coroner areas and depends on the priorities, capacity and skills of the local coroner service and local volunteers in the Coroners' Courts Support Service which are not consistent.
- There is a lack of consistency in how coroners manage inquests (including pre-inquest review hearings) in particular in relation to the disclosure of documents to bereaved people in advance of the inquest. Bereaved people are at a disadvantage when they do not have access to the evidence, and in order to achieve fairness it is important that the process for obtaining evidence is explained clearly to them.
- The majority of witnesses to the inquiry, two Chief Coroners, and almost everyone who has been commissioned to review aspects of the Coroner Service see the need for a unified service for England and Wales. There is unacceptable variation in the standard of service between coroner areas. The quality of each local coroner service should not have to depend on whether the local authority funding

the service and the Senior Coroner for that local authority's area have a shared understanding and priorities for provision for the service.

- As with calls for a national service for England and Wales, there is an overwhelming and long-standing view that the Coroner Service would benefit from the presence of an inspectorate overseeing its work.
- The failure of health and social care bodies to fulfil their duty of candour to bereaved people during coroners' investigations and inquests is disappointing.
- There is an inequality of arms when it comes to legal representation between public bodies and bereaved people. Bereaved people should not be put through the difficult and time-consuming process of meeting the exceptional cases requirements and the means test for legal aid where public authorities are legally represented at public expense at the inquest into the death of their loved one.
- It is unacceptable that the people who have been bereaved are not entitled to automatic non-means tested legal aid at inquests into multiple deaths following a public disaster. These inquests are complex and 'equality of arms' is a fundamental requirement to make sure those who have been bereaved can participate fully.
- The current arrangements for challenging coroners' decisions are unwieldy and cause unacceptable delays, stress and often expense, for bereaved people.
- There may be circumstances where, with the consent of the bereaved people concerned, it would be sensible for the High Court to be able to direct that the particulars of the Record of the Inquest be amended as appropriate without ordering a fresh inquest.
- The system for the Coroner Service to contribute to improvements in public safety is under-developed. The absence of follow up to coroners' 'prevention of future deaths reports' is a missed opportunity.
- The current arrangements for publishing coroners' reports and responses to those reports require improvement. The information published is the bare minimum and is difficult to search and analyse.

Recommendations

The Committee made the following recommendations in respect of the above findings:

- The MOJ should, as a matter of urgency, provide funding for support services for bereaved people at inquests (such as those provided by the Coroners' Courts Support Service), so that this support is available in every Coroner Area.
- Senior Coroners are encouraged to make sure that bereaved people are made aware by their staff of the specialist support organisations that are available to them both locally and nationally.
- The MOJ should implement a statutory Charter of Rights for bereaved people, modelled on the criminal justice system's victims' code.
- The MOJ should amend the Coroners' Rules to make it patently clear that the duty of candour extends to the Coroner Service. The Government should consider whether a similar duty to be candid at inquests should be extended to all public bodies.
- The MOJ should by 1 October 2021, for all inquests where public authorities are legally represented, make sure that non-means tested legal aid or other public funding for representation is also available for the people that have been bereaved.
- The MOJ should introduce an automatic entitlement to non-means tested legal aid for representation for bereaved people at inquests into mass fatalities.

- The MOJ should introduce a system of appeals similar to that in section 40 of the Coroners and Justice Act 2009 as originally enacted.
- The MOJ should unite coroner services into a single service for England and Wales.
- The MOJ should establish a Coroner Service Inspectorate to report publicly on how well each area accords with the Chief Coroner's 'Model Area', its readiness in case of mass fatalities and the level of service provided to bereaved people.
- Consequent upon the establishment of a national service and an inspectorate, there should be a review of the mechanisms available for handling complaints against coroners.
- The MOJ should provide funding so information about the risks to public safety discovered by coroners and inquest juries is freely available online, along with the actions that have been proposed in response.

Comment

The Committee's conclusion that there "*is a still an unacceptable variation in the standard of service between Coroner areas*" confirms the experience of practitioners in the field. The lack of consistency in the conduct of inquests between Coroner Areas is stark, and the depth and quality of the investigation into the deceased's death remains a postcode lottery.

A coroner in one local authority area investigating a hospital death may hold several pre-inquest review hearings, order extensive disclosure, and instruct three independent experts of varying disciplines to advise on the standard of care and causation, whereas a coroner in a neighbouring area investigating a similar case may provide little disclosure, refuse to obtain any expert evidence at all, and insist that the matter be heard in half a day.

In the absence of any formal route of appeal, and with judicial review of a decision the only option (a costly process with often very limited prospects of success), the result is that unrepresented bereaved families often go to an inquest with incomplete disclosure of medical records, when (without independent medical advice, or any medical knowledge) they are unaware of what more they need, or what the notes and records mean.

In stark contrast the other interested parties to the inquest (e.g. hospital trusts) typically have legal representation, and their representatives can gain an understanding of complex medical issues from their own witnesses, who are often experienced consultants.

The Committee highlighted that in complex inquests like Hillsborough the relevant public authorities – such as the police and medical services – are legally represented at public expense, and that it was unfair that bereaved people should not have similar representation. Practitioners however know that it is not just in the high-profile cases that public authorities are legally represented at public expense.

It is commonplace for hospital/mental health trusts and local authorities to be represented in inquests involving clinical care or mental health. In contrast, representation for most bereaved families must be on a conditional fee basis when it can be extremely difficult, pre-inquest and often with inadequate disclosure and little time for advance investigation, to persuade solicitors of good prospects for an ensuing damages claim.

