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Lawyers Service Newsletter

November 2017

Contents

Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

This is the third and last of our Lawyer Service Newsletters for 2017 and the only thing that remains certain is that the uncertainty for the future of clinical negligence claims, particularly low value claims, continues.

It seems almost unbelievable that it is now more than two years since we first had the DH's initial pre-consultation on its proposals to introduce fixed recoverable costs to clinical negligence claims. Indeed, the government has yet to provide a response to the formal consultation on FRC in clinical negligence claims which closed in May this year. Further, they don't seem to be any closer to being able to tell us when their response will be published. In our AvMA News Update section we have taken a closer look at what, if anything, has changed in that time and whether it is possible to identify a direction of travel.

Firms continue to express concerns about the way in which the Legal Aid Agency (LAA) handles a number of issues (for more detail see the AvMA update). AvMA Panel Members will be able to put their questions directly to the LAA representative who is attending the panel meeting on 1st December. If you are **not a** panel member but would like to put a question to the LAA representative please email your question to Norika@avma.org.uk by no later than **5.00 pm on Wednesday 29th November.** We will endeavour to put as many questions as possible to the LAA.

Many will be aware that the case of ***JR v Sheffield Teaching Hospital NHS Trust*** was due to have been heard in the Court of Appeal at the end of October. The decision was anxiously awaited as it was expected to offer clarity to the conundrum over accommodation claims in a time of a negative discount rate. However, this important issue did not receive the clarity required as the defendant bought off the risk in relation to both the accommodation and the lost years claims; the case settled prior to the hearing. As a result, this area remains as uncertain as ever.

As ever, we are pleased to include a range of articles in this Newsletter to help your clinical negligence practice. We are grateful to Judy Dawson of Park Square for her article on the duty to hold an inquest and Fran MacDonald of Old Square looks at the Human Rights Act issues (Article 3 and 8 in particular) behind the case of ***Hegarty v University Hospital***

NHS Trust (23.06.17) and reminds us of the difficulties in extending the 12 month limitation period imposed by the Human Rights Act (HRA)1998.

We are always delighted to include articles which help inform how clinical negligence claims might be approached and Aneurin Moloney of Hardwicke chambers has clearly and succinctly set out how Res Ipsa Loquita might be pleaded in these claims. Consent continues to be a key area of practice and Rochelle Rong of Ropewalk Chambers looks at "Informed consent, the law post Chester v Afshar". Another area which continues to attract clinical negligence claims is the use of vaginal mesh, and Marcus Coates-Walker of St John's Chambers provides some interesting insights into how these cases should be approached.

Medical experts remain of key importance to clinical negligence claims and I recommend Justine Valentine of St John's Chambers article on How to get the best from your medical expert in clinical negligence claims. This article could not have come at a better time as AvMA are looking at ways to improve the team working between lawyers and medico-legal experts. As part of this exercise we are preparing **questionnaires for lawyers about experts, the questionnaire will be emailed and available online from 1st December**. We are also preparing a similar but separate questionnaire for experts to comment on lawyers; we will be feeding back the findings from the questionnaires over the course of the next year. Last but certainly not least, is Bruno Gil of Old Square Chamber's article on the new "Judicial College Guidelines – what's changed?" Bruno's article notes that "locked in syndrome" is now recognised, and identifies the factors to be taken into account when assessing damages for serious brain injury.

AvMA's pro bono inquest service continues to be unable to meet the public demand for representation. We apply criteria to help us identify the cases we take on and those we don't. We are grateful to all counsel who provide assistance to us and who make a real and lasting difference to families by providing them with a voice at the inquest. We offer our thanks in particular to Andrew Wilson of Park Square Chambers who provided representation to LH's family and Alex Williams of Exchange Chambers who represented the family in the X inquest – both inquests have been written up and are included in this edition of the Newsletter.

We look forward to seeing our panel members at the Panel Meeting on 1st December and seeing many more of you at the AvMA 35th dinner event later in the evening of 1st December. If you haven't got your tickets for this event yet, don't miss out on the fun. Contact Ed Maycock of our Events Department for details of any availability!!!

Best wishes

Lisa O'Dwyer
Director Medico-Legal Services

AvMA news update

It is now more than two years since the DH first proposed a fixed recoverable costs (FRC) scheme for clinical negligence work but the issue has still not been resolved! However, in looking at the direction of travel it is worth reminding ourselves of what the original proposals were: In August 2015, the main tenets of the DH's proposals were that:

(i) Solicitor's costs would be awarded on a fixed fee basis relative to the value of the claim, rather than complexity.

(ii) Claims to the value of up to £250,000 may be included in the regime and

(iii) Experts' fees were to be capped at a maximum recoverable sum which reflects the likely number and cost of expert reports needed.

Two years on and the DH are still unable to provide any real detail on how the proposals are expected to operate in practice. In particular, there is still no indication of what level of remuneration is going to be offered on fixed fee work or what cap, if any, is to be imposed on experts' fees. The situation has caused considerable uncertainty for lawyers working in this difficult area of law and has made it impossible for firms to formulate any meaningful long term business plan.

However, it is not an entirely gloomy picture and there have been some apparent gains as a result of persistent lobbying. Currently, the DH has moved away from looking to fixing costs for claims up to £250,000, restricting a set costs regime to claims valued at less than £25,000.

In Jackson LJ's Report "Review of Civil Litigation Costs: Supplemental Report Fixed Recoverable Costs" published in July 2017, he comments that his objective is to promote access to justice. He says:

"...controlling litigation costs whilst ensuring proper remuneration for lawyers is a vital part of promoting access to justice...If the costs are too high, people cannot afford lawyers. If the costs are too low, there will not be any lawyers doing the work." (Page 10, para 12).

He also notes that:

"clinical negligence claims are often of low financial value, but of huge concern to the individuals on both sides. The complexity of such cases means that they are usually unsuited to either the fast track or my proposed intermediate track." (Page 9, para 9).

Jackson believes in the power of collaboration and in the spirit of this he recommends that the DH and the Civil Justice Council (CJC) set up a working party with both claimant and defendant representatives to develop a bespoke process for handling clinical negligence claims up to £25,000. He has also stated that if the process for clinical negligence claims were to be more streamlined then it may be fair enough to put a FRC regime on that.

