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The 1COR Quarterly Medical Law Review

Updates and analysis of the latest legal developments

Summer/Autumn 2021 | Issue 10

Welcome to the tenth issue of the QMLR, updating you on developments in Summer and Autumn 2021:

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MIND THE GAP – SECONDARY VICTIM CLAIMS CONSIDERED BY THE COURT OF APPEAL

Jo Moore

Paul & Ors v Royal Wolverhampton NHS Trust [2022] EWCA Civ 12

For readers hoping that 2022 would bring more clarity on the scope of secondary victim status in clinical negligence claims, the message from the Court of Appeal is… wait a little longer.

The Court of Appeal has handed down judgment in the jointly heard appeals *Paul v Wolverhampton NHS Trust*, *Polmear v Royal Cornwall Hospital Trust* and *Purchase v Ahmed*. Each case involves an allegedly negligent delay in diagnosis of a life-threatening condition, which eventually led to the sudden death of the primary victim. The gaps in time between breach of duty and death range from three days to 14 months. In *Paul* and *Polmear*, family members witnessed the death of their relative and in *Purchase*, the victim's family found her very shortly afterwards. Relatives who saw these horrifying events brought claims for their own psychiatric injuries (the secondary victim claims).*

While the facts differ, the legal question was the same in each case: what is the relevance of any gaps in time between the **negligence**, the **damage caused** to the primary victim, and the **horrific event** which causes injury to the secondary victim?

The requirements for establishing legal liability in secondary victim claims can be fairly shortly stated, per *Alcock v Chief Constable of the South Yorkshire Police* [1991] 4 All ER 907:

1. Close familial relationship between primary victim and claimant
2. Injury which arises from sudden and unexpected shock
3. Claimant either personally present at the scene of the injury, or in the immediate vicinity and witness to the aftermath
4. Injury to secondary victim is caused by witnessing death of or extreme danger to primary victim
5. A close temporal connection between the event and the claimant's perception of it.

The decisions of the House of Lords (and of the Court of Appeal in *Taylor v A Novo (UK) Ltd* [2013] PIQR P15) which established the principles the Court of Appeal grappled with, all concerned horrific accidents rather than clinical negligence. At [12] however, the Master of the Rolls concluded that the five elements set out above apply equally to clinical negligence claims.

Taking a first principles approach to the five elements in the clinical negligence context, the Master of the Rolls observed at [87]:

> *"If one were simply considering these requirements and applying them to the clinical negligence situation, I think one would say that, despite the fact that the horrific event took place later than the defendant's misdiagnosis: (a) the fact and consequence of the defendant's negligence (i.e. the event or accident causing the horrific event) was close in time and space to the moment when the secondary victim was caused the psychiatric injury, and (b) the secondary victim was either personally present at the scene of the horrific event or accident or was in the more or less immediate vicinity and witnessed the aftermath shortly afterwards."*

The judgment leaves no real doubt that were this the test, all three Claimants would have succeeded.

The sticking point, however, was the 2013 Court of Appeal decision *Taylor v A Novo*. In that case, the claimant's mother was injured at work, appeared to recover, and then suddenly died three weeks later in front of her daughter, who developed PTSD. Lord Dyson held that the mother's death was not the relevant incident for the purposes of the claim, as the death was removed in time from the negligence and its first consequence, the

accident at work. The requirement of proximity was not met as the daughter did not witness the accident. While there were two separate 'consequences' of the negligence (the initial injury at work and later, death at home) the central reasoning in *Novo* appears to turn on the gap in time between the breach of duty and the eventual shocking event. It therefore precludes any claim where there is such a gap and is not limited to facts like *Novo* where there were two separate injuries or consequences of the negligence (see the analysis of Lord Justice Underhill, at [104] of *Paul*)

The Master of the Rolls noted that "*there is no logical reason for these rules*" [12], and that it is hard to see why a gap in time between an act of negligence and its horrifying result should affect liability [80]. Nevertheless, the Court of Appeal held that it was bound by *Novo*, meaning no claim can be brought in respect of psychiatric injury caused by a separate horrific event removed in time from the original negligence, accident or first horrific event [12], [96].

However, the Master of the Rolls expressed reservations about whether *Novo* correctly interpreted the requirements of the five elements established by the House of Lords and indicated he would be minded to allow permission to appeal to the Supreme Court.

Lord Justice Underhill and Lady Justice Nicola Davies agreed. Like the Master of the Rolls, Lord Justice Underhill considered that absent *Novo*, the claims fell within the five requirements established by the House of Lords, albeit in a different context [103], and provisionally agreed that the issues merit consideration by the Supreme Court.

No-one will be surprised to hear that the Claimants applied for permission to appeal which has now been granted by the Court of Appeal. As the Supreme Court will not be bound by *Novo*, the Claimants may well submit that the simple formulation proposed by the Master of the Rolls at [87] (cited above) should be adopted, putting to bed the difficulties of interpreting *Novo* in clinical negligence claims.

Until then, the complexities illuminated by these joined appeals remain. Practitioners with ongoing secondary victim claims will eagerly await news from the Supreme Court.

Jessica Elliott considered the first instance decision in Polmear here, and the case of Paul was analysed by Rajkiran Barhey (in respect of the application for strike out/summary judgment) here and Gideon Barth (appeal from that decision) here.

REJECTION OF EXPERT EVIDENCE

Isabel McArdle

Griffiths v TUI (UK) Ltd [2021] EWCA Civ 1442

Introduction

The Court of Appeal has handed down a controversial judgment by majority on the ability of a party to invite the court to reject expert evidence, even when the point in issue has not been put to the expert in cross-examination. The minority judgment, from Bean LJ, contains stinging criticism of the majority position, and might pave the way for an appeal to the Supreme Court.

The decision has significant ramifications for all practitioners in fields where expert evidence arises.

Background

The Respondent, Mr Griffiths, took an all-inclusive package holiday with the Appellant travel company, during which he suffered a gastric illness. He alleged that this was the result of consuming contaminated food or drink as part of the all-inclusive deal which he purchased. He claimed damages from the Appellant.

At first instance in the County Court, the Mr Griffiths' was dismissed, with the judge not being satisfied that his illness was caused, on the balance of probabilities, by contaminated food or drink supplied by the hotel.

The travel company had not provided its own evidence on the issue, but Mr Griffiths had served an expert report from a microbiologist, Professor Pennington. The travel company had not cross-examined him at trial so he gave no oral evidence, but the travel company had made criticisms of his written evidence in closing submissions, inviting its rejection.

In other words, Mr Griffiths' expert evidence on causation was the only evidence on that matter before the judge. It was not tested in cross-examination at all. Despite this, the travel company criticised it in closing, and the judge rejected it.

The High Court reversed that decision, noting that the evidence of Prof Pennington was "uncontroverted", meaning unchallenged by any rival evidence on the issue and not challenged through cross-examination.

While:

> [33] *"… a court would always be entitled to reject a report, even where uncontroverted, which was, literally, a bare ipse dixit , for example if Professor Pennington had produced a one sentence report which simply stated: "In my opinion, on the balance of probabilities Peter Griffiths acquired his gastric illnesses following the consumption of contaminated food or fluid from the hotel…"*

The judge allowed the appeal because:

> [33] *"… what the court is not entitled to do, where an expert report is uncontroverted, is subject the report to the same kind of analysis and critique as if it was evaluating a controverted or contested report, where it had to decide the weight of the report in order to decide whether it was to be preferred to other, controverting evidence such as an expert on the other side or competing factual evidence. Once a report is truly uncontroverted, that role of the court falls away. All the court needs to do is decide whether the report fulfils certain minimum standards which any expert report must satisfy if it is to be accepted at all*" (Original emphasis).

Consequently, the first instance judge fell into error, the High Court found, and the appeal was allowed.

The Court of Appeal: the majority decision

The travel company appealed, arguing among other matters that the High Court decision misstated the limits of a trial judge's ability to examine the substance of an expert report which had not been challenged through cross-examination. Its reasoning and conclusions can be examined in such circumstances, it was argued, to establish whether the burden of proof has been met.

In the majority judgment, given by Asplin LJ, a comparison with criminal court handling of expert evidence was made:

> [57] *"…The jury must decide a case upon all the evidence in just the same way as a judge in a civil trial. Furthermore, where there is expert evidence which is within the domain of scientific expertise and no challenge is made to it, and there is no rational or proper basis for departing from it, the jury may not do so. In the same way, it is hard to envisage the circumstances in which it would be appropriate for a judge to do so. However, that does not mean that there is a strict rule that uncontroverted evidence must be accepted at face value whatever it says. As Davis LJ noted at [45] of his judgment [in R v Brennan [2015] 1 WLR 2060], the then most recent Crown Court Bench Book stated that where there was no dispute about the findings of an expert, the jury is likely to wish to give effect to them but was not bound to do so if there was good reason to reject them. As Davis LJ stated, this is consistent with the principle that if unchallenged expert evidence is to be rejected then it must be rejected for a reason."*
>
> [58] "*Rather than support the contention that there is a bright line between controverted and uncontroverted expert evidence, it seems to me that Davis LJ's judgment supports a more nuanced*

> *approach. Even in a criminal trial, the jury may reject uncontroverted expert evidence where there is reason to do so…"*

Crucially, in allowing the appeal, Asplin LJ went on:

> "[66] ***… As long as the expert's veracity is not challenged, a party may reserve its criticisms of a report until closing submissions if it chooses to do so.*** *The defendant is entitled to submit that the case or an essential aspect of it has not been proved to the requisite standard. He cannot be prevented from doing so because some of the evidence is contained in an uncontroverted expert's report. Furthermore, he cannot be required to file his own contrary expert's evidence in order to enable the court to weigh the evidence. The judge cannot be prevented from considering the quality of such evidence in order to determine whether the burden of proof is satisfied just because it is uncontroverted. As Judge Truman stated, the court is not a rubber stamp. If it were otherwise, the court would be bound by an uncontroverted expert's report which satisfied CPR PD 35, even if the conclusion was only supported by nonsense."* (Emphasis added)

Nugee LJ agreed with Asplin LJ and the appeal was allowed.

Court of Appeal: the Minority Judgment

Bean LJ evidently had a very strongly opposing view to the majority:

> [87] *"But it is even more trite law that, as Phipson on Evidence puts it:*
>
> *"In general,* ***a party is required to challenge in cross-examination the evidence of any witness of the opposing party if he wishes to submit to the court that the evidence should not be accepted on that point****. The rule applies in civil cases as it does in criminal. In general the CPR does not alter that position. This rule serves the important function of giving the witness the opportunity of explaining any contradiction or alleged problem with his evidence. If a party has decided not to cross-examine on a particular important point, he will be in difficulty in submitting that the evidence should be rejected." (19th edn, 2018, para.12-12).*
>
> ***Throughout my 28 years as a practising barrister this proposition would have been regarded as so obvious as not to require the citation of authority****. Certainly we were not shown any authority to the contrary. And I agree with Nugee LJ that there is no special rule for experts."* (Emphasis added)

He went on to express his disagreement with the majority's position, that only when an expert is being accused of dishonesty, is it necessary to put that accusation to the expert in cross-examination in order to be entitled to rely on it in a closing speech and for the judge so to find:

> [90] *"I do not accept that the principle set out in Phipson is confined to cases such as Browne v Dunn, in which it was held that a witness must be challenged in cross-examination if it is sought to allege that the witness is lying. The principle is wider than that, and applies both to lay witnesses and experts. It does not extend to every point of detail in a long witness statement: that is a matter for the discretion and common sense of the trial judge. But here Professor Pennington gave a clear conclusion on the very issue on which he was asked to give an opinion, namely that "on the balance of probabilities Peter Griffiths acquired his gastric illnesses following the consumption of contaminated food or fluid from the hotel". This could and should have been challenged in cross-examination."*

He evidently had great sympathy for the position of Mr Griffiths, given the outcome, despite his expert evidence not having been subject to any challenge in the witness box, which can only have led him to expect that it was evidence accepted by both parties:

> [98] "Mr Griffiths must be wondering what he did wrong. He instructed a leading firm of personal injury solicitors, who in turn instructed an eminent microbiologist whose integrity has not been questioned. Mr Griffiths and his wife gave evidence at the trial, were cross-examined, and were found by the judge

> to be entirely honest witnesses. The eminent expert gave his opinion that on the balance of probabilities Mr Griffiths' illness was caused by the consumption of contaminated food or fluid supplied by the hotel. No contrary evidence was disclosed or called, and the expert was not cross-examined. Yet the Claimant lost his case."
>
> [99] "Asplin LJ, with whom Nugee LJ agrees, says at [65] that "as long as the expert's veracity is not challenged, a party may reserve its criticisms of a report until closing submissions if it chooses to do so", and that she can see nothing which is inherently unfair in that procedure. With respect, I profoundly disagree. **In my view Mr Griffiths did not have a fair trial of his claim. The courts should not allow litigation by ambush**. I would therefore have dismissed TUI's appeal." (Emphasis added)

Comment

It is not yet known whether the case will proceed to the Supreme Court but given the strength of disagreement between the majority and minority in the Court of Appeal, the chances of permission being granted would appear to be good.

The decision has caused considerable controversy. Restricting the obligation to cross-examine an expert, in order to be entitled to invite the court to reject that expert's evidence, to situations where dishonesty is alleged, is a *major change* from what most practitioners considered to be the position before this Court of Appeal decision was handed down.

While a party choosing not to cross-examine and criticising an expert only in closing submissions will be taking a big risk that those submissions will not be accepted, the author's view is that this decision is nevertheless a serious departure from the principle quoted from *Phipson*, above, that it is necessary to cross-examine a witness (including an expert witness) if the court is to be invited to reject that witness' evidence for any reason.

It is difficult not to agree with the minority view, that the approach taken by the majority paves the way for trial by ambush. A party may be unable to predict every criticism which might be made of their expert witness' evidence such that they can pre-emptively serve evidence in rebuttal. That risk has historically been mitigated by the requirement that an expert have put to him or her such criticisms in cross-examination, so there is at least the opportunity in oral evidence to address them. Parties can now make criticisms of expert witnesses and choose not to give them the opportunity to answer them in cross-examination.

This raises not only the likelihood of ambush, but also risks experts producing longer reports, at great additional cost, to try to address all predicted criticisms which might be made of them.

It remains to be seen whether this decision is clarified or overturned in the near future, but there is likely to be considerable pressure to do so.

MONTGOMERY AND "REASONABLE ALTERNATIVES"

Richard Mumford

Malik v St George's University Hospitals NHSFT [2021] EWHC 1913 (QB)

This was a claim about spinal surgery, specifically whether a revision decompression at T10/11 was appropriately advised and whether the Claimant had been adequately advised of reasonable alternative or variant treatments to the surgery which ultimately worsened rather than improved his condition. As such, it engaged not only the principles outlined in *Bolam* and *Bolitho* but also *Montgomery* and is one of a relatively small number of cases since that decision in which a judicial application of the *Montgomery* principles has been required [see the author's previous analysis of *Montgomery* cases here]. In the event, the claim as to both the selection of surgery and the counselling of risks and alternatives was rejected; nonetheless, the decision casts light on how

Montgomery may be applied in practice and in particular the requirement to advise of "reasonable alternative" treatments.

The Claimant had a history of spinal problems which deteriorated markedly in July 2014 leading to admission to hospital. He was seen by the Defendant's consultant neurosurgeon, Mr Minhas, who diagnosed compression of the spinal cord at T10/11 and L3/4. Surgery was performed at T10/11 only. The Claimant's recovery was slow and incomplete such that he saw Mr Minhas again in April 2015 and an MRI scan was commissioned. The Claimant was reviewed by Mr Minhas again in July 2015 with the scans; there was a factual dispute as to whether the Claimant reported intercostal pain at that review as suggested by the records. Revision surgery to T10/11 and primary surgery at L3/4 was offered. There was dispute as to how the risks of the surgery were discussed but it was common ground that alternatives to surgery in the form of nerve root injection and/or a pain management programme were not discussed.

The judge preferred the factual evidence of the surgeon as to what symptoms were complained of in July 2015 and in particular that severe intercostal pain was part of the presentation. Against this finding, it was common ground between the surgical experts that it was reasonable to offer surgery – that dealt with the *Bolam/Bolitho* point. As regards consent, the judge found that whilst the surgeon had not offered or discussed the alternative treatments in question, this was not a breach of duty since "*I consider that a responsible, competent and respectable body of skilled spinal surgeons would have reasonably concluded that there were no reasonable alternative treatments available in the context of the parameters and discussion that the claimant had with Mr Minhas."* [93]. The judge went on to find that even if the Claimant had established a breach of duty in respect of consent, he would have failed on causation *since "The claimant has not satisfied me on a balance of probabilities that he would have declined the offer of having surgery in August 2015 if an injection (or any of the other mooted options) had been explained to him by Mr Minhas, with what were Mr Minhas' perfectly respectable opinions as to their respective risks and chances of providing any desired benefit. Equally I am not satisfied on a balance of probabilities that Mr Malik would have sought another opinion or delayed making his decision."* [95].

The judge's reasoning in dismissing the consent claim on breach is interesting. The Supreme Court in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 held: "*An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments"* [87] and "*the doctor's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision."* [90]. The Defendant's surgical expert in *Malik* is recorded at [77] as giving evidence that "*although some spinal surgeons would try an injection first, another perfectly reasonable group would consider it as causing an unnecessary delay in a curative procedure …*". That would appear to suggest that the Defendant's expert would accept that offering an injection would itself have been supported by a *"perfectly reasonable group*" of surgeons and therefore to have been a "*reasonable*" treatment in the sense of *Bolam/Bolitho* compliant. Was injection therefore a "*reasonable alternative*" treatment of which Mr Minhas was obliged to advise the patient? In the decision of the judge, it was not, since a reasonable body of surgeons would have formed the view that injection was not a reasonable treatment.

It may be argued an approach whereby the individual clinician determines the menu of reasonable treatments of which to make the patient aware, risks undermining the emphasis on patient autonomy and choice as set out in *Montgomery*. Conversely, it may be asked – what other way could it be? The treating clinician will inevitably have to form some view as to what the (reasonable) treatment options are and there must therefore be some test for determining the legitimacy of that view; it is difficult to see a workable alternative to the *Bolam/Bolitho* in those circumstances.

The court in *Bayley v George Eliot Hospital NHS Trust* [2017] EWHC 3398 faced a similar argument in relation to whether the option of ilio-femoral venous stenting should have been presented to a DVT patient; the court

appeared at [61] to accept the submission that the issue of what was or was not a reasonable alternative treatment was not to be determined by the doctors alone otherwise this would be "*introducing Bolam by the back door and in effect depriving the patient of the right to choose."* However, whilst adopting a wider approach involving consideration of *"all the relevant evidence*" as to whether the treatment was a reasonable alternative (in apparent contradistinction to a *Bolam* approach of determining whether a reasonable body of clinicians would agree that it was not), the judge ultimately found that the treatment in question was, at the time "*unproven*" and "*a long way off being appropriate*" and dismissed the claim.

It is however easy to imagine situations where a decision to categorise a treatment as not being a "*reasonable alternative*" and therefore not to at least make its existence known to the patient would be controversial. For example, take two forms of treatment ("A" and "B"), each with its own adherents who each regard the other school as unreasonable. Dr Smith favours treatment A but knows that within her department Dr Jones favours treatment B. Is Dr Smith obliged to make her patients aware of treatment B? The decision in *Malik* would suggest not, whereas the more nuanced or holistic approach in *Bayley* might suggest otherwise (despite the failure of the claim in that particular case). It would be interesting to know what the Supreme Court would have said about that, had they been required to express an opinion.

Explore the QMLR archive of articles on consent here.

Matthew Barnes acted for the Defendant in this case. He was not involved in the writing of this article.