Many practitioners will agree with the Committee's conclusion that bereaved people should not be put through the difficult process of meeting complex legal requirements – and be means-tested for legal aid – when the public authorities they often face in court are legally represented at tax-payers' expense.

It remains to be seen whether a cash strapped, post-pandemic government will be prepared to accede to the Committee's recommendations. The response from Government is due by 27 July 2021.

A Fresh Inquest – Necessary or Desirable?

Charlotte Gilmartin

HM Senior Coroner for Gwent, Re Inquest into the Death of Vaughn, Re [2020] EWHC 3670 (Admin)

A fresh inquest was ordered by the High Court in circumstances where the Deputy Coroner had been unaware of the presence of a suicide note which later came to light.

Facts

In April 2014, the Deceased was found alive but unresponsive at his home. He had taken a large quantity of paracetamol. He was taken to hospital but sadly died. A mental health team leader who had been treating him for some time attended the property and found a suicide note. He gave the note to the Deceased's brother, to whom it was addressed, and retained a copy and put it with the Deceased's medical records.

An inquest then took place before the Deputy Coroner in 2015. The Deceased's brother expected the mental health team leader to include a reference to the suicide note in the report to the Coroner. However, for reasons of failed process or procedure, that did not happen. The Deputy Coroner was therefore not aware of the existence of the note at the time of the inquest and returned a conclusion of misadventure.

Immediately after the inquest, the brother challenged the Deputy Coroner as to why no mention had been made of the suicide note. The brother requested that an inquest was re-opened. Unfortunately, the High Court noted, this was followed by a period of two years before anyone acted on the request. In 2018, the Attorney-General's office issued a fiat but its authority lapsed as no claim form was filed with the Administrative Court. A further fiat was requested in July 2019 and granted in August 2020.

Reasoning

Section 13 of the Coroners Act 1988 provides that:

> *"This section applies where, on an application by or under the authority of the Attorney General, the High Court is satisfied as respects a coroner ("the coroner concerned") either-*
>
> > *(a) that he refuses or neglects to hold an inquest or an investigation which ought to be held; or*
> >
> > *(b) where an inquest or an investigation has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interests of justice that an investigation (or as the case may be, another investigation) should be held."*

The High Court noted that the test in section 13(b) is in the alternative, such that (emphasis added) *"if it can be shown that a fresh inquest is **either** necessary or desirable, then it will be ordered"* [16]. It further noted the court's treatment of s.13 in *Attorney-General v Her Majesty's Coroner for South Yorkshire* [2012] EWHC 3738 (Admin), where the Lord Chief Justice said:

> *"The single question is whether the interests of justice make a further inquest either necessary or desirable. …it seems to us elementary that the emergence of fresh evidence which may reasonably lead to the conclusion that the substantial truth about how an individual met his death was not revealed at the first inquest, will normally make it both desirable and necessary in the interests of justice for a fresh inquest to be ordered… If a different verdict is likely, then the interests of justice will make it necessary for a fresh inquest to be ordered, but even when significant fresh evidence may serve to confirm the correctness of the earlier verdict, it may sometimes nevertheless be desirable for the full extent of the evidence which tends to confirm the correctness of the verdict to be publicly revealed."*

The High Court considered that on the facts of the case it was not necessary to order a fresh inquest, noting that the Coroners Service in Gwent had allowed a long time to pass without any, or any proper, explanation for the

delay, with the record showing that the deceased's death was attributable to misadventure. During that period they had only sporadically suggested that the inquest should be reopened [17].

However, the Court was "*easily persuaded*" that a fresh inquest was desirable, principally because of the wishes of the deceased's brother [18]. Further, having belatedly been provided with the suicide note and read it, the court held that a different conclusion was indeed likely [19].

Comment

This is a short but important judgment which serves as a useful reminder of the nature of the statutory test for ordering a fresh inquest – namely, that a fresh inquest will be in the interests of justice if it can be shown that it is *either* necessary or desirable. In interpreting the "*desirable*" limb, the High Court places significant weight upon the family's wishes even in circumstances where it did not consider that it was "*necessary*" to hold a fresh inquest.

It is interesting that the court held that, having read the suicide note, a different conclusion was likely, thereby giving a second reason why a fresh inquest was desirable. The proper interpretation of a note found with the deceased, and its probative value, is usually a matter for the coroner having considered all the evidence before them. Here, the High Court seems to stray into pre-judging this issue by referring to the note as a "*suicide note"* and holding that a different conclusion was likely.

Overall, the judgment gives practitioners seeking a fresh inquest a clear and concise statement of the law and guidance as to how it will be applied.

HIGH COURT REJECTS 'FAILURE TO REMOVE' ABUSE CLAIM

Dominic Ruck Keene

DFX v Coventry City Council [2021] EWHC 1382 (QB)

In a significant adverse judgment for child abuse claimants, Mrs Justice Lambert rejected a claim brought by a number of Claimants who alleged that the Defendant council's social services negligently delayed in instigating care proceedings and that, had they been removed from the family home earlier, they would have avoided serial abuse at the hands of their parents.

The facts

Save for a hiatus between June 2001 and February 2002, the Defendant's social services department had been engaged with the Claimants' family throughout the 15 years from 1995 to 2010. Between 1996 and 1999, the first and second Claimants were on the child protection register and, between March and September 2002, all of the Claimants were on the register. In April 2009, the Defendant issued care proceedings in the Coventry County Court. Initially, the removal of the children was sought under an emergency protection order. This was not successful. An interim order was granted in March 2010 removing all of the children, save for the eldest (a boy, by then aged 17), into foster care. In June 2010, full care orders were made and care plans removing the eight children from the family were approved by the court.

