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Lawyers Service Newsletter

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Contents

Editorial

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Director, Medico-Legal Services

So, pantomime season is upon us – will fixed costs for low value clinical negligence claims be rowed in by 6th April 2024? Oh no they won't! It appears that there is to be a delay in implementing the scheme given other ongoing related consultations, not least whether disbursement payments are to be in addition to FRC rates proposed or payable out of it.

FRC for clinical negligence claims valued at £25,000 - £100,000 were introduced on 1st October but only for cases where there has been an admission of liability and causation, these cases are to be dealt with in the intermediate track. As to when the admission has to be made, that too remains under consideration by government.

Thank you to all the firms who took the time to complete the AvMA low damages clinical negligence questionnaire. We have published the **Findings from the Questionnaire** as the first item in this Newsletter. The impact of including all fatal claims would appear to be considerable not least for families seeking representation at healthcare inquests under a CFA.

On the subject of inquests the Justice Committee (JC) has announced a new inquiry into the Coroner Service to examine progress made since their recommendations were published in 2021: JC New Inquiry. The consultation closes on 15th January.

The Supreme Court has again been hard at work this year. The cases of *Paul v The Royal Wolverhampton NHS Trust*, *Polmear v Royal Cornwall Hospital NHS Trust* and *Purchase v Ahmed* came before it as conjoined cases heard between 16–18th May 2023. It is hoped that the pending judgment, will establish some clear principles on secondary victim claims. In the meantime, while we are waiting for that judgment to be handed down, **Thomas Crockett**, barrister at Hailsham Chambers gives this further consideration in ***"Secondary Victim Claims: is the search for principle back on?"***

In June the Supreme Court dismissed the appeal in ***R (on the application of Maguire) v His Majesty's Senior Coroner for Blackpool & Fylde & another***. We are very pleased to refer you to the article bearing the case name written by three specialist healthcare inquest barristers from 7 Bedford Row: **Sarah**

Edwards (who has also represented AvMA clients on our pro bono inquest service); **Rose Harvey-Sullivan** and **Jasmine Leng**.

Leila Benyounes, barrister at Parklane Plowden looks at the Supreme Court's judgment in *McCulloch and Others v Forth Valley Health Board* in ***"Doctor knows best"***. The decision was handed down in July and is the first Supreme Court decision following *Montgomery v Lanarkshire Health Board* [2015]. Leila's article explores the Professional Practice Test which gives guidance to clinicians on whether an alternative treatment is reasonable and requires discussion with the patient.

It looks increasingly likely that Fixed Recoverable Costs (FRC) will be introduced for clinical negligence claims, against that background we are mindful of ***"Vulnerable clients and witnesses: some pointers, some challenges"***. This important article has been written by **Victoria Webb** barrister at Old Square Chambers who looks at the **Civil Justice Council's report on vulnerable witnesses** published in February 2020 and the subsequent changes made to the Civil Procedure Rules (CPR) in April 2021. Victoria looks at how subtle potential vulnerabilities can pose challenges such as where the claimant has undiagnosed autism or dyslexia.

As if to demonstrate Victoria's point further, **Craig Knightley**, an associate solicitor at Tees Law, looks at the problems with ***"Diagnostic Overshadowing in Patients with Autism and Learning Disabilities: The Serious Ongoing Concern"***. The increased risk of premature death is much higher in those with learning disabilities – 49% are avoidable as against 22% in the general population!

Case reports from our lawyers, are a great way of sharing learning and knowledge. **Sarah Hibberd**, an associate solicitor with Penningtons Manches Cooper, is author of ***"Medico-legal issues in maternity claims",*** this case report involved issues of hyperstimulation, pre-eclampsia and fetal growth restriction. Once again the case involves failures to monitor the CTG. The good news is that Sarah's client has gone on to qualify as an obstetrician determined to use her own experience to promote better obstetric care for all women.

Two separate articles on issues relating to practice and procedure, the first by **Bruno Gil** at Old Square Chambers looks at two recent cases: *Scarcliffe v Brampton Valley Group Ltd* [2023] and *Muyepa v MoD* [2022]. He has carefully gone through these cases in his article ***"Muyepa and Scarcliffe: Some Lessons from the High Court"*** and offers important take away points for practising lawyers particularly when instructing quantum experts. The second but no less important article ***"Chapman v Mid & South Essex NHS Foundation Trust* [2023]"** looks at who is responsible for the costs when the Claimant does not succeed on all issues. **Tamar Burton** barrister at Cloisters sets out the findings in this case which includes confirmation that two sets of allegations arising from two periods of treatment provided at different times, by different expert disciplines does not mean the issues should be treated as two different claims. It also confirmed that a 90% offer is a valid one for the purpose of Part 36 offer.

The Lucy Letby case has prompted widespread discussion about the dynamics within the NHS, not least how healthcare professionals are dealt with when they raise concerns about colleagues and whether the existing whistleblowing arrangements are robust enough. Switalskis are representing several families in civil claims resulting from Letby's treatment, **Tamlin Bolton** a Senior Associate Solicitor at the firm explains the benefits of a statutory inquiry in ***"Lucy Letby: The Statutory Inquiry"*** and how it is expected to contribute to identifying the truth of what happened in this shocking case.

Alison Hills, Senior Associate at Tees Law also considers the Letby case and notes there were some ten missed opportunities to consider Letby's actions. In ***"NHS Whistleblowing protection and how systemic change is desperately needed"*** she describes the plight of another whistleblower, Dr Chris Day, who raised patient safety concerns in 2014. The response was an NHS (publicly funded) arsenal of litigation tactics that continued to be engaged until as recently as December 2022, his experience rewarded him with career in tatters, finances compromised and what must be immeasurable stress.

Ironic then that I should end with an article where the opening line is *"A criticism of the NHS generally is that it does not learn from mistakes"*. Our thanks to **Justin Valentine**, barrister at St John's Chambers, Bristol for his article ***"The Serious Incident Investigation Report (Root Cause Analysis) is being phased out. Will this benefit patients and what are the implications for clinical negligence litigation?"***. PSIRF is set to replace the previous SIR investigation.

I look forward to seeing you at AvMA's Gala dinner on 1st December and wish you all a peaceful and restful holiday.

Best wishes

Findings from the AvMA LD FRC Questionnaire 2023

LISA O'DWYER
DIRECTOR OF MEDICO-LEGAL SERVICES (AVMA)

First, I would like to thank everyone who responded to this questionnaire.

AvMA recognises that different specialist clinical negligence firms have different commercial models and to that end will have different views on what represents an acceptable level of remuneration under a Low Damages Fixed Recoverable Cost (LD FRC) scheme. Nonetheless, the comments in the responses received demonstrate that firms share concerns that the current proposals for an LD FRC scheme for clinical negligence will affect access to justice for many potential claimants.

It is of considerable concern that access to justice may be compromised at a time when the NHS service is under more pressure than at any other stage in its history. The NHS is a much valued service but with long waiting lists; problems with staff recruitment and retention; low staff morale; funding issues; and a social care system which is struggling to deliver, patient safety has never been more of an issue.

With those significant background factors, the stage is clearly set for there to be an increase in clinical negligence claims, not a decrease; an increase in claims means an increase in financial costs. Let us not forget that this will be accompanied by an increase in the human cost caused by injuries which should have been avoided. The way to manage that must surely be to address the root of the problem, not to head claimants off at the pass by introducing FRC which in real terms means that many people with valid but low value, complex claims will not be able to find representation.

The AvMA Questionnaire was open to legal firms who have an AvMA or other Clinical Negligence accredited lawyer working within their clinical negligence department and firms who are members of our Lawyer Service, who may not have any accredited lawyers. 83% of those responding were accredited clinical negligence solicitors, so holding either AvMA Panel accreditation, Law Society or APIL accreditation in clinical negligence.

64 firms responded to AvMA's survey which is a good response especially when considered in the context of the government's consultation on FRC in lower damages clinical negligence claims which received a total of 98 responses (p12 of the government response). 20 of their responses were from defendant law firms, indemnifiers, insurers or other representative bodies. 29 responses were from other sources such as the Law Society, NHS, Medical Sector organisations such as the BMA. 49 responses were from claimant law firms.

Will firms continue to undertake low value clinical negligence work under LD FRC?

29% of respondents said they would not be undertaking low value damages work under the DHSC proposals. 33% will consider each case on its own merits and 36% said they will do LD FRC in clinical negligence but only if disbursements are additionally and separately recoverable.

54% of firms clearly state that the level of remuneration offered in the light track is not commercially viable and 51% state that the level of remuneration offered for the standard track is not commercially viable.

Protected parties:

Only 11% of firms will represent protected parties, even with the increased bolt-on proposed. That means that those whose capacity is in issue will be even more disenfranchised than they are already, that will certainly affect the elderly, whose capacity may fluctuate as well as those with learning difficulties. However, if disbursements are additionally and separately recoverable then the number of firms prepared to take such cases may rise to about 51%.

Fatal Claims:

It is AvMA's view that the questionnaire demonstrates that there is a clear need for the government to exclude all fatal claims from a FRC process, not just stillbirth and neonatal deaths.

Including fatal claims in the LD FRC scheme will severely impact on the public's ability to secure representation at inquest. The existing inequality of arms between the state and individuals is well documented. Many of you will be familiar with The Justice Committee's report on the Coronial Service, published in May 2021:

https://committees.parliament.uk/publications/6079/documents/75085/default/

The Justice committee said: *"...The Ministry of Justice should by 1 October 2021, for all inquests where public authorities are legally represented, make sure that non-means tested legal aid or other public funding for legal representation is also available for the people that have been bereaved"* (Paragraph 103).

The government's response to this published in September 2021 said: **https://committees.parliament.uk/publications/7221/documents/77640/default/**

"...the Government will be considering its approach to legal aid for inquests as part of its response to Bishop James Jones' report of his review of the Hillsborough families' experiences and we will respond to Bishop James' recommendation on legal aid then".

Bishop James' report '*The patronising disposition of unaccountable power*' is dated November 2017, the government has still not responded. Our survey makes it clear that including fatal claims in a FRC scheme will further impact on a family/loved one's ability to obtain representation at inquest under a CFA.

A staggering 89% of firms responding said they currently offer representation at healthcare inquest, however 61% of those firms will cease to provide representation at inquest if the subsequent civil claim were subject to FRC.

Only 29% of firms will continue to provide representation under the FRC scheme providing disbursements are additionally and separately recoverable. The firms responding see healthcare inquests as important and will continue to do inquest work under a CFA if all fatal cases were excluded from an LD FRC.

As mentioned in my editorial, the Justice Committee has recently launched **a new inquiry into the Coroner Service to examine progress - Committees - UK Parliament**, the terms of reference include addressing what progress the government has made in response to the Committees 2021 recommendations. We encourage you to respond on or before 15th January 2024 when the consultation closes.

Secondary Victim Claims: is the search for principle back on?

THOMAS CROCKETT
HAILSHAM CHAMBERS

Is the law relating to secondary victim claims finally heading for reform? Following the Court of Appeal's recent decision in the combined appeals of *Paul v The Royal Wolverhampton NHS Trust*, *Polmear v Royal Cornwall Hospital NHS Trust* and *Purchase v Ahmed* [2022] EWCA Civ 12, it seems that the stage is set for the law to be considered by the Supreme Court and many will be hoping for some long-awaited large-scale reform and rationalisation.

The law as it exists is controversial. Lord Oliver in *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310 identified factors which he opined must apply in secondary victim cases to allow recovery by the claimant. These have come to be known as the *'control mechanisms'* imposed by the common law to define the limits of liability in such cases. In summary, to succeed a secondary victim must establish:

1. the proximity of relationship between them and the primary victim

2. that their injury must arise from a sudden and unexpected shock

3. that they were personally present at the scene or immediate aftermath

4. that their injury arose from the death, extreme danger to, or injury of the primary victim

5. that there must be *"a close temporal connection between the event and the [secondary victim's] perception of it, combined with a close relationship of affection between the plaintiff and the primary victim"*.

The law has variously been described as a *"patchwork quilt of distinctions which are difficult to justify"*[1]. Certainly, it appeared in *Paul*, Sir Geoffrey Vos MR, Lord Justice Underhill VP and Lady Justice Nichola Davies were sufficiently concerned by their conclusion that, whilst they considered the Court of Appeal bound by the fifth of Lord Oliver's control mechanisms, that they pre-emptively considered the case should be considered by the Supreme Court.

Perhaps therefore soon will be the time for the common law to find the principle for which some considered the search for which had long been *"called off"*[2].

At the heart of each appeal in *Paul* was a secondary victim, who had sustained psychiatric injury following their witnessing of the death of a loved one. In each case, the shocking event which caused the psychiatric injury occurred after the allegedly negligent act which caused it. In all three cases, the deaths witnessed by the secondary victims occurred many months after alleged failures to diagnose the condition which eventually killed the primary victim.

In *Paul* and *Polmear*, the Courts below found that such a scenario could give rise to an actionable claim by secondary victims, and the defendant NHS Trusts appealed. In *Purchase*, the Court below applied *Taylor v A Novo* (UK) Ltd [2013] EWCA Civ 194, holding that this was authority for the proposition that no claim could be brought in respect of psychiatric injury caused by a separate horrific event which was removed in time from the original negligence, and the claimant appealed.

In *Novo*, Lord Dyson MR firmly rejected the argument that the control mechanism of temporal proximity should be more liberally interpreted and in contrast to the reluctant tenor of the Court of Appeal's judgment in *Paul*, opined that this was a feature of the common law's definition of the sometimes difficult and elusive *'neighbour'* principle. He opined:

> *"... in secondary victim cases, the word* "proximity" *is also used in a different sense to mean physical proximity in time and space to an event. Used in this sense, it serves the purpose of being one of the control mechanisms which, as a matter of policy, the law has introduced in order to limit the number of persons who can claim damages for psychiatric injury as secondary victims or to put it in legal terms, to denote whether there*

1 *Lord Steyn in* White v Chief Constable of South Yorkshire *[1999] 2 A.C. 455 at 500 B*

2 *Lord Hoffmann in* White *(ibid.) at 511 B*

is a relationship of proximity between the parties. In a secondary victim case, physical proximity to the event is a necessary, but not sufficient, condition of legal proximity.