Resiling from an Admission in a Pleaded Defence

Lizanne Gumbel QC

James Dulson v Svitlana Popovych [2021] EWHC 1515 (QB)

This decision of Deputy High Court Judge Lickley QC arose in the context of an application by a Defendant, who was a registered nurse practitioner, to resile from an admission of breach of duty made in a defence. The application was made pursuant to CPR 17.1(2) and PD 14 paragraph 7.

The key dates relating to the application were as follows:

9 July 1951	The Claimant born, aged 69 at the date of hearing.
23 June 2015	NICE guidelines introduced in respect of laryngeal cancer and oral cancer which provided: *Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for laryngeal cancer in people aged 45 and over with persistent unexplained hoarseness or an unexplained lump in the neck.*
20 July 2015	The Claimant's first consultation with the Defendant at which he complained of a sore throat, a dry mouth and a neck lump.
17 August 2015	The Claimant's second consultation with the Defendant when he reported the lump had grown.
3 September 2015	*Date on which the Claimant's expert alleged he should have undergone surgery.*
8 September 2015	The Claimant's third consultation with the Defendant when he again reported the lump had grown.
14 September 2015	The Claimant first referred to hospital
15 October 2015	The Claimant first seen by a consultant
12 November 2015	The Claimant underwent surgery involving biopsy of the base of the tongue, extraction of three teeth and a right modified radial neck dissection. He suffered complications of the surgery including loss of function in the right shoulder.
3 July 2018	Letter of claim served. No letter of response was received.

30 August 2019	Claim form issued
23 December 2019	Particulars of claim served
February 2020	The Defendant expert report of Nurse Wiltshire stated that the Defendant was in breach of duty on 20 July 2015.
1 April 2020	The Defendant served a defence dated 26 March 2020 admitting breach of duty by the Defendant in failing to refer the Claimant on 20 July 2015 when he presented with a neck lump.
23 July 2020	CCMC before Master Yoxall and permission given for the Defendant to obtain causation evidence from an ENT surgeon Mr Reece.
26 July 2020	Mr Reece drew attention to local guidance that suggested a neck lump did not require referral until it had been present for 3 weeks.
9 September 2020	Nurse Wiltshire, the Defendant nursing expert was asked about the local guidance and said she was not aware of it.
7 October 2020	Nurse Wiltshire was sent the local guidance.
8 October 2020	Nurse Wiltshire responded that on the basis of the local guidance there was no breach of duty on 20 July 2015 but still a breach of duty by the Defendant on 17 August 2015.
16 October 2020	Local guidance sent to the Claimant by the Defendant and the Defendant requested an extension of time to serve causation evidence.
18 December 2020	Application made to resile from admission supported by a witness statement from Ms Owen the Defendant's solicitor. The Claimant served causation evidence, not to be opened until the Defendant served their evidence.
15 January 2021	The Defendant served causation evidence stating it was not negligent for the Defendant to fail to refer on 15 July but was negligent to fail to refer on 17 August. Referral on 17 August would have resulted in surgery on 15 October (rather than 3 September with earlier referral). The Defendant expert accepted the outcome would still have been better than it was.
19 and 26 May 2021	Application heard
8 June 2021	Judgment given

The issue was whether the Defendant could resile from the admission made in the original defence that it was a breach of duty that the Defendant did not refer the Claimant to hospital on 15 July thereby resulting in surgery on 3 September 2015.

It is of note that:

(a) The basis of resiling from the admission was that in accordance with the local guidance the Defendant would not have been in breach of duty.

(b) However the Defendant was not aware of the local guidance.

(c) In accordance with the NICE guidance it would have been negligent not to refer the Claimant on 15 July 2015.

(d) The Defendant was in any event admitting breach of duty in failing to refer on 17 August and that later date of referral would still have resulted in a significantly better outcome than the Claimant achieved when surgery was delayed until 12 November 2015.

CPR 17 sets out the test required for amendments to statements of case. CPR 14 sets out the rules in respect of admissions and the practice direction to CPR 14 sets out in paragraph 17 the circumstances in which an admission may be withdrawn stating:

> *"7.1 An admission made under Part 14 may be withdrawn with the court's permission.*
>
> *7.2 In deciding whether to give permission for an admission to be withdrawn, the court will have regard to all the circumstances of the case, including –*

(a) the grounds upon which the applicant seeks to withdraw the admission including whether or not new evidence has come to light which was not available at the time the admission was made;

(b) the conduct of the parties, including any conduct which led the party making the admission to do so;

(c) the prejudice that may be caused to any person if the admission is withdrawn;

(d) the prejudice that may be caused to any person if the application is refused;

(e) the stage in the proceedings at which the application to withdraw is made, in particular in relation to the date or period fixed for trial;

(f) the prospects of success (if the admission is withdrawn) of the claim or part of the claim in relation to which the admission was made; and

(g) the interests of the administration of justice."

The judge considered the respective arguments of the parties on each of these criteria in considerable detail in paragraph 30 of his judgment.

The judge refused permission to the Defendant to withdraw the admission as:

(a) The local protocol could have been obtained by the Defendant before the admission was made and it was the Defendant's fault it was not obtained.

(b) The prejudice to the Claimant was greater and included further delays.

(c) In any event the point lacked any real prospect of success at trial.

On the facts of this case the refusal of the judge to allow withdrawal of the admission is unsurprising. The more surprising point is perhaps that the application should have been made in circumstances where an admission of breach of duty and causation of significant damage had to be made in any event and where the merits of trying to put back the date of surgery so as to argue the outcome would have been not quite as good as at the earlier date are less than clear. The argument based on trying to rely on guidance that the Defendant was unaware of is in any event a very doubtful one. As the judge said:

"There is no evidence the guidance was in force, adopted by the Health Centre and therefore applicable at the time. On the face of the documents supplied there is an apparent contradiction and the material is not complete. It is not suggested the Defendant was aware of the local guidance and acted in reliance upon it therefore how does Nurse Wiltshire square that with her point that competent Nurse Practitioners would follow such guidance?"

LIMITATION

Dominic Ruck Keene

Wilkins v University Hospital North Midlands NHS Trust [2021] EWHC 261 (QB).

Aderounmu v Colvin [2021 EWHC 2293 (QB)

The Facts – Wilkins

Deputy High Court Judge Hermer QC determined as a preliminary issue whether the claim against the Defendant Hospital for negligently failing to treat a significant post-knee replacement infection on 12 March 2009 was statute barred. The Claimant had attended A&E on 28 March 2009 due to concern with his wound. He subsequently had regular orthopaedic review, and as a result had revision surgery on 22 June 2010. He continued to suffer from pain and swelling to the left knee, and later underwent an arthroscopy of the left knee and

eventually a total knee replacement revision on 17 January 2012. The Claimant was in discussion with solicitors from June 2012 and received in March 2013 an orthopaedic report that contained a caveated conclusion that there was no breach of duty. The Claimant accepted his then-solicitors' advice that the claim would not continue and proceeded no further. His knee subsequently continued to deteriorate, leading eventually to an above knee amputation on 22 June 2016. He instructed new solicitors and proceedings were finally issued on 30 June 2019.

The Defendant pleaded that the Claimant had the requisite knowledge on each occasion that he had complained about pain post-surgery, starting from a visit to his GP in June 2009 when he stated a belief that he had a left knee infection post-operatively.

The Facts – Aderounmu

Master Cook similarly determined as a preliminary issue whether the claim against the Defendant GP was statute barred. The alleged negligence concerned a failure to refer the Claimant for urgent investigations for a possible stroke. Four days after the index review on 23 November 2009, the Claimant suffered a stroke with resulting serious neurological injury. The Claim was issued on 10 October 2017, however, the Claimant asserted he was and always had been a protected party since his stroke.

The Defendant asserted that at all times the Claimant had capacity to conduct litigation.

Expert Joint Statements

Master Cook as an aside noted in respect of the joint psychiatric statement that it was *"an overly lawyered document comprising 34 questions many of which had numerous sub clauses and in places descended into cross-examination. This is not helpful to the court. A joint statement should aid the understanding of key issues and each expert's position on those issues."* Similarly the joint neuropsychological report "*asked many questions which were nothing more than a cross-examination of the experts on their respective approaches or attempts to advance the arguments on behalf the parties' respective position*." He cautioned that "*Parties should resist the approach that has been taken in this case, a joint statement by experts pursuant to CPR 35.12 is for the benefit of the court and should not be a proving ground for the parties' respective cases. Written questions should be put to experts under CPR 35.6 within 28 days of the service of an experts report."*

Capacity

Master Cook referred to the relevant test under the Mental Capacity Act 2005, and further noted both that the question of capacity is issue specific and that an individual may have subject matter capacity but not litigation capacity.

Master Cook identified that in light of the expert evidence the principal issue was the extent to which the Claimant could hold and retain information pertinent to his decision making, and whether the statutory presumption of capacity was displaced. He held that the medical records demonstrated that the Claimant had been able to obtain documents from his treating clinicians for the purpose of assisting his immigration case and various other issues in his life, and noted that no concern had ever been raised about the Claimant's mental capacity by health professionals familiar with the issue of mental capacity in patients following stroke (including clinical psychologists who met him on almost 20 occasions) during either his four-month hospitalisation or subsequently over a period of almost nine years. Master Cook also emphasised that in this period of time the Claimant made decisions requiring mental capacity about a number of complex health and 'life' issues. He concluded that the Claimant currently had capacity to litigate and had done so at all material times:

"I have no difficulty in concluding on the basis of all the evidence before me … that, with appropriate assistance, the Claimant could deal with issues and make decisions in this litigation concerning the liability of the GP namely the fact that he should have been referred onwards and as to causation, that his current condition was the result of his GP's failure to refer. I am also satisfied that the claimant is able to give instructions about his losses and his current condition so as to enable particulars of his damages to be provided. I am also satisfied that he is able to understand and weigh the pros and cons of any offer of settlement that might be made. None of this requires

him to understand every element of his case and the full content of every expert report, this would be beyond most average litigants in clinical negligence claims."

Limitation Principles

Master Cook in *Aderounmu* referred to the familiar authorities of *Nash v Eli Lilly & Co* [1993] 1 WLR 782 at 409 F, *Johnson v Ministry of Defence* [2012] EWCA Civ 1505 and *Adams v Bracknell Forest Borough Council* [2005] 1 AC 76 for the principles that the requisite knowledge for the purposes of s.11 of the Limitation Act 1980 (i.e. that the injury was significant and at least partially attributable to the tortious act or omission, as well as of the identity of the Defendant) requires a state of mind of sufficient certainty to justify the Claimant embarking on the preliminary steps for making a claim for compensation. Further, knowledge can be both actual or constructive, in particular considering the constructive knowledge that would have resulted from expert advice that a Claimant ought reasonably have been expected to seek. The reasonableness of seeking such advice depends on the Claimant's situation, which includes the consequences of the injury that he has suffered.

With regards to the discretionary extension of time under s.33 of the Limitation Act, Master Cook referred to a number of the factors from the well-known summary by Sir Terence Etherton MR in *Chief Constable of Greater Manchester Police v Carroll* [2017] EWCA Civ 1992 at [42]. He noted that the burden is on the Claimant to show that the prejudice to them by not exercising that discretion would outweigh the prejudice to the Defendant, with the burden not necessarily being a heavy one. Further, the Defendant has the evidential burden of showing that the evidence adduced, or likely to be adduced, by them is, or is likely to be, less cogent because of the delay. It is particularly relevant whether and to what extent the Defendant's ability to defend the claim is prejudiced due to the lapse of time because of the absence of relevant witnesses and documents. Lastly, proportionality is relevant – including whether the claim has only a thin prospect of success, or is modest in value, and the extent and degree of damage to a Claimant's health, enjoyment of life and employability; and whether the Claimant would have a clear case against their own solicitors. Master Cook concluded by reference to *Cain v Francis* [2008] EWCA Civ 1451 that "*Overall the more recent authorities stress the importance of focusing more on the question of whether it is still possible for a fair trial to take place than on a punitive approach to delay*."

Deputy High Court Judge Hermer QC stated that the most authoritative guidance relevant to the claim before him was the House of Lords in *Haward & Other v Fawcetts* [2006] 1 WLR 682 and the Supreme Court in *AB & Others v Ministry of Defence* [2012] UKSC 9. He held that the relevant principles were that the Claimant must know enough for it to be reasonable to begin to investigate further; and the Claimant must only appreciate in broad terms that his problem was capable of being attributed to the index breach – the 'essence' or 'essential thrust' of the act or omission to which his damage is attributable. He concluded that "*In the context of a clinical negligence claim it is not necessary that the claimant appreciates the precise mechanism by which s/he has sustained an injury but rather it suffices that there is an understanding in broad terms that the medical care may be a possible cause of injury*."

Deputy High Court Judge Hermer QC also referred to *Carroll* and, in addition to the factors cited by Master Cook in *Aderounmu,* referred to the Defendant only deserving to have the obligation to pay due damages removed if the passage of time significantly diminished their opportunity to defend the claim on liability or quantum; that it is the period after the expiry of the limitation period that has particular weight; and that the reason for delay is relevant and may affect the balance "*if there are no good reasons for the delay or its length, there is nothing to qualify or temper the prejudice which has been caused to the defendant by the effect of the delay on the defendant's ability to defend the claim*" – albeit that delay caused by a Claimant's advisers rather than the Claimant may be excusable.

Limitation application – Wilkins

The Claimant in *Wilkins* argued that his date of knowledge did not run until May 2019 when he first received positive advice from an orthopaedic expert, or alternatively when he was told in 2016 shortly prior to his amputation that he had osteomyelitis. He had previously been under the mistaken misapprehension that no one was to blame for his ongoing pain and had been advised that no claim existed. This was consistent with the

advice that he had received through much of this period from his treating clinicians to the effect that his recovery, whilst slow and imperfect, was not a cause for concern.

Deputy High Court Judge Hermer QC held that by June 2012 it was clear that the Claimant was at least in broad terms ascribing his ongoing pain in his knee to the treatment he had received from the Defendant, to the point where he consulted solicitors –

> *"There is little doubt therefore that by this date the Claimant knew 'in broad terms' the 'essence' of the case against the Defendant.* ***His appreciation of the nature of the potential claim in 2012 may well have been different to the basis of his pleaded case in 2019, not least the focus of critique might have been on surgical technique rather than control of infection, but he certainly knew that his ongoing difficulties were capable of being ascribed to substandard care by the Defendant****. Knowledge that the Defendants medical care could be attributed to his ongoing pain is the type of 'broad knowledge' sufficient to start time running under s.11, indeed it was this knowledge that led him to take the preliminary steps of investigating a claim by the instruction of solicitors.* ***I reject the submission that the test as applied to this case, required the Defendant to appreciate the precise mechanism of injury, i.e. that it might be a failure to manage infection that was the cause of ongoing pain, rather than surgical technique or the type of screws utilised. That degree of knowledge does not equate to the less demanding test of knowledge of the 'broad thrust of the case'****. This is not the type of case (in contrast, for example, with certain types of industrial injury) in which a Claimant needs complex medical, or other expert, investigation, to work out whether he has an injury attributable to another****. By the time he approached solicitors in June 2012 the Claimant suspected with sufficient certainty (i.e. that it was reasonable to investigate) that his ongoing pain could be broadly attributed to his care at Cannock Chase under Mr Shaylor****.*
>
> *To be clear, I do not consider that the mere fact that the Claimant obtained legal advice in 2012 and/or a medico-legal report in 2013, by itself automatically establishes the requisite level of knowledge. The judgments of the majority in AB illustrate that whilst the date on which a Claimant first instructs a solicitor might well indicate sufficient knowledge, it is not of itself automatically determinative in every case (see, for example Lord Wilson at §13). Here though it is clear to my mind that the circumstances under which the Claimant approached his former solicitors (disgruntlement with his treatment in light of ongoing pain) that at least by 18 June 2012 after a consultation with a solicitor, confirming that they would take on the medical negligence case, that the Claimant had the requisite knowledge – indeed he was advised in clear terms that it was considered that a claim had reasonable prospects of success. It is to my mind wholly unrealistic to contend that the date of knowledge was not established until 2019 and the receipt of the positive report from a new expert – that is a submission divorced from the test propounded by the authorities in circumstances in which the Claimant had previously instructed solicitors to proceed with essentially the same claim 7 years earlier.*
>
> *Accordingly, in my judgment, the Claimant had the requisite knowledge prior to the receipt of the report by Mr Radford.* ***As Mr Stagg accepted the mere fact that Mr Radford's report concluded that liability could not be established cannot act to 'cancel out' pre-existing knowledge*** *(see Nash v Eli Lily [1993 1 WLR 782 at 795E-F). As set out above, the Claimant had the requisite knowledge before Mr Radford had been instructed."* [Emphasis added]

Accordingly, the claim was brought at least seven years after time began to run and thus at least four years after it became prima facie statute barred.

When it came to the application of s.33, Richard Hermer QC rejected the Defendant's submission that given the Claimant's previous expert had identified that there was no breach of duty the Claimant would have 'an impossible hill to climb' in making good his claim –

> ***"In my judgment, save in the very clearest of cases, a Court should exercise real caution before conducting a merits assessment as part of the s.33 balancing exercise.*** This is for at least three reasons.

Firstly, although in Principle 10 of Carroll, Sir Terrence Etherton MR, states it might be relevant to the assessment of proportionality to take into account that the claim "only has a thin prospect of success", I do not read that as a general exhortation to assess merits other than in the clearest of cases. Such a (mis)reading would be inconsistent with paragraph 60 of the judgment where his Lordship said:

> *"So far as concerns the legal strength of the claim, it would be entirely inappropriate at this stage to conduct a mini-trial on very limited evidence. It cannot be said that the claim is so weak or inherently implausible that it could be stuck out or dismissed on summary judgment."*
>
> *I take this passage as making* ***plain that generally speaking a Court should refrain from taking a view on merits save in the clearest cases, i.e. where is it obvious that a case has only thin prospects of success.*** *In so far as this conflicts with the obiter observations of Stuart Smith LJ in Dale v British Coal Corporation [1992] PIQR 373 who, whilst cautioning against determining merits generally, said (at 381) that "All that can be done and should be done is for the judge to take an overall view of the prospects of success…" then I respectfully prefer the subsequent more cautious approach of the general guidance provided in Carroll.*

Secondly this cautious approach to the assessment of merits, save in the clearest of cases, is borne out of both principled and practical concerns as to how it could be fairly and transparently integrated into the s.33 balancing exercise. ***If a claim is so weak that it is bound to fail, then the Court has relevant powers to dispose of it under the strike out and summary judgment provisions****. The CPR, and the considerable body of case law that has built up around summary disposal powers, provide very clear legal tests that enable the court to apply a transparent and consistent approach to the assessment of merits…*

Thirdly, as stated, none of this is to say that in clear and obvious cases the merits cannot be taken into account. An example of this is AB v MoD where counsel for the claimant accepted that his case was unsupported by expert evidence and indeed irreconcilable with binding authority. Equally, ***there may be cases in which the merits of the claim are so strong that they should impact on the exercise of discretion, for example because the defendant has made a relevant admission.***

The question is therefore whether this claim can be properly classified as so weak that the Court can properly take the merits into account in the exercise of its discretion under s.33. I do not consider that it can." [Emphasis added]

Deputy High Court Judge Hermer QC went to hold that the most relevant factor was the tension between what he considered to be unjustified delay and the absence of any real prejudice caused by that delay. He distinguished between the delay in the Claimant progressing his claim after receiving negative advice from his previous solicitors and that after the instruction of his current solicitors. With regards to the first, he held it could be explained by a mix of an understandable response to that negative advice and the serious deterioration in his health – "*It was not in any sense unreasonable of the Claimant to reject that advice – there was no obvious reason for a layperson to conclude that it was wrong or was based on a misunderstanding*." In respect of the second period there was a lackadaisical attitude to progressing the claim with only glacial progress made and the length of delay was unjustified. However, when it came to prejudice the most the Defendant was able to say that "*the passage of time can always be expected to cause 'general prejudice' not least in a clinical negligence claim where experts are to be asked to recall what the level of acceptable clinical care was many years ago. As a matter of generality that may be right but absence any evidence at all of how such general prejudice transmutes into actual prejudice to the operation of a fair trial in this particular claim, the forensic value of the submission is very limited indeed. This is particularly so where, as here, the substantive dispute between the parties is unlikely to be resolved by the recollection of either patient or clinician of the material events rather than the medical records*." He concluded that "*notwithstanding the delays in this case it would be equitable, in other words, fair and just, to allow the action to proceed. It is not just the fact that a fair trial remains possible that bears heavily on the exercise of discretion …. It is... the fact that a fair trial remains possible, indeed pretty much unimpacted by the passage of time, taken with the seriousness of the underlying claim and its importance*

to the claimant (concerning as it does an allegation of mistreatment leading to amputation of his leg) and also that he himself cannot be deemed culpable for the majority of the delay."