Richard Heaton (Permanent Secretary for MoJ) recently confirmed that Ministers have now accepted Jackson's recommendation for a working party and the Terms of Reference are in the process of being drafted. AvMA, SCIL, Law Society and APIL are working on an agreed form of words which could be submitted to the DH and CJC as suggested terms of reference for the working party. Of course, the real key to reducing clinical negligence litigation costs is to learn from mistakes and put patient safety at the centre of the NHS agenda.

It is notable that to date no one has been able to produce a grid for low value clinical negligence cases which can properly accommodate the complexities inherent in this work whilst promoting access to justice and remaining economically viable enough to incentivise experienced lawyers to do the work properly. It is perhaps worth remembering that Jackson has identified two ways for managing runaway litigation costs. Fixing the recoverable costs is just one of those options. The other is the imposition of a binding budget for individual cases at an early stage.

Cost budgeting has been part of the procedure for dealing with issued clinical negligence cases since 2013. Cost budgeting did have a difficult start, not least because of a lack of training and resources for judges and courts, however it is now seen as working or beginning to work - a view which is held by claimant and defendant groups alike. We should not forget that cost budgeting still remains an option for clinical negligence claims, although

clearly there is work to be done to limit the pre issue costs incurred.

The current climate presents a valuable opportunity for parties to get around the table and consider the factors that give rise to clinical negligence claims. This approach would encourage consideration of the cause of the problems, rather than merely addressing the symptoms. The working party suggested by Jackson may present the perfect opportunity to explore better, quicker and more cost-effective ways of litigating lower value clinical negligence claims.

In 2015 the Government also proposed a consultation on the loss of recovery of ATE premiums in clinical negligence cases. No consultation has ever been published and there has since been a wall of silence surrounding this proposal; any negotiations or discussions need to be mindful of this fact. The importance of claimants being able to access affordable funding for disbursements cannot be understated; quite simply, without it, there is no access to justice.

On a slightly different, but nonetheless important subject, the Health Service Safety Investigation Bill (HSSIB) was published on the 14th of September. The Bill proposes that individual trusts will be able to apply to HSSIB for accreditation which if successful, will enable them to carry out both external and internal investigations. The Bill also provides for a prohibition on HSSIB or accredited trusts disclosing things held by it in connection with its' investigations – this will include any witness statements, information or documents.

This prohibition on disclosure is part of the "safe space" concept. Safe space is intended to encourage clinicians to come forward and speak up about any failings or concerns about their own practice without fear of reprisals. However, this assumes that a clinician's fear is about litigation only. In fact litigation is only one of a raft of concerns that healthcare staff have; fear of reprisals from their own employers is a very real factor. It is difficult to see how a "safe space" helps them avoid that issue.

If the Bill goes through in its current form, then it will also likely mark a departure from the current right to disclosure of Serious Incident Reports and similar investigations. Instead, families and/or their lawyers will only be entitled to the HSSIB or accredited trust's report on the outcome of their investigations. There is no requirement for the report to include any information or document to which the prohibition applies. It is proposed that disclosure would only be available by way of an order from the High Court. The High Court would have to be satisfied that any application for disclosure was necessary in the interests of justice and that the interests of justice outweighed any adverse impact on future investigations.

It is AvMA's view that the Bill, as currently drafted, is contrary to the duty of candour and NHS Constitution; it would be a retrograde step in promoting an open and fair culture. We will be expressing our concerns to government.

We are aware that firms continue to experience difficulties with the Legal Aid Agency (LAA). The difficulties include concerns about applications for funding being denied on the grounds that a child is too young for formal diagnosis of neurological injury – this is despite medical evidence to the contrary. They include decisions taken by LAA to refuse extending the scope of the legal aid certificate, despite a supportive advice from leading counsel. AvMA Panel Members will be able to put their questions to the LAA on 1st December when a representative from the LAA attends the panel meeting to explain the background to some of their decisions.

Best wishes

Duty to hold (or reopen a suspended inquest)

JUDY DAWSON
PARK SQUARE CHAMBERS

The Inquest system in England and Wales upholds the important common law duty for there to be an investigation into the cause of a violent or unexpected death and moreover it should satisfy the requirements of ECHR Article 2. Judy Dawson of the Park Square Barristers Inquest Team discusses an important judicial review case exploring whether other investigations, reports, criminal processes or enquiries can fulfil such duty and requirements such that the Coroner can decide either not to hold or not to reopen a suspended Inquest.

R (on the application of Muhammad Silvera) (Claimant) v HM Senior Coroner for Oxfordshire (Defendant) & (1) Chief Constable of Thames Valley (2) Oxford Health NHS Foundation Trust (Interested Parties) (2017) [2017] EWHC 2499 (Admin)

Facts

Both the deceased and her daughter were under the care of the Oxford Health NHS Foundation Trust due to mental illness issues. There had been a series of incidences in which the daughter was found to have been violent or threatening to specifically her Mother and also to police officers and other carers which culminated in her being admitted to hospital pursuant to section 2 of the Mental Health Act 1983. She subsequently escaped and was then returned to hospital. A decision was made to move her to an open ward from which she absconded again and went missing, subsequently being discovered to be back at her Mother's house. Concerns were raised between the hospital and the police about the welfare of her Mother in such circumstances and there appeared to be a dispute about the responsibility of the two authorities to act. After further concerns were raised by other family members about the disappearance of the Mother, police attended at the home and discovered the Mother's body; her daughter was arrested in connection with her death.

Subsequent legal and quasi-legal proceedings

As would be expected, an Inquest was opened into the death and immediately suspended pending the outcome of the criminal investigation. At an early plea and directions hearing, the daughter pleaded guilty to manslaughter on the basis of diminished responsibility and was sentenced to detention in a secure hospital (in fact within a year of the same she died of unrelated medical problems).