... Lord Oliver said, the concept of proximity depends more on the court's perception of what is the reasonable area for the imposition of liability than any process of logic. In the context of claims by secondary victims, the control mechanisms are the judicial response to how this area should be defined. This has involved the drawing of boundaries which have been criticised as arbitrary and unfair. But this is what the courts have done in an area where they have had to fix the ambit of liability without any guiding principle except Lord Atkin's famous, but elusive, test."[3]

Sir Geoffrey Vos MR's lead judgment (with which both other Lord Justices agreed) was far less emphatic than that of the previous (but one) Master of the Rolls. Whilst he accepted that the Court of Appeal was bound by Novo, this was not without considerable reluctance and obvious heaviness of heart. He considered that there must be doubt as to whether the law applying to secondary victims in accident cases should apply to those in fatal clinical negligence cases where there is very frequently a delay between the index negligent act or omission and the death of the victim, particularly in misdiagnosis cases. This, it was posited, may also apply in a case where a negligent architectural design for a door may not cause its collapse and injury of a primary victim for years later.[4]

In terms, it was doubted why the fifth control mechanism requiring temporal proximity existed at all. Indeed, Sir Geoffrey opined:

"Looking at the matter without regard to the authorities, it is hard to see why the gap in time (short or long) between the negligence (whether misdiagnosis or poor design) and the horrific event caused by it should affect the defendant's liability to a close relative witnessing the primary victim's death or injury that it caused."[5]

Rejecting the arguments that other authorities, including North Glamorgan NHS Trust v Walters [2002] EWCA Civ 1792, should be understood to have liberalised and led to a more pragmatic and benign interpretation of this issue, Sir Geoffrey concluded that the Court was bound by Novo, notwithstanding his *"reservations"* as to whether it *"correctly interprets the limitations on liability to secondary victims contained in the five elements emerging from the House of Lords authorities"*.[6]

Whilst Lord Justice Underhill's added that *"if the point were free from authority I would be minded to hold that on the pleaded facts the Claimants in all three cases should be entitled to recover"*[7], he too considered the Court bound by Novo, the precise ratio of which he opined he did not find it easy to identify.[8]

Both the Master of the Rolls and Underhill LJ (with whom Nichola Davies LJ agreed) gave the clearest of indications that this was a matter which would benefit from consideration from the Supreme Court[9] and it seems very likely that this is where these appeals will end up.

Open to the Supreme Court will be the option of upholding the law, roundly derided by some as being constituted of *"the silliest rules"* in tort,[10] and/or as out of kilter with the modern world of 24-hour news cycles, increasingly accessible social media, and news and videos available to anyone with a mobile telephone from any number of citizen journalists, and as concerned the Court in Paul, societal perceptions of the arbitrariness that those suffering psychiatric illness by witnessing the horrific death of a family member cannot recover damages from the tortfeasor who caused that death in cases where the index negligent act/omission was not temporally synchronous to it.

As suggested in a recent article by the author and David Pittaway KC on secondary victim claims for the *Journal of the Malaysian Judiciary*,[11] the stakes will be high for all litigants in this appeal: victim, medical provider and insurer alike. Restatement of the law would likely to mean that secondary victim claims in very many cases, including in a great deal of claims where the originating tort is one of clinical negligence, will be continued to be extremely difficult for claimants, but the cutting of the Gordian Knot and the doing away of any *'control mechanisms'* is liable to increase the volume of claims, and give rise to potentially far increased liabilities in cases where harm to third parties is a foreseeable consequence of harm to a primary victim.

Originally published in January 2022, updates in editorial.

3 *At 26 – 28. Lord Atkin's* 'neighbour principle' *is of course taken from* Donoghue v Stevenson *[1932] AC 562, at 580*
4 *Paragraphs 76-79*
5 *Paragraph 80*
6 *Paragraph 99*
7 *Paragraph 103*
8 *Paragraph 104*
9 *Paragraphs 99 and 106*
10 *J. Stapelton. In* Restraint of Tort, *in P. Binks.* The Frontiers of Liability *(Vol. II) (Oxford, OUP. 1994) p. 95*
11 *July [2021]* Journal of the Malaysian Judiciary, *available, pp145-158. Available at:* **julai2021.pdf (jac.gov.my)**

R (on the app. of Maguire) v His Majesty's Senior Coroner for Blackpool & Fylde and another

SARAH EDWARDS, ROSE HARVEY-SULLIVAN AND JASMINE LENG: 7BR



7BR

In a judgment handed down on 21st June 2023, the Supreme Court unanimously dismissed the appeal in *R (on the application of Maguire) v His Majesty's Senior Coroner for Blackpool & Fylde and another*.

The appeal was long-awaited and hoped to clarify the application of Article 2 of the European Convention on Human Rights to inquests raising issues of healthcare. In short, the Court has confirmed that Article 2 of the Convention is rarely engaged in healthcare inquest settings, except in specific and exceptional circumstances.

Legal Background

Article 2 ECHR provides that *'everyone's right to life shall be protected by law. No-one shall be deprived of his life intentionally save in the execution of a sentence of a court.'*

The legal starting point to this appeal can be found in *Rabone v Pennine Care NHS Foundation Trust* [2012] 2 AC 72, which determined that the duties under Article 2 can be broken down as follows:

(1) A negative duty not to take life save in the exceptional circumstances set out in Article 2(1).

(2) A positive duty to protect life which comprises:

a. The general *'substantive'* or *'systems'* duty upon the state to implement legislative and administrative frameworks which protect the right to life. In the public health sphere, this requires states to enact regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of patients' lives.

b. The *'operational'* duty to implement measures to protect individuals in specific circumstances from *'a real and immediate risk to life where the state knows, or ought to know, of that risk'* (*Osman v UK* (1988) 29 EHRR 245).

(3) A procedural positive duty (known as the *'investigative'* or *'procedural'* duty) to investigate deaths which may arguably amount to a breach of duty of any of the substantive obligations.

In *R (Morahan) v West London Assistant Coroner* [2021] EWHC 1603, it was held that there is no universal form of procedural duty which applies across all cases, but that there are three different levels:

a. The *'basic procedural'* obligation, which requires steps to be taken to establish whether the cause of death was from natural causes, or whether there might be a potential breach of Article 2. This might be satisfied by a police investigation, for example.

b. The *'enhanced procedural'* obligation, which requires the state to take further steps to investigate possible breaches of Article 2 and is intended to provide accountability and redress. This applies where there is a particularly compelling reason why the state should be required to give an account of how a person came by their death. In some categories of case the enhanced procedural obligation is automatically engaged, such as deaths in custody, by virtue of the state's degree of responsibility toward the deceased.

c. The *'redress procedural'* obligation, which arises where there is no relevant or compelling reason giving rise to an enhanced procedural obligation, but there is still a possibility that a substantive Article 2 obligation has been breached. This can be satisfied by the ability to pursue a civil claim in negligence, for example.

In cases raising issues of arguable medical negligence, the enhanced procedural obligation rarely applies, and an inquest and the availability of a civil claim in negligence have generally been held to be sufficient to satisfy the state's procedural obligation *(R v Goodson) v Bedfordshire and Luton Coroner* [2006] 1 WLR 432).

Individual errors of judgment by medical professionals are almost never sufficient to engage Article 2 (*LCB v United Kingdom* (1998) 27 EHRR 212).

In *Fernandes v Portugal* (2017) 66 EHRR 28 the Grand Chamber clarified that article 2 is only engaged in exceptional healthcare inquests, namely where a) an individual's life is knowingly put in danger by denial of access to life-saving treatment or b) where a systemic

dysfunction results in a patient being denied access to life-saving treatment, and the authorities knew about and failed to mitigate that risk, thus putting lives, including that of the patient, in danger.

Facts of Maguire

The appeal concerned the death of Jackie Maguire, referred to throughout the judgment as '*Jackie*'. Jackie had Down's Syndrome and learning disabilities. She lived in a care home for adults requiring round-the-clock supervision where she was subject to a standard authorisation under the Deprivation of Liberty Safeguards ('*the care home*'). Crucially, she was dependent upon the staff at the care home for her day-to-day care as well as for access to medical treatment should she need it.

Jackie was nervous about medical interventions and would require support on the occasions that treatment was required. On other occasions Jackie would refuse medical treatment. In the weeks before her death she experienced symptoms including stomach pains and collapsing. On 21 February 2017 she suffered fits, stomach pains and vomiting, but refused to go to hospital when an ambulance was called.

Paramedics were concerned that overriding her wishes by manhandling her risked causing her harm. An out-of-hours GP advised that, while Jackie should ideally attend hospital, her condition was not so serious that they should override her wishes and she was allowed to remain at the care home overnight. The following morning Jackie's condition deteriorated, and she was admitted to hospital where she died of a perforated ulcer leading to cardiac arrest.

In the inquest that followed the Coroner determined, having heard evidence of the various systems said to be in place at the time of Jackie's death, that the enhanced Article 2 procedural duty did not apply. He was therefore not required or permitted to make findings as to the wider circumstances in which Jackie died.

Appeal

The central issue was whether Article 2 required an *'expanded verdict'*, but the Supreme Court held unanimously on appeal that it did not. In a leading judgment by Lord Sales, the Supreme Court provided an authoritative review of the caselaw on Article 2 and the obligations owed. It created no new substantive legal principles but rather collated and approved the body of principles that have previously been applied in the earlier cases cited above.

At paragraphs 49 – 51, the Court referred to *Fernandes v Portugal* (2017) 66 EHRR 28 in which the Grand Chamber clarified as follows:

'190. On the basis of the broader understanding of the states' obligation to provide a regulatory framework, the court has accepted that, in the very exceptional circumstances described below, the responsibility of the state under the substantive limb of article 2 of the Convention may be engaged in respect of the acts and omissions of healthcare providers.

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

192. The second type of exceptional circumstances arises where a systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving emergency treatment and the authorities knew about that risk and failed to undertake the necessary measures to prevent that risk materialising, thus putting patients' lives, including the life of the particular patient concerned, in danger.'

The Court went on to consider the following four questions:

1) Was there an arguable breach of the systems duty on the part of the care home, so as to trigger the enhanced procedural obligation?

2) Was there an arguable breach of the systems duty on the part of any of the healthcare providers, so as to trigger that obligation?

3) Was there an arguable breach of the operation duty on the part of the care home, so as to trigger that obligation?

4) Was there an arguable breach of the operation duty on the part of any of the healthcare providers, so as to trigger that obligation?

Considering the first question, the Supreme Court held that, *'the systems duty in this area services operates at a high level, is relatively easily satisfied, and it will only be in rare cases that it will be found to have been breached'* [145]. The Court re-emphasized that *'individual lapses in putting a proper system into effect are not to be confused with deficiency in the system itself'* [146]. In this case, the Court held that the care home did have proper systems

in place, such that there was no arguable breach of the systems duty.

On the second question, the Court again found that the failings identified were failings on the part of individual healthcare professionals, and not a general failure of the systems duty [182 - 184].

The third question required consideration of the state's responsibility towards Jackie, as regarded Jackie's placement in a care home. The Court determined that the care home had assumed responsibility to ensure she had access to the healthcare available to the population generally, and to guard against any specific risks to her health of which they were aware. As stated at paragraph 192: *'as regards the enhanced procedural obligation in the context of the operational duty, it is only if the appellant can show that there was an arguable breach of the operational duty, targeted on a specific risk to Jackie's life which was known or which ought to have been known that this obligation will be triggered.'*

The care home, on behalf of the state, did not assume responsibility for all aspects of her physical health – rather it is a graduated assumption of responsibility dependent upon their perception of the risks. To this end, the Court concluded that there was no arguable breach on behalf of the care home of the operational duty [204].

Considering the final question, the Court again determined that there was no arguable breach of the operational duty. The Court considered a number of factors that had been at play when healthcare professionals had decided not to take Jackie to hospital, including the desire to protect Jackie's autonomy and dignity, and concluded that the assessments undertaken had been reasonable in the circumstances [208].

Commentary

Whilst the judgment provides a useful and comprehensive overview of the Article 2 jurisprudence, particularly concerning inquests raising potential failings in healthcare, it has not altered the status quo for inquests sometimes characterised as *'medical'* or *'healthcare'* inquests. The position remains that Article 2 inquests involving deaths in care or medical settings will continue to be the exception. The threshold for an arguable breach of the systems duty remains high, and the operational duty is engaged only when it can be shown that the specific risk to health that materialised was known, or ought to have been known.

For bereaved families, and those navigating Article 2 on their behalf, the judgment will likely come as a disappointment. Many hoped that the decision of the Court of Appeal would be overturned allowing findings to be made regarding the broader circumstances by which Jackie came by her death.

This hope stemmed from frustration with the hurdles that come once an inquest is categorised as a *'medical'* or *'healthcare'* inquest. Refusal to grant an Article 2 inquest in such circumstances limits not only the scope of the inquest and the Coroner's ability to make findings with regard to wider care provided, but also the legal funding available to bereaved families – all of which can limit engagement in the inquest or the scrutiny that can be achieved. This can be especially concerning when the deceased was particularly vulnerable and/or dependent for their care upon healthcare providers, as was the case for Jackie.

In *Maguire*, the Court made clear that the existence of individual lapses of the system does not suggest that there is no system, or that the systems duty is engaged. One argument that may be anticipated is where a system arguably exists in theory but is so poorly implemented that it is arguably non-existent in reality. Practitioners representing families and NHS Trusts will be familiar with relatively common failings which include the poor implementation of systems for supporting those with communication needs; systemic dismissive or discriminatory attitudes towards those with learning disabilities resulting in missed opportunities or diagnoses (a common example missed being opportunities to treat sepsis); or the sorts of care coordination or continuity issues which can arise when there are multiple providers. In the context of the operational duty, Lord Sales emphasised that the correct approach was to focus upon the specific risks to Jackie's health of which the authorities were aware or ought to have known. He cited the factors set out by Lord Dyson in Rabone as relevant to a finding an assumption of responsibility in the context of provision of care for a vulnerable person to include heightened vulnerability due to their physical or mental condition and *"the nature of the risk."*

Following *Maguire*, it remains the case that each case must be considered on its own facts. There may well have been a very different result in Jackie's case if, for example, the care home had failed to call an ambulance or GP, despite being aware of her serious ill health and vulnerability. In seeking to persuade the coroner that there has been an arguable breach of the operational duty, practitioners will need to identify evidence of serious and pressing risks to the individual patient, that put the healthcare provider on notice of a risk to life. However, *Maguire* makes plain that the potential to argue for the application of Article 2 in care or healthcare settings, by virtue of the deceased's

vulnerability or dependence upon others for care, is limited.

It should be noted that different considerations apply to both involuntary and voluntary psychiatric patients, where there is an operational duty to protect the patient from a real and immediate risk of suicide of which the hospital is aware. The nature of the risk posed by such a patient is different to a patient in an ordinary hospital setting due to their reduced capacity to make a rational decision. Where the patient is involuntary, or the level of risk is of such a degree to warrant detention of a voluntary patient, Lord Sales noted that a *'stricter standard of scrutiny'* is applied.

In *Maguire* the Supreme Court made it clear that a Coroner's assessment of whether Article 2 applies (and whether the inquiry is sufficient) may alter throughout the course of the inquest as more information comes to light. Thus, the ambit of the enquiry may need to be expanded if it later appears that Article 2 is engaged, and vice versa. This is what happened in *Maguire*, where the Coroner initially determined that Article 2 was engaged on the basis that there had been an arguable breach of Article 2 in terms of affording Jackie access to treatment [99], but after hearing evidence, including evidence of the systems in place at the time, the Coroner ruled that he was satisfied that the investigation had sufficiently clarified matters such that Article 2 was no longer engaged [108].

Lord Stephens suggested that until an inquest is underway, and the real issues can be identified, there may be no proper way to assess whether there is an arguable breach of Article 2. Coroners will therefore need to proceed on the basis that there is a need for an expanded verdict and then review the position at the end of the evidence. Practitioners representing families of vulnerable patients can be expected to seize on these comments to argue at the Pre-Inquest Review that the inquest should at least commence as a *'full'* Article 2 inquest. This at least will allow families to have a full inquest into the circumstances of their loved one's death and may well entitle the family to public funding. Adjournments of inquests may also become more commonplace, if during the inquest, an arguable breach of Article 2 is identified.