The Claimants' case was that they each suffered abuse, including sexual abuse, and neglect whilst in the care of their parents before their removal from the family in 2010. The Claimants alleged that their parents were unfit to be parents and that this should have been obvious to the social workers involved with the family. Between 1992 and 1997, the father was convicted of four offences of indecency towards teenage girls. He had learning difficulties and had limited insight into his offending. The mother also had learning difficulties and it was alleged that she demonstrated repeatedly that she was either unable or disinclined to protect the Claimants from their father or from predatory men who visited the home. The risks to the children were increased by the presence in the home of the maternal grandmother who lived with the family until March 2004. She also had learning

difficulties and was associated with three "*risky adult*" men who visited the home. The home was often squalid and the children dirty and unkempt.

Assessment

Mrs Justice Lambert noted that by the end of the hearing, the Claimants' case on the existence of a duty of care was predicated solely on whether or not the Defendant had assumed responsibility for the Claimants, such as to give rise to a wide ranging duty of care on the part of the Defendant to keep the Claimants safe and to protect them from harm from third parties.

That assumption of responsibility was on the basis of either: (1) by the council assuming a responsibility to undertake recommended reporting and monitoring of the children; or (2) by assessing that the children were at risk of significant harm and deciding that care proceedings were necessary, the council assumed responsibility to pursue those proceedings competently; or (3) by taking on direct work with the Claimants and the family, the council assumed responsibility for carrying out that work effectively and reviewing its efficacy so that it provided reasonable protection to the Claimants.

The Claimants had relied upon the Defendant's interventions in their lives and argued that the social services department must have intended that the Claimants should rely upon it to protect them, otherwise their intervention would have been futile. It was submitted that a local authority can assume responsibility for children even though the children have not been taken into its care on the basis that the Claimant has entrusted the Defendant with his or her safety.

With respect to breach of that duty, the main focus of the Claimants' case was that a child protection conference in June 2002 reversed its earlier recommendation that care proceedings should be commenced, which was alleged to show a blatant lack of understanding of the purpose of professional work in protecting children.

Mrs Justice Lambert referred to the legal context as to whether or not the social workers owed the Claimants a duty of care and began by noting at [165] that

> *"... over recent decades the courts have adopted conflicting and at times inconsistent approaches to the question of whether a public authority owes a common law duty of care against the background of a statutory duty or power. In three recent cases, Lord Toulson in Michael v Chief Constable of South Wales Police [2015] UKSC 2, Lord Reed (majority reasoning) in Robinson v Chief Constable of West Yorkshire Police [2018] UKSC 4 and Lord Reed in N v Poole Borough Council [2020] AC 780, drew attention to this inconsistency and analysed how it had arisen. The judgments set out clearly (and with increasing emphasis) the correct approach to be taken by the courts when considering the establishment of a duty of care generally and by public authorities in particular."*

At [167] Mrs Justice Lambert gave what she described as a 'distillation of the key general principles' from those three cases:

> *"i) At common law public authorities are generally subject to the same liabilities in tort as private individuals and bodies. Accordingly, if conduct would be tortious if committed by a private person or body, it is generally equally tortious if committed by a public authority. It follows therefore that public authorities are generally under a duty of care to avoid causing actionable harm in situations where a duty of care would arise under ordinary principles of the law of negligence (Robinson at [33]).*
>
> *ii) Like private individuals, public authorities are generally under no duty of care to prevent the occurrence of harm. In Michael, Lord Toulson said at [97]: "English law does not as a general rule impose liability on a Defendant (D) for injury or damage to the person or property of a claimant (C) caused by the conduct of a third party (T): Smith v Littlewoods Organisation Ltd [1987] AC 270. The fundamental reason as Lord Goff explained is that the common law does not generally impose liability for pure omissions. It is one thing to require a person who embarks on action which may harm others to exercise care. It is another matter to hold a person liable in damages for failing to prevent harm caused by someone else".*

> *iii) The distinction between negligent acts and negligent omissions is therefore, as Lord Reed said in Poole at [28] of fundamental importance. Lord Reed reflected that the distinction to be drawn could be better expressed as a "distinction between causing harm (making things worse) and failing to confer a benefit (not making things better) rather than the more traditional distinction between acts and omissions, partly because the former language better conveys the rationale for the distinction drawn in the authorities and partly because the distinction between acts and omissions seems to be found difficult to apply".*
>
> *iv) Public authorities do not therefore owe a duty of care towards individuals to confer a benefit upon them by protecting them from harm, any more than would a private individual or body, see Robinson at [35]. Lord Reed continues at [36] "That is so, notwithstanding that a public authority may have statutory powers or duties enabling or requiring it to prevent the harm in question". The position is different if, on its true construction, the statutory power or duty is intended to give rise to a duty to individual members of the public which is enforceable by means of a private right of action. If, however, the statute does not create a private right of action, then "it would be to say the least unusual if the mere existence of the statutory duty (or a fortiori, a statutory power) could generate a common law duty of care". It follows that public authorities like private individuals and bodies generally owe no duty of care towards individuals to prevent them from being harmed by the conduct of a third party.*
>
> *v) The general rule against liability for negligently failing to confer a benefit is subject to exceptions. The circumstances in which public authorities like private individuals and bodies may come under a duty of care to prevent the occurrence of harm were summarised by Tofaris and Steel in "Negligence Liability for Omissions and the Police" 2016 CLJ 128. They are (i) when A has assumed responsibility to protect B from that danger; (ii) A has done something which prevents another from protecting B from that danger; (iii) A has a special level of control over that source of danger; or (iv) A's status creates an obligation to protect B from that danger."*