Two other investigations into the role of the public authorities took place: a "route cause analysis investigation report" by the NHS Trust, and a "domestic homicide review" by the Oxford Safer Communities Partnership under the Domestic Violence, Crime and Victims Act 2004 s.9. Both were conducted in private; the family members had no input into the former and relatively little input into the latter. The Claimant (son of the deceased) applied for the resumption of the Inquest. The coroner declined (upholding such decision after the claimant invited him to reconsider) finding that the other investigations satisfied ECHR art.2 when taken together.

Legal position

The Claimant contended that the Coroner had breached his investigative duties pursuant to Article 2 and had acted irrationally and in breach of his common law duty to fully investigate the death. He therefore sought judicial review of this decision.

Effect of criminal proceedings and other inquiries

Where criminal proceedings and/or other inquiries have been held, the Coroner may be correct in deciding that the matter has been fully investigated; it is a question of fact and degree. The House of Lords decision in ***R (Amin) v Secretary of State for the Home Department [2004] 1 AC 653*** provides a very helpful analysis and example of the law in this area. In that case a 19 year old prisoner in a Young Offender Institution was murdered by his cell-mate. The Secretary of State refused a request by the family for a public enquiry and a Judge subsequently granted a declaration that an independent public enquiry with the deceased's family legally represented, provided with the relevant material and able to cross-examine the principle witnesses should be held to satisfy the state's procedural

duty under Article 2 to investigate the death. The Court of Appeal held that the four sets of investigations that had already been carried out were sufficient. These were;

a) The criminal trial. The only issue in this case however was whether the Defendant was guilty of murder or manslaughter by reason of diminished responsibility. Although evidence was heard as to the circumstances, there was no exploration of events before the murder or cell allocation procedures for example.

b) The Inquest. In fact (as in the instant case) the inquest had been adjourned pending the criminal investigation and thereafter the Coroner had refused a request to resume the same.

c) There was a police investigation into whether the Prison Service or any individual should be prosecuted. It concluded that there was insufficient evidence.

d) There was an Inquiry by Mr Butt to investigate the circumstances of the murder and in particular the issue of shared accommodation (both specifically and generally). The family had been consulted about the terms of reference but were not present at any stage of the investigation. The family had been provided with the majority of the report which made 26 recommendations.

e) There was a Commission for Racial Equality Investigation into racial discrimination in the prison service with specific reference to the circumstances leading to the murder of the deceased. The family's requests to be allowed to participate in its inquiry and for the hearings to be in public were both refused. There was a part of the hearing held in public at which high level policy matters were discussed and the family were given the opportunity of meeting with Counsel beforehand to put forward suggestions for cross-examination, which they refused. The report was published and made criticisms and recommendations.

In holding that such investigations and enquiries were not sufficient to properly fulfil the state's duty to investigate the death, and overturning the decision of the Court of Appeal Lord Bingham stated;

"A profound respect for the sanctity of human life underpins the common law as it underpins the jurisprudence under articles 1 and 2 of the Convention. This means that a state must not unlawfully take life and must take appropriate legislative and administrative steps to protect it. But the duty does not stop there. The state owes a particular duty to those involuntarily in its custody. As Anand J succinctly put it in Nilabati Behera v State of Orissa (1993) 2 SCC 746 at 767 "There is a great responsibility on the police or prison authorities to ensure that the citizen in its custody is not deprived of his right to life". Such persons must be protected against violence or abuse at the hands of state agents. They must be protected against self-harm: Reeves v Commissioner of Police of the Metropolis [2000] 1 AC 360. Reasonable care must be taken to safeguard their lives and persons against the risk of avoidable harm.

The state's duty to investigate is secondary to the duties not to take life unlawfully and to protect life, in the sense that it only arises where a death has occurred or life-threatening injuries have occurred: Menson v United Kingdom (Application No 47916/99) (unreported) 6 May 2003, page 13. It can fairly be described as procedural. But in any case where a death has occurred in custody it is not a minor or unimportant duty. In this country, as noted in paragraph 16 above, effect has been given to that duty for centuries by requiring such deaths to be publicly investigated before an independent judicial tribunal with an opportunity for relatives of the deceased to participate. The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others."

Most importantly and significantly in relation to the index case, Lord Bingam went on to state;

"There was in this case no inquest. The coroner's decision not to resume the inquest is not the subject of review, and may well have been justified for the reasons she has given. But it is very unfortunate that there was no inquest, since a properly conducted inquest can discharge the state's investigative obligation, as established by McCann v. United Kingdom 21 EHRR 97".

The decision

Perhaps not surprisingly in view of Lord Bingham's comments, judicial review of the decision not to reopen the inquest was granted, with it being held that the decision not to do so was unlawful, in breach of the obligations under Article 2 of the Convention, and in breach of the common law duty to investigate a death.

Commentary

This is another significant case enshrining the rights of family members to have a full and proper public investigation into a death.

ARTICLE BY

JUDY DAWSON
PARK SQUARE CHAMBERS

Breach of Articles 3 & 8 of the ECHR & clinical negligence

FRAN MCDONALD
OLD SQUARE

Introduction

This article discusses the threshold for bringing claims for breach of Articles 3 (the prohibition against inhumane or degrading treatment) and 8 (the right to respect for private and family life) in the context of a clinical negligence claim.

It emphasises the high threshold established by domestic caselaw, and the difficulty in extending the 12-month limitation period under s. 7(5) of the Human Rights Act 1998.

These issues were recently ventilated in the cases of Henderson v Dorset Healthcare University Foundation NHS Trust [2017] Med. L.R. 57 before Warby J and ***Hegarty v University Hospitals Birmingham NHS Foundation Trust*** [2017] EWHC 2115 (QB) before HHJ Platts (sitting as a Judge of the High Court).

In ***Henderson*** the claimant had been diagnosed as suffering from paranoid schizophrenia. At the time, she was under the care of the defendant NHS Trust. An inquiry later made findings critical of the defendant's conduct. A health worker, a Ms Loyne, had tried to alert the Trust that the claimant had suffered a significant deterioration.

The claimant's case was that there was a failure to take sufficient steps to provide treatment. In her deteriorated state the claimant killed her mother and suffered psychiatric harm as a result.