For practitioners representing bereaved families *Maguire* is simultaneously disappointing reading, and a helpful reminder of the law in this complicated area.

Sarah Edwards, Rose Harvey-Sullivan and Jasmine Leng are all barristers practising in inquests at 7BR. Sarah is particularly experienced in inquests involving complex medical issues and related civil actions. She and Rose are authors of **Coronial Investigations and Inquests**, *published by Lexis Nexis, which Rose also edits. Meanwhile, Rose's inquests work often focuses on very vulnerable individuals and issues in maternity care. Prior to coming to the bar, Jasmine's work at INQUEST covered issues of state accountability in psychiatric care, criminal justice and immigration detention, while her current inquests work focuses on healthcare.*

Doctor Knows Best- Supreme Court clarifies *"Professional Practice Test"*

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On 12th July 2023, the Supreme Court handed down its judgment in ***McCulloch and Others v Forth Valley Health Board* [2023] UKSC 26** the first Supreme Court decision on the issue of informed consent since ***Montgomery v Lanarkshire Health Board* [2015] UKSC 11**.

Five Justices unanimously dismissed the appeal holding that the *"professional practice test"* is the correct legal test for doctors when providing treatment options to a patient. Treatment options need to be supported by a responsible body of medical opinion, and should include all *"reasonable"* treatment options, but not all *"possible"* treatment options. The Court affirmed that the narrowing down from *"possible"* alternative treatments to *"reasonable"* alternative treatments is an exercise of *"clinical judgement"* and therefore to be judged subjectively from the perspective of the doctor.

In this fatal accident case, the question was whether the doctor should have advised the patient of a particular treatment option, as it was contended that if such advice had been given, the treatment would have been accepted by the patient, thereby avoiding the patient's death.

The Facts

Mr McCulloch died on 07/04/12 aged 39 years, shortly after admission to hospital having suffered a cardiac arrest at home. The cause of death was recorded as idiopathic pericarditis and pericardial effusion: it was agreed that Mr McCulloch died as a result of cardiac tamponade.

Mr McCulloch had first been admitted to hospital on 23/03/12 with a history of severe pleuritic chest pains, worsening nausea and vomiting. Tests showed abnormalities compatible with a diagnosis of pericarditis. By 24/03/12, after a deterioration, Mr McCulloch was intubated and ventilated in the intensive treatment unit. Following some improvement that day, a decision was made not to transfer Mr McCulloch to a different hospital to facilitate pericardiocentesis, a potential treatment which had been discussed with him.

Dr Labinjoh, an experienced consultant cardiologist, for whose acts and omissions it was contended the respondent was vicariously liable, was first involved in Mr McCulloch's care on 26/03/12 when she was asked to review an echocardiogram. Dr Labinjoh recorded that Mr McCulloch's presentation did not fit with a diagnosis of pericarditis and she would discuss with Dr Wood, who was exploring immunocompromise, malignancy.

Mr McCulloch's condition improved and on 30/03/12 he was discharged home on antibiotics to be reviewed by Dr Wood in four weeks' time with a repeat echocardiogram and a chest X-ray to be arranged in advance.

The discharge letter recorded the diagnosis as acute viral myo/pericarditis and pleuropneumonitis with secondary bacterial lower respiratory tract infection.

On 01/04/12 Mr McCulloch was re-admitted to hospital by ambulance with central pleuritic chest pain, similar to the previous admission. After treatment with intravenous fluids and antibiotics, Mr McCulloch was transferred to the acute admissions unit on 02/04/12 and a repeat echocardiogram was arranged.

Dr Labinjoh's second involvement was on 03/04/12. Dr Labinjoh's evidence, which was accepted in the lower court, was that she was not asked to review Mr McCulloch but to assist in the interpretation of the third echocardiogram. She did not consider that it differed from the first two echocardiograms in a way that gave cause for concern.

Dr Labinjoh visited Mr McCulloch on the acute admissions unit on 03/04/12 to assess whether his clinical presentation was consistent with her interpretation of the echocardiogram. Mr McCulloch denied having any chest pain, palpitations or breathlessness on exertion or lying flat.

Dr Labinjoh recorded *"no convincing features of tamponade or pericardial constriction. The effusion is rather small to justify the risk of aspiration... I am not certain where to go for a diagnosis from here".*

Dr Labinjoh's understanding was that the management plan agreed with Dr Wood was still in place and did not prescribe any medical treatment. Dr Labinjoh did not discuss the risks and benefits of NSAIDS as she did not regard it necessary or appropriate in her professional judgement to prescribe NSAIDS, but did advise Mr McCulloch against pericardiocentesis at that time, a potential treatment which had previously been discussed.

By 06/04/12 Mr McCulloch's condition had improved, and the plan was for discharge. Dr Lainbjoh was unable to review Mr McCulloch prior to discharge as she was due to operate elsewhere but indicated in a telephone call that the decision to discharge should be made by the responsible consultant.

Mr McCulloch was discharged on the evening of 06/04/12 remaining on oral antibiotic medication. On 07/04/12 at 14.00 Mr McCulloch suffered a cardiac arrest at home and was taken to hospital where he died at 16.46 after a prolonged period of attempted resuscitation.

Conclusions from the Lower Courts

The appellants' claim failed at first instance before the Lord Ordinary and on appeal to the Inner House.

The Lord Ordinary held that whilst the experts agreed that it was standard practice to prescribe NSAIDs to treat pericarditis, this was not a straightforward case of acute pericarditis: the diagnosis remained uncertain, and Mr McCulloch had not complained of pain.

The Lord Ordinary rejected the appellants' argument that the decision in *Montgomery* meant that Dr Labinjoh was under a duty to discuss with Mr McCulloch the option of using NSAIDs to reduce the size of pericardial effusion and to discuss its risks and benefits where, in her professional judgement, she did not regard it as appropriate to do so.

The Lord Ordinary concluded that *"no case based on failure to advise of the risks of a recommended course of treatment, or of alternative courses of treatment along the lines of* Montgomery*, has been made out"*.

The Inner House, having agreed with this approach to the legal test, upheld the decision of the Lord Ordinary.

Supreme Court

The two principal issues which arose on this appeal were:

1. What legal test should be applied to the assessment as to whether an alternative treatment is reasonable and requires to be discussed with the patient?

2. Did the Inner House and Lord Ordinary err in law in holding that a doctor's decision on whether an alternative treatment was reasonable and required to be discussed with the patient is determined by the application of the professional practice test?

The appellants contended that the assessment of whether an alternative is reasonable is to be undertaken by the circumstances, objectives and values of the individual patient, and therefore objectively, whereas the respondent contended that this was to be assessed by reference to the *"professional practice test"* and therefore subjectively from the perspective of the doctor.

The Supreme Court held that the correct legal test to be applied to the question of what constitutes a reasonable alternative treatment is the *"professional practice test"* found in *Hunter v Hanley* [1955] SC 200 and *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

The Court held that as Dr Labinjoh took the view that prescribing NSAIDs was not a reasonable alternative treatment because Mr McCulloch had no relevant pain and there was no clear diagnosis of pericarditis and, because that view was supported by a responsible body of medical opinion, there was no breach of the duty of care to inform required by *Montgomery*.

Numerous reasons were cited by the Court in support of the application of the professional practice test including consistency with *Montgomery*, consistency with medical professional expertise and guidance (the BMA and GMC were interveners in the appeal), avoiding conflict in a doctor's role, avoiding bombarding the patient with information and, ultimately, avoiding uncertainty.

The Court further considered a hypothetical example where there are ten possible treatment options and there is a responsible body of medical opinion that would regard each of the ten as possible treatment options. The Court held that the question then is the exercise of the individual doctor's clinical judgement, supported by a responsible body of medical opinion, if it is determined that only four of those options are reasonable. The doctor is not negligent by failing to inform the patient about the other six even though they are possible alternative treatments.

As set out at paragraph 57 *"the narrowing down from possible alternative treatments to reasonable alternative treatments is an exercise of clinical judgement to which the professional practice test should be applied"*.

The duty of reasonable care would then require the doctor to inform the patient not only of the treatment option that the doctor is recommending but also of the

other three reasonable treatment alternative options (plus no treatment if that is a reasonable alternative option) indicating their respective advantages and disadvantages and the material risks involved in such treatment options.

The Court held overall that in line with the distinction drawn in *Montgomery* between the exercise of professional skill and judgement and the court-imposed duty of care to inform, the determination of what are reasonable alternative treatments clearly falls within the former and ought not to be undermined by a legal test that overrides professional judgement. In other words, deciding what are the reasonable alternative treatments is an exercise of professional skill and judgement.

Conversely, it was held that if the professional practice did not apply in determining reasonable alternative treatments, one consequence would be an unfortunate conflict in the exercise of a doctor's role: by requiring a doctor to inform a patient about an alternative medical treatment which the doctor exercising professional skill and judgement, and supported by a responsible body of medical opinion, would not consider to be a reasonable medical opinion.

Comment

But how does the professional practice test sit with 1) differences in clinical opinion or skill, and 2) availability of treatment? The former may arguably influence whether a treatment is deemed *"reasonable"* by a clinician and therefore offered to a patient as an option. The filter imposed by the subjective clinical judgement of a clinician in determining what is a reasonable option may mean that there will be cases of patients being denied information about other reasonable treatment options which are also supported by a responsible body of medical opinion. This may not sit easily with the emphasis on patient autonomy in *Montgomery*.

And what happens if a particular treatment is supported by a responsible body of medical opinion and deemed reasonable by a clinician but is only presently available at certain centres? Arguably, unavailable treatment cannot be deemed a treatment option, whether a clinician determines it to be reasonable or not, but if information is withheld by a clinician and there is a narrowing of the provision of information, does this not reintroduce the paternalism which *Montgomery* sought to stamp out?

As determination of reasonable alternative options must be supported by a responsible body of medical opinion, expert evidence will be key in these claims. It may be thought that claims for failing to disclose alternative treatments will be easier to defend as expert evidence obtained by a defendant that an alternative treatment option was *"not reasonable"* will generally be sufficient. Therefore, for those embarking on such claims, an early exploration with experts as to prevailing medical standards and potential reasons that a treatment might not be deemed *"reasonable"* or *"clinically appropriate"* will be essential.

McCulloch provides a significant clarification of a doctor's obligation to obtain informed consent for treatment, applying the *"professional practice test"* as defined in *Bolam* and qualified in *Bolitho*. In providing this clarity, it will be welcomed by the medical profession.

But, if a doctor's duty is to inform a patient about material risks to enable a patient to make an informed choice as confirmed in *Montgomery*, does this decision not dilute the protection of a patient's autonomy by giving doctors the power to limit the provision of information to patients and rule out available treatment options?

On the other hand, is it realistic to require doctors to inform patients of any possible treatment without recourse to the exercise of their professional skill and judgement, with the added protection of the support by a responsible body of medical opinion?

If the decision in *Montgomery* *"reflected a move away from medical paternalism protecting a patient's autonomy and right to self-determination"*, does this decision in *McCulloch* not go one step forward by endorsing patient choice, but go two steps back by narrowing that choice?

Vulnerable clients and witnesses: some pointers, some challenges

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Introduction

There is growing recognition of the need to pay attention to what additional support or adjustments are required to ensure the best participation of vulnerable parties and witnesses in civil proceedings. This article considers the changes to the CPR in April 2021 made as a result of the Civil Justice Council's recommendations and sets out some challenges and pointers for legal representatives when approaching the issue.

Some background

In February 2020 the Civil Justice Council (CJC) released its report on *"Vulnerable Witnesses and Parties Within Civil Proceedings: current Position and Recommendations for Change"*[1]. The provenance of the CJC report had been a specific recommendation of The Independent Inquiry into Child Sexual Abuse. As part of its remit, that Inquiry had looked at the extent to which existing support services, the compensation framework and the civil justice system were fit to deliver reparations to victims and survivors of child sexual abuse. In particular, it noted the experience of claimants in civil cases who had not been afforded the same protections as vulnerable witnesses in criminal cases. That Inquiry recognised in an interim report that fair legal processes had to be adapted to address the vulnerabilities of victims and parties if victims and survivors of child sexual abuse were to obtain justice.[2]

The Ministry of Justice then requested the CJC consider effective support to vulnerable parties and witnesses in civil actions generally, not solely in relation to claims arising from sexual assault / abuse. The CJC's report provides an excellent overview of the research, initiatives and learning from criminal, family and civil spheres, resources available (including the Equal Treatment Bench Book[3] and the Advocate's Gateway toolkits (including a toolkit on vulnerable witnesses in the civil courts[4]). It made a number of recommendations spanning CPR rule changes, case management and training, among other matters.

Current approach in civil proceedings

With effect from 6 April 2021, the overriding objective in CPR 1.1(2)(a) was amended, to add the following text in underline:

"Dealing with a case justly and at proportionate cost includes, so far as is practicable –

(a) ensuring that the parties are on an equal footing and can participate fully in proceedings, and that parties and witnesses can give their best evidence".

Further, CPR 1.6 now introduces a new Practice Direction 1A which makes provision as to how the court is to give effect to the overriding objective in relation to vulnerable parties or witnesses.

These amendments not only foreground ensuring effective participation of the vulnerable as a central principle in civil proceedings, but also (by CPR 1.3) place a requirement on parties to be proactive on the issue. This is to be welcomed. Those of us having difficulty with ensuring the participation of a vulnerable party, or wishing to call a potentially vulnerable witness, have a clear springboard from which to make submissions on how and why any particular needs should be accommodated.

The definition of vulnerability is to be found in Practice Direction 1A. It reflects the CJC's comment that potentially vulnerable witnesses/parties *"are not a homogenous group"*. In short, the Practice Direction provides very broad and open-ended guidance of what it means to be vulnerable in the context of civil litigation: *"when a factor*

1 https://www.judiciary.uk/wp-content/uploads/2022/07/VulnerableWitnessesandPartiesFINALFeb2020-1-1.pdf
2 https://www.iicsa.org.uk/reports-recommendations/publications/inquiry/interim/recommendations.html
3 *Current edition at* https://www.judiciary.uk/wp-content/uploads/2023/04/Equal-Treatment-Bench-Book-April-2023-revision-2.pdf
4 https://www.theadvocatesgateway.org/toolkits-1-1-1

– which could be personal or situational, permanent or temporary – may adversely affect a person's participation in proceedings or the giving of evidence". A non-exhaustive list of factors that may cause vulnerability is provided.

Only a potential impact is required (*"may adversely affect"*). Moreover, it is clear that vulnerability need not amount to a recognised disability, or a medically diagnosable condition, nor, in terms of age, apply only to those under 18. Importantly, it recognises that an individual can be vulnerable due to the subject matter of the litigation itself. Therefore, a bereaved family member may be viewed as vulnerable due to the potential for their participation or giving of evidence to be adversely affected by the fact that the subject matter of the litigation focusses on the fatality of their loved one. This may be particularly the case where have already been through an inquest, have other health issues or are elderly, and are struggling with the demands of the court process and litigation.