She also referred to *Stovin v Wise* [1996] AC 923 and *Gorringe v Calderdale Metropolitan Borough Council* [2004] 1 WLR 1057, stating that:

> *"In Stovin, Lord Hoffmann reasserted the importance of the distinction between harming the claimant and failing to confer a benefit typically by protecting the claimant from harm. He observed that the liability of a public authority in tort in the case of positive acts was in principle the same as that for a private individual, but it may be restricted by its statutory powers and duties. In relation to failures to perform statutory duties Lord Hoffmann remarked that if such a duty does not give rise to a private right to sue for breach, it would be unusual if it nevertheless gave rise to a duty of care at common law which made the public authority liable. Even more emphatically, in Gorringe, Lord Hoffmann said at [32] "Speaking for myself, I find it difficult to imagine a case in which a common law duty can be founded simply upon the failure (however irrational) to provide some benefit which a public authority has power (or a public law duty) to provide".*

Lastly, with regards to the specific instance of assumption of responsibility and the judgment in *Poole*, Mrs Justice Lambert noted that it is *"possible even where no assumption can be inferred from the nature of the function itself, that it can nevertheless be inferred from the manner in which the public authority has behaved towards the claimant in a particular case."* (her emphasis).

Mrs Justice Lambert began her conclusion by finding that this was an 'omissions' case i.e. a failure to confer a benefit. The alleged injury was inflicted by third parties rather than resulting from any direct act by the Defendant. The omission in question was a failure on the part of the local authority to exercise its statutory functions to commence care proceedings and/or to investigate. However, that in itself was not determinative of the claim in favour of the Defendant:

> *"… whilst the fact that a public authority is operating within a statutory scheme does not of itself generate a common law duty of care, it does not follow that a failure to exercise a statutory function,*

> *including taking a step which can only be taken lawfully by statute, can never be compensable at common law. Whether a duty of care is generated by (on the facts of this case) an assumption of responsibility depends upon whether there is, putting it colloquially, "something more": either something intrinsic to the nature of the statutory function itself which gives rise to an obligation on the Defendant to act carefully in its exercising that function, or something about the manner in which the Defendant has conducted itself towards the Claimants which gives rise to a duty of care."*

Mrs Justice Lambert held that while the Defendant had obtained an external report in 1997, it was obtained not for the benefit of the Claimants, but for "*the benefit of social services in determining the parents' ability to keep the children safe, the level of risk which the father posed to his children and whether the threshold for registration or care proceedings was met … in order to assist the social workers acting on behalf of the local authority to determine how best to fulfil their statutory obligations."*

Further, with regards to foreseeability, *"the local authority's assessment of risk may not be shared by the parents nor the children. Had proceedings been commenced, the parents would have been separately represented and the children's interests represented by a Guardian ad Litem. It would not necessarily follow that the local authority's viewpoint would be aligned with that of the family, children or parents*." According, it was not reasonably foreseeable that the Claimants would rely on the Defendant.

Mrs Justice Lambert further held that a recommendation that care proceedings be commenced could not be:

> *"… described as a positive act which had the effect of generating a duty of care, nor characterised as the provision of advice or service upon which the Claimants might reasonably foreseeably rely, so giving rise to a duty of care to act carefully.*
>
> *Like Lord Reed in Poole, I see nothing about the nature of the statutory function which the Defendant was exercising which gave rise to a duty of care. Ms Gumbel has not pointed me in the direction of anything which was said or done by the Defendant in the context of the obtaining of the Reaside report (or the Defendant's response to it) or in the context of the decisions made in 2002 which entailed that the Defendant assumed or undertook a responsibility towards the Claimants to perform its functions thereafter with reasonable skill and care. The position is, I find, similar to that in Poole and for similar reasons I reject Ms Gumbel's argument that a duty of care was generated."*

She also distinguished *Phelps v Hillingdon* [2000] UKHL 47 and *Barrett v Enfield* [1999] UKHL 25:

> *"… in Phelps, the injury (described as the failure to ameliorate the effect of the speech problems) was not inflicted by a third party but was a direct consequence of the negligent educational psychology assessment for which the local authority was liable. As such, the claim falls into a different category from the present case. As does Barrett, in which the court found that the impugned conduct occurred after the children had been taken into care. Lord Slynn drew on the analogy of a school which accepted a pupil and thereby assumed responsibility for the child's educational needs giving rise to a duty of care. The court found that the effect of taking the child into care was that the local authority assumed responsibility for the child's care thereafter. This is obviously very different from the facts of the case before me. Ms Gumbel did not advance a similar argument to that advanced on behalf of the Claimants in HXA v Surrey County Council [2021] EWHC 250 (QB), namely, that because a duty of care was recognised following the making of a care order, so a duty of care could be reverse engineered back to an earlier stage of the local authorities' involvement with the family. However, had she done so, I would have rejected it for the same reasons as those given by Deputy Master Bagot QC in that case."*

Her overall conclusion was that:

> *"… on the facts of this claim, no duty of care was owed by the Defendant to the Claimants. I have considered whether there was anything in the nature of the statutory functions being exercised by the Defendant under section 47 and section 31 of the 1989 Act or the manner in which those functions were exercised which generated a duty of care. Having done so, I find nothing which suggests to me that the*

> *Defendant assumed responsibility to exercise those functions with reasonable skill and care. Having looked for "something more" as I have put it, I find nothing. The facts do not fall within any category in which the common law has recognised a duty arising. That being the case I come full circle and agree with Mr Weitzman that the Claimants are, in this case, impermissibly seeking to create a common law duty of care from the Defendant "merely operating a statutory scheme" contrary to the, now well-established, principle set out in Stovin and Gorringe."*

Mrs Justice Lambert further held that there was, in any event, no breach of duty. She noted that risk assessment by social workers involved an evaluation and balancing of a range of different factors and had to take into account the views of a wide range of agencies. The decision to commence care proceedings or not also had to be judged within the framework of the 1989 Act and associated legislative guidance. The guidance emphasised the foundational belief that children are generally best looked after within the family without resort to legal proceedings. It also stated that no order should or would be made by the court, even though the threshold for care proceedings may have been reached, unless an order would positively contribute to and improve the welfare of the child.