In ***Hegarty v University Hospitals Birmingham NHS Foundation Trust*** the claimant, who suffered from somatisation disorder, had two operations performed on her spine, both of which she said had only served to worsen her condition. It was agreed she was now in chronic and debilitating pain, and was wheelchair bound.

The case was based on both a failure to discuss treatment and on alleged ill- treatment. It was admitted that there had been a negligent failure to discuss possible alternatives to the second operation, the surgeon simply taking the view a second operation was "mandated" due to the claimant's symptoms and signs. Applying ***Border v Lewisham and Greenwich NHS Trust*** [2015] EWCA Civ 8, the claim under this head failed as on the evidence that she would have reluctantly agreed to second operation, even if all the alternatives had been fully explained. Even if this threshold had been crossed, HHJ Platts said "I am not persuaded [any possible alternative's outcome] would have been materially better so as to justify compensation."

Mrs Hegarty gave evidence that a number of doctors and nurses on the ward were rude and patronising toward her, shouting and insulting her and being neglectful in their care of her. She particularly complained about one Auxiliary Nurse nicknamed 'Jaz', who she said called her a "nasty bitch", went into her room solely to give her dirty looks, and had insulted her family. She further claimed Jaz had invited her into a room with a patient who had MRSA and then shouted, "Fuck, fuck," when he heard that the claimant was to be transferred – the Judge said the implication of the allegation was that Jaz wanted Mrs Hegarty to remain on the ward so that he could continue to be abusive and bullying towards her.

These allegations were rejected by the Judge as an exaggerated reconstruction of events by the claimant. Mrs Hegarty did however prove breach of duty due to (i) seven occasions when there was a delay in administering morphine sulphate treatment for pain relief (ii) causing her to urinate in a water jug by not attending to her needs (iii) obliging her to shower in her surgical socks or not replacing her socks afterwards on at least one occasion, and (iv) not following up her complaints. Damages of £4,500 were awarded, £1,000 of which related to Mrs Hegarty's increased anxiety.

ECHR claims

Both Ms Henderson and Mrs Hegarty sought damages for breach of Articles 3 and 8 in addition to negligence. Article 3 provides:

> *"No one shall be subjected to torture or to inhuman or degrading treatment or punishment."*

The very high threshold for ill-treatment to be sufficiently severe to engage Article 3 was emphasised by the European Court of Human Rights such cases as ***D v United Kingdom*** (1997) 24 EHRR 423 and ***X v Denmark*** (1983) 32 DR 282. In ***Keenan v United Kingdom*** [2001] 33 E.H.R.R. 38 the Court sad:

> "[108] [Whether ill-treatment is sufficiently severe] *depends on all the circumstances of the case, such as the duration of the treatment, its physical and/or mental effects and, in some cases, the sex, age and state of health of the victim.*
>
> [109] *In considering whether a punishment or treatment is 'degrading' within the meaning of Article 3, the court will also have regard to whether its object is to humiliate and debase the person concerned and whether, as far as the consequences are concerned it adversely affected his or her personality in a manner incompatible with Article 3. This has also been described as involving treatment such as to arouse feelings of fear, anguish and inferiority capable of humiliating or debasing the victim and possibly breaking their physical or moral resistance or as driving the victim to act against his will or conscience.*

The ECtHR additionally held in ***Keenan*** that an inability to properly complain or receive adequate health care will also be relevant.

In the context of clinical negligence, Scott Baker J stated in ***R (Howard) v. Health Secretary*** [2003] QB 830 at [114] that *"clinical negligence is not a sufficient foundation for an Article 3 claim"* even where (as was alleged) gross negligence resulted in death. The meaning of Article 3 in the domestic context was again considered by Singh J's (now Singh LJ) in his characteristically careful judgment in ***R (HA) (Nigeria) v Secretary of State for the Home Department*** [2012] EWGC 979 (Admin), at para 174 onward, applying ***Kudla v Poland*** [2002] 35 EHRR 198. In the view of Singh J, breach of Article 3 could possibly be found without any ill-intent or improper purpose being shown, or where the claimant's suffering arises from a naturally occurring condition, such as an illness or disease (although suffering must be more than that which is simply inherent).

Since ***R (Howard)*** ECHR rights under Article 2 (the right to life) have been utilised in the clinical negligence context. For example, the state's positive obligation to investigate under Article 2 was said to be engaged even in cases involving *"simple negligence in the care and treatment of a patient in hospital"* in certain circumstances such as deaths from systemic failings by state agents by Richards J, in ***R (Goodson) v. Bedfordshire and Luton Coroner*** [2006] 1 WLR 432. However, it is clear the high bar remains for Article 3. Both the high standard of proof and the required intensity of distress were emphasised by the (now retired and much-missed) HHJ Seys-Llewellyn QC, sitting as a High Court Judge in ***R (VC) v Secretary of State for the Home Department*** [2016] EWHC 273 (Admin), [2016] 1 W.L.R. 3704 at 3735B.

Article 8, often simply referred to the right to privacy, provides:

> *"(1) Everyone has the right to respect for his private and family life, his home and his correspondence.*
>
> *(2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others"*

Article 8 has been held by the European Court of Human Rights to apply to actions which interfere with the physical integrity or mental health of a person provided they reach a certain degree of severity. See ***Bensaid v UK*** (2001) 33 EHRR 205 at [46]:

> *"Not every act or measure which adversely affects moral or physical integrity will interfere with the right to respect to private life guaranteed by Article 8. However, the Court's case-law does not exclude that treatment which does not reach the severity of Article 3 treatment may nonetheless breach Article 8 in its private life aspect where there are sufficiently adverse effects on physical and moral integrity."*

In ***Storck v Germany*** (2005) 43 EHRR 96 at [143] the Court emphasised that that more minor interferences with a person's physical integrity can fall within the scope of Article 8 if they occur against the person's will.

Failure to engage Articles 3 and 8

Both claimants' claim for breach of human rights failed both on limitation and substantive grounds.