The Practice Direction goes on to give guidance as to what sorts of things courts should think about when considering whether a factor may affect the ability of an individual to undertake activities which are part and parcel of participating in proceedings and giving evidence. It lists six activities that should be considered. In *AXX v Zajac* [2022] EWHC 2463 (KB), Master McCloud considered the scope of one those activities, that of the ability of an individual to *"put their evidence before the court"* (paragraph 5(c) of the Practice Direction). In that case, the Claimant AXX had sustained a traumatic brain injury and was suffering from significant psychiatric issues (psychosis, paranoia and delusion) which, on the Claimant's case, had been caused by the index accident.

There was no dispute the Claimant was vulnerable by reason of his psychiatric conditions. There was also a difficulty with him not being medicated. The particular difficulty discussed in the Judgment was that, when visited by any expert to assess his medical condition, the Claimant either engaged to only a limited degree, or refused to engage at all, because of those conditions. The Master ruled that to *"put their evidence before the court"* included *"doing so indirectly by way of cooperating with and speaking to medical experts for the purpose of expert reports to the Court"*.

The Practice Direction is loose as to precise guidance on how a Court should go about giving effect to the overriding objective, but sets out in general terms:

a. The Court, with the assistance of the parties, should try to identify vulnerability of parties or witnesses as early as possible;

b. The Court may identify the nature of the vulnerability in an order and may order appropriate provisions to be made to further the overriding objective; and

c. The Court should consider ordering *"ground rules"* before a vulnerable person gives evidence. That may mean directions in relation to the nature and extent of that person's evidence; the conduct of advocates and / or parties, special measures or other support, exercising the powers of the court to prohibit, limit or modify cross-examination or appoint a legal representative to conduct a cross-examination.

Clearly there is no one size fits all approach here. The case of AXX is illustrative. There the Master made a specific case management direction, namely, ordered a split trial on causation, in order to address the particular difficulty of the Claimant's non-engagement with the medical experts. The Claimant's representatives had sought a split trial, since resolving causation before quantum was thought to hold a real prospect of enabling the Claimant to put his quantum evidence before the court. The hope or expectation was that, if successful on causation, an interim payment to enable psychiatric treatment (including a case manager) would likely follow. If and when medicated, he would then be more likely to engage with experts and his prognosis would also be clearer. In ordering a split trial, the Master commented that it was the court's duty to attempt to mitigate against the effects of the Claimant's vulnerability, splitting causation from quantum maximised the likelihood of this, and the measure was proportionate. In making this ruling she commented that the Practice Direction is a *"structured reasoning tool"* but was *"neither an exhaustive set of provisions nor intended to be construed narrowly as if a statute"*.

Some challenges and pointers

Clearly in some civil litigation, by virtue of the injuries suffered by a Claimant, where there is a formal diagnosis of a mental disorder, learning disability or physical disability, or due to the young age of an individual, it is obvious that there may be a need for specific adjustments to be made, and solicitors barristers and judges will be alive to that. The challenge I think and as noted by others is what to do when vulnerabilities are more subtle but may be just as likely to impact on the ability to participate or give evidence. However, I consider that the wording of the overriding objective and the Practice Direction here is helpful in enabling a legal representative to raise more subtle issues with the court because i) it is clear that a particular characteristic of an individual or other factor

only has to have the potential to adversely impact their participation or giving of evidence in order to meet the definition in PD1A; and ii) we have a duty to raise the matter as early as possible, in order to assist the court, even if we do not have all the answers when so doing.

In terms of arrangements for vulnerable individuals giving evidence, PD1A flags the possibility of a court ordering a grounds rule hearing, which is likely to be most appropriate where there is a clear specific vulnerability and concrete steps needed to be put in place in advance of trial. In *Morrow v Shrewsbury Rugby Union Football Club Limited* [2020] EWHC 379 (QB), where the Claimant had suffered a head injury and was experiencing anxiety, an intermediary and grounds rules hearing was ordered on an interim application. The ground rules hearing was presided over by the trial Judge and a discussion of it and the outcome is included in the final judgment. While the Judge expressed strong reservations as to whether the intermediary or any of the ground rules had in the event been necessary, of course, that is said with the benefit of hindsight. Moreover, the counter-factual, where none of those measures had been put in place, is not known. One can't ignore that the key effects of the intermediary and making of the ground rules may have been that the Claimant was reassured, and that the advocates and Judge had valuable additional time to consider how to approach the trial most appropriately.

Where more subtle potential vulnerabilities are present and it would appear disproportionate to have a separate ground rules hearing, it may be appropriate to seek directions on more generic *"common sense"* points that may be broadly relevant and helpful to the individual concerned, or at least put them forward for consideration. Such matters can be easily dealt with at a PTR. Ideas for such *"common sense"* directions can be gleaned from the Equal Treatment Bench Book could be ensuring a more detailed trial timetable setting out a specific start time and end time for the vulnerable individual's evidence, and duration of cross examination, timetabling their evidence at the start of the day if possible (flagged as a useful idea in the *Equal Treatment Bench Book*), building in additional breaks, ordering an agreed list of agreed facts and an agreed *"jargon-free"* list of issues for determination at trial.

The CPR requires us as legal representatives to assist the court in identifying vulnerability early and this may not always be possible. However, there are helpful prompts in the new versions of the claim form, directions questionnaires and listings questionnaires which ask whether a party or witness is vulnerable, in what way, and what steps, support or adjustments they wish the court and the Judge to consider. Legal representatives should take a fresh step back on each occasion they fill in such a form, to consider matters as they stand at that time and taking a broad view of vulnerability.

A further challenge may be where there are communication or language difficulties, or undiagnosed issues such as dyslexia or autism, in particular in the older population. While legal representatives won't have all the answers here, aiming for clear and jargon-free communication as a general approach to practice with all our clients is an excellent starting point.

Finally, the Professional Negligence Bar Association and the Personal Injuries Bar Association have a joint working group looking at the issue of vulnerable witnesses in civil proceedings, which may involve reviewing toolkits on the topic for the Advocate's Gateway. This initiative is to be welcomed.

Diagnostic Overshadowing in Patients with Autism and Learning Disabilities: The Serious Ongoing Concern

CRAIG KNIGHTLEY
TEES

In the complex landscape of healthcare, the phenomenon of diagnostic overshadowing has far-reaching implications for the accurate diagnosis and treatment of patients with autism and learning disabilities, particularly in the context of sepsis.

It is well known that individuals with learning disabilities, autism, or a combination of both face an elevated risk of sepsis compared to the general population. Moreover, their susceptibility to infections is heightened, and the progression of the illness tends to be more rapid.

Communication difficulties may also make it challenging for them to convey their symptoms effectively. Additionally, healthcare providers may sometimes misconstrue symptoms of sepsis as a normal part of the patient's pre-existing illness, known as diagnostic overshadowing, which represents a further significant challenge that impedes access to proper healthcare and support.

The Learning Disability Mortality Review Report (LeDeR) published in May 2018, based on findings from over 1,000 reviews into the deaths of people with a learning disability, highlighted sepsis as a key contributor to premature mortality, with 11% of deaths reviewed being recorded as sepsis related (likely an underestimate). The Report recommended a national focus on sepsis for people with a learning disability, to raise awareness of prevention, early identification, and treatment.

Shockingly, the 2021 LeDeR states that 49% of deaths reported were rated as *"avoidable"* for people with learning disabilities, compared to 22% for the general population.

At least some of the *'avoidable'* deaths will be due to diagnostic overshadowing. The phenomenon presents several challenges:

Delayed or Missed Diagnosis: Perhaps the most concerning consequence is the delayed or missed diagnosis of sepsis. Healthcare providers may concentrate on the pre-existing illness, inadvertently overlooking other medical issues, including sepsis.

Attribution of Symptoms: Symptoms that might be indicative of both a pre-existing illness and sepsis can be attributed solely to the pre-existing illness, preventing the accurate identification of sepsis.

Lack of Targeted Treatment: When overshadowing occurs, the patient may not receive the specific interventions and treatments needed for co-existing medical conditions, particularly sepsis.

These precise issues arose in a recent inquest in which I supported the family of a young man with autism and learning disabilities, with the Coroner concluding, amongst a number of other failings, that there was a failure to diagnose sepsis contributed to by neglect.

The Coroner, following a thorough and robust investigation, made the following narrative conclusion:

AB presented with physiological markers indicative of sepsis at the point of his admission to Colchester General Hospital on the 12th September 2021. His Physiological markers repeatedly evidenced sepsis and were consistent with peritonitis throughout his admission, up to, at the point of, and post discharge on the 16th September 2021. By the time of AB's discharge the sepsis had become systemic. The evidence shows that during AB's hospital admission from the 12th to the 16th September that the following matters more than minimally contributed to his death:

a. A failure to undertake further imaging or other objective diagnostic technique prior to discharge;

b. A failure to undertake a digital rectal examination proximate to discharge;

c. There was a failure to recognise the deterioration of the physiological infection markers contained within AB's blood work resulting in a failure to diagnose sepsis, contributed to by neglect;

d. Insufficient consideration of the impact of AB's autism on his presentation and communication combined with a concomitant failure to make reasonable adjustments

to account for AB's autism, including a failure to engage with the hospital's Learning Disability service;

e. A failure to undertake a multi disciplinary assessment of the requirement for a surgical procedure to manually remove faecal matter from AB's colon; and

f. The absence of an appropriate antibiotic course from the 15th September 2021, or acute observation and monitoring, combined with a premature discharge on the 16th September 2021.

It was clear during the inquest that despite the national focus from NHS England on raising awareness of sepsis for people with a learning disability, much still needs to be done to ensure that clinicians are always mindful of a potential diagnosis of sepsis and the dangers of diagnostic overshadowing.

Recognising the significance that autism and learning disabilities often occur alongside other health conditions is imperative to counteract the adverse effects of diagnostic overshadowing. Clinicians must adopt a proactive stance when dealing with patients who have autism and/or learning disabilities.

This should involve; conducting thorough assessments, fostering collaboration among various specialists, and embracing a holistic approach to patient care, delivering individualised care plans, continued awareness and education, and regular re-evaluation to ensure that individuals with learning disabilities receive an accurate, timely diagnosis, targeted treatment, and the necessary support for their well-being.

Medico-legal issues in maternity claims

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A case report featuring hyperstimulation, pre-eclampsia and fetal growth restriction

Maternity claims involve a wide variety of conditions that can develop during pregnancy and labour and can result in significant injury to mother and baby if not managed appropriately. When investigating potential claims with numerous conditions and complications running alongside each other, the different elements must be disentangled to establish exactly what has happened and what has caused injury to the claimant.

We have recently settled a claim which involved the delayed diagnosis of pre-eclampsia, undiagnosed fetal growth restriction (FGR), and the delayed diagnosis and treatment of hyperstimulation.

Routine scans and antenatal checks are of central importance in ensuring pregnancies progress safely. These checks help to ensure that any complications are diagnosed as early as possible so a management plan can be put in place.

Pre-eclampsia can lead to serious complications if it is not diagnosed early. It is a condition that should be readily identifiable using simple antenatal checks and if suspected, should be promptly followed up. Early signs of pre-eclampsia can include high blood pressure (hypertension) and protein in the urine (proteinuria) which should be detected during routine appointments through blood pressure checks and urine dips.

FGR may be identified by taking fundal height measurements and plotting these, and ultrasound measurements, on GROW charts, which are used to ensure a baby is growing within the expected range for their gestation. If there are concerns about fetal growth, women should be referred for a growth scan to provide a more accurate assessment of the baby's weight, to assess the level of amniotic fluid around the baby, to check the blood flow between the mother and the baby and, if required, to arrange serial scanning to monitor growth and ensure delivery occurs at the safest time. Growth restricted babies often do not have the same reserves for labour as a baby within the expected growth parameters and they are, therefore, more vulnerable to the effects of lack of oxygen during delivery. This is why it is so important these babies are identified, and specialist care is provided to ensure an appropriate management plan is put in place.

Hyperstimulation is a serious complication of induction of labour and is categorised as five or more contractions within 10 minutes, or when single contractions last more than two minutes. Left untreated, uterine hyperstimulation can cause fetal heart rate abnormalities, uterine rupture or placental abruption, which can cause babies to suffer hypoxic injury.

Case report

The claimant presented to the defendant trust with reduced fetal movements at 37+3 weeks gestation in her first pregnancy. A urine test performed a week previously at a routine antenatal appointment was noted to have identified early signs of pre-eclampsia, but this test had been overlooked and not followed up. Investigations were carried out, including a growth scan, and the baby was noted to be growth restricted. Concerns about fetal growth restriction had not been identified during previous attendances. The combination of growth restriction and pre-eclampsia prompted admission for induction.

On admission, the CTG indicated that the baby was well oxygenated, with a heart rate of 130 beats per minute (bpm). The CTG, restarted at 11.23pm, showed the baby's baseline rate had increased to 160bpm and the Propess pessary for induction was inserted at 11.40pm. The CTG was recommenced at 12.06am and the baby's heart rate was again noted to be 160bpm, down to 150bpm by 1.10am. This was still 20bpm higher than normal for the baby. The CTG was then discontinued.

Between midnight and 2am, the claimant reported side effects of the induction, including bleeding vaginally, severe pain, sickness and diarrhoea. She was very distressed and despite repeatedly expressing her concerns

that something was wrong, she was not listened to. From 3am, she experienced unbearable contractions and continuous pain and was prescribed pethidine at 4.10am.

When she was eventually put back on a CTG monitor at 6.41am, it was grossly abnormal and her contraction frequency was more than five contractions every 10 minutes. The claimant recalls that she was contracting nine times in a 10-minute period. On recognising this, the trust removed the Propess, transferred the claimant to the delivery suite, and administered terbutaline to reduce the stress on her and the baby. The claimant underwent an emergency caesarean section and her baby was born in poor condition with pH levels that indicated they had been struggling for a prolonged period of time. The baby was resuscitated, required immediate care in the neonatal unit and was noted to be on 0.4th centile.

Complaint and trust investigation

The claimant was very concerned about the treatment provided to her during labour so she made a complaint and attended a meeting with the trust to discuss what had gone wrong. The trust investigated and acknowledged:

• There were missed opportunities to detect fetal growth restriction.

Retrospective plotting of the fundal height measurements on the GROW chart demonstrated that the measurements at 26+3 and 31+5 had not been accurately plotted. The trust also acknowledged that the measurements at 28, 34 and 36 weeks had not been plotted at all. Had they been plotted correctly, it should have prompted a referral for a growth and wellbeing scan either at 28+5 weeks or, at the latest, by 31+5 weeks as by that stage there was a visible change in growth velocity from above the 50th centile to below it. If FGR had been detected earlier, the claimant would have undergone additional scanning and CTGs which would have informed the management plan and the safest time for delivery.

• There was a delay in recognising the early warning signs of pre-eclampsia.

The claimant's urine sample at 31+5 weeks had showed a trace of protein and there was then a failure at 34+5 weeks to check the urine again. A urine test performed at 36+5 weeks showed 1+ protein and was sent to the lab for a Protein Creatinine Ratio (PCR). The PCR was reported the same day with a result of 66 (over 30 is an early warning sign of pre-eclampsia). This warranted further medical investigation, but the result was overlooked and not actioned. Only when the claimant presented for reduced fetal movements was the result reviewed and pre-eclampsia diagnosed. The trust acknowledged there had been missed opportunities for earlier detection and monitoring of significant proteinuria.