Comment

The case will be a further blow to those seeking to bring 'failure to remove' claims post *Poole* (analysed in QMLR here). Despite the considerable level of active involvement of social services with this particular family and the level of apparent risk posed by the parents, nevertheless, no assumption of responsibility was found.

Lizanne Gumbel QC and Justin Levinson, also of 1 Crown Office Row, appeared for the Claimant but have not contributed to the writing of this article.

THE COURT OF APPEAL CONSIDERS VICARIOUS LIABILITY

Thomas Beamont

The Trustees of the Barry Congregation of Jehovah's Witnesses v BXB [2021] EWCA Civ 356

In an important contribution to the law on vicarious liability, the Court of Appeal has considered an appeal against a decision of Mr Justice Chamberlain, discussed in QMLR by Charlotte Gilmartin here. In that decision, the Defendants were held vicariously liable for the rape of the Claimant by Mark Sewell, an Elder in the Defendants' church.

The appeal was in respect of both stages of the test for vicarious liability. The Defendant contended that:

1. The judge had erred in his conclusion that the activities undertaken by Mark Sewell were an integral part of the Defendants' business activities, and that the risk of the rape was created by the Defendants assigning those activities to Mark Sewell; and
2. The judge erred in concluding that the rape was sufficiently closely connected to Mark Sewell's position, so as to justify the imposition of vicarious liability.

Stage 1: the relationship

The Court of Appeal upheld the reasoning of the judge below that the activities undertaken by Mark Sewell were an integral part of the Jehovah's Witness organisation. The following findings, in particular, were endorsed:

1. Elders are the spiritual leaders of the congregation;
2. An elder may be removed if he fails to maintain the high standards expected of him, whether in performance of his duties as an elder or in his personal life;

3. Elders are the principal conduit through which the teachings of the faith are disseminated to congregations;

4. In so far as a congregation of Jehovah's Witnesses acts as a body, it acts through its elders;

5. An elder is as integral to the business of a congregation of Jehovah's Witnesses as a priest is to the "business" of the Catholic Church.

Further, the Court noted that the relationship between the activities and the organisation was yet stronger than the position in *A v Trustees of the Watchtower Bible and Tract Society* [2015] EWHC 1722 (QB), in respect of sexual assaults committed by a ministerial servant.

As to the creation of the risk of the rape, the court observed that the findings of Mr Justice Chamberlain included that the organisation conferred power and authority on its leaders, and made rules for all aspects of its followers' lives. The court considered that the attempt to re-litigate the factual question of the conferral of power on Mark Sewell by the Defendant was misconceived, in circumstances where it had not been raised at trial.

Stage 2: the close connection

Perhaps the most interesting discussion of principle within the judgment is in respect of the second test, which considered whether the activities of Mark Sewell were sufficiently closely connected with the tort committed by Mark Sewell. The court said as follows at [84]:

> *"Contained within the tailored test in cases of sexual abuse is the concept of the conferral of authority upon the tortfeasor by the defendant. In my judgment, the tailored version of the test applies in cases in which adults are alleged to have been sexually abused as it does in such cases involving children because the rationale for the test is the same. The issue is the connection between the abuse and the relationship between the tortfeasor and the defendant. It is not the particular characteristics of the victim. On the facts of this claim, what is relevant for the purpose of the close connection test is the conferral of authority by the Jehovah's Witness organisation upon its elders, coupled with the opportunity for physical proximity as between an elder and publishers in the congregation."*

Reference to the 'tailored test' is to the dictum of Lord Reed in the *Christian Brothers* case at [36], that a *"more tailored version of the close connection test is applied"* in the context of sexual abuse of children. It is well-established that the 'tailored' version applies in respect of adult victims of abuse, because the rationale for the test is the same: the relevant considerations are the conferral of authority, and the opportunity for physical proximity.

The decisive factors were that Mark Sewell's position in the Defendant church was an important part of the reason why the Claimant had associated with him in the first place, that they would not have remained friends with him but for that position, and that the risk had been created or enhanced by the Defendants as they had impliedly instructed the Claimant to continue to associate with him, and invested in him the authority of an elder.

Conclusion

The Court of Appeal judgment is a reminder of the courts' recognition of the role of 'grooming' in the satisfaction of the close connection test. Males LJ described the *"essential issue* [of] *whether it was an abuse of the authority over her conferred on him by virtue of his status as an elder*."

While such a concept is familiar to practitioners in the area, the judgment in *BXB* is an apposite reminder that the 'close connection' often does not relate to the specific act of the assault itself. When considering the tortious act as a whole, the question may be influenced by events long preceding the assaults: in this case, the reason for the initial and ongoing association, and the investment of authority by the Defendant in the tortfeasor.

COUNCILS, PRIVATELY RUN CARE HOMES AND VICARIOUS LIABILITY

Thomas Beamont

SKX v Manchester City Council [2021] EWHC 782 (QB)

In *The Catholic Child Welfare Society and others v Various Claimants* [2012] UKSC 56, Lord Phillips set out that two stages are to be addressed in establishing whether a party may be vicariously liable for the torts of another:

1. Is the relationship between the defendant and tortfeasor capable of giving rise to vicarious liability?
2. Is there a sufficiently close connection between that relationship and the act or omission of the tortfeasor?