In ***Henderson*** Warby J's judgment illustrates the need for precision when identifying the acts or omissions which breached Article 3 rights. He doubted (but did not rule out) whether it could be breached without a loss of liberty:

"The claimant's case is wholly based on failure to act, or failure to act in time. Although it is clear that omissions as well as acts can involve violations of Article 3, the jurisprudence shows that ill-treatment must attain a certain minimum level of severity to fall within the scope of Article 3 . It is clear on the admitted facts that the defendant showed a lack of urgency in dealing with an emergency situation, but some steps were taken. It is very far from clear what it is about the defendant's failings that is said to meet the threshold standard of ill-treatment. Nor is it clear quite what is to be alleged about the impact on the claimant that engages Article 3. ...Mr Bowen managed to persuade me that the claim might be tenable. But I was left with the strong feeling that if the case was "fully pleaded out" it might upon analysis prove to be unarguable. The authorities cited lend no support to the view that a failure to afford adequate mental health treatment to an individual at liberty in the community is capable of amounting to a violation of Article 3. If that is possible, as it may be, it would surely depend on the precise circumstances of the case.

Similarly, Warby J could not follow how Article 8 applied in these circumstances where the lack of detention/ treatment was the key allegation:

"The position is rather worse when it comes to the case that the defendant's omissions involved a violation of the right to respect for private and family life under Article 8. It is far from obvious what aspect of Article 8 is relied on. There is no explanation at all in the draft pleading. Counsel for the defendant described the case as pleaded as "unfathomable", which is harsh but not unfair. Mr Bowen explained that reliance was placed on the protection afforded by Article 8 to physical integrity. But again, the case was put in general terms by reference to authority, and oral argument is no substitute for a pleading. I accept the defendant's submission that the Article 8 claim is insufficiently particularised to enable the Court to find that it has any prospect of success."

In ***Hegarty*** the claim was based on treatment without explaining options, and on acts of ill-treatment. The Judge reminded himself that allegations of breaches of the Human Rights Act, particularly under Article 3, were extremely serious. Judge Platt said of Mrs Hegarty's Article 3 claim:

"[I]t seems to me that the allegations raised by the claimant fall well short of the minimum level of severity required to come within the scope of Article 3"

Turning to the Article 8 claim, he said:

"I cannot see that Article 8 is engaged in the circumstances of this case, save for a limited period of relatively minor phobia of hospitals and some increased pain, at most. It seems to me that any effect on the claimant's private or family life has been as a result of her physical condition which has, subsequently, deteriorated rather than the matters which have formed the subject of this action".

Limitation

Section 7(5) of the Human Rights Act 1998 provides:

"Proceedings under subsection (1)(a) must be brought before the end of -

(a) the period of one year beginning with the date on which the act complained of took place; or

(b) such longer period as the court or tribunal considers equitable having regard to all the circumstances"

Warby J held that Ms Henderson's human rights claim, which was brought on amendment after 6 years, would in any event have been time-barred. The claim was "*unconscionably late in the proceedings*" given the delays in advancing it and the effect it had on case management. Further Warby J's opined that the factual basis for a claim under Articles 3 and 8 was potentially wider than one based on negligence, so delay could well be prejudicial:

"the defendant would have to address evidential issues relating to the human rights claims for the first time more than six years after the event. Assessment of precisely how that would prejudice the defendant is difficult, but I am confident there would be genuine prejudice. Fairness, and the need to ensure proportionality and efficiency, all favoured the refusal of permission."

Similarly, Judge Platt in ***Hegarty*** said:

There is, in my judgment, a good reason why Parliament has provided that in the normal course of events, claims should be formulated and made within the 12-month period. In my judgment, that time should only be extended for good reason and no good reason has been shown here.

Judge Platt refused to extend the 12-month limitation period under the HRA. This was due to the fact that:

The claimant had only applied at the last minute, orally at trial, for an extension of time. Grounds for an application were first set out in writing in the claimant's skeleton argument for trial in only one short paragraph, rather than in a statement of case.

It was argued that on the available evidence, the claimant had clearly been in poor health before bringing the proceedings, but no specific evidence has been adduced as to why that was a reason for not bringing the claim before expiry of limitation or why there was a delay in issuing ;

The claimant was made aware in 2012 that the defendants would not consent to an extension of time for bringing the Human Rights claim. Nonetheless, they did nothing for two years before it was pleaded. No explanation for that delay has been provided;

In terms of prejudice, the defendant has been unable to trace witnesses, in particular Jaz and one other nurse, and the recollection of those witnesses who have given evidence is, understandably, impaired by the passage of time.

The issues raised by any claim under the Human Rights Act were, largely, co-extensive with the common law allegations I have considered and no further award beyond which the claimant is entitled common law was necessary to afford just satisfaction to her.

Discussion

The lesson for claimant practitioners who wish to use the Human Rights Act 1998 and Articles 3 and 8 in particular can be summarised as follows:

- Bear in mind the 12-month limitation period, and do not assume without good evidence and a good reason for the delay, that time will be extended. Prejudice will be potentially more easily inferred given the wide issues raised by the articles and the seriousness of the allegation.
- If allegations are to made, they need to be made both at the outset and formulated with clarity, identifying the particular acts or omissions complained of and how they impacted on personal integrity (either physical or mental) or caused suffering.
- To amount to breach of Article 3, the ill-treatment will need to be particularly severe and is likely to be difficult absent a loss of liberty.
- Consider whether damages in excess of those awarded at common law will be awarded by way of just satisfaction even if you are successful, and so whether they justify the risk of an issue based costs order.

ARTICLE BY

FRAN MCDONALD
OLD SQUARE

Res ipsa loquitur in clinical negligence

ANEURIN MOLONEY
HARDWICKE

The maxim res ipsa loquitur or 'the thing speaks for itself', is a long-standing rule of evidence more commonly utilised in other areas of personal injury law. In a PI setting it has been applied in a wide range of cases including objects falling from buildings, malfunctioning machines, collapsing cranes, and stones in buns.

In clinical negligence, claimant practitioners often bolt-on an assertion that res ipsa loquitur applies when drafting letters of claim or pleadings. This is often seen in cases where negligence appears more likely on the bare facts.

However, there are strict controls on the application of res ipsa loquitur. Three conditions are required to be met:[1]

1. The event is one that would ordinarily not occur in the absence of negligence/fault;
2. The thing causing the damage must have been under the control of the defendant;
3. There is no evidence as to why or how the accident occurred.