• The baby's increased baseline rate (BLR) to 160bpm should have been investigated prior to commencing induction.

Whilst 160bpm is at the threshold of normal, it was not normal for the claimant's baby and it would have been safer to investigate why the BLR had increased, and allow it to settle or to help it to settle with medication, prior to commencing induction. There had already been an unexplained rise in the BLR before contractions commenced, which indicates the baby was already starting to use up their reserves for labour.

• Induction should have taken place on the labour ward.

An individualised assessment should have identified that this was a high-risk pregnancy with an increased chance that the baby could develop hypoxia in the presence of contractions due to smaller size and the impact of pre-eclampsia on placental function. Induction on the labour ward would have allowed better monitoring and rapid access to the obstetric team.

• The claimant was not adequately monitored during induction so there was a delay in recognising hyperstimulation.

The claimant experienced symptoms between midnight and 2am which should have raised concerns about hyperstimulation. Once the Propess for induction has been administered, monitoring is recommended for 30 minutes and, if a woman experiences painful contractions, CTG monitoring should be recommenced for at least 30 minutes. In the claimant's case, the trace stopped at 23.53 (only 13 minutes post insertion) and recommenced at 12.06am when the BLR was still higher than normal for the claimant's baby. In the absence of contractions, the guidelines recommend the CTG is repeated every six hours but sooner if regular contractions have started.

By 3am, the claimant was experiencing very painful contractions which should have prompted CTG monitoring, observations and the suspicion of hyperstimulation. The need for analgesia should also have prompted a CTG and a vaginal examination. The trust acknowledged that the recommended guidance was not followed. A CTG at 3am would most likely have shown that the baby did not have reserves for labour, prompting closer monitoring, abandonment of induction and facilitation of birth. By 06.41 when the CTG was restarted, the claimant had suffered hours of hyperstimulation and the baby was in severe distress.

Clinical negligence claim

Based on an initial review of the complaints correspondence, medical records and discussions with the claimant, there was sufficient information to send an early pre-action protocol letter of notification. The defendant trust was invited to commence its own investigations and make early admissions on breach of duty and causation, with a view to resolving the claim swiftly and proportionately and reducing the amount of expert evidence required. Unfortunately, a response from the trust was not forthcoming and therefore we proceeded to obtain specialist obstetric evidence.

The obstetrician confirmed that the care provided after induction of labour was grossly negligent. There were multiple breaches of duty, including the failure to obtain a reassuring fetal heart rate pattern before commencing prostaglandin insertion. He noted that the CTG showed a raised baseline with no obvious accelerations and the CTG should therefore have been continued or a medical review sought, before proceeding with the induction. He concluded that the failure to do so, on the background of known preeclampsia, was a serious breach of duty. There were also negligent failures to continue CTG monitoring after prostaglandin insertion, to repeat the CTG after the claimant reported a significant increase in pain and after opiate analgesia had been administered. When the CTG was recommenced, it showed a grossly abnormal heart rate and there was a negligent failure to call for urgent bedside review and transfer the claimant directly to theatre for a category 1 caesarean section, resulting in an additional 30 minutes of exposure to hypoxia.

With proper monitoring and care during labour, the claimant could have undergone induction of labour safely. However, as a result of the defendant's negligence, the claimant suffered significant pain and distress from ongoing hyperstimulation, and the birth of her baby by emergency caesarean section was unnecessarily traumatic and rushed. The baby suffered prolonged acute hypoxia and was born with very poor blood cord gases, requiring neonatal care. The traumatic circumstances of labour and the poor condition of her baby at birth caused the claimant to suffer significant emotional distress.

Expert evidence was obtained from a consultant psychiatrist who concluded that the claimant had suffered from post-traumatic stress disorder, experiencing vivid flashbacks and sleep paralysis. She described ruminations, feelings of self-blame and avoidance behaviours. The claimant was angry that she had not been listened to, compounded by the fact that, as a trainee doctor working in maternity care, she had medical knowledge to support the concerns she was expressing. Despite this advantage, her distress was ignored and she felt vulnerable and frustrated. She had been planning a career in obstetrics and, at that time, continuing in this role felt impossible. Recognising her own symptoms, the claimant sought psychotherapy, incorporating Eye Movement Desensitisation and Reprocessing (EMDR) which helped to alleviate some of her ongoing symptoms. She was understandably anxious during her second pregnancy and retains residual feelings of anger and frustration as well as some post-traumatic symptoms in the form of sleep paralysis and avoidance behaviours. It was concluded that she would benefit from further psychotherapy in the form of cognitive behavioural therapy.

Outcome

Following service of the letter of claim, the defendant made an offer to settle and, after negotiation, the claim for maternal injuries was successfully concluded and the claimant received compensation.

Thankfully, the claimant's baby is currently meeting milestones and, at this stage, appears to have avoided neurological injury despite suffering a prolonged period of acute hypoxia. A potential claim for the baby is therefore on hold and being kept under review.

In addition to obtaining compensation, we also managed to secure an apology from the defendant trust, acknowledging that the standard of care provided had led to a distressing experience for the claimant, her baby and her family. The claimant was very grateful to receive this apology, describing it as *'the final piece of the puzzle'*.

Despite the trauma caused by her own birth experience, the claimant decided to qualify into obstetrics. She is keen to prevent other women experiencing the same trauma and she is educating her colleagues about the importance of listening to mothers' concerns during labour and recognising the signs of hyperstimulation. In addition, the circumstances of her labour have motivated her to set up an maternal health company. It is reassuring to see that the claimant is using her negative experience in such a positive way, with a view to improving standards in maternity care.

Muyepa and *Scarcliffe*: Some Lessons from the High Court

BRUNO GIL
OLD SQUARE CHAMBERS

OLD SQUARE CHAMBERS

Mr Justice Cotter has handed down judgment in the case of *Scarcliffe v Brampton Valley Group Ltd* [2023] EWHC 1565 (KB). The decision has themes in common with last year's decision of *Muyepa v Ministry of Defence* [2022] EWHC 2648 (KB). Both cases feature excoriating criticisms of experts for both sides and they see substantial sums of claimed losses not being recovered by the Claimant. Read together, they give a clear indication of the issues that are being picked up in personal injury and clinical negligence litigation. It seems that there are points to take away for lawyers on both sides. Points which, if ignored, will be to the detriment of our clients. The intention of this article is to pick out these themes and consider their implications.

To introduce these claims briefly:

Muyepa was a non-freezing cold injury claim. Those familiar with the case will know that it ended in a finding of fundamental dishonesty against the Claimant – a point that is largely irrelevant to the parts of the judgment analysed below. This was a case which, at its highest, was pleaded at £3,766,615. A substantial part of that total came from two heads of loss, namely care and loss of earnings. The quantification of those heads was based upon the calculations set out in the Claimant's expert reports for care and employment. Concessions were made on behalf of the Claimant as the case progressed, and more was abandoned at trial, although the case was never put below £1.6M. At trial, it was held that the claim was, in fact, worth £97,595.33, i.e. 2.6% of the original claim.

Scarcliffe was an orthopaedic injury – fractures of the transverse processes of L2 and L3 - leading to chronic pain. Judgment had been entered in favour of the Claimant. The case proceeded only in respect of quantum. As with *Muyepa*, the care claim formed a very substantial part of the total damages, which ran to a total of £6,189,507.49. Even after some concessions at trial, the Claimant contended for over £5M. The Claimant recovered £275,063.03, i.e. 4.4% of the pleaded value.

Lessons for Both Sides: The Role of the Expert

For anyone who reads both judgments, it will be clear that parties are being encouraged to have a paradigm reset when it comes to the role of experts.

In both cases, some (but not all) of the medical and non-medical experts faced criticism, largely resulting from a misconception as to their role. Mr Justice Cotter appears keen to disabuse parties and experts of this misunderstanding. Their role is not to be cheerleader, nor to think of themselves as part of the Claimant's or Defendant's "*team*". They are independent, objective Part 35 experts who owe an overriding duty to the Court. If that is not heeded, criticism can be expected. No expert would wish to read the phrase "*a rather unfortunate attempt to shore up an untenable opinion*" as a description of their oral evidence, as occurred in *Muyepa*.

This misunderstanding of the role potentially comes from inexperience. By that I do not just mean a lack of experience of trial, which is an unfortunate and unavoidable consequence of so few high-value personal injuries fighting to trial. I mean also that they have gone relatively unchallenged by their legal representatives for years. Both sides have developed their '*stable*' of preferred experts, who have been sequestered away, writing reports and joint statements for the same solicitors time and again. Those who rely on litigation work for their main income understandably want to maintain their source of instructions. They are incentivised to provide reports that serve their side's interests. With both sides' eyes being on settlement rather than trial, reports have been not robustly tested and challenged, and inevitably have inflated over time beyond sustainable limits, as was exposed in both *Muyepa* and *Scarcliffe*.

The loss of objectivity can be further compounded if an expert neglects to consider or address the range of opinions on a given issue. An objective analysis requires setting out and opining upon reasonable alternative views. It is a very important part (or ought to be) of the expert's evidence. It is provided for by Practice Direction 35 3.2(6), yet it is often not heeded (as was the case in *Muyepa* with

both the care and employment reports). That frequent omission is either because the experts have forgotten the requirement, or never knew it.

It is incumbent upon us lawyers to ensure that the experts instructed in our cases truly understand what CPR 35.3 means. This extends to the principles set out in *"The Ikarian Reefer"* [1993] 2 Lloyd's Rep. 68 (Comm Ct)[1] which can be found in a distilled form in Practice Direction 35. We need to be satisfied that the expert is not simply telling us what we want to hear. This rigour will allow us to identify the true strengths and weaknesses of the case but is also for the expert's own benefit to avoid embarrassment and professional damage at trial. It is also why there is a call within the judgment of *Muyepa* for experts to provide a breakdown of their claimant:defendant split, so that parties and the Court can be alive to the risk of a partisan view (conscious or unconscious).

Lessons for both sides: Updating Experts

Both cases remind parties of the need to keep experts up-to-date on developments so that they have a complete picture and can consider whether their opinion has changed. Even after the reminder in *Muyepa* on this point, in *Scarcliffe* both the Claimant's pain expert and care expert were being called to give evidence at trial without having adequately considered and addressed relevant important changes. This fell foul of the sixth *Ikarian Reefer* principle.

Clearly, a failure to heed new information and to change opinion as necessary will lead to difficult and embarrassing cross-examination for the expert. Perhaps more importantly it may mean that parties are approaching the case (and negotiating) on a fundamentally incorrect basis.

The solution is for legal representatives to notify the experts of any evidence which may materially alter their opinion, and for the experts to then be tested and pushed to ensure they are considering the new developments objectively, providing an updated opinion as necessary.

In practical terms, this might look like the following: (i) obtain a care report, (ii) conference with the care expert to test their evidence and ensure they understand their duties (iii) obtain finalised medical evidence from other disciplines (iv) further conference with care expert to understand how matters have changed (v) updating report as necessary (vi) draft finalised schedule. That example is without any surveillance and allegations of fundamental dishonesty which would only add to the requirement for further conferences and addenda.

Clearly there is a tension between that approach and the case management directions we are used to seeing at CCMCs. We will all be familiar with the *"one and done"* approach many judges take to conferences, allowing a single conference in the Expert phase and nothing further. But *Muyepa* and *Scarcliffe* should send a clear message and can be relied upon by parties at CCMC to show, that expert evidence cannot sensibly be considered as complete with the simple report-conference-joint statement model in high-value litigation. Even if parties have only achieved permission for the one conference in directions, if evidence arises which may materially alter the opinion of the experts, that could be considered a significant development for budgeting purposes.

Lessons for both sides: Critical Analysis for Quantum

It would be wrong to think that the problem lies entirely with the inexperience of experts. Mr Justice Cotter observes in *Scarcliffe* that, all too often, lawyers are simply transposing the erroneous content of care (and it equally applies to employment) reports into their schedules and counter schedules. There is limited critical analysis or challenge, and insufficient thought on whether the sums can properly be sustained at trial. As mentioned above, we lawyers should be making sure that the experts aren't

1 *(i) expert evidence presented to the court should be, and should be seen to be, the independent product of the expert uninfluenced as to form or content by the exigencies of litigation*

(ii) an expert witness should provide independent assistance to the court by way of objective, unbiased opinion in relation to matters of his expertise

(iii) an expert witness should state the facts or assumptions upon which his opinion is based. He should not omit to consider material facts which could detract from his concluded opinion

(iv) an expert witness should make it clear when a particular question or issue falls outside his expertise

(v) if an expert's opinion is not properly researched because he considers that insufficient data is available, then this must be stated with an indication that the opinion is no more than a provisional on. In cases where an expert witness, who has prepared a report, could not assert that the report contained the truth, the whole truth and nothing but the truth without some qualification, that qualification should be stated in the report

(vi) if, after exchange of report, an expert witness changes his view on a material matter having read the other side's expert's report or for any other reason, such change of view should be communicated (through legal representatives) to the other side without delay and when appropriate to the court

(vii) where expert evidence refers to photographs, plans, calculations, analyses, measurements, survey reports or other similar documents, these must be provided to the opposite party at the same time as the exchange of reports.

getting their reports wrong in the first place. Beyond that, we should be making sure that the schedules and counter schedules we produce properly align with the relevant legal principles for recovery of damages, regardless of what the experts have opined. This point particularly applies to claimants, as discussed below.

Lessons for Claimants: Legal Principles of Recovery

As Mr Justice Cotter put it in *Muyepa*: *"comparatively few personal injury/clinical negligence cases reach a hearing where the issues of care/aids and equipment are contested, and as a result few reminders are given by the Courts of the correct approach"*. Unfortunately, in carrying the burden of proving loss, the Claimant, his legal representatives, and his instructed experts are especially exposed to criticism if the incorrect approach is taken to trial.

Mr Justice Cotter has gone to lengths within the judgments to remind claimants of the relevant principles of recovery in care and/or aids and equipment claims. Very briefly, the principles are that:

1) the *sine qua non* is the need must have been caused by the injury;

2) need *simpliciter* is not enough, it must be a reasonable requirement (i.e. no recovery if the cost is disproportionate to the benefit);

3) when assessing reasonableness, all relevant circumstances must be considered, including whether care might negate the need for items of equipment/aid and vice versa; and

4) damages cannot be recovered if the loss would always have been incurred in any event e.g. buying a new microwave, or providing care that always would have been provided.

In both *Muyepa* and *Scarcliffe*, the care experts fell foul of these principles.

In *Muyepa*, the care report included things such as:

a) equipment, the need for which was not caused by the accident (for example, a chair to help the Claimant stretch his back out in a case to do with peripheral neuropathy of the extremities with no associated back pain);

b) equipment that was plainly not reasonably necessary as the cost was disproportionate to the benefit (for example, a wash dry toilet, whirlpool bath, and body drier); and

c) equipment and expenditure that the Claimant was going to have purchased himself in any event (such as car breakdown assistance)

In *Scarcliffe*, the care report did things such as:

a) included sums for walking two dogs for 40 years when one of those dogs had already died and the other was 8 and was content exercising itself in the large garden;

b) ignored the reality that grandparents would have always provided some childcare;

c) failed to acknowledge that the Claimant's wife would have done many of the domestic activities claimed but for the injury;

d) failed to consider the provision of statutory care in the immediate or long term;

e) used the full care rates for any task, no matter how menial; and

f) included a "*need*" for assistance looking after/supervising children, doing the school run etc post-retirement, at a time when the Claimant's eldest children would be in their late twenties.