As is well known, in recent years there have been a series of appellate cases on the subject of vicarious liability in the context of abuse and assaults.

In *SKX*, Cavanagh J considered a claim against a Defendant local authority, which turned on the application of the first question, in circumstances where the tortfeasor was not an employee of the Defendant, but of a wholly different company.

Facts

SKX was a case arising out of the Bryn Alyn Community ("BAC"), a privately-owned group of children's homes with a long history of abuse-related litigation and was the subject of a major public inquiry. In 1989, the Claimant had been placed at Bryn Allen Hall by the Defendant, and was subjected to serious sexual abuse by the Chief Executive of the BAC, John Allen.

The Claimant was one of several who had previously brought claims under a Group Litigation Order, a number of years ago, against BAC's insurer. In that case, the Court of Appeal had held that the insurer's exclusion clause excluded recovery in respect of abuse committed by the company's managers, including John Allen (see *KR and others Royal & Sun Alliance Plc* [2006] EWCA Civ 1454).

Accordingly, *SKX*'s claim against Manchester City Council was on the basis that it was vicariously liable for the assaults committed by John Allen. No fault was alleged as against the council. An unsuccessful claim that the council owed a non-delegable duty to the Claimant was also pursued, but is outside the scope of this note.

Argument

The Claimant's case relied by analogy on *Armes v Nottinghamshire County Council* [2017] UKSC 60, in which the Supreme Court held that a local authority was vicariously liable for acts of abuse carried out by a foster parent, with whom the defendant had placed the claimant in that case. The argument was that the Defendant local authority was vicariously liable for the acts of John Allen, even though he was an employee of the company which ran the BAC.

The court noted that, as is well known, vicarious liability can arise in the context of relationships which are *"not employment but which are sufficiently akin to employment to make it just to impose such liability."* (see *Barclays Bank Plc v Various Claimants* [2020] UKSC 13 at [16]).

However, the court found that the relationship between the company and the Defendant local authority was *"a classic client/independent contractor relationship"* ([53]). The company was an independent business, looking after children from many local authorities of which the Defendant was just one. The local authority was *"just another client".* Accordingly, John Allen was part of the company's independent business, and not that of the Defendant.

By contrast, in *Armes* the foster parents were found not to be regarded as carrying on business of their own. They had been recruited by individuals (in the same way as the local authority recruited employees), were paid

allowances, and were provided with equipment and in-service training ([57]). In the circumstances, the foster parents were in a relationship akin to employment with the defendant.

Importantly, and following the guidance of Lady Hale in *Barclays Bank* (see [27] of that judgment), it was therefore not necessary to consider Lord Phillip's 'five incidents' as set out in the *Christian Brothers* case, which set out the principled basis for the imposition of vicarious liability.

Conclusion

The judgment in *SKX* is of note for two reasons.

The first is that is a reminder of the central importance of establishing the type of relationship, i.e. one akin to employment, assessing the broader (and often more difficult) question of the 'close connection' between that relationship and the tortious acts.

The second, and related, point of note is that the questions are to be taken in turn. The 'five incidents' did not fall for consideration: if the Claimant falls at the first hurdle, then vicarious liability will not be imposed, and the policy criteria underlying the imposition of vicarious liability will not come under the court's scrutiny.

THE VACCINE DAMAGES PAYMENT SCHEME

Alice Kuzmenko

As of 26 July 2021, over 83.8 million vaccines against coronavirus have been given in the UK. Vaccination is continuing at a rate of around 205,000 doses per day. But what can a person do if they suffer a severe disablement due to their vaccine?

Since 31 December 2020, one of the options open to such people is the Vaccine Damages Payment scheme. The scheme has long been in operation for other vaccines, primarily for children's vaccines such as those against measles, mumps, and rubella. The scheme allows for a one-off tax-free payment of £120,000. This could affect some benefits and entitlements and will be accounted for if a civil case is later pursued, but the scheme does not require proof of fault, and claimants will have up to six years from the date of the vaccination in which to claim (or the date they reach the age of 21, or would have if they had not died, if that date is later).

The catch? Causation. Claimants need to show, on the balance of probabilities, that the vaccine caused them a disability that amounts to at least a 60% (mental or physical) disablement.

Claimants can evidence such disablement with medical evidence from their doctors or the hospital involved in treatment. However, what does a 60% disablement look like in practice?

Schedule 2 of The Social Security (General Benefit) Regulations 1982 provides a table with descriptions of injuries and the degree of disablement percentage it amounts to. The first issue is that the injuries listed are largely focused on the loss of limbs, particularly through amputations, or loss of sight, hearing, or very severe facial disfiguration – it does not appear to be equipped to deal with neurological damage or mental disabilities for example. Secondly, it is clear from those injuries listed that the 60% threshold is hard to meet. For example, loss of both hands would be 100% disablement. Loss of a whole hand would be 60%. But if you lose four fingers from one hand, that only amounts to 50% disablement and inhibits you from claiming. Loss of sight to an extent where you could not perform any work for which eyesight is essential is 100% disablement, yet loss of vision in only one eye amounts to 30% and is well below the threshold. Evidently, few will be in a position to show sufficient disablement, despite this threshold having already been reduced by The Regulatory Reform (Vaccine Damage Payments Act 1979) Order 2002 from 80% to 60% disablement.

More than this, a claimant would still be required to prove, on the balance of probabilities, that the vaccine was the cause of the injury. While this may be more straightforward if the injury takes place shortly after a vaccine, this will be harder to prove as time passes.