Limitation application – Aderounmu

Master Cook reviewed various references in the Claimant's medical records concerning the extent to which he had made contemporaneous comments concerning his anger at the Defendant for failing to refer him to hospital. He concluded that "*The Claimant certainly had the knowledge in December 2010 that his injury was significant. It is clear that by this time he knew that his injury was attributable to an omission on the part of his GP and that this was probably a breach of duty*." Accordingly he had actual or constructive knowledge no later than 20 December 2020.

In applying s.33, Master Cook noted with regards to the reason for delay that it was a finely balanced decision that he had litigation capacity. He also accepted that "*he may have had strong Christian principles which would have predisposed him against making a claim against his GP, this is clearly recorded in his medical notes. It is also clear to me that he was recorded as being in a very emotional state about the issue. There is also in my view a difference between making a complaint to the GP or hospital about what had happened and taking legal advice with a view to bringing a civil claim*." It was likely that until October 2017 the Claimant was primarily pre-occupied with conducting his immigration litigation.

With respect to the cogency of the evidence *"in common with many clinical negligence claims the medical records will be of central importance and in this case they are all readily available. As I have already observed Dr Colvin has an independent recollection of the consultation and does not appear to be in anyway handicapped by the passage of time from giving a full and accurate account of her actions. This is to be contrasted with the usual position which is that the medical practitioner has no independent recollection of the consultation and has to rely on a combination of the medical notes and their usual practice. The standard of care provided will be the subject of evidence from appropriate GP experts which it would seem both parties have already obtained."*

Master Cook concluded that: *"Standing back considering all the circumstances of the case and balancing the prejudices to the Claimant and to the Defendant, in my judgement the balance comes down in favour of the Claimant whom has undoubtedly suffered a serious neurological injury. I am particularly satisfied that it will be possible to have a fair trial of the issues arising in this claim. In the circumstances I find that it would be equitable to allow this action to proceed."*

Comment

These judgments are valuable demonstrations of the overall approach that can often be taken by the courts in interpreting the Limitation Act 1980 in clinical negligence cases. On the one hand there is a relatively strict application of the knowledge-based limitation period with the extent to which an injured Claimant is in effect put on notice by the fact of their injury and not expected to know the precise mechanism of that injury. Further, claimants should expect defendants to trawl their contemporaneous medical records as to their reaction to their injury. On the other hand there is a more generous exercise of discretion, particularly in cases that are largely dependent on expert interpretation of medical records rather than particular clinician recollections. The reality is that many clinicians have limited recall of individual patients even within the primary limitation period and it is often going to be difficult for defendants to demonstrate significant additional prejudice through any additional loss of recollection due to the passage of time.

Master Cook's warning concerning the content of joint statements is also a useful reminder of the need to consider expert agendas carefully, less the resulting statement runs foul of the same criticisms as made in *Aderounmu*. Lastly, Master Cook's assessment of the Claimant's capacity is a helpful example of how the question of litigation capacity is approached, particularly in the context of a limitation argument that a claimant lacked capacity and therefore that the limitation clock never started to run.

CAUDA EQUINA SYNDROME

Shaheen Rahman QC

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

In *Hewes v West Hertfordshire Acute Hospitals NHS Trust & Ors* [2020] EWCA Civ 1523 (see Issue 8), the Court of Appeal considered, for the first time, a case of alleged delay in the treatment of Cauda Equina Syndrome ("CES"). CES is a medical emergency requiring urgent surgery to release pressure on the spinal nerve roots. Delay can lead to catastrophic damage. However, it is difficult to diagnose. Many people present with symptoms consistent with CES; the overwhelming majority do not have it.

Hewes did not purport to determine any principles of general application to CES cases, which turn on their own facts. One such case was *Jarman*, heard by Deputy High Court Judge Coppel QC. The Claimant presented at A&E on 3 March 2015 with red flag symptoms of CES, in particular perineal numbness, but examination by an orthopaedic registrar identified no objective signs of it. The diagnosis was likely disc prolapse. She was to come back for an MRI in the *"next few days"* or return to A&E if she deteriorated. In the event the MRI was not performed for 15 days, and CES was confirmed. Despite surgery she was left with permanent injuries.

Breach of duty

The judge rejected the Claimant's case that an MRI had been planned within a few days because the diagnosis was suspected CES, given the contemporaneous notes and the registrar's evidence to the contrary [25]. Although following an MDT the MRI request had been wrongly sent as 'routine' rather than 'urgent', it had still taken place within an appropriate urgent timescale. Hence this error made no material impact. Although the scan did not take place within a few days as planned, this was poor service rather than negligence [27].

The judge also rejected the Claimant's alternative case that she *should* have been diagnosed with suspected CES; noting [35]:

> *"CES can only be definitively diagnosed with an MRI scan. Prior to a scan, diagnosis of possible CES is a matter of clinical assessment based on symptoms and signs. However, a number of symptoms of CES are also typical of other, less serious lower back conditions. This means that the number of patients presenting with symptoms indicative of CES is far greater than the number of patients who could be scanned given conventional resource constraints."*

Both orthopaedic experts confirmed that they themselves would have sent the Claimant for an emergency scan, and it was of note that all the neurosurgical and neurology experts would have too [38]. Nonetheless, the registrar's assessment had been *"comprehensive"* and *"roundly praised"* [39]. Moreover, no literature or guidelines supported the view that a patient with symptoms, but no signs, of CES required an emergency MRI. A 2019 study suggested that prospectively the risk of a patient presenting as the Claimant did having CES was negligible [40]-[42]. The study post-dated the alleged negligence, but there had been a trend for greater scanning since then. Ergo, a patient who would not be sent for an emergency scan in 2019 would be even less likely to have been sent for one in 2015 [43].

The Claimant's expert's view that a body of reasonable orthopaedic opinion would have supported a scan within four days of the Claimant's presentation at A&E, but not thereafter, was fundamentally flawed [44]:

> *"Once CES is suspected, a scan should be undertaken as quickly as possible and, in effect on an emergency basis (and see the finding of the Court of Appeal in Hewes […]) There is nothing to be gained by delay (in particular the resource implications are the same for the treating hospital) and potentially much to be lost…"*

The judge accepted that the expert was *"guilty, to some extent at least, of framing his position to fit the Claimant's primary legal argument"*. Further criticisms of his performance in cross-examination were made by contrast with the Defendant's expert [45]-[46].

Causation

It was the view of the Claimant's neurosurgical expert that after the optimal window of 48 hours for surgery, the Claimant would have to show some neurological deterioration in the period of delay, otherwise the outcome would have been the same [53]. The judge noted *"significant challenges"* for the Claimant on causation as even if a deterioration in the relevant period could be established, "*there would remain the question of whether that deterioration can be established to have caused a specific injury or measurable damage which can be identified and quantified in damages"* [56]. That the Claimant had not returned to hospital was in itself evidence that her condition had not significantly deteriorated in the judge's view [57]. Adopting a granular approach, the judge rejected each matter relied upon to evidence deterioration in the period of delay [59]-[67]. He considered some of these features were accounted for by more specialist assessments at later dates. He criticised the lack of literature to support the more high level view adopted by some of the Claimant's other "*eminent"* experts that earlier surgery would have led to a better outcome [68]-[70].

Comment

A convincing win for the Defendant, perhaps fortunate that the judge was so ready to go behind the timeframe explicitly recorded for the MRI and where all the experts themselves would have ordered an emergency MRI. By contrast, the Claimant's orthopaedic expert was rather unlucky to have been criticised for recognising a responsible body of opinion contrary to his own practice, something that might ordinarily speak to a balanced and objective view. The judge also set a high bar and adopted a stringent approach to the question of causation of damage. Others may have given more credence to the experience of eminent experts that earlier surgery generally leads to a significantly better outcome. The failure to return to hospital might also have been put aside, given the Claimant was awaiting an MRI scan and had been told she did not have CES. Of interest are the judge's comments and recognition of the resource allocation decisions at play when determining who should get an emergency MRI. There may however be a sting in the tail for Defendants in the judge's suggestion that once CES is suspected, a resources argument would not hold water and that the trend has been towards a lower threshold for scanning. The case is also notable for having, in common with many CES cases, a background of Part 20 proceedings since the Claimant had settled a case against her employers arising from an injury at work that precipitated her CES. This meant that additional expert evidence obtained by the employers was deployed by the Claimant, adding to the complexity of the litigation (see article covering this point in Issue 8 here).

DETERMINING CAUSATION IN A BACTERIAL MENINGITIS CASE

Shaheen Rahman QC

Davies v Frimley Health NHS Foundation Trust [2021] EWHC 169 (QB)

This was a claim brought by the widower of a woman who died of bacterial meningitis. She had been admitted to hospital two days earlier with a history of severe headache and middle ear infection. The Defendant admitted that following her admission there had been a negligent delay between 10:40 and 13:20 in commencing intravenous antibiotics. Quantum had been agreed and the only issue to be determined was that of causation.

Causation on the balance of probabilities

His Honour Judge Auerbach, sitting as a Judge of the High Court, identified the question to be determined as what would have happened if IV antibiotics had been commenced at 10:40 – was it more likely that Mrs Davies would have survived or died? It was appropriate to draw on the picture painted by all the evidence, namely the evidence about Mrs Davies and what happened to her, the evidence of the experts on the basis of their experience and judgment and the literature to which they referred. It was also appropriate to rely on whatever insight could be properly gained from the benefit of hindsight. He noted that in the case of *Schembri v Marshall* [2020] EWCA Civ 358 (Issue 5) the Court of Appeal had upheld a judgment in favour of the estate of a patient who had died of pulmonary embolism, despite the fact that it was not possible to identify the precise mechanism

by which she would have been saved had she been in hospital, because the bigger picture pointed to that conclusion [117]-[121].

The judge noted that untreated bacterial meningitis is deadly and progresses fast, but that IV antibiotics are highly effective in treating the disease and therefore survival rates are high [125]-[126].

Expert evidence was heard from microbiologists, ENT specialists and neurosurgeons. The overall consensus was that the meningitic process had begun the evening or night before admission. By the time of admission the intracranial pressure was raised but not critically so. Likewise temperature and pulse were raised but did not point to the process being fatally advanced. Mrs Davies was in appalling pain but was still able to communicate. By around 14:00 her condition was much worse and she declined rapidly. The overall picture indicated that IV antibiotics would probably start to take effect in the brain between 30 minutes and an hour and a half after administration and would quickly neutralise any bacteria continuing to come in from the ear [131]-[137].

The judge considered that the overall picture of events as they unfolded, of Mrs Davies' background risk, presentational and diagnosis indicators, pointed to the overall conclusion that had IV antibiotics been administered at 10:40 it was more likely that she would have survived than died [138].

However, it was necessary to decide causation on the basis of the whole of the evidence, including any later events that might show the case to be different from how it appeared at the point of admission. The Defendant relied upon the fact that the outcome had been fatal, despite good prognostic indicators at 13:20. It was argued that the rapidity of her decline meant that antibiotics at 10:40 would not have saved her. The judge rejected that argument and accepted the Claimant's microbiology expert's answer that the disease had been progressing during the period of delay, and deterioration was not linear. Rather, it reaches a crisis point at which there will be a sudden decline, as in this case. The judge also considered that the range of literature gave more or less detailed or direct support to the Claimant's case on causation, but none undermined it [139]-[143].

Further, the judge did not consider that the Defendant's microbiologists' experience matched that of the Claimant's and did not accept that the clinical course was particularly unusual or pointed to a conclusion that by 10:40 it was too late. The Claimant's ENT expert supported the Claimant's microbiologist's view, whereas the Defendant's ENT expert more squarely deferred to other experts. As to the neurosurgeons, whilst the Claimant's expert did not ultimately support his case on causation, he did not go against it. On the other hand, the Defendant's expert's opinion that this was a fulminant infection already beyond treatment by the time of admission to hospital represented an isolated viewpoint and was rejected [150]-[164].

The judge concluded that whilst Mrs Davies had an aggressive disease it was still amenable to treatment and had not reached the tipping point after which she was likely to die by 10.40. Accordingly, the claim succeeded on the basis of conventional "but for" causation [166]-[167].

Material contribution

The judge nonetheless proceeded to consider the alternative causation argument, based on the Claimant's expert neurosurgeon's view that the outcome was uncertain but that *"any delay between about 10:10 and 12:00 in administering antibiotics made a material contribution to her decline and death"* [168]-[169].

The judge set out the leading authorities on material contribution and the parties' submissions on further cases but did not fully subscribe to the analysis of either side [170]-[199]. His view on establishing causation of damage was as follows:

- Where the harm is divisible, a party will be liable if their culpable conduct made a contribution to the harm, to the extent of that contribution;
- Where the harm is indivisible, a party will be liable for the whole of it if they caused it applying "but for" causation;
- If two wrongdoers have both together caused an indivisible injury in respect of which it is impossible to apportion liability between them, then each is co-liable for the whole of the injury suffered [200].

These were described as the *"orthodox"* routes to liability (though be warned, the meaning of 'divisible' and 'indivisible' harm is something of a moveable feast in the context of material contribution - see UK Healthcare Law blog post on the case). A distinct further route arose in the limited types of cases to which the approach in *Fairchild v Glenhaven Funeral Services Limited* [2003] 1 AC 32 applied. In mesothelioma cases the effect of the Compensation Act 2006 was that each contributor to the risk was co-liable for the whole of the harm. Otherwise it is apportioned as in the asbestos exposure case of *Heneghan v Manchester Dry Docks Limited* [2016] ICR 671 [201].

The judge noted that in *Bailey v Ministry of Defence* [2009] 1 WLR 1052 the Court of Appeal had pointed to the existence of an additional *"novel"* route by which a party could be held liable for the whole of the harm caused, but that in *AB v Ministry of Defence* [2010] EWCA Civ 1317 it was held that both *Bailey* and *Bonnington Castings v Wardlaw* [1956] AC 613 were in truth conventional cases of divisible harm and that in the latter there ought to have been an apportionment. That was in effect the position of the court in the cases of *Heneghan* and in *Sienkiewicz v Grief (UK) Limited* [2011] 2 AC 229 and of the Privy Council in *Williams v The Bermuda Hospitals Board* [2016] AC 888 [203]-[207].

He concluded at [210]-[211] that:

> *"In the present case Mrs Davies died from a disease which, whilst it involved a process that took its course over a period of time, led to the indivisible outcome of death. The sole task of the Court has been to determine on the balance of probabilities whether, in a but for sense, the failure to start IV antibiotics by 10:40 on the day of admission caused her death or not.*
>
> *As I have said while I fully appreciate that some of the experts felt ultimately unable on the clinical evidence available in this very difficult case, to answer that counterfactual question in quite that way, the Court is obliged, on the evidence it has, including such assistance as the experts feel able to provide to do so, as best it can. That I have done. For the reasons I have given, I do not think that any other legal doctrine could have been brought to bear in this case"*

Comment

The judge's approach was in line with that approved in *Schembri*, emphasising that the ultimate determination of the issues of causation is for the court, assisted by experts and other evidence as appropriate to reach a conclusion, standing back and applying common sense and pragmatism. The judge's analysis of the material contribution argument has been cited in the recent case of *Thorley v Sandwell & West Birmingham Hospitals NHS Trust* [2021] EWHC 2604 – to be covered in a later edition. Soole J agreed with the approach and considered himself bound by *AB.* However, he opined that this was a legal issue that was ripe for authoritative review.

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

QUANTUM: CONTRASTING OUTCOMES IN TWO FATAL ACCIDENT CASES

Matthew Donmall

Chouza v Martins and others [2021] EWHC 1669 (QB)

Steve Hill Ltd v Witham [2021] EWCA Civ 1312

Although very different cases on the facts, these two recent judgments show the risks involved in litigation. *Chouza* shows the danger that having heard the evidence, a judge might accept almost the entirety of a claimant's case. *Steve Hill Ltd* shows how a significant change of circumstances can undermine the basis of a claim, even if it occurred after trial while an appeal was pending.

Chouza arose from a fatal road traffic accident. The deceased was a Spanish national and 50 at the time, leaving a wife and four children. He ran his own business in Spain, but this had run into difficulty and the deceased had

commenced contracting for another company, Andeona, as an operator of a construction plant and an HGV driver. A claim for €995,601 in future financial dependency was advanced, the Defendant arguing for just a quarter of that, at €254,078. Mr Justice Martin Spencer concluded the dispute overwhelmingly in the Claimant's favour, awarding €824,088. The way the evidence was resolved shows the difficulty a defendant can face in attacking contentions advanced by a claimant. For example, the Defendant argued that it was "*unlikely in the extreme*" that but for his death, Andeona would have paid the deceased €250 a day net as an employee. The judge found that he was *"a hard-working man"*, and found the evidence of the managing director, Ms Magdalena, persuasive, citing her statement that *"I don't know what the future would have held if the deceased had survived but we would have paid whatever it took to keep him on because he was such a valued contributor to the company."* Efforts by the Defendant's counsel to challenge such evidence were wholly unsuccessful. The decision is also notable for the judge being persuaded to depart from the conventional dependency percentages of 75% / 66 % if no dependent children, on the basis that the deceased spent very little on himself, instead awarding 85% / 70%.

Steve Hill Ltd concerned an appeal from an assessment of damages in a fatal mesothelioma claim. The deceased and his wife, a nurse, had fostered two children with special needs, and under the fostering agreement, one of them had to remain at home to look after the children, and the couple had determined that the deceased would do so. When the deceased became seriously ill, it was necessary for his wife, the Claimant in the action, to stop work. With his death she lost her full-time career. The judge found that it was the Claimant's dependency on her husband which had been lost and valued that loss at the cost of the replacement care, i.e. the value of the services lost as a result of her husband's death. The attack on this aspect of the decision on appeal was dismissed. The Appellant sought to argue that the true loss of the deceased's services was to the children. Nicola Davies LJ observed that the Claimant had lost the benefit of the service her husband provided in caring for the children: *"That being so, she can legitimately claim the cost of securing those services to enable her to place herself in the position she was prior to her husband's death."* However, the appeal did succeed on a wholly new aspect of the case, namely that the award was erroneous in light of events since trial, as the children had subsequently been removed from the Claimant's care. The Court of Appeal noted that although dependency was valued at the date of death, the continuance of dependency was an issue that was relevant to that valuation, and unsurprisingly considered that the factual matrix had fundamentally changed since the judgment. The approach set out in *Ladd v Marshall* [1954] 1 WLR 1489 was followed (the new evidence was credible, highly relevant to the outcome, and could not have been obtained with reasonable diligence prior to the trial). The Court of Appeal considered "*To refuse to admit the evidence 'would affront common sense, or a sense of justice'*", and the case was remitted to the trial judge for re-evaluation.

DENTAL NEGLIGENCE, VICARIOUS LIABILITY AND NON-DELEGABLE DUTY: A TEST CASE

Robert Kellar QC

Hughes v Rattan [2021] EWHC 2032 (QB)

In *Hughes v Rattan* [2021] EWHC 2032 (QB), the High Court was asked to answer the following question: was the owner of a dental practice liable for the dental negligence of a self-employed dentist engaged to work in the practice? The claim arose from NHS care provided by three different associate dentists. The preliminary issue was whether the practice owner was liable by reason of: a) a non-delegable duty of care; or b) vicarious liability. The court answered: "yes" and "yes".