As above, fault does not simply lie with the experts who had lost sight of (or never knew) the relevant principles. Criticism was equally levelled at the legal representatives for adopting the erroneous approach within the schedules. It is worthwhile all lawyers reading paragraphs 292 to 298 of *Muyepa* for a reminder of the principles.

Lessons for Defendants: If You Want Peace, Prepare for War

The received wisdom for some time in personal injury and clinical negligence litigation has been that fighting to trial is too expensive. It is, therefore, more cost effective to settle claims and they should be run accordingly.

The cost-benefit analysis held true in the past, but less so now. First and foremost, the mathematics have altered with the change in discount rate in 2017 and 2019, pushing damages far higher. When one compounds that with the issue of care (and to an extent employment) report inflation over the same period, the analysis can change substantially.

Take the example of an accident in early 2016 (the same period as *Muyepa*). At that time, the discount rate was 2.5%. Let's say that the claimant claimed future care of £25,000 per year for life when 40 years old. The multiplier would have been 26.25 (£656,250). At hypothetical trial, the Defendant manages to reduce the multiplicand to

£17,500 (£459,375). The Defendant saved £196,875 on damages, but the litigation costs might have made it a close-run thing.

Transpose the example to today but assume a higher degree of inflation of the care claim (with a few errors in principle such as those seen in *Muyepa* and *Scarcliffe*). Let us say £35,000 claimed per year, but with the same result of the Defendant achieving £17,500 at trial. At -0.25%, with a multiplier of 47.6, the Defendant's saving has grown to £833,000. A sum that would more likely than not cover both costs budgets with plenty left over.

One can see that in cases where mistakes have been made by the experts and the claimant's legal representatives, as in *Muyepa* and *Scarcliffe*, the expense of trial for the Defendant is quickly surpassed by the savings that can potentially be made on assessment of damages. The economic argument for settlement did not stack up in these cases. Cost efficiency was found in fighting.

There will be further such cases where there are substantial savings on offer to the defendant who is prepared to fight to trial. This will be so until care claims (and loss of earnings claims) are properly and objectively advanced by the experts, based upon the entirety of the evidence and the correct legal principles.

Final Thought

Muyepa and *Scarcliffe* provide some important lessons on how to get claims right, and why many of the cases currently working their way through the litigation process may not be worth as much as the parties believe due to misunderstandings on the part of the experts and the lawyers. It would be a mistake to suppose that this is a storm in a teacup relating to just one High Court Judge. Parties should not continue with business as usual and hope that they get a different judge should their matter go to trial. The more prudent course would be to assume that the senior judiciary with personal injury/clinical negligence experience talk to one another about these issues, provide/devise training to more junior judges, and that these cases will be cited regularly in front of judges of all levels who will pick up the baton. It seems likely that the issue of the role of experts and erroneously overstated damages is not going to go away soon.

Chapman v Mid & South Essex NHS Foundation Trust [2023] EWHC 1871

TAMAR BURTON
CLOISTERS

In 1998 Rosemary Chapman fell on her patio and was subsequently diagnosed with spondylolisthesis. After a long history of back pain, on 20 March 2017, she was belatedly diagnosed with a prolapsed thoracic disc, which had been present for at least 8 years. She underwent surgery to remove the troublesome disc 10 days later. Tragically, by the time of her surgery, the prolapse had progressed and Mrs Chapman was left paraplegic.

In February and March 2023 her clinical negligence claim came to trial. Her claim related to two periods of treatment. First, her appointments with a Consultant in Chronic Pain Management at Southend University Hospital on 24 December 2009 and 30 September 2010; and second, her attendance at the Emergency Department at Basildon University Hospital on 9 March 2017, where she was seen by an emergency nurse practitioner.

At trial Mrs Chapman was successful in her claim in respect of the first period of treatment but not the second: for the liability judgment see [2023] EWHC 1290 (KB). This article concerns the costs judgment by trial judge Mrs Justice Hill. There were a number of costs arguments in play that are relevant for clinical negligence practitioners.

Who should pay the costs when a Claimant does not succeed on all issues?

At trial the Claimant succeeded on six out of seven allegations. Despite this the Defendant argued that the usual costs rule - that the loser pays the winner's costs - should not apply.

The Court, referencing Sir Stanley Burton's comments in *Webb v Liverpool Women's Hospital NHS Foundation Trust* [2016] EWCA (Civ) 265; [2016] 1 WLR 3899 that it was *"not unusual for a claimant to succeed on some but not all allegations particularly in a personal injury case"*, found that the Defendant was the unsuccessful party under CPR 44.2(2)(a).

As in *Webb*, a claimant does not need to succeed on every issue in order to be the successful party.

Was this one claim or two claims?

The Defendant sought to persuade the Court that the Claimant had brought two separate claims and should pay the costs arising from the claim that had not succeeded. This was on the basis that the allegations in respect of the two periods of treatment had initially been brought against two separate Trusts, that the allegations were seven years apart and that they concerned different clinical specialisms.

This argument was given short shrift by the Court. Hill J found that the two Trusts the Claimant had initially sued had merged in April 2020 less than a month after Mrs Chapman's case was issued. The Defendant had therefore been a single entity for almost the entire lifespan of the case. As this was a single claim, and she had succeeded in six out of seven allegations, the Claimant was the successful party.

The Court found at §11 that: *"the fact the two sets of allegations in the claim involved different periods of time, different expert disciplines and different levels of factual dispute does not mean that they were properly considered as two separate claims."* This is a useful passage for clinical negligence litigators dealing with a broad temporal scope of allegations involving different types of clinicians.

Can a 90% Part 36 offer be an effective offer?

On 22 December 2022 the Claimant made an offer to settle her claim on a 90% basis. The precise wording of the letter was: *"an offer to settle the liability and causation issues in this action for 90% of damages assessed on a 100% liability basis, that is with a deduction of 10% from the full value of the claim."* Despite the clarity of the letter, the Defendant sought clarification of its meaning and this was provided in unambiguous terms by Mrs Chapman's solicitors. Hill J noted that the Defendant's request for clarification was *"arguably unnecessary"*.

Time for accepting the Claimant's Part 36 offer expired on 13 January 2023 and the offer was not accepted. At the

liability trial the Court found that absent the Defendant's breach of duty, surgery to remove the prolapsed disc would have been performed in 2010 and the Claimant would have had a full neurological recovery, with normal bladder, bowel and sexual function albeit she would have had persisting pain and disability arising from her pre-existing spondylolisthesis. Mrs Chapman had therefore succeeded both in relation to breach of duty but also in the commonly more challenging area of proving her causation case (namely, that she would have been neurologically normal but for the Defendant's breaches). The judge rejected the Defendant's argument that Mrs Chapman had been contributorily negligent.

The Defendant argued that the Claimant's 90% Part 36 offer was not an effective offer and relied on the judgment of Collins Rice J in *Mundy v TUI UK Ltd* [2023] EWHC 385 (Ch). In *Mundy* the Claimant, who brought a claim in relation to the food poisoning he sustained on an all-inclusive trip to Mexico, appealed against the trial judge's costs order. Mr Mundy had made two Part 36 offers, one of which was a 90% Part 36 offer and the other was a monetary offer of £20,000. Both Part 36 offers were rejected by the Defendant. The Defendant's Part 36 offer of £4,000 was not accepted by Mr Mundy. At first instance, the trial judge awarded damages of £3,805.60 on a 100% basis. When it came to costs, the trial judge awarded the Claimant his costs up to the expiry of the Defendant's offer and found that the Defendant was entitled to its costs after that date. The Claimant appealed. On appeal, Collins Rice J held that the 90% offer was not an offer to settle the claim or a quantifiable part or issue in the claim. She was not persuaded that a 90% Part 36 offer could fall within CPR 36.17(1)(b). The Claimant's appeal was dismissed.

Hill J found that Collins Rice J's analysis in *Mundy* did not apply to the present case. Hill J distinguished *Mundy* on the basis that the situation in *Mundy* arose due to the difficulty of comparing monetary offers with liability offers. Hill J found that the analysis in *Mundy* did not apply in the present case as a split liability trial had been ordered and the only substantive offer made by either party was the Claimant's 90% Part 36 offer. Further, *Mundy* was distinguishable because the manner in which the Claimant's 90% offer applied to the causation issue had been made clear in correspondence.

Hill J therefore concluded that the Claimant's 90% offer was a valid one for Part 36 purposes.

Is it unjust in these circumstances for the Defendant to face the consequences of the Part 36 offer?

The judgment is also a good reminder, should one be needed, that it is a high threshold under CPR 36.17(3) and (4) to persuade a Court that is "*unjust*" for the natural consequences to flow from an effective Part 36 offer.

The Defendant argued that it was unjust for the usual Part 36 costs consequences to follow because the Claimant's allegations against the emergency nurse practitioner were serious and likely to damage the nurse's reputation. The Defendant argued that the allegations had been rejected at trial and the emergency nurse practitioner had been vindicated. Hill J disagreed and found that the high hurdle for establishing injustice was not satisfied in this case. Ventilation of these issues could have been avoided by the Defendant if it had made admissions on breach of duty in relation to the Claimant's treatment in 2009 and 2010.

Hill J then awarded 5% over the base rate under CPR 36.17(4)(c).

Analysis

This decision will provide comfort to Claimant lawyers who frequently approach cases on a split liability basis and compromise claims by way of 90% Part 36 offers. The costs decision in *Chapman* sits comfortably alongside other authorities where 95% Part 36 offers have been recognised by the Courts as effective offers: see, for example, the clinical negligence case of *JMX (A Child) v Norfolk and Norwich Hospitals NHS Foundation Trust* [2018] EWHC 185 (QB) as well cases such as *Jockey Club Racecourse Ltd v Willmott Dixon Construction Ltd* [2016] EWHC 167 (TCC); *Huck v Robson* [2002] EWCA Civ 398.

Lucy Letby: The Statutory Inquiry

TAMLIN BOLTON
SWITALSKIS

With most certainty, it would be impossible to count the number of people impacted by Lucy Letby's crimes.

Starting with the families, who went through countless hours of worry and trepidation each time she was arrested, undoubtedly angry and shocked when she was finally charged and then months of horrific, detailed evidence recounting what happened to their children in the Countess of Chester neonatal unit and under Letby's care.

We saw in August 2023, verdicts provided on some but not all of the cases, following what must have been a very difficult exercise of deliberation by the Jury. It has since been confirmed by the CPS that only one of the cases where a verdict could not be reached will be retried.

Despite the outcome of the Criminal Proceedings, not all questions have been answered by these investigations; such as, was enough done by Trust officials to protect these children from Letby's actions? Were concerns and complaints about Letby's conduct taken seriously and acted upon in a timeous and appropriate manner?

As representatives for a number of the families in the civil cases, we look now to the timeline of events inside the Neonatal unit at the Countess of Chester Hospital NHS Trust and the concerns raised by the Consultant Paediatricians to their senior management along that timeline.

I do not believe it is the suggestion of anyone involved in the civil claims or from those paediatricians that are now considered whistle-blowers (following them speaking publicly as to their concerns about management at Countess of Chester), that all the young lives that were ended and all episodes of harm would have been avoided had hospital officials acted sooner and in response to the concerns raised. The key here will be to consider each piece of information reported to management by clinical staff along a precise timeline and the Trust's own internal audits. We are keen to understand what knowledge did the hospital officials have and what did they choose to do with it? There are pressing questions that need to be answered.

The Police have made it clear that they intend to review the medical records of 4000 children across the two hospitals where Letby worked, the Countess of Chester Hospital and Liverpool Women's Hospital (as part of Operation Hummingbird). Whilst there is no suggestion that Letby harmed each of these 4000 children, it does leave some concern that these acts may have taken place well before the timeline considered in the recent trial.

In tandem with Operation Hummingbird, the UK Government have confirmed that a statutory inquiry will now take place. The initial options were for an independent inquiry or a statutory inquiry. Both had merit and both had drawbacks. What really matters is twofold; we have to bear in mind that the families involved in these crimes trusted the NHS to look after their babies. They have undoubtedly lost confidence in the NHS and will need continual reassurance that the NHS fully comply with an inquiry. There was some concern that if the Government maintained the view that the inquiry be independent, where witnesses were not compelled to give evidence and no mechanism available to order disclosure of key documents, the families and the wider public would have to place a lot of faith and confidence in the willingness of the NHS to engage with the investigation.

Secondly to this, it was vital that a thorough investigation into the events at Countess of Chester was achieved by a process that guaranteed a detailed investigation. A process that had the ability to ensure all evidence was available to the Inquiry. Our concern has always been, if we put the families through another lengthy process about what happened to their children and we give those concerned doctors an opportunity to present their concerns, then the entire process is fruitless if we reach the end of that process without having considered key internal evidence from the NHS Trust. To know the upcoming Inquiry is a statutory Inquiry, where witnesses are compelled to provide evidence and disclosure can be

ordered gives some reassurance that the Trust will co-operate and provide the answers these families need.

It has been confirmed that Lady Justice Thirwall will lead the Inquiry and details between the parties are now being finalised. The Inquiry will be announced by Steve Barclay, Health Secretary in due course and in time we will hope that the public and the families will have the full picture.

We see it time and time again that management in NHS Trusts are ignoring concerns of their clinicians and the process of Governance is failing. It is vital that the upcoming Inquiry moves with pace to ensure everything that happened on that unit and the actions of management are not repeated.

As always, for all those impacted by this case we offer our deepest sympathies and applaud the bravery and resilience in which you have dealt with the harm that has been caused to you and your families.

If you have been impacted by the actions of Lucy Letby, please get in touch so that we can begin to support you.

NHS Whistleblowing protection and how systemic change is desperately needed

ALISON HILLS
TEES LAW

I am sure that many across the country are still trying to get to grips with the case of Lucy Letby, and how the deaths of multiple innocent babies could have resulted from someone in such an important position of trust and responsibility.

The former NHS nurse became the fourth woman in the UK to be handed down a whole life sentence, after completion of a 10-month long trial. The police are even now launching an investigation into potential corporate manslaughter charges against the Countess of Chester Hospital, where Letby was based.

It is understood that the Investigation will examine the period of time in which Letby carried out her killing spree; a 12-month period between June 2015 and 2016, which will include a probe into the leadership of those in senior positions at the Hospital at the time. It is further understood that those in leadership positions at the relevant time had as many as ten opportunities to act upon concerns that Letby was linked to a spike in deaths at the Chester based neonatal unit.

But how did it ever get to this you may ask? Let me examine the case of Dr Day, which may provide some answers to this pertinent question.

Dr Day's story: the background

Dr Chris Day is a Doctor who qualified in 2009 from the Barts & London School of Medicine, and has been subject to a decade long legal battle in respect of whistleblowing protections following his raising of patient safety concerns about an intensive care unit, which served two London boroughs and the way the NHS responded to them.