It is also worth bearing in mind that a sum of £120,000 for these injuries is not as high as the equivalent that would be recommended under the JC Guidelines.

Together, all of these barriers may inhibit any sense of relief for those anxious about getting vaccines for fear of potential repercussions.

Nevertheless, the lack of a requirement to show fault, and the low cost of filling in the 16-page claim form to be sent to the DWP makes for a route which should provide an easier and quicker form of financial relief if a person was severely disabled by their vaccine.

The scheme also has in place appeal systems in the form of a 'mandatory reversal', whereby the DWP reviews the original decision, and either sends a new decision if they think it should be changed, or a 'mandatory reversal note' explaining why not. There is no limit on the number of mandatory reversals sought, nor the time limit in which to do so. Alternatively, the decision can be appealed to the Social Security and Child Support Tribunal and taken thereafter through the courts, as did John, a child who developed narcolepsy and cataplexy after receiving the Swine Flu vaccine in 2009 (covered by the UKHRB here).

PARENTAL CONSENT AND PUBERTY BLOCKERS: THE FALL OUT FROM *BELL*

Rajkiran Barhey

AB v CD & Ors [2021] EWHC 741 (Fam)

In the last issue of QMLR this author considered the High Court's decision in *Bell v Tavistock,* which concerned whether children were capable of consenting to puberty blockers ("PBs") as treatment for gender dysphoria. A three-judge panel in the Divisional Court (which included Lieven J) concluded at [145] that:

> *"… 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."*

The Divisional Court did not consider the question of parental consent to PBs as the Tavistock had made clear in *Bell* that they had a policy that a parent could not consent to PBs on behalf a child who was not *Gillick*-competent [47]. The appeal in *Bell* was heard by the Court of Appeal on 23-24 June 2021.

The issue in the present case

The present case, which also came before Lieven J, concerned an application by the parents of XY (AB and CD) for a declaration that they had the ability in law to consent on behalf of XY to the administration of PBs.

The Second and Third Respondents' position (Tavistock and Portman NHS Foundation Trust and University College London Hospital NHS Trust, respectively) was that, for patients who are already receiving PBs, given that a stay has been granted in respect of [138][4] of *Bell* and the extreme distress which these patients would suffer if treatment were discontinued, treatment for existing patients should continue on the basis of parental consent

[4] Which states: *"It follows that to achieve Gillick competence the child or young person would have to understand not simply the implications of taking PBs but those of progressing to cross-sex hormones. The relevant information therefore that a child would have to understand, retain and weigh up in order to have the requisite competence in relation to PBs, would be as follows: (i) the immediate consequences of the treatment in physical and psychological terms; (ii) the fact that the vast majority of patients taking PBs go on to CSH and therefore that s/he is on a pathway to much greater medical interventions; (iii) the relationship between taking CSH and subsequent surgery, with the implications of such surgery; (iv) the fact that CSH may well lead to a loss of fertility; (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."*

alone, as long as the patient continues to want the treatment. Thus, unlike *Bell,* the court now had to consider parental consent.

The issues were set out at [34] as follows:

> *"a. Do the parents retain the legal ability to consent to the treatment?*
>
> *b. Does the administration of PBs fall into a "special category" of medical treatment by which either:*
>
> *i. An application must be made to the Court before they can be prescribed?*
>
> *ii. As a matter of good practice an application should be made to the Court?"*

Do the parents retain the legal ability to consent to the treatment?

The issue was whether, even if XY was *Gillick* competent, her parents retained a *"concurrent right to consent"* to treatment on her behalf. The question of whether XY was *Gillick* competent had not been reviewed following *Bell*, and so the judge considered both scenarios: either (i) that XY was not *Gillick* competent, or (ii) that she was *Gillick* competent, but it remained relevant whether her parents could also give operative consent to the treatment [51].

Lieven J began by setting out the principle that parents are central to treatment decisions concerning their children and that, in general, judges ought to respect parents' wishes. She then went on to consider in detail the judgments of Lord Donaldson and Lord Scarman in *Gillick* itself and subsequent authorities. She concluded at [67] to [69] that:

> *"Although there is some difference in nuance between the speeches in Gillick, it is accepted that Lord Scarman reflects the view of the Committee. The very essence of Gillick is, in my view, that a parent's right to consent or "determine" treatment cannot trump or overbear the decision of the child. Therefore, the doctors could lawfully advise and treat the child without her mother's knowledge or consent. In Gillick, the parent did not have the right to know that the treatment was being given, so it makes little sense to assume that the parent could act to stop the child's decision being operative on whether the treatment takes place or not…*
>
> *However, in the present case, the parent and the child are in agreement. Therefore, the issue here is whether the parents' ability to consent disappears once the child achieves Gillick competence in respect of the specific decision even where both the parents and child agree. In my view it does not. The parents retain parental responsibility in law and the rights and duties that go with that. One of those duties is to make a decision as to consent in medical treatment cases where the child cannot do so. The parent cannot use that right to "trump" the child's decision, so much follows from Gillick, but if the child fails to make a decision then the parent's ability to do so continues. At the heart of the issue is that the parents' "right" to consent is always for the purpose of ensuring the child's best interests. If the child does not, for whatever reason, make the relevant decision then the parents continue to have the responsibility (and thus the right) to give valid consent.*
>
> *This might arise if the child is unable to make the decision, for example is unconscious. However, it could also arise if the child declines to make the decision, perhaps because although Gillick competent she finds the whole situation too overwhelming and would rather her parents make the decision on her behalf. In the present case, in the light of the decision in Bell, and the particular issues around Gillick competence explained in that judgment, it has not been possible to ascertain whether the child is competent. In this case, there are two options. If the child is Gillick competent, she has not objected to her parent giving consent on her behalf. As such, a doctor can rely on the consent given by her parents. Alternatively, the child is not Gillick competent. In that case, her parents can consent on her behalf. It is not necessary for me or a doctor to investigate which route applies to give the parents authority to give consent. Therefore, in my view, whether or not XY is Gillick competent to make the decision about PBs, her parents retain the parental right to consent to that treatment."*

Issue Two - Is there a special category of medical treatment requiring court authorisation, and do puberty blockers fall within it ?