Once those three conditions are met, the court may draw an inference of negligence against the defendant. The burden of proof then shifts to the defendant, who must prove that the accident was not caused by their negligence. Where the defendant cannot discharge that burden, a claimant may succeed in their claim without proving precisely how their injury was caused.

Pre-Bolam

Its use in clinical negligence gained some traction before ***Bolam and Bolitho***. ***Mahon v Osborne*** [1939] 1 All ER 535, is an early example of the application of res ipsa loquitur in a case where a surgical swab had been left inside a patient's body.

In ***Clarke v Worboys*** (1952) Times, 18 March, CA, a patient noticed burns on her buttock shortly after surgical excision of a breast tumour. The surgery involved cauterisation. The Court of Appeal held that this was a case where res ipsa loquitur applied. The outcome was not one that would ordinarily occur in the absence of negligence, and the surgical team were unable to explain how the injury was caused.

In ***Cassidy v Ministry*** of Health [1951] 2 KB 343, Denning LJ succinctly summarised the maxim's application to clinical negligence cases: *"I went into hospital to be cured of two stiff fingers. I have come out with four stiff fingers and my hand is useless. That should not happen if due care had been used. Explain it if you can."*

Post-Bolam

Post-***Bolam***, its use waned. In ***Delaney v Southmead Health Authority*** [1995] 6 Med LR 355, Stuart-Smith LJ said that he was doubtful whether res ipsa loquitur would be of assistance in medical negligence cases, where unexpected results often occur in the absence of negligence.

Glass v Cambridge Health Authority [1995] 6 Med LR 91 is a rare example of res ipsa loquitur surviving ***Delaney***. Here, an otherwise fit and healthy 35 year old underwent an exploratory laparotomy, during which the oximeter alarm went off. It was considered to be a false alarm and switched off. Later, the patient went into cardiac arrest during surgery and suffered brain damage. The Court of Appeal held that res ipsa loquitur applied, and that the defendant had not discharged the reversed burden.

Further doubt of the application of res ipsa loquitur in clinical negligence cases was expressed by Hobhouse LJ in ***Ratcliffe v Plymouth and Torbay Health Authrity*** [1998], where it was observed:

> *"Res ipsa loquitur is not a principle of law and it does not relate to or raise any presumption. It is merely a guide to help identify when a prima facie case is being made out. Where expert and factual evidence is being called on both sides at trial its usefulness will normally have been long since exhausted."*

However, in the same Court of Appeal case, Brooke LJ (with whom both Hobhouse LJ and Sir John Vinelott agreed) reviewed a number of cases concerning the application of res ipsa loquitur in clinical negligence and stated the following principles:

1 *Scott v London and St Katherine's Docks [1861 – 73] All ER Rep 246*

"(1) In its purest form the maxim applies where the plaintiff relies on the res (the thing itself) to raise the inference of negligence, which is supported by ordinary human experience, with no need for expert evidence.

(2) In principle, the maxim can be applied in that form in simple situations in the medical negligence field (surgeon cuts off right foot instead of left; swab left in operation site; patient wakes up in the course of surgical operation despite general anaesthetic).

(3) In practice, in contested medical negligence cases the evidence of the plaintiff, which establishes the res, is likely to be buttressed by expert evidence to the effect that the matter complained of does not ordinarily occur in the absence of negligence.

(4) The position may then be reached at the close of the plaintiff's case that the judge would be entitled to infer negligence on the defendant's part unless the defendant adduces evidence which discharges this inference.

(5) This evidence may be to the effect that there is a plausible explanation of what may have happened which does not connote any negligence on the defendant's part. The explanation must be a plausible one and not a theoretically or remotely possible one, but the defendant certainly does not have to prove that his explanation is more likely to be correct than any other. If the plaintiff has no other evidence of negligence to rely on, his claim will then fail.

(6) Alternatively, the defendant's evidence may satisfy the judge on the balance of probabilities that he did exercise proper care. If the untoward outcome is extremely rare, or is impossible to explain in the light of the current state of medical knowledge, the judge will be bound to exercise great care in evaluating the evidence before making such a finding, but if he does so, the prima facie inference of negligence is rebutted and the plaintiff's claim will fail. The reason why the courts are willing to adopt this approach, particularly in very complex cases, is to be found in the judgments of Stuart-Smith and Dillon L.JJ. in Delaney [see P181 supra].

(7) It follows from all this that although in very simple situations the res may speak for itself at the end of the lay evidence adduced on behalf of the plaintiff, in practice the inference is then buttressed by expert evidence adduced on his behalf, and if the defendant were to call no evidence, the judge would be deciding the case on inferences he was entitled to draw from the whole of the evidence (including the expert evidence), and not on the application of the maxim in its purest form."

Unlike Hobhouse LJ, Brooke LJ considered that expert evidence would serve to strengthen a res ipsa loquitur argument where the expert confirmed that the result would not ordinarily occur in the absence of negligence. Brooke LJ also explained that any non-negligent possible explanation would have to be greater than merely theoretically or remotely possible.

Modern compromise?

In more recent times there have been a number of cases in which res ipsa loquitur or similar principles were held to apply.

Thomas v Curley [2013] EWCA Civ 117 concerned a common bile duct injury sustained during laparoscopic cholecystectomy. In what was described as 'an uncomplicated operation', injury was caused in an area other than that where the operation took place. The Court of Appeal held that this fact "*called for an explanation as to how that might have occurred in the absence of negligence*." Despite this feature, the Court of Appeal went on to say that this approach "*has nothing to do with the reversal of the burden of proof and nothing to do with res ipsa loquitur*." It was held that negligence had been proved directly by the claimant.

A similar approach was taken by Jackson LJ in ***O'Connor v The Pennine Acute Hospitals NHS Trust*** [2015] EWCA Civ 1244. Here, it was held that whilst the defendant had not proffered any plausible explanation for how an injury could occur in the absence of negligence, this did not reverse the burden of proof, or invoke res ipsa loquitur. Jackson LJ did state that the defendant's failure to provide an explanation was a matter that the trial judge was entitled to take into account, which supported the finding of negligence against the defendant.