Dr Day was working in an intensive care unit and his case stems from protected disclosures that he made over a period of 10 months from August 2013. As part of the protected disclosures, he uncovered significant risks to the safety of patients at the Queen Elizabeth Hospital in London, in the way it operated its intensive care unit at night, which had departed significantly from national standards.

National standards dictate that in intensive care units, there is supposed to be 1 Doctor to 8 patients, but at this Hospital at night, it was standard practice to have a ratio of 1 Doctor to 18 patients, and this was in addition to supporting the emergency department and admission of new patients from the wards.

Part of the key standards also include the fact that you need to have a Doctor immediately available who is trained in the use of airway tubes and ventilators, but neither of these 2 important standards were in place during the night shifts. Essentially, post-internship Doctors were left in charge of the unit at night with the consultant at home available over the phone.

Every night in an ICU serving two London boroughs, these inexperienced doctors had more than double the number of patients that would be safe for even an experienced senior ICU doctor.

Dr Day correctly raised his concerns about the risks to patient safety given this untenable position but when these concerns were raised they were initially explained away. His concerns sadly proved to be correct after two patients died in the months following Dr Day raising his concerns; one of whom bled to death when an inexperienced doctor performed a procedure incorrectly and did not notice in time. When Dr Day persisted with his concerns, one of the Trust's medical directors wrote an email to Health Education England, the national organisation in charge of junior doctors' careers playing down Dr Day's safety concerns. The email ended with the words *"His inability to let these issues go is starting to worry me. I would consider not employing him again as a result"*. The two avoidable deaths were excluded from the investigation into Dr Day's case and attempts were made to exclude them from the whistleblowing litigation.

Despite the obvious validity to Dr Day's safety concerns and also the fact that in private, a senior doctor in Health Education described the situation as *"totally unacceptable*

and unsafe," the NHS spent four years and hundreds of thousands of pounds of public money discrediting Dr Day and denying the status of Dr Day's concerns as reasonable beliefs before conceding their status during a hearing in October 2018. As result of the dispute, Dr Day's contract was terminated and his career path to a consultant was destroyed, as he is now forced to work ad hoc shifts as a locum with no employment protections or career stability.

The initial legal case

Dr Day's initial case was brought against Lewisham & Greenwich NHS Trust and Health Education England, who are responsible for commissioning the postgraduate employment and training of doctors who are on their career path to a consultant or GP. His case centres around the legal responsibility for the employment status of junior Doctors and he argued at two employment Tribunals that he should have been protected under whistleblowing regulations.

It was asserted by Health Education England that Dr Day was not a "*worker*" who falls under the ambit of the Employment Rights Act 1996. Dr Day therefore took his case to the Court of Appeal, who held that he was defined as being a "*worker*" and his case was referred back to the employment Tribunal.

Despite his initial concerns being raised in 2014, it was not until October 2018 that the final hearing of his first whistleblowing claims was heard, because of the lengthy disputes over the definition of his being a "*worker*".

In a debate in the House of Commons on 3 July 2019 the reality of what went on to stop Dr Day's case being heard was exposed by two MPs who are both former lawyers.

Justin Madders raised concerns about Dr Day's case by stating that the Tribunal's actions had been a *"lengthy and, in my view, wholly unnecessary legal battle in which Health Education England effectively sought to remove around 54,000 doctors from whistleblowing protection by claiming that it was not their employer."*

Norman Lamb also raised his own concerns, and in particular with regards to the failure to disclose the contracts between Health Education England and the Trusts which outlined the nature of control that Health Education England have over the employment of junior Doctors; contracts which were drafted by the very same law firm who had been defending the case against Dr Day. Mr Lamb stated in the House:

"Does the hon. Gentleman agree that this is totally unacceptable and that it smacks of unethical behaviour for that law firm to make money out of not disclosing a contract that it itself drafted?"

The settlement

Dr Day's case was settled in 2018 halfway through a 21 day hearing, but this meant that (a) he was forced to drop all his allegations of whistleblowing detriment that he had maintained since 2014, (b) he had to indicate in a public statement that he believed that the NHS had acted in good faith in his case and (c) there was also a clause protecting all sides from wasted costs arising from negligence and misconduct.

The fact that his case settled shortly before Dr Day's legal team were due to examine 14 NHS witnesses came as somewhat of a surprise to those who had been following his case. He had been in the public eye for several years speaking openly about how his career had been destroyed as a result of raising patient safety concerns which were known to have been linked to two avoidable deaths, as well as fighting for whistleblowing protection for junior doctors.

By the time of the 2018 settlement, Dr Day's case had been widely reported in the press but despite this, he was silenced about speaking out about how the settlement had come about.

His silence continued until Lewisham & Greenwich NHS Trust and Health Education England started to speak out about it, denying that both costs threats were made to Dr Day, as well as forcing him to make a public statement.

Following the settlement, Lewisham & Greenwich NHS Trust alleged that Dr Day's whistleblowing disclosures related to one night in A&E only, rather than ongoing issues about the intensive care ward. They also alleged that an external investigation had demonstrated that the Trust had responded appropriately to Dr Day's whistleblowing disclosures, and they denied that they had threatened Dr Day with adverse costs orders.

This was despite the fact that Dr Day had provided evidence of his serious patient safety disclosures relating to ongoing issues in the Intensive Care Unit at night and evidence of 12 serious criticisms made by the relevant investigation. Dr Day's position in this was backed up by two senior consultants, the former health minister Sir Norman Lamb and the chancellor of the exchequer Jeremy Hunt. Dr Smith, who is a senior consultant anaesthetist, trained barrister and expert witness for medical negligence claims also gave evidence to the Tribunal that Dr Day's

disclosures were not of an isolated incident, as had been alleged and that there was no question that *"there was a clear and present danger to patient safety in the intensive care unit"* at the time the disclosures had been made.

The costs position and destruction of evidence

A witness statement which was submitted by Dr Day's wife to the employment Tribunal in May 2022 confirmed that the potential costs liability that they had been threatened with, could be up to £500,000; more than the value of their home, and therefore Dr Day had simply had no choice but to accept the settlement back in 2018.

The Trust's position on costs then evolved a few months later into an account of how Dr Day's own legal team had approached the Trust's legal team, whilst he was giving evidence, with the impression that he was not being truthful. The NHS then sold this information to the press and MPs as the real reason for him settling his case and withdrawing. This account from the Trust was then categorically denied by Dr Day's former legal team at a further hearing which took place in June 2022.

Concerningly, it also came to light during the June 2022 hearing that an NHS Director primarily responsible for briefing the press and MPs about his case had deliberately destroyed an entire email account (which included 90,000 emails relating to the case) during the course of the hearing, and even admitted to this in an unsigned witness statement, the day before they were due to give evidence.

Not only that, but virtually all the evidence that Dr Day relied upon in support of his case which included evidence from those who worked with him and supervised him was excluded from formal investigations and ignored by the Tribunal.

Despite the fact that scores of evidence was destroyed during the course of proceedings, and other evidence which would have assisted Dr Day's case was completely ignored, the judgment was found against him.

A further hearing was heard in December 2022 whereby Dr Day pursued a wasted costs application against Hill Dickinson, who represented Health Education England. The Judgment provides a good summary of how up to 54,000 junior Doctors were argued out of whistleblowing protection, how the Court was misled about how Doctors are employed, and how documents and contracts were withheld from the Court, from the very same law firm who were paid to draft up the contracts, worth tens of millions of pounds and were now representing the NHS Trust in the proceedings.

The current position and how this all relates to the Letby case

After 10 years of litigation, over 20 hearings and £700,000 of public money being spent to defend Dr Day's claim, he still has not had the opportunity to cross examine those who were responsible for the destruction of his career and cover up of the patient safety issues in his case. He is still forced to work as a locum Doctor with no career prospects or employment stability, and with a professional reputation in tatters that he is desperately trying to restore.

There will now be a full hearing which is likely to offer further insight into the context and objections that junior doctors have about their pay and working conditions, which ironically, is likely to coincide with the dates of the proposed industrial action.

In 2019, Norman Lamb prepared a witness statement to the Tribunal about Dr Day's case in which he said:

"I feel strongly that staff working in the NHS must be able to raise patient safety issues without any fear of adverse consequences for so doing. If a culture exists in which staff fear that their careers or employment could be jeopardized, it has a chilling effect on peoples willingness to speak out. This in turn puts patients at risk"

I couldn't agree more.

If this is how Doctors who raise legitimate patient safety concerns are treated; then is it any wonder that tragedies such as the Lucy Letby case are allowed to happen?

Dr Day has commented upon the Letby case as follows:

"The Letby case is a powerful consequence of how we allow NHS leaders and their lawyers to respond to NHS staff that speak up. In Letby a group of six consultants were ignored and discredited.

My case also sends a toxic message to both NHS staff who might be considering speaking up or NHS leaders that might be considering supporting a whistleblower about their chances of being treated fairly by the system. It also sends a message to poor leaders about what the system will let them get away with. It seems me it is this system that paved the way that the NHS handled the Letby case".

A few final words...

It is absolutely crucial that medical professionals should be able to speak out when they have fears about patient safety, without fear of reprisal, of lengthy expensive, legal proceedings or the possibility of their careers being ruined. There needs to be systemic change to allow an honest, open culture of accountability to ensure that cases such as Lucy Letby never happen again.

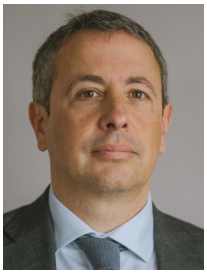
We can only hope that the bravery and strength that Dr Day has shown over the last decade, will be the start of that.

NB. Dr Day has set up a crowd funding page to assist him for the next stage of his case. For more information, please see the link below:

Making Money Arguing Junior Doctors Out Of Whistleblowing Protection (crowdjustice.com)

The SIIR (RCA) is being phased out. Will this benefit patients?

JUSTIN VALENTINE
ST JOHN'S CHAMBERS



St John's CHAMBERS

... and what are the implications for clinical negligence litigation?

A criticism of the NHS generally is that it does not learn from mistakes. Despite the "*never event*" framework, the number of such incidents remains stubbornly high. In response to the perceived failures to the improvement of patient safety, NHS England are introducing the Patient Safety Incident Response Framework ("*PSIRF*" pronounced "*pea surf*") to replace the Serious Incident Framework. The transition to PSIRF from the Serious Incident Framework should be completed by autumn 2023.

The Serious Incident Framework

Clinical negligence practitioners will be familiar with the Serious Incident Framework and, in particular, the Serious Incident Investigation Report ("*SIIR*") prepared pursuant to that framework (sometimes referred to as an RCA, root cause analysis, or SUI, serious untoward incident). The Serious Incident Framework, last updated in 2015, endorses the application of root cause analysis as "*a powerful mechanism for driving improvement*" and notes "*the fundamental purpose of safety investigation, ... is to learn from incidents, and not to apportion blame*".

In relation to the threshold for investigation, the Serious Incident Framework provides:

In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

The Serious Incident Framework provides an indicative list of incidents requiring investigation including:

- Unexpected or avoidable death.
- Unexpected or avoidable injury resulting in serious harm.
- Actual or alleged abuse.
- Never events as defined by the Never Events Policy and Framework which are, in broad terms, patient safety incidents that are wholly preventable and which have the potential to cause serious patient harm or death. There is a list of never events which is periodically updated.

There is no doubt that SIIRs can be helpful in clinical negligence litigation. In many cases, breach of duty, if not causation, can be established from the report. For example, in two recent cases I have dealt with:

1. A letter of claim was drafted in relation to the stillbirth of twins based purely on the SIIR and without obtaining breach or causation expert evidence. The allegations focused on failures of cardiotocography monitoring in light of reduced fetal movements and failure to undertake obstetric review to consider mode and timing of delivery. Causation was not expressly dealt with in the SIIR but a full admission was made in the letter of response.

2. A letter of claim was drafted, again without commissioning expert evidence, in relation to the death of a patient subsequent to hysteroscopy resulting in perforation of her bowel and the development of peritonitis not immediately recognised. The SIIR was conclusive as to breach and implied causation. A full admission was made in the letter of response.

Despite this, it is not uncommon for a Defendant trust to seek to row back from acknowledgements of "*missed opportunities*" in SIIRs. To a certain extent, this is a valid stance. SIIRs are not prepared with litigation in mind and will not apply the *Bolam* test.

Since SIIRs are not prepared with litigation in mind, they are not subject to legal professional privilege and neither is material gathered nor witness statements obtained for the purpose of the SIIR. Witness statements are not generally voluntarily disclosed but in appropriate cases can and should be requested.

The use of SIIRs in litigation depends on the relevant health provider investigating and preparing a report. In many areas of clinical negligence litigation they are rarely seen, and even when clearly appropriate are not always

undertaken. For example, in a recent case where I acted, a claim was advanced against a tertiary neurosurgery centre on the basis of delay to treat timeously degenerative cervical myelopathy at the C4/5 level. It was known, by the claimant's legal team, that after initial decompression surgery the claimant underwent *"revision"* surgery a few days later. In the letter of response, it was noted that the initial surgery was carried out at C5/6 rather than C4/5 in error and the *"revision"* surgery was merely surgery at the right level. Surgery at the wrong level of the spine was, at the time, a "never event"[1]. Subsequent medical records persisted in identifying the level of first surgery as C4/5 and the second surgery as "*revision*". Despite this, no SIIR was prepared and no explanation has been offered for this failure[2].

There were previously funding repercussions for never events (on the basis that commissioners should withhold payment for the cost of the relevant episode of care). However, this was removed in 2018 since financial sanctions "*reinforced the perception of a '*blame culture*'*"[3] (and was probably a significant disincentive to be open about such incidents).

The Patient Safety Incident Response Framework ("*PSIRF*")

NHS England is introducing a new framework for the response to patient safety incidents which all providers must have in place by autumn 2023. The finalised Patient Safety Incident Response Framework 2022 is emphatic that *"The PSIRF is not a different way of describing what came before – it fundamentally shifts how the NHS responds to patient safety incidents for learning and improving"*.

There is a move away from root cause analysis which is perceived as attempting to identify single causes and apportioning blame (though in fact the Serious Incident Framework was also emphatic that it was about learning and not apportioning blame). Rather, a systems-based approach is to be adopted. North Bristol NHS Trust were early adopters of PSIRF and as noted in their Plan ,[4] "*An incident is the system showing us symptoms that something is wrong*".

An investigation report within PSIRF is entitled *"Patient safety incident investigation (PSII) report"* a template for which is available online[5]. The PSII template notes that "*PSIIs focus on improving healthcare systems; they do not look to blame individuals*". Rather:

> *The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.*

Certainly, in one PSII I have recently seen there was evidence of a systems-orientated approach. The case concerned a missed ano-rectal malformation when conducting a Newborn and Infant Physical Examination ("*NIPE*") which tragically resulted in the baby's death. The findings included explicitly system factors such as:

1. No formalised NIPE technique assessment for clinicians joining from other hospitals.

2. The impact of Covid which meant that virtual consultations and assessments took place, including a maternity support worker only undertaking a doorstep assessment.

3. Covid prevented the father attending clinic appointments. It was recognised that as a key carer for the baby and the mother's advocate, key information regarding bowel movements was not made known to the practitioners which may have been had the father been present.