Non-Delegable Duty of Care

The judge analysed the issue of non-delegable duty by reference to the principles affirmed by Lord Sumption in *Woodland v Swimming Teachers Association and others* [2013] UKSC 66.

(1) The claimant is a patient or a child, or for some other reason is especially vulnerable or dependent on the protection of the defendant against the risk of injury. Other examples are likely to be prisoners and residents in care homes.

(2) There is an antecedent relationship between the claimant and the 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. It is a characteristic of such relationships that they involve an element of control over the claimant, which varies in intensity from one situation to another, but is clearly very substantial in the case of schoolchildren.

(3) The claimant has no control over how the defendant chooses to perform those obligations i.e. whether personally or through employees or through third parties.

(4) The defendant has delegated to a third party some function which is an integral part of the positive duty which he has assumed towards the claimant; and the third party is exercising, for the purpose of the function thus delegated to him, the defendant's custody or care of the claimant and the element of control that goes with it.

(5) The third party has been negligent not in some collateral respect but in the performance of the very function assumed by the defendant and delegated by the defendant to him.

The court held that it was not necessary to show that the practice owner had accepted "personal responsibility" to provide the Claimant with dental treatment as a pre-requisite to satisfying the *Woodland* factors. No such requirement had been identified in *Woodland* itself. Nor did it matter that the practice owner had complete freedom to delegate work to his associates. The court observed that the ability to delegate relevant acts to third parties was a feature of all cases in which a non-delegable duty was alleged to arise. Absent such delegation the existence of a non-delegable duty would not arise as an issue in litigation. The court then turned to address the specific *Woodland* factors.

The first factor was satisfied. It was apparent that the Claimant was a patient of the practice and not just a patient of each treating associate dentist. For example, the practice held patients' records and contact details, arranged appointments and took payments for treatment. Moreover, the Claimant, as a patient of the practice, had placed herself under the care of the practice in circumstances where she was vulnerable to the risk of injury (given the nature of dental treatment) and dependent upon the practice in respect of the treatment provided. *Woodland* did not require the Claimant to prove "a high threshold of vulnerability" beyond establishing that she was a patient.

As to the second factor, there was a sufficient "antecedent relationship" between the Claimant and the practice from which a positive duty to protect the Claimant from harm could be imputed. In coming to that conclusion, the court analysed the General Dental Service Contract ("GDS Contract") between the PCT and the Defendant. As part of that contract it was the practice owner (and not individual associates) who undertook to provide an agreed amount of dental services to patients. The practice was also responsible for holding patients' records, booking patients' appointments and taking patients' payments. Moreover it was the practice, and not individual associates, which supplied the premises, nurses and equipment necessary to perform dental services. All of these factors supported the existence of an "antecedent relationship" between the practice and the patient.

The third *Woodland* factor was also made out by the Claimant. The Claimant had no control over how the practice owner chose to perform his obligations. The practice owner could choose whether to provide NHS dental services himself or via employees, associates or sub-contractors. At most the Claimant could request, although not insist upon, a particular dentist from the pool of dentists which had been selected to provide dental services at the practice. The fact that the Claimant could choose to reject the services altogether was irrelevant.

It was conceded by the Defendant that if the first three *Woodland* factors were made out the fourth and fifth would follow.

Vicarious Liability

As to vicarious liability, the court applied the approach described by the Supreme Court in *Various Claimants v Barclays Bank plc* [2020] UKSC 13. Following that approach, the question for the court was whether the relationship between the practice owner and the associates was sufficiently "*akin to employment*" to make it fair and just to impose vicarious liability. The relevant distinction was between a situation "*akin to employment*" and a situation where a genuinely independent contractor was in business on their own account. Post-*Barclays* this was the correct starting point rather than beginning with consideration of the five policy factors that had been identified by Lord Phillips in the *Christian Brothers* case.

The sheer fact that the associate dentists were self-employed, responsible for their own tax and national insurance and not in receipt of the kind of benefits that would be received by employees did not answer the question one way or another. Nor, held the court, was it decisive that associate dentists had a large amount of freedom over how much time they worked at the practice and how their work was divided between NHS and private patients.

Whilst associates were free to make clinical decisions and provide treatment as they saw fit, a relatively slight amount of control was sufficient for the purposes of the law on vicarious liability. A number of factors suggested that there was a sufficient degree of control present. These included that the practice owner could decide when the premises were open and when his nursing and reception staff were made available. Furthermore associates agreed to comply with the practice's policies and procedures and to comply with the requirements of the GDS contract regarding appraisal, CPD and clinical governance.

However the most significant question, in the court's view, was whether associate dentists were working as part of their own independent business or as an integral part of the Defendant's. The court held that associates were an integral part of the Defendant's business. In reaching that view it was influenced by a range of factors. These included that:

The work was undertaken in premises owned by the practice owner and using staff, equipment and other facilities that he provided;

The dental work that the associate dentists undertook enabled the practice owner to meet his overarching obligations to the PCT under the GDS Contract to provide NHS dental services.

Payment for the NHS work undertaken by the associate dentists was made by the PCT to the practice owner, who then retained a 50% share.

Whilst the associate dentists bore an element of the business risk in terms of the amount of work they undertook, the practice owner bore the substantial majority of the financial risk and potential profits in terms of the dental work undertaken at the practice.

The court therefore concluded that the relationship in this case was sufficiently "*akin to employment*" to make it fair, just and reasonable to impose vicarious liability.

Comment

The liability of dental practice owners for the negligence of dental associates has previously been considered by the County Court (see our previous pieces on *Ramdhean v Agedo* and *Breakingbury v Croad*). However, this is the first time that the issue has been considered by the High Court. Post *Woodland* and *Barclays*, whether healthcare providers are liable for the negligence of their independent contractors remains a hot topic. This is therefore an important test case for those involved in healthcare litigation.

At first blush, this case suggests that the wind is blowing in favour of claimants on this important issue. The older case law about non-delegable duties was concerned with care provided in a hospital setting. However, this case

demonstrates that hospital care is not a pre-requisite to the existence of a non-delegable duty. Moreover, it is also unnecessary for a claimant to prove a high degree of vulnerability or dependence. It suffices (for the purposes of the first Woodland factor) that they can prove they were a patient of the defendant.

Similarly, the case demonstrates that it is possible to establish vicarious liability for practitioners who are indisputably self-employed and who enjoy a high degree of clinical autonomy. The key issue is whether that person is working as an integral part of the defendant's business. If they are the Supreme Court's decision in Barclay's Bank is not a bar to the imposition of vicarious liability.

In the author's view, the case is likely to be relied upon to support the imposition of vicarious liability/non-delegable duties more widely. On the other hand, it is clear that the outcome of this case turned upon its own particular facts. For example, the court was heavily influenced by a careful analysis of the terms of the GDS contract between the Primary Care Trust and the practice owner in relation to NHS work. Those terms would not be relevant to private dental work. Indeed, the court stated in terms that it had not been asked to decide whether the same duties would be owed to private dental patients. Accordingly, the analysis performed by the court in *Hughes* will need to be performed by the court afresh in future cases.

In the author's view, it is likely that a substantial number of cases will follow in the wake of *Hughes v Rattan*. The boundaries of non-delegable duty and vicarious liability in the healthcare context remain to be drawn.

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THE BOUNDARIES OF VICARIOUS LIABILITY FOR HISTORIC CHILD ABUSE EXPLORED ONCE AGAIN

Dominic Ruck Keene

Blackpool Football Club v DSN [2021] EWCA Civ 1352

The facts

The Court of Appeal considered an appeal against a finding that a football club was liable for the sexual abuse inflicted on a 13-year-old youth player in 1987 by a volunteer scout (Mr Roper) during a tour of New Zealand, and further that the primary limitation period should be disapplied under s.33 of the Limitation Act 1980. At the relevant time the club's financial situation was dire and, as a result, it could only afford to employ a minimum number of staff and was dependent upon volunteers for functions which might, in a bigger or better funded club, have been performed by paid employees. The trial judge had found that "*Identifying, recruiting and retaining the allegiance of promising young footballers was…part of the core business of the club*." The volunteer scout in question was held by the trial judge to have had a "*particular role in spotting promising players below the minimum schoolboy signing age of 14, taking them under his wing, coaching and watching them… and encouraging them to form an allegiance to Blackpool FC before the time came when they might (if good enough) be formally signed up*." With regards to the tour of New Zealand the Court of Appeal noted that it was not billed or described as a Blackpool FC trip, and there was no evidence that Blackpool FC as such had any involvement in the planning, running, administration or financing of the trip other than the contribution of £500, or had endorsed, still less adopted the tour. The trial judge had recorded witness evidence to the effect that either the, or a, primary purpose of the Thailand leg of the trip was for the scout to recoup his outlay on the tour by purchasing counterfeit sports goods which he would then sell in England.

The claim

The Claimant argued that Blackpool FC's relationship with the scout was akin to employment as the club had caused or permitted him to hold himself out as a representative of the club and derived benefit from the relationship by using him as a source of young footballing talent. The club created the risk that the scout would take advantage of the opportunity afforded by his employment to abuse the Claimant.

Vicarious Liability principles

Stuart-Smith LJ began his review of the relevant principles by stating that the focus is on whether there was a true relationship of employment between D1 and D2, and whether D1 was acting in the course of employment when he committed the relevant tort. Further, he quoted Clerk and Lindsell to the effect it was and remained established that "*if the employer has employed an independent contractor to do work on his behalf, the general rule is that the employer is not responsible for any tort committed by the contractor in the course of the execution of the work. Furthermore, since the employees of the contractor, whilst acting as such, stand in the same position as their employer, it is equally the case that the employer of the contractor is not liable for the torts committed by the contractor's employees."*

Stuart-Smith LJ referred to the various relevant leading decisions since 2012 and distinguished between those where there was a conventional employer/employee relationship (*Mohamud v WM Morrison Supermarkets plc* [2016] UKSC 11, and *Various Claimants v WM Morrison Supermarkets plc* [2020] UKSC 12 from those where there was not *(Various Claimants v Catholic Child Welfare Society* [2012] UKSC 56, *Cox v Ministry of Justice* [2016] UKSC 10, *Various Claimants v Barclays Bank plc* [2020] UKSC 13, and *BXB v Watch Tower and Bible Tract Society of Pennsylvania* [2021] EWCA Civ 356).

He noted that following *Christian Brothers* it had become conventional to approach the issue adopting the two-stage test of considering the relationship between D1 and D2 to see whether it is one that is capable of giving rise to vicarious liability and also examining the connection that links the relationship between D1 and D2 and the tortious act or omission of D1 – "*recognising that resolution of the issue involves a synthesis of the two stages*."

Stuart-Smith LJ cited the familiar passage from Lord Phillips's judgment in *Christian Brothers* setting out the policy reasons that *"…usually make it fair, just and reasonable to impose vicarious liability on the employer when these criteria are satisfied: (i) the employer is more likely to have the means to compensate the victim than the employee and can be expected to have insured against that liability; (ii) the tort will have been committed as a result of activity being taken by the employee on behalf of the employer; (iii) the employee's activity is likely to be part of the business activity of the employer; (iv) the employer, by employing the employee to carry on the activity will have created the risk of the tort committed by the employee; (v) the employee will, to a greater or lesser degree, have been under the control of the employer."*

He went on to note that Lord Phillips had identified that the modern significance of control was that an employer could direct what an employee does, not how he does it, and that Lord Phillips had endorsed the approach of Rix LJ in *Viasystems (Tyneside) Ltd v Thermal Transfer (Northern) Ltd* [2005] EWCA Civ 1151, namely that liability might arise where an employee was *"an integral part of [the employer's] business"* or *"embedded in [the employer's] organisation".*

Stuart-Smith LJ referred to the consideration of the connection test in both *Christian Brothers* and *Lister v Hesley Hall Ltd* [2001] UKHL 22 as establishing:

"*…two important points. First, the fact that an employer's enterprise creates a foreseeable risk and gives the employee the opportunity to commit sexual abuse is not sufficient to justify the imposition of vicarious liability on the employer. Second, the additional feature that justifies the distinction between the groundsman and the warden of the residential home is that the warden has been employed to discharge the school's responsibilities to the children who have been entrusted by the employer to his care*."

Stuart-Smith LJ also referred to Lord Phillip's judgment in *Christian Brothers* referring to the close connection test whereby vicarious liability is imposed where "*a defendant, whose relationship with the abuser put it in a position to use the abuser to carry on its business or to further its own interests, has done so in a manner which has created or significantly enhanced the risk that the victim or victims would suffer the relevant abuse. The essential closeness of connection between the relationship between the defendant and the tortfeasor and the acts of abuse thus involves a strong causative link*." He commented that the significant features of Lord Phillips's formulation:

"*…go beyond the simple requirement of a "strong" or "close" connection between the risk created by the employer's enterprise and the wrongful act. In addition, the formulation involves (a) "placing" the abuser in their position, (b) using them to carry on its business, and (c) thereby significantly increasing the risk created by the employer's enterprise. Both (a) and (b) imply a degree of control and direction of the abuser by the "employer*".

With respect to the facts of *Christian Brothers* he held that the element of control was "*central to Lord Phillips' analysis and conclusion. The institute's control of the individual brothers was complete: it directed the individual brothers to teach at the school (i.e. what they should do) and dictated their conduct when there (i.e. how they should do it*)."

Stuart-Smith LJ next referred to *Cox* and described it as providing clarification in respect of control and developing the law through the significance of the assigning of work by D2 to D1. With respect to control, he held that Lord Reed in *Cox* should be interpreted as saying that:

"*…the presence or absence of an ability to direct how an individual did his work is unlikely to be of independent significance in most cases….the presence or (particularly) absence of control is a material consideration for a court deciding whether or not to impose strict vicarious liability upon D2. It is, in my view, always to be borne in mind as a potentially material consideration when deciding whether to extend vicarious liability by incremental analogy from the safe confines of an employer/employee relationship*."

He cited Lord Reed's summary of stage 1: "*a relationship other than one of employment is in principle capable of giving rise to vicarious liability where harm is wrongfully done by an individual who carries on activities as an integral part of the business activities carried on by a defendant and for its benefit (rather than his activities being entirely attributable to the conduct of a recognisably independent business of his own or of a third party), and where the commission of the wrongful act is a risk created by the defendant by assigning those activities to the individual in question*."

Stuart-Smith LJ referred to *Morrison 1* and noted that:

"*…there must be a sufficient (i.e. strong/close) connection between the position in which he was employed and the employee's wrongful conduct. The decided cases show that this second question is highly fact-sensitive and requiring of detailed scrutiny. Where it is proposed to extend the imposition of vicarious liability beyond its traditional bounds, the rigour to be attached to the second question (as well as to the first) must, in my judgment be even greater because notions of entrusting functions, assigning work, and the extent of the "employer's" control are likely to be more fluid than in a conventional employer/employee relationship. Third, and quite apart from the distinction between those relationships that are akin to employment on the one hand and akin to independent contracting on the other, it is always to be remembered that it is not sufficient simply to provide the "employee" with the opportunity to commit the tort*."

Stuart-Smith LJ considered that *Barclays* and *Morrison 2* had adopted a more restrictive approach than *Morrison 1* and *Armes*, and cited Lady Hale's identification in *Barclays* of the question being "*whether the tortfeasor is carrying on business on his own account or whether he is in a relationship akin to employment with the defendant. In doubtful cases, the five "incidents" identified by Lord Phillips may be helpful in identifying a relationship which is sufficiently analogous to employment to make it fair, just and reasonable to impose vicarious liability. Although they were enunciated in the context of non-commercial enterprises, they may be relevant in deciding whether workers who may be technically self employed or agency workers are effectively part and parcel of the employer's business. But the key, as it was in [the Christian Brothers' case, Cox's case] and Armes … , will usually lie in understanding the details of the relationship. Where it is clear that the tortfeasor is carrying on his own independent business it is not necessary to consider the five incidents*."

Stuart-Smith LJ held that as matter of principle the final sentence in that summary was applicable to stage 1 and to stage 2 as it was entirely possible for there to be a relationship between D1 and D2 which would in principle be capable of giving rise to vicarious liability but for the tortious acts in question to fail to satisfy stage 2 because, when committing the acts, D2 was acting "*on his own independent business*."

Stuart-Smith concluded his summary of the development of vicarious liability by holding that "*Where an employer/employee relationship is lacking there is a broad spectrum from those which are, in reality, only technically different from a conventional employer/employee relationship to those which are readily identified as being either true independent contractor/employer relationships or relationships that have essentially the same characteristics*." The need for Lord Phillips's five criteria is in doubtful cases to help identify the relationship that is sufficiently analogous to employment to make it fair, just and reasonable to impose vicarious liability albeit those criteria cannot provide definitive outcomes. Nevertheless it was material that:

"*101…. that the journey towards extending the scope of relationships where vicarious liability should be imposed beyond conventional employer/employee relationships is substantially based upon the approach of Rix LJ to dual vicarious liability in Viasystems and the approach of the Canadian courts, with particular reference to Bazley v Curry, which have as their hallmarks features of control, enterprise risk and integration of the tortfeasor into the business. Where the relationship is such that the "employer" is not even in a position to direct what the tortfeasor shall do, as Lord Reed held at [21] of Cox's case, "the absence of even that vestigial degree of control would be liable to negative the imposition of vicarious liability." The same idea is implicit in Lord Reed's reference (at [24] of Cox's case) to the defendant creating a risk by assigning particular business activities to the tortfeasor: see also [31] of Cox's case.*

102. Questions of vicarious liability will generally not arise unless the tortfeasor can be described as doing something for, or for the benefit of, the "employer" or their enterprise. That will therefore seldom be a determinative characteristic. More is required, both at stage 1 and stage 2, than that the "employer" has engaged the tortfeasor to carry out work which gave them the opportunity to commit the tortious acts in question. To my mind, the authorities suggest that it is the combination of the creation of enterprise risk inherent in the employer's "business", combined with the measure of control (if only in assigning the tortfeasor to roles that significantly enhance that risk), that will frequently provide the touchstone for the synthesis of stage 1 and stage 2. That of itself necessitates a close examination of the relationship between the tortfeasor and the person upon whom vicarious liability may be imposed, both when addressing whether their relationship is one which is capable of giving rise to vicarious liability and when considering whether the connection that links the relationship between D1 and D2 and the tortious act or omission of D1 is sufficient to justify the imposition of vicarious liability on the facts of the particular case.

103. I would add that there is a risk that the phrase "integral to" may be used loosely in circumstances where it adds little or nothing to the observation that the primary tortfeasor has been performing one or more functions that are beneficial to the "employer's" enterprise. To my mind, there is a strand running through the cases from Viasystems onwards which suggests that what one should look for is not merely a beneficial involvement with (or for) the "employer's" enterprise but a real degree of integration of the primary tortfeasor into the employer's business or relevant activity. This is not capable of hard-edged definition in advance; but it may in appropriate cases provide an additional marker when seeking to distinguish between relationships that are properly to be regarded as "akin to employment" and those that are not. Integration in this sense may be seen to be present on the facts of the Christian Brothers' case, Cox's case, Armes and BXB but to be absent Barclays' case.