Jackson LJ did not go so far to say that the circumstances called for an explanation by the defendant. However, his approach is virtually one of drawing an inference of negligence because of the absence of explanation by the defendant.

It is difficult, if not impossible, to distinguish Court of Appeal's 'calling for an explanation' approach in ***Thomas***, with Denning's approach in ***Cassidy***. Requiring the defendant to explain anything must at least amount to a modification of the ordinary burden of proof.

Similarly, Jackson LJ's 'taking into account' of the lack of plausible explanation by the defendant, is at least in part an inference of negligence.

Surgical cases can be more evidentially challenging for claimants. They will usually not have witnessed events because they have been under general anaesthetic. Often the surgeons are unaware of complications until after surgery. Where an unexpected surgical outcome occurs in these circumstances, claimants will often find it useful to advance an alternative case on a res ipsa loquitur footing.

Alternatively, an unexpected outcome may be said to call for an explanation (***Thomas***). Or, if the defendant fails to put forward a more than theoretically possible explanation, this may itself be a factor which goes to prove negligence, or allows negligence to be inferred (***O'Connor***).

Pleading

A final note on pleading res ipsa loquitur. The prevailing view is that it is not necessary to plead the doctrine itself, however, the claimant must allege and prove the facts that allow the inference to be drawn.[2]

It is likely to assist claimants hoping for a judge to adopt a ***Thomas*** or ***O'Connor*** approach, to clearly set out that the facts that require a more than theoretically possible explanation by the defendant.

ARTICLE BY

ANEURIN MOLONEY
HARDWICKE

2 *Scott and Bennett v Chemical Construction (GB) Ltd [1971] 3 All ER 822*

Informed consent – the law post Chester v Afshar

ROCHELLE RONG
ROPEWALK CHAMBERS

Since the House of Lords decision in ***Chester v Afshar*** [2004] UKHL 41, allegations of failure to obtain informed consent from a patient have metamorphosed from matters of subsidiary importance, often added as an afterthought in a clinical negligence claim, to an important weapon in a Claimant's armoury that often occupies the centre ground in clinical negligence litigation.

However, whilst the patient's right to autonomy and self-determination has been powerfully reaffirmed in the seminal decision in ***Montgomery v Lanarkshire Health Board*** [2015] UKSC 11, the simple fact that there has been an absence of informed consent does not necessarily mean that the claimant will succeed in recovering damages from the defendant doctor or health authority. As recent authorities have demonstrated, the law of informed consent has its obvious limits. Through a review of some of the more recent case law, the author intends to explore the law of informed consent post ***Chester v Afshar***, and discuss the way in which the law in this area has been applied.

Valid or real consent requires a broad understanding on the part of the patient of the nature and purpose of the procedure (***Chatterton v Gerson*** [1981] QB 432 at 443). Where, through the doctor's failure to provide sufficient information, a procedure or treatment is carried out without the patient's informed consent, an action may lie in negligence for breach of duty. There are two essential elements to such a claim: first, the claimant has to prove that the doctor in question was negligent in the provision of advice and/or information on the proposed treatment; and secondly, in accordance with the principle established in ***Chester v Afshar***, the claimant has to prove that the defendant's negligence has caused him to suffer pain, suffering, loss and damage. Inherent in this requirement is the need to prove that but for the defendant's negligence, the claimant is unlikely to have suffered the adverse outcome in respect of which the claim is brought.

The duty of disclosure

The case of ***Montgomery v Lanarkshire Health Board*** concerned a duty owed by a doctor to a pregnant patient in relation to the advice as to the particular risks of shoulder dystocia if her baby were born by vaginal delivery which could be avoided by a caesarean section. In ***Montgomery***, the Supreme Court unequivocally confirmed the principle of 'informed consent' as part of the law in England, Wales and Scotland. Endorsing the approach of Lord Scarman in ***Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital*** [1985] AC 871, the Supreme Court reviewed a long line of cases, including the Australian High Court decision in ***Rogers v Whittaker*** (1992) 175 CLR 479, and confirmed that in the law of negligence, doctors owe a duty to take reasonable care to ensure that a patient is aware of material risks of injury that are inherent in treatment. There is "a fundamental distinction between, on the one hand, the doctor's role when considering possible investigatory or treatment options and, on the other, her role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved... The doctor's advisory role cannot be regarded as solely an exercise of medical skill without leaving out of account the patient's entitlement to decide on the risks to her health which she is willing to run...Responsibility for determining the nature and extent of a person's rights rests with the courts, not with the medical professions."

With regard to the extent of the doctor's duty to provide disclosure, ***Montgomery*** confirms that the doctor "is under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments." The test of 'materiality' is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.

The 'therapeutic exception' is maintained. The doctor is entitled to withhold from the patient information as to a risk if he reasonably considers that its disclosure would be seriously detrimental to the patient's health. The doctor is also excused from conferring with the patient in circumstances of necessity.

The assessment of whether a risk is material cannot be reduced to percentages. The significance of a given risk is

likely to reflect a variety of factors besides its magnitude and is therefore fact-sensitive, and sensitive also to the characteristics of the patient. The doctor's advisory role involves dialogue and will only be performed effectively if the information provided is comprehensible. Finally, it is important that the therapeutic exception should not be abused to subvert the principle of informed consent by enabling the doctor to prevent the patient from making an informed choice where he is liable to make a choice which the doctor considers to be contrary to his best interests.

The assessment of the materiality of a particular risk associated with a proposed course of treatment is both fact-sensitive and patient-sensitive. Apart from obtaining (expert) evidence in respect of the nature, magnitude and potential consequences of the relevant risk, the claimant's factual evidence in relation to his personal circumstances and subjective evaluation of those factors are also likely to play an important part in answering the question of whether the defendant's failure to provide information amounts to a breach of duty.