Lieven J explained that the first sub-issue was whether there was a special category of medical treatment requiring authorisation, and the second sub-issue was whether PBs fell within that category [71].

She made two interesting preliminary remarks. First, at [72] she commented that:

> *"Firstly, the judgments concerning medical treatment decisions that should be brought to court are sometimes less than clear as to whether they are referring to a legal requirement or merely to good practice. However, it is in most cases probably a distinction without much difference. If it is good practice to apply to the Court, then if a clinician does not do so s/he is at risk of considerable criticism and possibly disciplinary action by the professional body. Therefore, a principle of good practice may have a very similar effect to a legal requirement."*

Secondly, she noted that all of the parties were arguing the same position – that even if there were a limited category of medical treatment requiring authorisation, PBs do not fall within this category. She considered that, given *Bell*, there was a strong counter-argument, however no party sought to argue that position.

At [74] Lieven J noted that: *"the argument that there is a special category of medical treatment, which only the court can authorise, rests on a series of decisions concerning sterilisation of girls and women, some of which involve under 16 year olds."*

Lieven J went on to consider the previous authorities concerning sterilisation procedures, before going to consider the authorities relating to withdrawal of clinically assisted nutrition and hydration and Hayden J's guidance from January 2020 concerning when applications relating to medical treatment should be made to the Court. She also considered two Australian cases concerning the administration of puberty blockers to children and the relevant regulatory framework, including the Cass Review, an independent NHS England review into this area of services and treatment.

At [111] Lieven J also noted the argument put forward that placing PBs into a special category of treatment that would require court authorisation would amount to direct discrimination under the Equality Act 2010 and/or would breach Article 8. Although it was not necessary for her to deal with the point in the present case, she commented at [112] that: "*this argument raises complex issues of discrimination law both under the Equality Act 2010 and the Human Rights Act 1998. It also appears to me that a very similar argument might be raised in the Bell appeal."*

Ultimately, Lieven J concluded that her analysis of the authorities demonstrated that there are very few cases which support a special category of treatment of children requiring court approval. She noted at [116] that:

> *"There are a range of cases where there does have to be Court approval, but this is where there is a clinical disagreement; possible alternative treatment of the medical condition in issue; or the decision is, in the opinion of clinicians, finely balanced. These are fact specific instances rather than examples of any special category of treatment where the Court's role is required simply because of the nature of the treatment."*

She observed that the position is different in relation to incapacitated adults, who do not have parents and therefore the court has to fulfil that protective role.

She observed that it could be argued that, for the reasons set out in *Bell*, PBs are sufficiently different from other forms of treatment and therefore should be treated differently. Although, as per *Bell,* children were very unlikely to be able to understand the implications of PBs, she commented at [120] that: *"parents are, in general, in a position to understand and weigh up these matters and consider what is in the long and short term best interests of their child."* Overall, therefore, PBs did not fall into any special category of medical treatment for which applications to the court were always required before they could be administered.

Lieven J pointed to two particular concerns which she had regarding PBs. First, she commented at [123] that: *"The taking of strong, and perhaps fixed, positions as to the appropriateness of the use of PBs may make it difficult for a parent to be given a truly independent second opinion. However, in my view this is a matter for the various regulatory bodies, NHS England and the Care Quality Commission, to address when imposing standards and good practice on the Second and Third Respondents."*

Second, she noted a concern that parents might feel under 'reverse pressure' from their children to consent to PBs. However she noted that there was no evidence before her that this was an issue in XY's case.

She finally noted that if the clinicians were concerned that pressure was being placed on parents, if the case was finely balanced, or if there was disagreement between the clinicians then the case should be brought before the court.

EVENTS & NEWS

News & Events

Hear from expert speakers, including **Richard Booth QC**, at the Legal Training Consultancy's Half Day Online Clinical Negligence Conference chaired by **Clodagh Bradley QC** on Thursday 24th September. Use promo code COR25 for 25% off ticket price for our QMLR subscribers when booking your place here.

Save the Date! Join us virtually on 21st October for a series of talks chaired by **John Whitting QC**. More details and invitations will be available closer to the date or you can get in touch via events@1cor.com.

The **1COR Bundle 2021-22** is available here. Get a glimpse into life in Chambers, a discussion of emerging themes in Covid-19 litigation and an overview of our key cases from the last twelve months.

Podcast

On **Law Pod UK** Editor in Chief Rajkiran Barhey and Richard Mumford discuss five key medical law updates with Emma-Louise Fenelon. Further news, events, and webinars can be found on our website.

Letters to the Editor

Feel free to contact the team at medlaw@1cor.com with comments or queries. Explore our website at www.1corqmlr.com and follow us on Twitter @1corQMLR.

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

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Alice Kuzmenko joined chambers as a tenant after successfully completing her pupillage with us. She is building her practice in all areas of chambers work. In this time, she has drafted pleadings, submissions, and advices in varying areas of law, and has undertaken advocacy at the county courts and immigration tribunals. She has experience assisting with disclosure in complex and high value litigation. Alice is on the Junior Junior panel for the Brook House Inquiry and is instructed in the Napier Barracks judicial review litigation.