104. As has been recognised on numerous occasions, stages 1 and 2 are not susceptible to a "tick-box" approach; nor do the statements of principle to which I have referred provide a precise definition that can simply be applied so as to give a ready answer when the question of vicarious liability arises beyond the safe confines of an employer/employee relationship. It is for that reason that the Court is enjoined to adopt the common law approach of comparison with previous decided cases with a view to taking incremental steps where that may be appropriate: see Dubai Aluminium at [26] per Lord Nicholls, and Morrison 2 at [24] per Lord Reed." [Emphasis added]

Application of the test for vicarious liability

Stuart-Smith LJ started his consideration as to whether Blackpool FC should be liable by holding that:

"…the mere giving of an opportunity to commit abuse is not sufficient and that the critical question is whether the features of the relationship between Mr Roper and Blackpool FC are to be regarded as akin to employment

as opposed to Mr Roper carrying on business (broadly construed) on his own account. The fact that the opportunity to commit abuse would have been removed if Blackpool FC had severed its connection with Mr Roper is equally applicable whether the relationship was akin to employment or one where Mr Roper was acting on his own account: it is therefore not of itself informative about the nature of the relationship. Similarly, the fact that, as the Judge found, there was no more important task for the club than spotting and capturing young players for the club and that Mr Roper was one of a number of unpaid volunteers who did that scouting and conferred important benefits upon the club by the introduction of players is also consistent with his acting either in a role that was akin to employment or one where he was effectively doing that work as an independent third party….

…I do not consider it to be helpful to assert that "Roper's activity was part of Blackpool's business activity." It would, in my judgment, be more accurate to say that Mr Roper's scouting activities conferred benefits upon Blackpool FC that were important for the development and survival of its business. This alternative formulation carries the point that the benefits he conferred could equally have been conferred by someone in a relationship that was akin to employment or someone acting independently."

While it was true that the scout's position gave him access to and the opportunity to abuse boys who he came across in the course of his scouting activities, that was not enough in itself to satisfy the requirements of Stage 1. There was no evidence of any control or direction of what he should do. His activity was not exclusively for Blackpool as he was also involved in assisting boys trying to get into other clubs. There was a complete absence of even a vestigial degree of control. With particular reference to the tour, every aspect of the planning, running, administration and financing was exclusively down to the scout, bar the minimal contribution of £500 from the club.

If it was necessary to apply Lord Phillips's five criteria; the club had no power to direct the scout to carry out scouting activities and there was no obligation on him to scout either at all or in any particular way. There was no evidence of contract between the club and the scout. There were no ties imposing obligations on either side. There were none of the elements of control and assignment seen in *Cox*. By contrast to *Armes*, the Club had no statutory duty to boys who wanted to play football and did not place boys with the scout – the opposite was true. "*Furthermore, the continuing involvement of the local authority in Armes in controlling, monitoring, supervision and approval of the foster parents was a feature that has no equivalent in the present case. To my mind, Armes is at present the high-watermark for an expansionist approach to the imposition of vicarious liability; and the present case falls far short of being analogous."* As with the doctor in *Barclays*, the scout was under no obligation to accept work and it was irrelevant that he was essential or integral to the club's business. With regards to enterprise risk, what was necessary is the creation of such risk and increasing risk by:

"….using the "employee" to further the objects of the business in circumstances where there is a level of control rendering the relationship between the defendant and the "employee" at least akin to employment. Thus, in the present case, it is not sufficient to say that the running of a football club with the need to attract young and talented players gives rise to the risk that it will also attract sexual predators. What is required is to show that the relationship between the defendant and the predator involves a degree of control and direction of the abuser by the defendant that makes it akin to employment rather than the utilisation of someone over whom the defendant does not even exercise a vestigial degree of control. That vestigial degree of control must be present during the course of the relationship: it is not sufficient to show that the employer has the power to terminate it:"

Stuart-Smith LJ further held in applying Stage 2 that the tour to New Zealand could not be described as part of the scout's normal activities. The scout had exercised complete control over the tour, and the club had not endorsed the trip –*"Not only was it not in any real sense a Blackpool FC operation, neither Blackpool FC nor anyone else had held it out as being one."*

Comment

Stuart-Smith LJ's detailed judgment is both an authoritative summary of the relevant caselaw in this ever-developing care of law, and a valuable contribution in its own right to the boundaries of vicarious liability. In its application of the relevant principles to the particular facts of the case, the Court of Appeal has signalled that

the more restrictive approach adopted in *Barclays* and *Morrison 2* is likely to be here to stay until, or if, the Supreme Court are asked to consider the issue once again.

QOCS AND SET-OFF

Pritesh Rathod

Ho v Adelekun [2021] UKSC 43

In a case to which qualified one-way costs shifting ('QOCS') applies, can a defendant set-off a costs order in its favour against the claimant's costs where there is no damages award that the defendant can set-off its costs against? That was the issue which the Supreme Court was confronted with in *Ho v Adelekun* [2021] UKSC 43.

Background

The underlying claim concerned a road traffic accident in which Ms Adelekun (the Claimant) suffered personal injuries. She alleged negligence on the part of Ms Ho (the Defendant). Liability was denied and the Claimant issued proceedings. The Defendant made a Part 36 Offer which was accepted. A Tomlin Order was drawn up on the usual terms.

There was an issue between the parties as to whether the costs payable by the Defendant were fixed costs as set out at CPR Part 45, Section IIA (as contended for by the Defendant and which would have amounted to some £16,700) or whether they were conventional costs on the standard basis (as contended for by the Claimant and which would have amounted to some £42,000). At first instance, the Deputy District Judge considered that only fixed costs were payable. This was reversed on appeal by the Circuit Judge. However, on a second appeal, the Court of Appeal reinstated the decision of the Deputy District Judge ([2019] EWCA Civ 1988). In addition, the Court of Appeal ordered that the Claimant pay the Defendant's costs of the costs assessment appeal incurred before the Court of Appeal and below.

At that stage, the Defendant asked the Court of Appeal to set off the costs order in its favour against the £16,700 fixed costs that she was liable to pay to the Claimant. The Claimant objected on the basis that there was no order for damages in favour of the Claimant to enforce the costs order against. In *Cartwright v Venduct Engineering Ltd* [2018] EWCA Civ 1654; [2018] 1 WLR 6137, it was held that where a claim is disposed of in favour of a claimant by way of settlement rather than following a trial, there is no "court order" for damages and thus no damages order against which costs can be enforced pursuant to the QOCS rules, even where the settlement agreement is annexed to a Tomlin order; CPR 44.14(1) permits enforcement of costs order against a claimant without permission of the court "*but only to the extent that the aggregate amount in money terms of such orders does not exceed the aggregate amount in money terms* ***of any orders for damages and interest*** *made in favour of the claimant*" (emphasis added).

The Court of Appeal was minded to agree that the effect of a set-off of costs against costs would have been to permit enforcement of a costs order in an impermissible way. However, it considered itself bound by its previous decision in *Howe v Motor Insurers' Bureau* [2020] Costs LR 297, where it was held that a set-off of opposing costs orders was not affected by QOCS because set-off is not a type of enforcement. On the assumption that set-off was permissible, the Court of Appeal exercised its discretion in favour of such a set-off. However, the Court of Appeal gave permission to appeal to the Supreme Court on the issue of the availability of set-off.

Appeal before Supreme Court

For the purposes of the appeal, it was accepted that QOCS applied. It was also accepted that since the claim was settled after an acceptance of a Part 36 Offer, there was no "*order for damages*".

The Defendant argued that set-off of costs against costs was already well-recognised, particularly in Legal Aid cases (following the decision in *Lockley v National Blood Transfusion Service* [1992] 1 WLR 492). The Claimant

argued that the rules relating to QOCS mentioned set-off of costs against damages only and thus necessarily excluded a set-off of costs against costs. Both parties emphasised the competing policy considerations in favour of their respective arguments.

Lord Briggs and Lady Rose (with whom the other members of the Court agreed) declined to be drawn on the policy considerations, considering that those were best left to the Civil Procedure Rules Committee. On the question of construction, however, the court held that QOCS is intended to be a complete code about what a Defendant in a personal injury case can do with costs orders made against the claimant. It further held that a set-off is a means of enforcement (because after all, setting off costs against damages is a permissible form of enforcement of a costs order in a defendant's favour).

Given that CPR 44.14(1) does not mention enforcing defendants' costs orders against the extent of claimants' costs orders, a set-off of costs against costs would not be permissible where there was no damages order. The court did not rule out a set-off of costs against costs in QOCS cases pursuant to CPR 44.12, but only where there was an order for damages and interest and then, only to the extent of such an order.

Comment

The case concerns a discrete but important issue for those practising in the fields of personal injury, clinical negligence and costs. The scenario whereby a defendant obtains an order for costs in an interim application in a case which is ultimately settled is not uncommon. The effect of the Supreme Court's decision (or more accurately, the combined effect of the decisions in *Cartwright* and *Ho*) is that where there is no order for damages, the defendant's costs in such a scenario would be unenforceable.

It will be interesting to see how the implications of this decision manifest themselves in practice. Will it mean that (somewhat counterintuitively) defendants will be more inclined to require matters to go to trial in order to preserve their ability to enforce costs orders from interim applications? The Supreme Court did note that the court could make an adjusted or discounted "one-way" costs order to reflect the parties' relative success in the proceedings although it also noted that that would water down the costs protection that claimants enjoy. Whether such discounted or adjusted costs orders catch on remains to be seen. The court itself recognised that its decision may at first blush look unfair, which may prompt the Civil Procedure Rules Committee to revisit the issue.

THIRD PARTY COSTS ORDERS AND EXPERTS

Giles Colin

Robinson v Mercier, Liverpool County Court [2021] 9 WLUK 400

The Court made a Third Party Costs Order ("TCPO"), in the sum of £50,543.85, pursuant to Part 46.2 and Part 46.8 CPR 1998 and Section 51 of the Senior Courts Act 1981, against Dr Mercier, General Dental Practitioner.

Dr Mercier acted as an expert witness for the Claimant in a case brought against Liverpool University Hospital NHS Trust ("the Trust"). Dr Mercier was critical of the actions of a Consultant Maxillofacial Surgeon employed by the Trust, specifically an extraction performed under general anaesthetic.

The sum of £50,543.85 represents the costs that were incurred by the Trust in defending the case, as a direct consequence of Dr Mercier's advice.

Legal Background

Part 35.3(1) and (2) CPR 1998 makes it plain that "*It is the duty of experts to help the Court on matters within their expertise"* and that "*this duty overrides any obligation to the person from whom experts have received instructions or by whom they are paid."* The Practice Direction to Part 35 reinforces this statement. Part 34.14

CPR 1998 enshrines the right of the expert to ask the Court for Directions for the purpose of assisting them in carrying out their functions.

In *Philips v Symes* (No 2) [2004] EWHC 2330 (Ch) Peter Smith J. stated at [95]: "*It seems to me that in the administration of justice, especially, in spite of the clearly defined duties now enshrined in CPR 35 and PD 35, it would be quite wrong of the Court to remove from itself the power to make a costs order in appropriate against an Expert who, by his own evidence, causes significant expense to be incurred, and does so in flagrant reckless disregard of his duties to the Court.*"

An application for a TPCO is "*exceptional*." However, the ultimate question to be addressed is whether, in all the circumstances, it is just to make an order, following the decisions of *Symphony Group Plc v Hodgson* [1994] QB179 and *Dymocks Franchise Systems (NSW) v Todd (Costs) 2004 UKPC 39*.

The trial

At trial, Dr Mercier conceded that he (i) did not have any experience of performing an extraction under general anaesthetic within the last 20 years; (ii) had *no* experience of consenting a patient for extraction under general anaesthetic; and, (iii) that he was not as well placed as the Defendant's expert witness (a Consultant Maxillofacial Surgeon) to comment on the case. Dr Mercier had not worked in a hospital setting and he had not worked as a Maxillofacial Surgeon. The Claimant discontinued her claim following Dr Mercier's evidence.

In her judgment, Ms Recorder Hudson concluded that "*but for Dr Mercier's report, this claim would not have been brought*". She concluded that Dr Mercier had shown a flagrant reckless disregard for his duties to the Court and that he did so from the outset in preparing a report on a subject matter in which he had no expertise [38]-4[9].

In addition, Ms Recorder Hudson rejected submissions on behalf of Dr Mercier that the Trust could in any way be criticised for having failed to take action itself to bring the point to the attention of Dr Mercier, his legal advisers, or the Court, before Trial.

Comment

This judgment is the second significant TCPO against an expert in clinical negligence litigation. Whilst in liability trials, it is inevitably the case that one opinion will be preferred over another opinion, that does not of itself imply any criticism on the part of the expert. Instead, it is part and parcel of the litigation process.

However, the present case ought to serve as an important reminder to experts that they must only accept instructions which fall strictly within their own area of expertise, both in terms of specialty, and in terms of contemporaneous practice. In particular, it is surprising that even today there are long since retired experts continuing to provide opinions in relation to events that have occurred many years after their time in clinical practice has ended.

Finally, all experts should be mindful that their duty to the court is an ongoing duty. Dr Mercier only made the key concessions under cross-examination at trial. It should have been obvious to Dr Mercier, at the outset, that he was not able to comment on whether a person exercising a wholly different role had made errors that could be deemed to be negligent. Instead, the Trust had been put to considerable expense in financing costly litigation that should not have been brought [51] - [53].

Giles Colin was instructed on behalf of the Trust by David Locke of Hill Dickinson LLP for the purposes of the TPCO only.

A Review of Fundamental Dishonesty in 2021

Suzanne Lambert

Iddon v Warner [2021] EWHC 587 (QB)

Calderdale and Huddersfield NHS Trust v Metcalf [2021] EWHC 611 (QB)

Brint v Barking, Havering and Redbridge University Hospitals NHS Trust [2021] EWHC 290 (QB)

Michael v IE & D Hurford Ltd [2021] EWHC 2318 (QB)

Mustard v Flower & Ors [2021] EWHC 846 (QB)

Introduction

Over the last few years, fundamental dishonesty has become a more prominent concern in personal injury and clinical negligence claims and 2021 did not disappoint, with a number of cases involving defendants seeking or threatening to obtain findings of fundamental dishonesty.

The basic principles relating to the two separate and distinct regimes by which a finding of fundamental dishonesty can be made were previously summarised in an earlier article that appeared in Issue 2 of QMLR and therefore these are not rehearsed in detail here.

This article does not seek to review every single case where fundamental dishonesty has arisen over the last year, particularly as each case is fact specific. However, there were a number of key issues and reminders for both claimants and defendants involved in clinical negligence litigation that are worth highlighting.

Iddon v Warner (Successful claimants: s57 Criminal Justice and Court Act 2015)

One of the two routes by which a fundamental dishonesty finding can be obtained is s57 of the Criminal Justice and Courts Act 2015, which applies in cases where, absent a finding of fundamental dishonesty, the claimant would have successfully recovered damages. However, the finding of fundamental dishonesty results in the claim being dismissed and the claimant being deprived of damages unless the dishonest claimant is able to show that she would suffer substantial injustice.

The case of *Iddon v Warner* [2021] EWHC 587 (QB) demonstrates the potential benefits of surveillance and the pitfalls associated with social media. Breach of duty was admitted by the GP Defendant following a missed diagnosis of breast cancer, which resulted in the Claimant undergoing an unnecessary mastectomy and axillary dissection. The Claimant claimed that the unnecessary treatment had left her with debilitating chronic pain, which meant that she could not undertake a number of activities, including open water swimming and other competitive sporting activities. The Claimant sought damages in excess of £900,000.

However, in defending the claim for damages, the Defendant hired a surveillance analyst who covertly recorded the Claimant over the course of four days. The recordings evidenced that the Claimant was not a woman crippled by pain as she was able to drive longer distances than she claimed and also carry items. A review of her social media also revealed references to open water swimming and organised running events. Official results of her performance in sporting events, including a 10km run and a one-mile swim in open water, were inconsistent with her claim of debilitating pain. In a witness statement in response to that evidence, the Claimant sought to explain that she had applied to enter the events but did not in fact compete so that a friend took her place. That account was supported by a statement from her husband and another unsigned and undated statement from the friend in question. However, in cross examination, the Claimant admitted that this account was not true but still maintained that she was in chronic and debilitating pain.

At trial, the Defendant made an application for the claim to be dismissed pursuant to s57. Deputy High Court Judge Sephton dismissed the claim and entered judgment in favour of the Defendant on the basis that, on the

balance of probabilities, the Claimant had been fundamentally dishonest in relation to the claim and therefore, unless the court was satisfied that the Claimant would suffer substantial injustice, the claim had to be dismissed.

In making the finding of fundamental dishonesty, HHJ Sephton QC considered the evidence in light of the authorities as to the meaning of fundamental dishonesty in some detail and concluded that the evidence did not support the claim that the Claimant suffered from chronic pain of any significance. Moreover, by the standards of ordinary decent people, the Claimant's actions were dishonest in a number of respects, including in her assertions to the medical experts, in her witness statements, in recruiting her husband and friend to put forward a false account, in verifying the schedules of loss, and in the witness box. The judge found that the Claimant deliberately took those steps in order to mislead the Defendant and the court about the extent of her injuries and to make the consequences of the admitted breach appear more serious than they were. Her dishonesty therefore justified the adjective "fundamental".

As s57 is a punitive provision, the mere fact that the Claimant was being penalised by having her entire claim dismissed (and losing damages for those heads of loss that were not tainted with dishonesty) did not mean that she would escape from that provision. Rather, the only means of escape would be if she could show that she would suffer substantial injustice (as explained by the High Court in *London Organising Committee of the Olympic and Paralympic Games (In Liquidation) v Sinfield* [2018] EWHC 51 (QB). In this case, the culpability and extent of her dishonesty far outweighed any injustice to her in dismissing her claim.

In a final blow to the Claimant in what the judge described as a "sad case", the judge found that, had the Claimant not been fundamentally dishonest, she would have been awarded £70,050.32 for the admitted negligence. That sum of notional damages clearly falls well short of the inflated sum in excess of £900,000 that was claimed but, no doubt, at the end of lengthy litigation would have been preferable to the position in which the Claimant found herself.

Calderdale and Huddersfield NHS Trust v Metcalf (contempt of court for fundamental dishonesty)

The Claimant in *Calderdale and Huddersfield NHS Trust v Metcalf* [2021] EWHC 611 (QB) was even more unfortunate. In that case, the Defendant NHS Trust admitted a delay in diagnosing and treating the Claimant's cauda equina syndrome, made an apology and made an early interim payment of £75,000. However, quantum was claimed in excess of £5.7 million and surveillance footage showed that she had exaggerated her physical injuries and disabilities. Three months before trial, the Claimant admitted lying repeatedly between 2015 and 2019 when she was assessed by experts, served her signed schedule of loss and witness statements, and agreed that the claim should be dismissed on the basis of fundamental dishonesty and the interim payment should be repaid. It was agreed that the Claimant would have been entitled to damages in the region of £350,000.

However, in a separate application for contempt of court brought by the Defendant, the Claimant was sentenced to six months' imprisonment. Mr Justice Griffiths observed that the Claimant's dishonesty, left undiscovered, would have resulted in her extracting millions of pounds from the Defendant and the NHS, and that her course of conduct over a number of years placed her in the upper bracket of the scale, which was a maximum of two years' imprisonment. That said, there were a number of mitigating factors in her case which reduced the sentence, including the fact that she had lost the prospect of any compensation, she was in poor health, had a two-year-old child, and had made early admissions.

Brint v Barking (Unsuccessful claimants: CPR r.44.16)

A finding of fundamental dishonesty also has consequences for unsuccessful claimants. Pursuant to CPR Rule 44.16, which is the second route by which a fundamental dishonesty finding can be obtained, the Qualified One-Way Costs Shifting ("QOCS") costs protection is removed in cases where a finding of fundamental dishonesty is made. The provision was introduced as an exception to the QOCS regime that came into force in 2013 as part of the Jackson reforms by removing the QOCS costs protection for unsuccessful claimants where there is a fundamental dishonesty finding and imposing liability on such claimants to pay costs. It is therefore very attractive to successful defendants who would not otherwise recover their costs under QOCS.

However, the case of *Brint v Barking, Havering and Redbridge University Hospitals NHS Trust* [2021] EWHC 290 (QB) serves as a reminder of the high threshold for obtaining a fundamental dishonesty finding.