4. A lack of formal training for maternity support workers performing postnatal assessments of babies.

The first and fourth of these can readily be translated into allegations of breach of duty as system failures (for which arguably there would be no need for expert evidence).

However, in another PSII I have recently seen, which related to misdiagnosis of glandular cystitis as adenocarcinoma resulting in unnecessary removal of the bladder, no system errors were identified and, in fact, no errors at all, the report noting that "*good practice was identified in all areas of the care episode*". In the event, a

1 *It was removed from 1st February 2018* "while NHS improvement works with the relevant professional organisations to ensure development of robust national barriers to prevent this incident"; *Never Events list 2018.*

2 *No duty of candour notification was made either; the claimant was entirely unaware of the error until receipt of the letter of response.*

3 *Never Events policy and framework, revised January 2018.*

4 *Available here:* **https://www.nbt.nhs.uk/about-us/our-standards/patient-safety**

5 **https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/**

histopathology report was commissioned by the claimant which was categorical as to breach.

In addition to the emphasis on a systems-based approach, the aim is to undertake far fewer investigations and to do them better and it is implicit, whatever the merits of the systems-based approach may be, that a key driver for the change was the burden on providers of producing so many SIIRs (and possibly the litigation that they prompt). This is unfortunate since practitioners will know that many claimants contact solicitors subsequent to receipt of an SIIR; without an SIIR, preliminary investigation is more difficult or may not take place at all.

There is no longer a specified list of incidents which must be investigated. Rather, organisations must decide for themselves what to investigate informed by local and national priorities. For example, North Bristol NHS Trust identified inpatient falls, medication errors, responding well to clinically changing conditions, pressure injuries and discharge issues as their five patient safety priorities in 2021. National guidance recommends that there are 3-6 investigations for each priority area per year and for North Bristol NHS Trust "*this will likely result in 20-25 investigations per year*" as compared to an average of 59/ year for the two previous financial years.

PSIIs must also be completed for "*never events*" and for deaths more likely than not due to problems in care.

The concept of "*never events*" is, perhaps, not in keeping with PSIRF. In this regard, the work of Professor Peter Brennan on the role of "*human factors*" in improving patient safety is illuminating[6]; everyone makes mistakes particularly when tired, hungry, stressed or when there is significant hierarchy preventing speaking up. According to that analysis the concept of a "*never event*" is unhelpful and conceptually misguided. It is suggested that for the sake of consistency, the never event framework may be subject to review before too long, though recent high-profile deaths as a result of sepsis and calls for sepsis to be a "*never event*" may make such a step politically unpalatable.

It will no doubt be disappointing for patients and families (and possibly for their lawyers) that serious incidents which would previously meet the criteria for investigation will no longer do so. There are investigations triggered by incidents in particular clinical areas, for example maternal or baby deaths/serious injury should be investigated by the Healthcare Safety Investigation Branch ("*HSIB*")[7] who adopt a systems-based approach with an emphasis on human factors consistent with PSIRF.

However, for incidents not fulfilling the PSIRF, HSIB or other criteria (the majority of those where previously there would have been an SIIR), the statutory duty of candour, pursuant to Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, remains in place and should be complied with where there is a "*notifiable safety incident*". Regulation 20(8) provides:

> *In relation to a health service body, "*notifiable safety incident*" means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in—*
>
> *a) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or*
>
> *b) severe harm, moderate harm or prolonged psychological harm to the service user.*

By Regulation 20(2) and (3) the person involved (patient or family as the case may be) must be notified as soon as reasonably practicable of a safety incident. The notification must "*be recorded in a written record*" and "*provide an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification*".

Consistent with this renewed emphasis on the duty of candour, North Bristol's PSIRF Plan notes under the heading "*Patient safety incidents that have resulted in severe harm*":

> *These incidents would have automatically been a serious incident under the Serious Incident Framework. It is crucial that these incidents are not routinely investigated using the PSII process, otherwise we will be recreating the Serious Incident Framework.*
>
> *The routine response to an incident that results in severe harm will be to follow the Statutory Duty of Candour requirements. This will both provide insights to thematic learning and provide information about the events to share with those involved.*

However, AvMA, amongst others, have been critical of failings in relation to compliance with the statutory duty

6 *For example, here:* **https://wchh.onlinelibrary.wiley.com/doi/full/10.1002/tre.858**

7 *HSIB's maternity investigations are to be transferred to the CQC from October 2023 and HSIB will become the Health Services Safety Investigations Body ("*HSSIB*") with enhanced powers to investigate "*high-level*" patient safety incidents including statutory legal privilege known as a "*safe space*". The concept of "*safe space*" for such investigations is controversial.*

of candour[8] and national reports have also noted failure to comply with the duty[9]. In that context, whilst it is to be hoped that PSIRF will succeed in its aim to improve patient safety, it may be that there will be little in the way of explanation or investigation in individual cases where the local and national priorities are not engaged. This will likely make the route to compensation more difficult.

8 https://www.avma.org.uk/policy-campaigns/duty-of-candour/regulating-the-duty-of-candour-2/

9 *See, for example, the Ockenden Report into maternity services at the Shrewsbury and Telford Hospital NHS Trust, March 2022.*

Conference news

Forthcoming conferences and events from AvMA

For full programme and registration details, go to www.avma.org.uk/events or email conferences@avma.org.uk

AvMA Specialist Clinical Negligence Meeting

Afternoon of 1 December 2023, Grand Connaught Rooms, London

The annual meeting for AvMA Specialist Clinical Negligence Panel members provides the opportunity to meet, network and discuss the latest key developments and issues facing clinical negligence law. Registration and a networking lunch will commence at 12.30, with the meeting starting at 13.30 and closing at 17.00. Booking still open.

AvMA Holly Jolly Christmas!

Evening of 1 December 2023, Grand Connaught Rooms, London

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Clinical Negligence: Law Practice & Procedure

12-13 December 2023, Shoosmiths LLP, Birmingham

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1 February 2024, Hilton Leeds City Hotel

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21-22 March 2024, Royal Armouries Museum, Leeds

(Golf Day & Welcome Event 20 March 2024)

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Sponsorship opportunities are available.
For more information, please contact Paula Santos at paulas@avma.org.uk

AvMA/Circle 5k Run – 20 March 2024, Royal Armouries, Leeds

Strap on your running shoes or even attempt cartwheels! The Circle Case Management Pre-Conference Charity Run is back! Be prepared for some healthy competition, a breath of fresh air, and an opportunity to support AvMA's crucial mission.
Tickets are £25 and include a running vest and a bottle of water. 🏃
www.avma.org.uk/5krun

Kindly sponsored by: clarke willmott ENABLE

AvMA/PIC Curry Night 2024 Edition! 🍛

Prepare your taste buds for a mouth-watering experience at our Curry Nights across the country. Save the dates and keep an eye out for the venue announcements and ticket sales. All proceeds go directly towards supporting AvMA's noble work. Don't miss out; let Emma Wolley from PIC know you'll join us for a flavourful evening.

- Exeter Curry Night
  05 March 2024
- Birmingham Curry Night
  09 April 2024
- Bristol Curry Night
  07 May 2024
- Brighton Curry Night
  04 June 2024
- Newcastle Curry Night
  18 June2024
- Manchester Curry Night
  09 July 2024
- Leicester Curry Night
  10 September 2024
- Norwich Curry Night
  08 October 2024

Get in touch

To find out more about how AvMA can work with you to create a really exciting event for your firm, please contact Paula Santos for an informal chat.
Email: fundraising@avma.org.uk **Tel:** 020 8688 9555

OR CHOOSE YOUR OWN EVENT...

Action against Medical Accidents, Freedman House, Christopher Wren Yard, 117 High Street, Croydon CR0 1QG
Tel: **020 8688 9555** Email: fundraising@avma.org.uk www.avma.org.uk

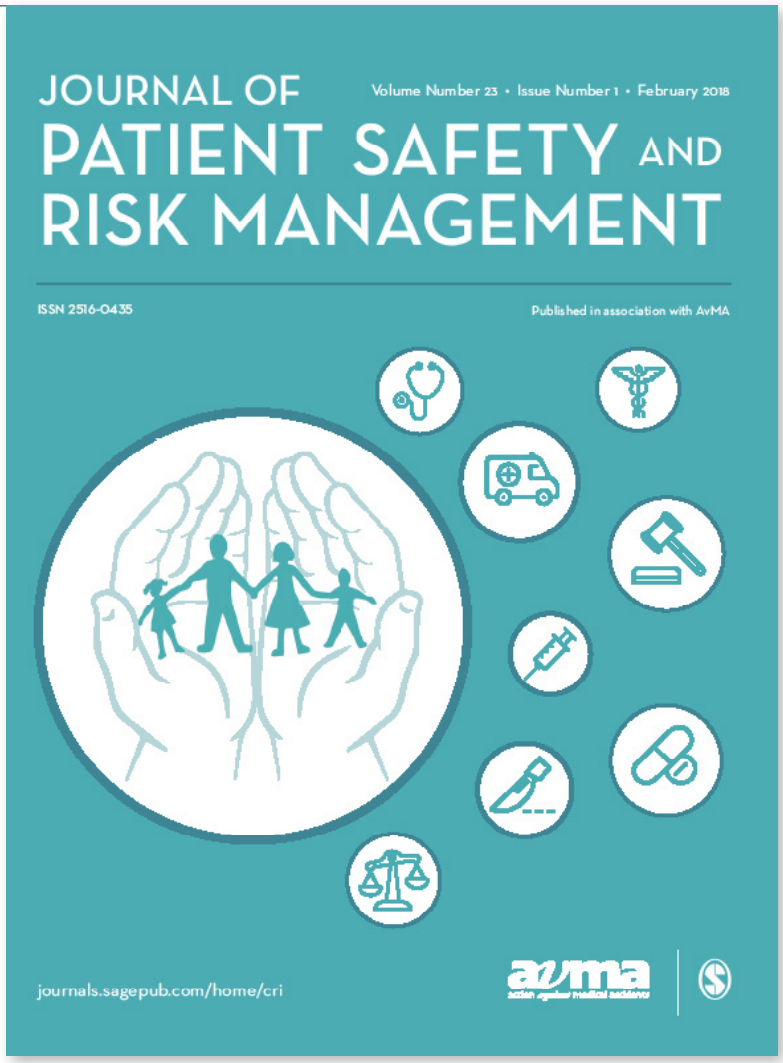
Journal of Patient Safety and Risk Management

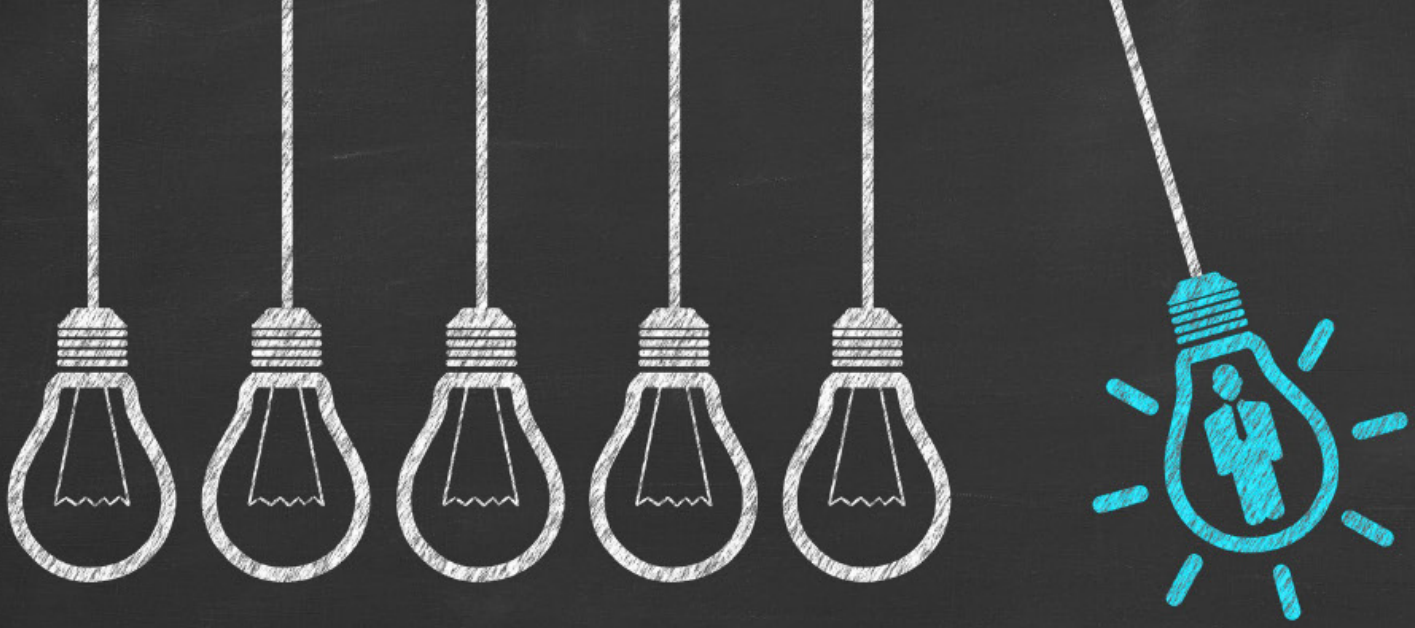
The Journal of Patient Safety and Risk Management, published in association with AvMA, is an international journal considering patient safety and risk at all levels of the healthcare system, starting with the patient and including practitioners, managers, organisations and policy makers. It publishes peer-reviewed research papers on topics including innovative ideas and interventions, strategies and policies for improving safety in healthcare, commentaries on patient safety issues and articles on current medico-legal issues and recently settled clinical negligence cases from around the world.

AvMA members can benefit from discount of over 50% when subscribing to the Journal, with an institutional print and online subscription at £227.10 (+ VAT), and a combined individual print and online subscription at £177.22 (+ VAT).

If you would like more information about the journal, or are interested in subscribing, please contact Sophie North, Publishing Editor on

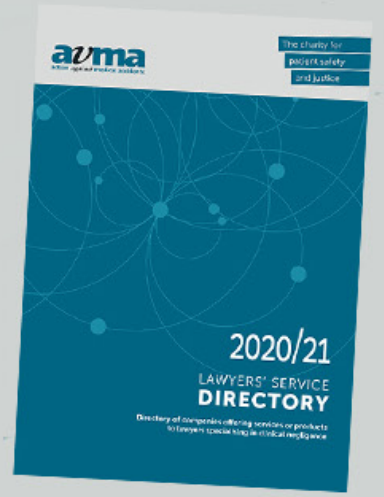
sophie.north@sagepub.co.uk





THE EASIEST AND MOST RELIABLE WAY TO FIND SERVICE PROVIDERS SUPPORTING CLINICAL NEGLIGENCE SOLICITORS

The AvMA Lawyers' Service Directory provides listings of key service providers geared to the clinical negligence solicitor, including:



- Costs consultants
- Disability property specialists
- Rehabilitation consultants
- Nursing experts
- Counselling
- Mediators
- Court of Protection deputyship and personal injury trusts
- Medical records pagination, collation and review
- Investment managers

AvMA Lawyers' Service members can access the listings for free at

www.avma.org.uk/directory

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