The claim arose from an extravasation injury suffered by the Claimant following a CT scan with contrast at the Defendant's hospital. Although it was accepted that the Claimant had suffered an extravasation injury, the alleged events at the hospital leading to the injury (relating to consent) and the extent and nature of the Claimant's injuries said to be attributable to the alleged breaches were in dispute. In particular, the Defendant did not accept that the Claimant had suffered CRPS and PTSD as a result of the alleged negligence. On the eve of the trial, the Defendant notified the Claimant that it intended to allege that she had been dishonest in respect of her claim pursuant to s57 (in the event that she was successful).

As it turned out, the Claimant's case was unsuccessful as the judge did not accept that there had been any breach of duty in relation to any part of the scan. The judge found that the Claimant's evidence on the whole was unconvincing and unreliable. Further, in relation to causation, although the judge accepted that the Claimant had a genuine disability, her current symptoms and level of disability were not caused by the extravasation injury.

Even though s57 was not relevant as the Claimant was unsuccessful, Judge Platts went on to deal with the issue of fundamental dishonesty because the Defendant had raised an important and serious allegation in that regard against the Claimant, and the Defendant subsequently sought to rely on CPR r44.1 in seeking its costs against the unsuccessful Claimant. In support of its application, the Defendant relied upon the Claimant's *"incredible or unreliable*" version of the events at the time of the scan; her "*failure to give a satisfactory account of her benefits claim*" and / or her "*failure to give a satisfactory account of her long-standing multiple prior health conditions in her witness statement and to the experts instructed in her case*". The Defendant also made a late application after the trial had concluded and after closing submissions, but before judgment was handed down, for further evidence (the Claimant's DWP records) to be admitted.

Judge Platts began by reminding himself of the test of dishonesty as set out in *Ivey v Genting Casinos Limited (t/a Crockfords Club)* [2017] UKSC 67 (at para 74): (i) whether subjectively the claimant had a genuine or honest belief, and (ii) whether, applying the objective standards of ordinary decent people she was dishonest. Although the totality of the Claimant's evidence in this case overall was unreliable (having already found that her evidence about the events at the time of the scan and about her prior health condition was unreliable and that her evidence about the benefits claim was unsatisfactory), Judge Platts found that she was not dishonest.

The judge identified a number of relevant factors in relation to his finding on fundamental dishonesty. Apart from the fact that the Claimant's complaints had been prompt and consistent and it was highly unlikely that she would have invented the complaints in a short period of time and remained consistent, it is of particular note that the allegation first came extremely late in the litigation (on the eve of trial) even though the Defendant knew the Claimant's account of the scan and of her prior condition when her witness statement was served. It was therefore not a case where *"the spectre of dishonesty"* arose during the live evidence. The lateness of the Defendant's averment suggested that it was not considered to be an appropriate allegation to be made until the start of trial and there was nothing which justified the change of approach.

Additionally, none of the experts or treating clinicians had accused her of being dishonest in her presentation (except for Dr Carnwarth, the Defendant's psychiatric expert, raising the possibility of a factitious disorder) and it had not been suggested by any of the experts that she was motivated by financial or monetary reward (in fact Dr Carnwath agreed in evidence that she did not appear to be so motivated). The Claimant's failure to be fully frank from the outset about her receipt of Disability Living Allowance was of more concern. However, the judge accepted her evidence that she thought it irrelevant because it related to her back problem about which she was not making a direct claim and also considered it relevant that she never actively denied receiving the benefit and indeed volunteered that she had received it to the Defendant's care expert.

In relation to the belated application to admit the Claimant's DWP records, the Judge held that it would be unfair and disproportionate to do so. The application was not made promptly and the DWP records should have been

requested sooner when the Defendant became aware that the Claimant was in receipt of benefits, and no good reason had been given for the delay; the records appeared to be of limited relevance; the Claimant would have to be recalled to give evidence in order to comment on them, which would result in further costs including input from four expert witnesses, another day's hearing, further submissions and further judicial consideration. The Judge indicated that his preliminary view was that the Defendant should pay the Claimant's costs of the unsuccessful application to admit the additional records.

Therefore, this case indicates that where defendants consider that there is a "*spectre of dishonesty*" early investigations should be undertaken (including requesting any additional records), and if there is an appropriate dishonesty allegation to be made, it should be made in good time so that the claimant is given appropriate notice. Although Judge Platts indicated that the DWP records appeared to be of limited relevance in this case, in another case earlier investigation and reliance on the records might have resulted in a finding of fundamental dishonesty.

Michael v IE & D Hurford Ltd (the difference between CPR r.44.16 and s57)

The case of *Michael v IE & D Hurford Ltd* [2021] EWHC 2318 (QB) is not a clinical negligence case but is noteworthy as it clearly illustrates the distinction between a dishonest claim (the test under CPR 44.16) and a dishonest claimant (the test in s57).

The claim arose from a road traffic accident involving an Uber driver whose vehicle was rear-ended. Liability was admitted but, at trial, quantum of damages remained in dispute, with the Defendant insurer alleging that the claims for credit hire, personal injury and associated damages (including physiotherapy costs) were fundamentally dishonest. The claim for the cost of eight sessions of physiotherapy was supported by an invoice and unsigned, detailed notes of the treatment sessions. However, in cross-examination, the Claimant claimed not to understand the claim, saying that he had only attended one session. He also accepted that he had a second part-time job of which he had informed his solicitors and provided them with all the required credit card and bank statements. He added that he could not understand why the evidence was not before the court.

Notwithstanding the discrepancies in the claim, at first instance, the trial judge found that, whilst the claim may have been dishonest, the Claimant was not. The judge disagreed that the Claimant was "*basically fraudulent*", and therefore, the application by the Defendant to rely upon s57 of the Act to strike out the claim was refused.

On appeal, the Defendants asserted that (i) the finding that the Claimant had attended only one out of eight physiotherapy sessions; (ii) the consequences of CPR Pt 22 and signing a statement of case which contained inaccuracies; (iii) the fact that the Claimant had signed the disclosure statements containing the documents supporting the physiotherapy claim; (iv) the Claimant's failure to disclose certain credit card statements as an omission from his disclosure statement; and (v) the respondent's failure to include in his reply that he had a second job were sufficient to establish fundamental dishonesty.

Mrs Justice Stacey explained that an application made under s57(1)(b) of the Act considered whether a claimant has been fundamentally dishonest, whereas in CPR 44.16 (in relation to disapplying QOCS) the court considers whether the claim is fundamentally dishonest.

Stacey J held that the judge was entitled to conclude from the Claimant's cross-examination evidence that he was not dishonest. He was clearly unfamiliar with the contents of his own statement, but he was entirely honest when questioned, even volunteering information that was detrimental to his special damages claim. The judge was also entitled to conclude that the Claimant did not understand the documents that he had signed or that his solicitors had signed on his behalf or what the basis of the claim made on his behalf was.

Further, she explained that an inaccurate witness statement, statement of case, or disclosure statement was not necessarily evidence of dishonesty on the part of the claimant. Stacey J thus distinguished between a dishonest claim and a dishonest claimant. Stacey J suggested that an honest claimant bringing a dishonest claim may not be as rare as Julian Knowles J in *London Organising Committee of the Olympic and Paralympic Games (in liquidation) v Sinfield* [2018] EWHC 501 (QB) suggested when he posited that "*…it will be rare for a claim to*

be fundamentally dishonest without the Claimant also being fundamentally dishonest, although that might be a theoretical possibility, at least". By way of example, she suggested that where, as in the instant case, "*the benefit of the disputed elements of a claim (such as physiotherapy treatment, vehicle storage and transportation and credit hire fees) are not paid to a claimant for their benefit, but paid to the service provider, by a claimant's solicitor*", it was possible that the claim but not the claimant might be fundamentally dishonest.

Therefore, it is possible for s57 to produce a different result from CPR 44.16 in terms of whether a finding of fundamental dishonesty is made.

Somewhat surprisingly, Stacey J went on to suggest that a Defendant who seeks to obtain a finding of fundamental dishonesty may wish to explore in evidence the relationship between a Claimant and his solicitor:

> "*Where, as here, there was a genuine accident with genuine injuries and vehicle damage, but also aspects of the evidence which appear troubling or dishonest, a Defendant may, in order to prove dishonesty on the part of a Claimant him or herself, need to explore in evidence potential complicity or collusion by a Claimant with their solicitor. It may depend in part on the adequacy of the explanation for the inaccuracies provided by the Claimant. That did not happen in this case*"

Mrs Justice Stacey added that:

> "*If the Defendant solicitors consider that potential dishonesty lies with a Claimant's solicitor and not their client then surely their attention is better directed at the solicitor firms, rather than the hapless client who has instructed them?*"

This suggested approach is problematic for defendants faced with aspects of a claim which they suspect are fundamentally dishonest as it is not enough to prove that the claim is dishonest but that the claimant himself is fundamentally dishonest, and (on the basis of this judgment) to do so may require investigations into potential collusion or complicity between the claimant and his solicitors. Given that the spectre of dishonesty does not always arise until oral evidence and the claimant is cross-examined at trial (as it did in this case), it would be difficult for a defendant to investigate and establish complicity and collusion for the purposes of establishing that the claimant is fundamentally dishonest in advance of trial. The claimant's solicitors are also likely to bat away any speculative investigations as to potential collusion by raising legal professional privilege.

Given that appealing findings on fundamental dishonesty will be difficult and that the hurdle is a high one:

"*However, where the trial judge has heard the evidence and has not concluded that the Claimant was dishonest, I direct myself that it would require a very clear case indeed for an appellate court effectively to overturn the trial judge's conclusion in that respect and find that the Claimant was dishonest despite not having seen the witnesses give evidence.*"

Mustard v Flower (when to plead fundamental dishonesty)

Mustard v Flower & Ors [2021] EWHC 846 (QB) is another personal injury case arising from an RTA. However, it provides valuable insight as to when and how to plead fundamental dishonesty.

The Defendant made an application to amend its defence to include the following paragraph

> *"4.4 The Claimant's accounts of the RTA and its immediate aftermath, and the nature and severity of her symptoms both before and after the accident have varied over time, are unreliable and are in issue. They have been exaggerated (or in the case of her pre-RTA history minimised) either consciously or unconsciously – the Third Defendant cannot say which absent exploring the issues at trial. In the event that the Court finds that the Claimant has consciously exaggerated the nature and/or consequences of her symptoms and losses, the Third Defendant reserves the right to submit that a finding of fundamental dishonesty (and the striking out of the claim pursuant to section 57 Criminal Justice and Courts Act and/or costs sanctions including the disapplication of QOCS) is appropriate*."

Master Davison refused the Defendant's application, specifically the inclusion of the underlined sentence. He described aspects of the proposed Amended Defence as "*somewhat doom-laden wording*". He cautioned against pleading fundamental dishonesty on a "*contingent*" or speculative basis and made clear that it is open to the trial judge to make a finding of fundamental dishonesty whether it had been specifically pleaded or not, once the claimant has been given adequate warning or notice of the issues raised and has had an opportunity to deal with it so that the claimant is not ambushed at trial (in accordance with *Howlett v Davies* [2017] EWCA Civ 1696).

Master Davison acknowledged however that, until a claimant has given evidence and been cross examined at trial, neither the defendant nor the judge may be in a position to make conclusions about the claimant's honesty. Therefore, in many cases it is not practical or proper to require a defendant to have made such an allegation prior to trial as it would not be proper for the defendant's legal representatives to allege fundamental dishonesty based upon a mere suspicion.

Conversely, where there is a proper basis for a plea of fundamental dishonesty and the defendant intends to apply under s57, then, subject to the direction of the judge dealing with case management or the trial judge, this should ordinarily be set out in a statement of case or written application at the earliest opportunity. As he explained:

> *"… nothing in the foregoing is intended to detract from the modern "cards on the table" approach. Where the defendant does have a proper basis for a plea of fundamental dishonesty and intends to apply under section 57, then, subject to the direction of the judge dealing with case management or the trial judge, that should ordinarily be set out in a statement of case or a written application and that should be done at the earliest reasonable opportunity. What I am intending to discourage are pleas of fundamental dishonesty which are merely speculative or contingent."*

In this case, Master Davison held that the proposed amendment served no purpose as the Defendant could make a s57 application without foreshadowing it in a pleading and, at the time of the application and on the current evidence, the plea of fundamental dishonesty did not have real prospects of success. Moreover, it caused prejudice to the Claimant in pursuing the claim as it had to be reported to her legal expenses insurers.

It is of note that Master Davison did allow the rest of the amended pleading about exaggeration because it allowed the Defendant to explore these matters at trial. Thus, while it is appropriate and necessary for a defendant to put the claimant on notice that it will be making or exploring allegations of exaggeration, defendants should be careful not to use the threat of fundamental dishonesty as a blunt instrument if there is insufficient evidence to support such an allegation.

"Let the Doctors Decide"

Marina Wheeler QC

Bell and A v Tavistock and Portman NHS Trust and others [2021] EWCA Civ 1363

In *Bell and A v Tavistock and Portman NHS Trust and others* [2021] EWCA Civ 1363 the Court of Appeal advised judges to avoid formulating policy in an area of social and moral complexity.

Ever since the Divisional Court restricted the medical treatment of children experiencing gender dysphoria at the end of last year (see *R (on the application of Bell and A) v Tavistock and Portman NHS Trust and others*), discussed in QMLR here), the decision has provoked heated debate. Some lamented the distress of young sufferers deprived of treatment. Others applauded limits they said would prevent irreparable harm. On 17 September 2021 the Court of Appeal reversed the decision, but the dispute will continue to rage both in and outside the courts.

The first Claimant, Keira Bell, is a former patient of the Tavistock who was prescribed puberty blockers at 16 to delay the onset of female sexual characteristics. She transitioned to male using cross-sex hormones, had a double mastectomy, and then changed her mind, regretting the "*brash decision*" she said would negatively affect the rest of her life. Her case – accepted by the Divisional Court — was that the "*innovative*" and "*experimental*" nature of the treatment, specifically the use of puberty blockers, made it unlikely a child could validly consent to it.

The current law on consent, set out in the leading case *Gillick v West Norfolk and Wisbech Health Authority* [1986] AC 112, holds that a child can validly consent to treatment if they have sufficient maturity and intelligence to understand fully what is proposed (known as "Gillick competence").

The Divisional Court in Bell did not find the prescription of puberty blockers in the absence of court order to be unlawful and it rejected the Claimant's argument that information about treatment provided to potential recipients was misleading or inadequate. It was unconvinced, however, about the ability of children to understand and weigh the information and thereby give valid and informed consent.

Relevant information, said the Divisional Court, would include "*the fact that the vast majority of patients taking puberty blocking drugs proceed to taking cross-sex hormones*", that these may lead to a loss of fertility and sexual function, and that the evidence base for this treatment is "*as yet highly uncertain*". There was no age appropriate way to explain this, said the court. Accordingly it was "*highly unlikely*" a child under 13 would be competent to consent and very doubtful a 14 or 15 year old could. 16-18 year-olds were presumed to have capacity but where there was any doubt about treatment being in their best interests authorisation from the court would be advisable. In practice, noted the Court of Appeal, this declaration was interpreted by clinicians as a requirement to obtain the court's permission to treat.

The Court of Appeal allowed the appeal and dismissed the claim for judicial review, stating that it was impermissible for the court below to issue a declaration and guidance in circumstances where it did not find illegality. Advisory declarations were known but not, it stated, where a claim of illegality had failed. The court below had also imposed an "*improper restriction*" on the test of Gillick competence by departing from the principle that children under 16 could make their own decisions if assessed as competent by their treating clinicians.

In essence, the Court of Appeal found that the judges below had stepped into the shoes of clinicians: it is "*for doctors to decide on competence not judges*".

It is a matter of clinical judgment, said the court, tailored to the patient in question, how to explain matters to ensure that the giving of consent is sufficiently informed. The declaration, however, came close *"to a checklist or script that clinicians are required to adopt for the indefinite future".*

Some factors included were statements of disputed fact, others "*beg questions to which different clinicians would give different answers*". In other words, the declaration was problematic due to its rigidity but also because it covered areas of disputed fact, expert evidence and medical opinion and "*implied factual findings which the Divisional Court was not equipped to make".*

The Divisional Court had explicitly stated that that it was not "*the court's role to judge the weight to be given to various different experts"*. It also reminded itself (correctly said the Court of Appeal) that its role was not to "*determine clinical disagreements between experts about the efficacy of treatment".* That was for NHS and regulatory bodies. But despite these statements, the Divisional Court did make factual findings and seek to resolve matters of clinical dispute in ruling that:

(a) treatment was experimental (in the sense that its long-term consequences are unclear); and

(b) the *"vast majority"* of patients prescribed puberty blockers went on to receive cross sex-hormones.

This was impermissible, according to the Court of Appeal. "*Judicial review*," it said "*is not the forum to resolve contested issues of fact, causation and clinical judgment"* and the court was wrong to decide between the evidence of competing experts without it being properly admitted or tested in cross-examination.

The evidence of the Tavistock clinic (and the Trusts to which patients were referred) was that the treatment was safe, internationally endorsed, reversible and subject to a rigorous assessment process. Allowing the declaration to stand would require clinicians to suspend or temper their clinical judgment and defer instead "*to what amounts to the clinical judgment of the court*" when deciding if a child could validly consent to treatment.

The guidance was also said by the court to have been "*insufficiently sensitive to the role of parents in giving consent*". On this point, the court referred approvingly to Lieven J's decision in *AB v CD* [2021] (some months after the Divisional Court's judgment, to which she contributed, covered in QMLR here). In that case she held that unless the parents were overriding the wishes of the child, they could consent on the child's behalf to puberty blockers without the need for a best interests application to the court. Children may have difficulty understanding the consequences of treatment, it was said, but their parents would not.

Throughout the judgment, in different ways, the court pressed for judicial restraint. Controversial ethical issues which attract polarised views "*are best assessed in a regulatory and academic setting and not through litigation*", it said. Moreover, as advised by Lord Philips in *R (Burke) v General Medical Council* [2005] EWCA Civ 1003, courts should avoid expressing opinions in areas of social and ethical controversy where there is no specific issue to resolve between the parties. The Divisional Court in *Bell* fell into this error.

The Court of Appeal's conclusion was clear: applications to the courts may be appropriate in specific, difficult cases but it was wrong to give guidance to clinicians about when such circumstances may arise. Having said that, the judgment ends with its own counsel of caution. Clinicians will "*inevitably take great care*" before recommending treatment to a child, said the court, and will be "*astute to ensure*" consent is properly informed by the advantages and disadvantages of proposed treatment in light of "*evolving research*" and any long-term consequences it may have.

Somewhat ominously it goes on to warn: *"[C]linicians will be alive to the possibility of regulatory or civil action where, in individual cases, the issues can be tested"* and, in that vein, notes a January 2021 Care Quality Commission report critical of aspects of obtaining consent at the Tavistock clinic.

Regardless of the outcome (and leaving aside the prospect of a further appeal), Ms Bell's litigation has shone a bright light on a controversial and complex area of medical practice. As figures before the court show, treatment for gender dysphoria among children is increasing: in 2009 there were 97 referrals to the Tavistock clinic; in 2019 there were 2,519. Given these figures, Ms Bell is unlikely to be the only young person who has changed their mind about treatment. If this is right, a clinical negligence claim is just a matter of time. Unlike proceedings for judicial review, that will provide a forum where the court is required to make factual findings, form judgments about clinical practice, and resolve disputes between experts. On that occasion, the judges will have to decide.

This piece originally appeared on the UK Human Rights Blog.

Jeremy Hyam QC, Alasdair Henderson and Darragh Coffey of 1 Crown Office Row, were instructed by the Claimants/Respondents in this case. They were not involved in the writing of this piece.

WHEN DOES THE ARTICLE 2 INVESTIGATIVE DUTY ARISE?

Rajkiran Barhey

R (Morahan) v West London Assistant Coroner [2021] EWHC 1603 (Admin)

Facts

Tanya Morahan ("Tanya") had a history of paranoid schizophrenia and harmful cocaine use. From mid-May 2018 she was an inpatient at a rehabilitation unit operated by the Trust. She was initially detained under s.3 of the Mental Health Act 1983 but on 25 June 2018 the section was rescinded. On 30 June 2018 Tanya left the unit but didn't return until the next evening, 1 July. On the afternoon of 3 July 2018, again with her doctors' agreement, she left the ward but didn't return. The Trust asked the police to visit her. They visited on 4 July 2018 but she did not answer the door. She was ultimately found dead on 9 July 2018 [2].

Background

The Coroner opened an inquest and found that Article 2 was not engaged. The family brought judicial review proceedings, arguing that (1) the circumstances of Tanya's death fell within a class which gave rise to an automatic duty to conduct a *Middleton* inquest; (2) alternatively that such duty arose because there were arguable breaches of a substantive operational duty (the *Osman* duty) owed by the Trust to take steps to avert the real and immediate risk of Tanya's death by accidental drug overdose, a risk which was or ought to have been known to the Trust [3].

Article 2

The decision was handed down by Popplewell LJ.

He began by explaining that Article 2 imposed three distinct duties on the state:

1. **A negative duty** to refrain from taking life without justification;
2. **A positive duty** to protect life with two specific aspects:
    a. **The framework duty**, which includes a duty to put in place a legislative and administrative framework to protect the right to life, involving effective deterrence against threats to life, including criminal law provisions to deter the commission of offences, backed up by a law enforcement machinery for the prevention, suppression and sanctioning of breaches of such provisions; and in the healthcare context having effective administrative and regulatory systems in place (sometimes called the systems duty).
    b. **The positive operational (Osman) duty** to take positive measures to protect an individual whose life is at risk in certain circumstances.
3. An investigative duty to inquire into and explain the circumstances of a death. However there are two different investigative duties with different scopes and different legal bases. The first is a substantive duty to investigate each death; this is part of the framework duty. The second, called **the enhanced investigative duty**, is a procedural obligation which only arises in cases where it is possible that there has been a breach by the state of one of its substantive operational or systems duties. [para 30].

The decision focused on the positive operational duty and the enhanced investigative duty.

The positive operational duty

Popplewell LJ explored four key authorities relating to the operational duty – *Rabone v Pennine Care NHS Foundation Trust* [2012] 2 AC 72, *Lopes de Sousa Fernandes v Portugal* (2018) 66 EHRR 28, *Fernandes de Oliveira v Portugal* (2019) 69 EHRR 8 and *R (Maguire) v Blackpool and Fylde Senior Coroner* [2020] 3 WLR 1268.

The first key point deriving from his analysis of the authorities was that it is relevant to the existence of the operational duty to consider whether there is a real and immediate risk to life. The Claimant had argued that the existence of a real and immediate risk was not a precondition to the existence of the operational duty but was in fact relevant only to breach, but the court disagreed with this analysis (see [47] and [66]).

Second, the operational duty will not arise in relation to all voluntary psychiatric patients. There may be some voluntary psychiatric patients such as Melanie Rabone who are indistinguishable from detained patients but there will be others who are analogous to an outpatient and who, for example, are not even close to meeting the criteria for detention (see [49] and [60]).

Third, the existence of the operational duty is not to be analysed solely by reference to the relationship between the state and the individual, but also by reference to the type of harm of which the individual is foreseeably at real and immediate risk [65].

Furthermore, in cases where people are cared for by an institution which exercises control, the question whether an operational duty is owed to protect them from a foreseeable risk of a particular type of harm is informed by whether the nature of the control is linked to the nature of the harm. For example, in relation to prisoners, the nature of the control exerted by the prison increases the risk of suicide and therefore prisons have an obligation to protect detainees against the risk of suicide. Popplewell LJ further explained that where there is no link between the control and the type of harm, the imposition of an operational duty to protect against the risk would be to divorce the duty from its underlying justification as one linked to state responsibility. For example, a psychiatric hospital would owe no duty to protect a patient (voluntary or detained) from the risk of accidental death from a car accident whilst on unescorted leave [67].

The enhanced investigative duty

Following a detailed consideration of the leading cases, Popplewell LJ explained that the state's Article 2 investigative duty has two aspects. The first is a substantive obligation on the state to investigate every death, irrespective of its circumstances, as part of the framework duty. He referred in this regard to Lord Phillips' comments in *Smith* that "*any effective scheme for protecting the right to life must surely require a staged system of investigation of deaths, under which the first stage takes place automatically in relation to every death.*" This duty is fulfilled by our system of registration of deaths, which requires a death certificate certifying a cause of death from a doctor or a coroner. If there is doubt as to whether the cause of death is natural causes, then there will be a report to the coroner, followed by inquiries, possibly a post-mortem and/or an inquest. This substantive duty arises immediately following death and may be the precursor to the enhanced procedural obligation [92].

The second aspect of the Article 2 investigative duty is the enhanced procedural obligation which only arises following certain deaths and is fulfilled usually, but not always, by holding a *Middleton* (or Article 2-compliant) inquest. This enhanced investigative duty is parasitic on a substantive duty and arises in two circumstances – (1) where there is an arguable breach of the state's substantive Article 2 duties and (2) in some categories of case, automatically.

He went on to consider the categories of cases in which the enhanced procedural obligation arises automatically - killings by state agents, suicides or near suicides in custody, unlawful killings in custody, suicides of conscripts, and suicides of involuntary mental health detainees. Following a review of the authorities, he concluded that the reason why the enhanced procedural obligation arises automatically in these cases is because, due to the nature and/or circumstances of these types of deaths, they raise a sufficient possibility of state responsibility to require the enhanced investigation [100]-[101]. The justification for the automatic imposition of the duty is not the wider rationale identified in *Amin* and *Middleton* of learning lessons with a view to preventing deaths (which is part of the framework duty).

Therefore, there is no difference in terms of the rationale for the enhanced investigative obligation between cases where the duty arises automatically and those where it does not – in both types of case the rationale for the enhanced investigative duty is that there is a sufficiently arguable breach of a substantive obligation by a state agent. In automatic cases, there is always a sufficiently arguable breach because of the nature and

circumstances of the death [103]-[104]. In so far as Greene J suggested in *Letts* that the existence of the duty in automatic cases is not linked to an arguable violation of a substantive obligation of state agents, Popplewell LJ disagreed with Greene J [111].

Popplewell LJ pointed to the case of *Tyrell* as exemplifying the relevant principles. *Tyrell* concerned the death of a prisoner from cancer. An investigation by the Prisons and Probation Ombudsman (mandatory following any prison death) concluded that there were no failures with the healthcare received by the deceased prisoner. Therefore, in the absence of any evidence that even raised a suspicion of state failure the court concluded that the coroner had been right to not hold an Article-2 compliant inquest because the enhanced investigative duty did not arise. Suicides or unlawful killing in custody would, by their nature, inevitably always raise legitimate suspicion of a breach of the state's substantive obligations and therefore the enhanced investigative duty would always arise, but deaths from natural causes would not, necessarily [120]-[121].

Summary of key principles

There is a helpful summary of the nine key principles at paragraph 122:

"(1) There is a duty on the state to investigate every death. This is part of its framework duty under article 2 by way of positive substantive obligation. This duty may be fulfilled simply by identifying the cause of death. It may require further investigation and some explanation from state entities, such as information and/or records from a GP or a hospital.

(2) In certain circumstances there is also a distinct and additional enhanced duty of investigation which requires the scope of the investigation to have the minimum features summarised by Lord Phillips in Smith at paragraph 64. In this country the enhanced investigative duty is usually, but not always, to be fulfilled by a Middleton inquest.

(3) The enhanced investigative duty is procedural and parasitic on a substantive duty. It cannot exist where there is no substantive duty.

(4) The circumstances in which an enhanced investigative duty, as a procedural parasitic duty, arises are twofold:

(a) whenever there is an arguable breach of the state's substantive article 2 duties, whether the negative, systemic or positive operational duties; and

(b) in certain categories of circumstances, automatically.

(5) The categories in which it has been identified as arising automatically include killings by state agents, suicides or attempted suicides and unlawful killings in custody, suicides of conscripts, and suicides of involuntary mental health detainees. These have been identified by a developing jurisprudence and these categories cannot be considered as closed.

(6) The underlying rationale for the categories of cases which automatically give rise to the enhanced investigative duty is that all cases falling within the category will always, and without more, give rise to a legitimate suspicion of state responsibility in the form of a breach of the state's substantive article 2 duties. The justification for the automatic imposition of the duty is not the wider rationale identified in Amin and Middleton, associated with the framework duty, of learning lessons with a view to protecting against future deaths.

(7) The touchstone for whether the circumstances of a death are such as to give rise to an automatic enhanced investigative duty is whether they fall into a category which necessarily gives rise, in every case falling within the category, to a legitimate ground to suspect state responsibility by way of breach of a substantive article 2 obligation.

(8) In this context legitimate grounds for suspicion connotes the same threshold of arguability as has to be satisfied in cases where the enhanced investigative duty does not arise automatically.

(9) In addressing whether a category of death automatically attracts the enhanced investigative duty, the type of death is important. Deaths from natural causes are not to be treated in the same way as suicides or unlawful killings. This follows from (6) and (7)."

Application to the facts of the case

Popplewell LJ found that, in Tanya's case, the operational duty did not arise because the factors identified in *Rabone* were not fulfilled – there was no real and immediate risk of death from a cause of which the Trust was or ought to have been aware, there was no assumption of responsibility, Tanya was not particularly vulnerable in the sense relevant to the duty and her risk was not exceptional. Therefore the duty did not arise. He found that even if the duty did arise, there was no arguable breach. Finally, he found that there was no automatic enhanced investigative duty in the case of an accidental death of a voluntary psychiatric patient because (1) voluntary psychiatric patients cannot be treated in the same way as an involuntary detainee for these purposes as their circumstances vary in specific cases and (2) there was no justification for extending the automatic duty to cases of accidental death.

Comment

It is very common at pre-inquest hearings for there to be discussion about whether Article 2 is engaged. *Morahan* provides an incredibly helpful exploration and summary of all the key principles which are relevant to this question and so it is likely to become a key case for practitioners to refer back to again and again. Popplewell LJ's judgment synthetises the case law in this area and explains how the various strands fit together.

This article also appeared on the UK Human Rights Blog.

Is an Expert Report Prepared for the Purposes of an Inquest Covered by Litigation Privilege?

Matthew Hill

In the matter of an application for Judicial Review by Linda Kercher and Carol Mitchell [2020] NICA 31; [2020] Inquest L.R. 76

NB The judgment was handed down in June 2020, but has only recently been made available online.

A niche question, but an important one for those in the field, particularly as the Northern Ireland Court of Appeal has found that it is not.

The case concerns a coroner's decision to seek disclosure of an expert report prepared on behalf of the families of two soldiers who were found dead at their barracks. The families resisted disclosure relying on s.17B(2)(a) of the Coroners Act (Northern Ireland) 1959, which provides that a person cannot be compelled to produce a document to a coroner if he or she could not be required to do so in civil proceedings in Northern Ireland. (An equivalent provision for England and Wales is found at para. 2(1)(a) of Schedule 5 of the Coroners and Justice Act 2009.) The expert report, they argued, attracted litigation privilege. The coroner's case was that as inquests were non-adversarial they were not litigation, and hence no privilege could be asserted.

NICA found for the coroner, with reluctance. Had it had a blank sheet, it would have held that litigation privilege applied. There were good reasons why it should do so, not least as it allowed for a participant in an inquest to take reasonable steps to inform and prepare its position (see the dissenting speech of Lord Nicholls in *Re L (a minor)* [1997] AC 16). However, the court considered itself bound by the majority in *Re L* and the authority of *Three Rivers District Council and Others v Gov of the Bank of England (No 6)* [2005] 1 AC 610 (HL), and in particular the conditions for litigation privilege set out as [102] by Lord Carswell in the latter case:

(a) litigation must be in progress and contemplation;

(b) the communications must be made for the sole or dominant purpose of conducting that litigation; and

(c) litigation must be adversarial, not investigative or inquisitorial.

Although the court found for the coroner on the point before it, the victory was pyrrhic. Morgan LCJ, delivering the judgment of the court, joined the High Court in questioning the wisdom of the coroner's decision to seek disclosure of the report. The coroner had already instructed his own expert, whose report he had found to be satisfactory; what public interest was there in seeking disclosure of the families' report in what appears to have been an unprecedented way? The court invited the families to consider an application under s.17A(4)(b) of the 1959 Act, which provides that a person can resist disclosure to the coroner on the basis that it "*is not reasonable in all the circumstances to require him to comply with such a notice*" (see also para. 1(4)(b) of Schedule 5 of the 2009 Act for England and Wales). The court's view (obiter) was that, "*it appeared to us that the balance was highly likely to favour the view that a requirement to disclose the report was not reasonable"* [37].

Lessons

Those involved in coronial proceedings may wish to take note of this judgment, and in particular the tight definition of litigation privilege. However, properly interested persons should be aware of the alternative basis for resisting disclosure provided by the relevant statutory provisions on reasonableness. Coroners will no doubt read the final paragraphs of the NICA judgment and ask themselves whether seeking disclosure of such reports is really appropriate in the first place.

It should also be noted that where an expert report is prepared for the "*dominant purpose"* of adversarial litigation, privilege will apply as long as the other two conditions set out in Three Rivers (No. 6) are also met.

There is a further implication of the judgment that is of practical interest. The 2009 Act makes it a criminal offence to "*suppress or conceal"* a document where it is likely that the coroner "*may wish to be provided with it":* para. 7(2)(a) and 7(3) of Schedule 6. If an expert report is not covered by litigation privilege, then it is at least possible that a coroner may wish to be provided with it. That being so, is there an obligation on those connected with an inquest to inform the coroner about the existence of such a report, even if they do not wish to rely on it in evidence?

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APPLICATION FOR FRESH INQUEST REFUSED

Caroline Cross

Farrell v HMC for North East Hampshire [2021] EWHC 778 (Admin)

Applying for a fresh inquest is not straightforward. First, the bereaved have to get permission from the Attorney General. Only once that authority has been granted will they be allowed to apply to the High Court to reopen the inquest (section 13 of the Coroners Act 1988). Often cases are reopened because new evidence has come to light or there has been insufficiency of inquiry, for example where a person is found guilty of the murder of the deceased or new scientific data is provided. Further, it has to be necessary or desirable in the interests of justice that an investigation be (re)opened.

This case does not provide any new legal principles, but it is a strong statement about the importance of testing the evidence before granting the fiat: inquests should not be reopened just to allay the concerns of family members.

Facts and judgment

This case has a tragic backstory brought about by a complete breakdown of relations between a mother and her stepdaughter.

Ray Farrell died on 24 October 2016 aged 53 as a result of malignant mesothelioma, which he developed following asbestos exposure working as a mate's fitter. He had settled a civil claim with his former employer prior to his death. The documentary-only inquest recorded the cause of death as mesothelioma. There was no post-mortem or toxicology, as the histology of mesothelioma was considered sufficient.

Concerns were first raised by his daughter, Kelly, who had not been informed of her father's illness and therefore was shocked to discover his illness and death. Her suspicions were raised by two matters: two carrier bags full of medicines awaiting disposal following his death and a response from the Senior Coroner to her email that there were no toxicology or blood samples because Mr Farrell's wife, and her stepmother, was very anxious to avoid a post-mortem. In fact, it was Mr Farrell who did not want a post-mortem.

Her concerns were then taken up by Ray's mother, Mrs Farrell. She applied for a fresh inquest on the basis that Mr Farrell's wife, Amanda Burden, hastened his death by deliberately giving him inappropriate medication. Ms Burden and Mr Farrell had been married in February 2016, although they had been in a relationship for eight years. She was, Mrs Farrell alleged, motivated by financial gain. Mrs Farrell applied with the fiat of the Attorney General under s.13 of the Coroners Act 1988 for the quashing of the original inquest due to a lack of appropriate investigation. The Senior Coroner supported the fiat, although doubted whether the outcome would be any different.

However, it was robustly dismissed by the Divisional Court, which included the Chief Coroner, on the basis that there was no basis of a fresh inquest reaching a different conclusion or finding any substance to Mrs Farrell's suspicions.

Mrs Farrell, a retired nurse who represented herself, raised a number of issues, which were resolved by the Divisional Court:

(a) The wedding of her son and Ms Burden was hastily arranged in February 2016. A new will was signed on the same day, witnessed by his parents. She alleged that Ray was drugged and lacked capacity for either the marriage or the drawing up of the will. But the Divisional Court pointed to documentary evidence that the wedding was clearly planned, he had capacity to make that decision, his parents attended and no one had raised any concerns at the time or in the eight months leading to his death. As to Ray being drugged at the time of his wedding, this was undermined by the fact that the drug, Midazolam, was not prescribed until 10 days before his death.

(b) As to the absence of a post-mortem, Mr Farrell had specifically requested that no post-mortem took place, as evidenced by the GP's medical records and correspondence with the Senior Coroner prior to his death.

(c) There was nothing suspicious in relation to the timing and nature of Mr Farrell's death, or the amount of medication he had received. His GP had expected him to die and he was receiving palliative care. The court had a report from Professor Britton, a distinguished retired consultant physician who was a mesothelioma expert. Having reviewed the medical records, he concluded that the timing and nature of Mr Farrell's death was usual for a patient suffering from mesothelioma, and there was nothing in the history or records that caused him concern or that would have hastened his death. Also, there was nothing surprising about the volume of medication given he was receiving end of life care.

(d) The alleged financial motivation by Ms Burden did not make sense – why would she seek to hasten his death by days, when there was no reason to think that his financial position would change within that time?

(e) There was no realistic prospect of a fresh inquest reaching a different conclusion because there would be no new findings of fact or any new empirical data.

Lord Justice Popplewell, giving the judgment of the court, concluded at [44]:

> *"To permit a reinvestigation would cause unwarranted distress to Ms Burden by the continued public airing of the serious allegations being made by Mrs Farrell, and similarly to other healthcare professionals accused of impropriety or failings. It would cause cost and delay to the coroner's service. It would divert the health professionals involved away from their public service by requiring preparation for and attendance at a hearing. The interests of justice do not require that Mrs Farrell be given a platform to air her unjustified suspicions."*

He also stated:

> *"This is not the kind of exceptional case in which there has been an insufficiency of investigation and a fresh inquest can be justified simply to allay concerns of members of the bereaved family irrespective of the possibility of a different outcome. Judging by the misguided passion with which Mrs Farrell advanced her suspicions before this court, and her maintenance of arguments flatly contradicted by the contemporaneous records, I fear that she would no more be satisfied by their rejection at a second inquest than she is with the fact they were not considered at the inquest which has taken place."*

Comment

This was not the first court case between Mrs Farrell and Ms Burden. Mrs Farrell also sued Ms Burden and her friend in their capacity as Mr Farrell's co-executors, claiming she was owed money out of his estate because she had contributed to his house purchase. That case was also dismissed, on the basis she could not prove that the sum was a loan rather than a gift. The court, though, noted the catastrophic breakdown in relations between Mrs Farrell and Ms Burden.

In this case, the court's judgment highlighted the exceptional nature of reopening an inquest, balancing the cost and delay to the coroner's service, and the diversion of health professionals from their work against the need to review allegations. Given the evidence did not support Mrs Farrell's position at all, that would have been sufficient on its own to dismiss the application. However, the court also stressed the importance of not giving Mrs Farrell a platform to make further unsubstantiated claims against Ms Burden or the healthcare staff. It is a salutary reminder to ensure there is a sound legal basis for reopening an investigation, rather than the bereaved simply attempting to usurp an outcome they do not like.

Peter Skelton QC of 1 Crown Office Row, represented Ms Burden in this case. He was not involving in writing this article. This piece also appeared on the UK Human Rights Blog.

Withdrawal of Benefits, Article 2 and Inquests

Alice Kuzmenko

Dove v HM Assistant Coroner for Teesside and Hartlepool [2021] EWHC 2511 (Admin)

Facts

Ms Whiting had spinal conditions since her early twenties, which gave her back pain, required surgery, and regular painkillers. She also had a history of mental health problems (depression, drug dependence, and emotionally unstable personality disorder) and a history of suicidal ideation. From 2006, Ms Whiting was receiving income support. In 2012, ESA was being introduced. The Department of Work and Pensions ("the Department") awarded Ms Whiting ESA for 2 years and categorised her as being in the support group. In 2014, Ms Whiting was reassessed. Her support category ESA was extended until 2016.

In September 2016, Ms Whiting needed reassessment. She requested a home visit due to her mobility problems and anxiety. While it was not disputed that this should have occurred, the Department failed to make the referral.

In December, the Department wrote to Ms Whiting, requiring her to attend an appointment. She did not attend. The Department sent a letter seeking the reasons for her non-attendance, but took no steps to obtain further information through a telephone call or a 'safeguard visit'. In January 2017, Ms Whiting returned the form, explaining that she did not receive the appointment letter and was currently housebound with pneumonia, so requested that the Department contact her GP. They did not. Yet in February, the Department decided that she did not show 'good cause' for her non-attendance, there was no evidence of limited capability for work, and stopped Ms Whiting's ESA from 7 February 2017 without considering her mental health problems.

On 10 February 2017, Ms Whiting, ill in hospital, called the Department. They read the decision letter to her and advised her to request a reconsideration with her medical evidence. She did so on 13 February. A Citizens Advice Bureau (CAB) representative wrote to the Department on 15 February to seek a reconsideration and explain that Ms Whiting was not always able to deal with her post due to her anxiety and depression. However, on 21 February, Ms Whiting was found dead. The medical cause of death was recorded as being the synergistic effects of morphine, amitriptyline, and pregabalin, and cirrhosis.

On 25 February, the Department completed its mandatory reconsideration, and upheld its decision. But on 23 March, it revised its decision and reinstated Ms Whiting's ESA from January, due to the 15 February letter they received from the CAB.

At the inquest touching upon Ms Whiting's death, the Coroner referenced the ESA problems, but gave a short-form conclusion of suicide.

CAB complained about the Department's handling of Ms Whiting's case, which culminated in an ICE report criticising the Department. The criticisms included failing to refer Ms Whiting for a home visit for her reassessment, failing to call her/undertake a safeguard visit, and failing to contact her GP.

Dr Turner undertook a psychiatric report and concluded that Ms Whiting would have experienced distress and shock at the news of the cessation of her ESA, and was likely to have suffered a substantial depressive impact with activation of suicidal ideas, due to her presenting with BPD. Further, "*there was likely to have been a causal link between [the Department's] failings outlined in the…ICE report and Jodey's state of mind immediately before her death*." [36]

Application and judgment

The Applicant's four grounds for an order to quash the Coroner's determination and to direct that a new inquest take place were as follows:

1. There has been an insufficiency of inquiry by the Coroner at common law;
2. There has been an insufficiency of inquiry by the Coroner under article 2;
3. Fresh evidence is now available which may reasonably lead to the conclusion that the substantial truth about how Ms Whiting died was not revealed at the first inquest; and
4. A different conclusion would be likely at a fresh inquest.

Ground 1 – insufficient inquiry at common law

The Applicant argued that it was in the public interest to inquire beyond the mere immediate cause of death – it may include acts and omissions directly responsible for the death. In circumstances where there was no investigation into the flawed handling and determination of Ms Whiting's ESA claim, a new inquest was in the public interest, particularly to require public exposure of the failings identified in the ICE report to ensure accountability and to prevent future deaths.

The court found that the Coroner's inquiry was sufficient, both on the public interest test and on the *Wednesbury* test (that the Respondent argued was the appropriate test). The inquest "*considered Ms Whiting's medical background, the medical cause of her death, the circumstances in which she was found dead and (to the extent that it could arise from the evidence before her) the apparent reasons for her suicidal mental state*" [71]. Further,

the Coroner heard evidence from Ms Whiting's family about the impact of the cessation of ESA. The court also iterated that there is a review system in place, the third tier of which is an ICE report that investigates failings and therefore hold the executive to account. It is not a role for the Coroner.

Ground 2: article 2 of the Convention

Alternatively, the Applicant submitted that the evidence disclosed an arguable breach of the Article 2 operational duty: "(*i) the Department had assumed responsibility for Ms Whiting's welfare and safety by providing her with the income necessary to survive and had done so in order to prevent an identified risk to her mental health if her benefits were withdrawn; (ii) Ms Whiting was particularly vulnerable; and (iii) the risk to her which the withdrawal of her benefits had posed was exceptional"* [78].

The court did not accept that the Department assumed responsibility. 'Safeguarding' in their internal guidance did not import such assumption of responsibility. Rather, it was used to convey practically, in everyday language, the actions that decision-makers should take. It was undoubtedly accepted that Ms Whiting had significant physical and mental health problems that made her particularly vulnerable, but this alone did not establish an operational duty, and without assumed responsibility, there is no general obligation to prevent suicide.

The Applicant relied on the systems duty, using a National Audit Office report, which stated that the Department had received four PFD reports from coroners since 2013, of which two were related to suicide. It also investigated 69 suicides of benefit claimants since 2014-15. The Applicant submitted that from these numbers, it can be inferred that the system did not function adequately. Further, the ICE report identified numerous failings, giving rise to an arguable breach of at least some part of the systems duty.

The court dismissed this ground, having found that the failings identified were individual, not systemic, and that Article 2 was not engaged.

Ground 3: fresh evidence

The Applicant submitted that the new ICE report might reasonably lead to the conclusion that the first inquest did not reveal substantial truth about Ms Whiting's death, so the report rendered a new inquest "*necessary or desirable in the interests of justice*" [90].

The court accepted that the ICE report found significant failings but disagreed that an inquest should adduce substantial evidence of those failings. Dr Turner's report merely identified a causal link between the ICE report failings and "*Ms Whiting's state of mind immediately before her death*" – it was not concluded that the cessation of the ESA caused her to commit suicide, and Dr Turner did not rule out other causes. The causal link to death is therefore speculative. Consequently, the court did not accept that the interests of justice required a new inquest in light of the fresh evidence.

Ground 4: potential for a different conclusion by a coroner

It was argued that the new evidence made it more likely that a new coroner would return a different conclusion (i.e. a narrative conclusion identifying the Department's role in Ms Whiting's death, and any relevant acts/omissions contributing to it). The court however found that the inquest conducted was fair, dealt with the legal grounds and evidence before it, and complied with *Jamieson* requirements. It was not required to do more, so a new inquest was not in the interests of justice.

Comment

Although this case is somewhat unique in its progression, this judgment will be useful for practitioners dealing with suicide cases after benefits are ceased.

Firstly, provision of benefits to vulnerable people does not amount to an assumption of responsibility. Moreover, any guidance the relevant department produces should not be read with the "*precision of law*" [81]. This might mean interpreting terms as "safeguarding" with a practical rather than legal eye.

Secondly, it confirms the high bar for Article 2 being engaged – knowledge of vulnerability alone is insufficient. Instead, vulnerability must be in a particular context such as in *Maguire* or *Rabone* and there needs to be a clear assumption of responsibility.

Lastly, this case shows the clarity required for causation. Links between failings and the "*state of mind immediately before her death*" was insufficient. Practitioners should therefore remain astute to the significance of the expert's wording used in respect of causality, and challenge experts on whether they can support causality as to death, or merely the state of mind prior to it.

UNORTHODOX COVID VIEWS AND MEDICAL REGULATION

Richard Smith

White v General Medical Council [2021] EWHC 3286 (Admin)

A case in which the High Court reminds the regulator of requirements for imposing curbs on free speech.

Dr Samuel White is a GP. Earlier this year he posted a seven-minute video on Instagram explaining that he had resigned from his job because, he said, he could no longer stomach the lies surrounding the NHS approach to the pandemic and because medical professionals were having their hands tied behind their backs in treating patients. He stated that he was being prevented from using treatments that had been established as being effective both as prophylaxis and treatment for Covid-19, naming hydroxychloroquine, budesonide inhalers and ivermectin, which he described as safe and proven. He raised concerns about the safety of the Covid-19 vaccine and claimed that 99% of people who contract the virus survive, with the only fatalities in those with multiple medical problems. He stated that masks do absolutely nothing. He invited his viewers to do their own research but referred to a number of websites which supported his view.

A complaint was made to the General Medical Council, which commenced an investigation into his fitness to practise as a doctor. The GMC referred his case to an Interim Orders Tribunal on the basis that his practise should be restricted pending investigation and the conclusion of the case. The role of an IOT is not to find facts, but to conduct a risk assessment based on the information before them and determine whether an interim order is necessary to protect patients or otherwise in the public interest.

At a hearing before the IOT on 17 August 2021 the GMC invited the imposition of conditions on Dr White's practise. As is customary, the GMC did not suggest what conditions would be appropriate, leaving that to the IOT's judgment. Dr White strenuously objected to any restriction being placed on him. He submitted a lengthy witness statement and extensive literature in support of the claims made in the Instagram post. Counsel instructed on Dr White's behalf argued that an interim order would breach his article 9 (freedom of thought, conscience and religion) and article 10 (freedom of expression) rights.

The IOT determined that it was necessary to make an interim order on the basis that Dr White may pose a real risk to public safety if allowed to practise unrestricted. They considered that the allegations that Dr White posted misinformation online could have a real impact on patient safety. The IOT stated that they *"consider[ed] that any doctor has a responsibility to provide sufficient and balanced information about Covid-19 to allow any potential patients and other members of the public to access the potential risks and benefits of any treatment or preventative measures under consideration and then make an informed choice"*, a responsibility with which it appeared to the Tribunal Dr White was not complying.

Interim conditions were imposed including:

> *"4. He must not use social media to put forward or share any views about the Covid-19 pandemic and its associated aspects.*

> *5. He must seek to remove any social media posts he has been responsible for or has shared relating to his views of the Covid-19 pandemic and its associated aspects."*

Dr White appealed against the imposition to the High Court. Dove J, handing down judgment on 3 December 2021, was scrupulous in not commenting on the merits of the views that Dr White had expressed. In allowing the appeal he identified that the effect of the conditions were to place clear and obvious limitations on Dr White's right to freedom of expression under article 10. He noted that section 12 of the Human Rights Act 1988 makes specific provision in relation to the granting of relief which might affect article 10 rights. One of the conditions imposed by section 12 is that:

> (3) No such relief is to be granted so as to restrain publication before trial unless the court is satisfied that the applicant is likely to establish that publication should not be allowed.

It was not disputed that section 12 applied to the IOT proceedings and the "*relief*" referred to therein could be read as applying to the interim order. The judge found, however, that the IOT had not addressed their minds to the issue of whether they could be satisfied that it was likely that publication of the matters covered by the conditions would not be allowed following a final fitness to practice hearing. He commented that this was, perhaps, understandable given there was no reference to this in the guidance provided to the IOT, which focusses on the function of risk assessment. It was held that the failure to consider section 12(3) was an error of law which vitiated the decision to impose conditions and the IOT's order was quashed.

This decision poses difficulties for the GMC in bringing doctors before an IOT in these circumstances. The "*trial*" referred to in section 12(3) will, in this context, be a final Fitness to Practise hearing before a Medical Practitioners Tribunal. The function of such a tribunal is to determine whether, on the facts it finds, a doctor's fitness to practise is impaired and, if so, what the appropriate sanction will be. The available sanctions are conditions, suspension and erasure from the medical register. The GMC will not be in a position to say at the interim stage, prior to completion of its investigation, what sanction it is likely to seek. It is only if it were to be considering seeking conditions, which included curtailment of the doctor's social media output, that the requirements of section 12(3) could ever be met. There would be difficulties in obtaining such an order from the MPT, but it is conceivable. However, the GMC is unlikely to want to tie its hands by saying at the interim stage that it would want to seek such an order at a final hearing. Indeed, the GMC are not usually prepared to say what conditions they consider it appropriate for an IOT or MPT to impose at the hearing, let alone months or more in advance.

The solution would seem to be that, if the GMC consider it appropriate to go to an IOT in a case such as this, they seek conditions which do not infringe the doctor's right to free expression (although such conditions might not be directed at the risk identified), or they seek an interim suspension (which might be said to be disproportionate). The other option is not to seek an interim order, but to wait for a final hearing; in those circumstances the GMC could be criticised for failing to take sufficient action against doctors who are seen by the majority as peddling false claims.

It will be interesting to see if the GMC bring Dr White back before an IOT and, if so, what approach they take.

Departure From the GMC Sanctions Guidance

Jasper Gold

General Medical Council v Bramhall [2021] EWHC (2109) (Admin)

In a series of acts referred to by HHJ Farrer QC as "*conduct borne of professional arrogance of such magnitude that it strayed into criminal behaviour*", Mr Bramhall used an argon beam cauterising tool to sign his initials on the livers of multiple patients. In the aftermath of a criminal conviction, the General Medical Council (GMC)

sought his erasure from the medical register. The MPT, disagreeing with the GMC over the severity of his actions, preferred a 5-month suspension.

This case was the GMC's appeal against that decision. It raised interesting questions about how the GMC's Sanctions Guidance is applied in hard cases, and about whether, and how, its recommendations can be departed from.

Background

Mr Bramhall is a transplant surgeon. In 2013, after carrying out a transplant on a patient, he used his cauterising tool to mark his initials – a signature of sorts – on the livers of one of his patients. Then, whilst performing another transplant, he did it again. When one of the patients underwent further surgery with a different surgeon, his actions were noticed, and he confessed to what he had done.

One of the patients so branded went on to develop serious psychiatric symptoms, described as a condition which did not amount to PTSD only because the patient had not witnessed the causative event, and that event did not threaten her with death or serious injury. Mr Bramhall's conduct was treated as a criminal matter, and he pleaded guilty to, and was convicted of, two counts of assault by battery in the Crown Court at Birmingham in 2017.

Regulatory Proceedings

Following Mr Bramhall's conviction, the GMC brought regulatory proceedings seeking his erasure from the register. The MPT predictably found that Mr Bramhall's fitness to practice was impaired. Turning to the question of sanction, the MPT directed itself to the GMC's Sanctions Guidance.

The MPT's approach is striking for the weight it gave to mitigating factors (an important factor in the appeal, discussed below), despite their relative lack of importance in regulatory proceedings designed as they are to protect the public, and the reputation of the medical profession. The MPT noted in mitigation Mr Bramhall's exceptional clinical skill and dedication to his patients, as evinced in numerous testimonials, and his full acceptance of wrongdoing and genuine remorse, as well as that his actions were out of character.

Aggravating Mr Bramhall's conduct, though, was its repeated nature, that it was committed against unconscious patients in theatre, and that it was a significant breach of trust. Noting that it was "*unlikely*" that Mr Bramhall would offend again, and that he had demonstrated insight, the MPT determined that while a suspension was necessary to uphold public confidence, his convictions were not incompatible with continued registration, so erasure was not an "*appropriate or proportionate response*" (at [11]). The MPT decided on a sanction of five months' suspension.

The GMC's Appeal

The GMC, supported by The Professional Standards Authority for Health and Social Care appealed on several grounds (see [12]). Most importantly, they argued that "*The Tribunal failed to consider relevant parts of the Sanctions Guidance and/or departed from the Sanctions Guidance by failing to direct erasure without giving any, or any adequate, reasons".*

The High Court, acting in its appellate capacity, heard the GMC's appeal. The test applicable was whether the MPT's decision was "*either wrong, or unjust because of a serious procedural or other irregularity*" ([15]). The Judge, Mrs Justice Collins Rice, noted that while the court was required to approach the MPT's determinations of what was necessary to maintain public confidence with "*diffidence*", given their professional expertise, the extent of the diffidence required depended on the subject-matter; where dishonesty, or sexual misconduct (for example) were concerned, a court may feel more able to intervene.

The judge's approach, read as a whole, was to break the issue down into four questions: first, had the MPT followed the Sanctions Guidance? Second, were the MPT required to follow the Sanctions Guidance? Third, if not, what must the MPT do (if anything) to justify their departure from it? And fourth, had that, on the facts, been done?

Answering the first question, the judge noted that Mr Bramhall's multiple convictions for offences of deliberate violence, his patients' vulnerability, his abuse of their trust, and the lasting harm caused were each alone sufficient to bring his conduct within the Sanctions Guidance's recommendation for erasure. As such, she found that the MPT had not followed the Sanctions Guidance.

Turning to the question of whether the Sanctions Guidance is binding, the judge held that the MPT were not bound immutably by the Sanctions Guidance, rather it provided an "*authoritative steer*". The key to proper engagement with the Sanctions Guidance was understanding what was required to depart from that authoritative steer.

Answering the third question, the judge held that departures from the Sanctions Guidance must follow from "*careful and substantial case-specific justification*" rather than "*generalised assertion that erasure would be a disproportionate sanction*" (at [22]-[25], internal quotation marks omitted).

The case turned, then, on the fourth question: whether the MPT's decision met that requirement. The MPT, the judge observed, was faced with unique circumstances, and "*unique circumstances always pose a challenge for applying general principles*", but this was not a basis in itself for disregarding those principles. On the contrary, *"it is precisely where principles and rules are most challenged by unique and ambivalent facts, that procedure and guidance may have the most important work to do"* (at [33]). This engaged a duty on the MPT to state clearly their reasons for that departure ([36]), which the MPT did not discharge.

The judge identified two ways the MPT fell short: first, it failed to engage with the indicators for erasure in a clear, substantial and specific manner. Second, having determined that suspension was an appropriate sanction, the MPT failed to engage directly with the possibility of erasure, preferring to stop, as it were, at suspension, and deciding that erasure was disproportionate because suspension was sufficient. This meant erasure was never considered on its own merits; it was judged disproportionate without ever being addressed directly.

Both of these were errors of principle which made it impossible to see the MPT's decision as other than vague and subjective. Nor was the judge able to remedy this deficiency by reading the MPT proceedings as a whole: for example, while the Tribunal said it had given "*particular weight*" to public confidence, it did not explain or show how it did so. The appeal was, therefore, upheld, and the matter remitted to be reconsidered by a reconstituted panel.

The judge then considered the GMC's contention that the MPT had failed to properly interrogate Mr Bramhall's attitude, mixing up candour and insight. This ground of appeal was also upheld ([50]).

Comment

Aside from its undeniably striking facts, this case is important for two reasons. First, it provides a neat encapsulation of the requirements which must be satisfied by an MPT panel who wish to depart from the GMC Sanctions Guidance: clarity, and careful attention to the relevance and weight of each factor taken into account is necessary and should probably be made explicit and spelled out in a manner not necessary where the sanction imposed is the same as that envisioned by the Sanctions Guidance. Shortcuts, however tempting, are unlikely to save time in the long run.

But perhaps more interesting is the judge's observations on the interaction between general principles and unusual, striking fact-patterns. It is trite to observe that hard cases make bad law, but Mrs Justice Collins Rice gave a corrective to the instinct that sometimes underlies the truth of that observation. At [31], she set out two different ways of looking at Mr Bramhall's conduct, two "*competing high-level narratives*", as she put it. Was he (paraphrasing the judge somewhat) a brilliant, dedicated expert of whose skill the public would be unfairly deprived by overreaction to a hubristic mistake, or a contemptuous, power-tripping egomaniac?

Her answer was that, whatever the narrative, a proper sanction would only be arrived at by careful, proper structures, and transparently accessible process. The case's irregularity made these things more important, not less. A hard case might be less likely to make bad law when it is not given special treatment on account of its difficulty.

EVENTS & NEWS

News & Events

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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