Application of Montgomery

In ***A v East Kent Hospitals University NHS Foundation Trust*** [2015] EWHC 1038, Dingemans J. held that the evidence before him did not show that there was a material risk to which Mrs A should have been alerted. A concerned the alleged failure by the defendant trust to advise the claimant during her pregnancy that her baby might be suffering from a chromosomal abnormality. Having reached the conclusion that the expert evidence was to the effect that the risk of chromosomal abnormality was 1 in 1,000, or could be described as theoretical, negligible or background, the judge went on to conclude that in the circumstances, there was no need to have any discussion about fetal karyotyping with the claimant. A reasonable patient, in the position of Mrs A, would have attached no significance to risks at this background level. ***Montgomery*** is not authority for the proposition that medical practitioners need to warn about risks that are theoretical and not material.

Claimants have relied upon the ***Montgomery*** decision with success in a number of cases including ***Spencer v Hillingdon Hospital NHS Trust*** [2015] EWHC 1058 QB, ***Webster v Burton Hospitals NHS Foundation Trust*** [2017] EWCA Civ 62 and ***Thefaut v Johnston*** [2017] EWHC 497 (QB).

In the post-***Montgomery*** world, the existence of a signed consent form is no longer conclusive on the issue of consent. In cases where the prospective claimant has suffered an adverse consequence following treatment, circumstances surrounding the consent process should form part of the pre-action investigation. Questions should be asked as to when the consent form was signed; what was said at the time and by whom; what were the exact circumstances of the signing of such a form; and whether alternative treatment options were available, and if so, whether they were discussed with the claimant.

Causation

In ***Chester v Afshar***, the House of Lords made a policy decision to vindicate the claimant's right of autonomy and dignity by allowing "a narrow and modest departure from traditional causation principles". The readers are undoubtedly familiar with the facts in Chester, which concerned the defendant neurosurgeon's failure to warn the claimant of the small but unavoidable risk of surgery. The risk, which was only in the order of 1 to 2%, was neither created nor increased by the defendant's failure to warn. The claim would have failed on traditional causation principles. In allowing the claim on policy grounds, Lord Steyn took account of the fact that "in the context of attributing legal responsibility, it is necessary to identify precisely the protected legal interest at stake. A rule requiring a doctor to abstain from performing an operation without the informed consent of a patient serves two purposes. It tends to avoid the occurrence of the particular physical injury the risk of which a patient is not prepared to accept. It also ensures that due respect is given to the autonomy and dignity of each patient."

In subsequent cases, the Court of Appeal has declined to extend the ***Chester v Afshar*** principle outside the field of clinical negligence and emphasised its limited application in cases where there has been a breach of the doctor's duty to advise a patient of the disadvantages and dangers of the proposed treatment so as to enable the patient to give informed consent (***White v Paul Davidson & Taylor (A Firm)*** [2004] EWCA Civ 1511 & ***Beary v Pall Mall Investments (A Firm)*** [2005] EWCA Civ 415). In ***Crossman v St George's Healthcare NHS Trust*** [2016] EWHC 2878 (QB), a case that was concerned with the defendant trust's negligent failure to follow the plan for conservative management of the claimant's condition, HHJ Peter Hughes QC emphasised, obiter, the "exceptional and limited nature of the extension to conventional causation principles that the majority of the House of Lords intended to make in ***Chester v Afshar***". Each case must depend on its own facts. In ***Crossman***, the claimant was aware of the change in the implementation of his treatment plan and did not challenge it. He was duly warned of the risks of

surgery and the surgery was carried out by the surgeon he had consulted. In the circumstances, the ***Chester*** modification of the normal approach to causation would not be justified. The case succeeded instead on the conventional 'but for' test of causation.

The issue of causation, where an undisclosed risk has materialised, is closely tied to the identification of the particular risk which ought to have been disclosed. In order to succeed in a claim founded on allegations of failure to obtain informed consent, there must be "a strong nexus in fact between the initial wrongful advice and the ultimate injury" – ***Thefault v Johnston*** [2017] EWHC 497 (QB). Where it is established that there was a negligent failure to properly advise the claimant of the proposed procedure, the court must ask the question: what would the claimant have done had the appropriate advice or information been given before the procedure was carried out? As with the question of materiality of risk, the factual evidence of the claimant, and the way in which it is presented, is crucial.

The case of ***Correia v University Hospital of North Staffordshire NHS Trust*** [2017] EWCA Civ 356 concerned the treatment of a painful recurrent neuroma in the claimant's right foot. The claimant developed Chronic Regional Pain Syndrome following a relatively rare surgery to her foot. The original claim was founded on allegations of negligence both in the advice given at the pre-operative consultation and in the performance of the operation. The claimant also advanced a claim based on the nature of her consent to the operation. It was common ground that the operation, if it were to be competently performed, involved three stages: surgical exploration and neurolysis, excision of the neuroma and relocation of the nerve. At the pre-operative consultation, the surgeon explained his proposed surgical procedure, to which the claimant consented. There was no reference in either the consent form or in the operation sheet to nerve relocation following excision of the neuroma. It was common ground at trial that relocation was a necessary part of the surgical process if a neuroma were located and excised. At trial, the recorder gave judgment for the defendant on the issue of liability.

The claimant appealed the recorder's decision. The Court of Appeal was asked to determine, *inter alia*, the 'informed consent issue'. Simon LJ summarised the *ratio* in ***Chester*** as follows: "If there has been a negligent failure to warn of a particular risk from an operation and the injury is intimately connected to the duty to warn, then the injury is to be regarded as being caused by the breach of the duty to warn; and this is to be regarded as a modest departure from established principle of causation". Simon LJ went on to say that on the recorder's findings, there can be no justifiable complaint about the process of consultation and consent up to the moment when the operation began. The procedure was to be an appropriate three-stage operation (assuming that a neuroma were found) and it was to this operation that the claimant consented. It does not follow that the negligent omission of the third stage negated the claimant's consent. "The negligent failure to deal appropriately with the nerve ending did not make this either a different operation for the purposes of consent, nor an operation for which specific consent was required. It was a breach of duty which had the potential to give rise to liability for damages if all the other elements of the tort of negligence were made out. The claimant made an informed choice to have the surgery, and the injury was not 'intimately linked' with the duty to warn."

The claimant in ***Correia*** had another problem. Whilst it was argued on appeal that had she been warned of the material risks of an operation which omitted the third and crucial step of relocation, she would not have undergone the operation, there was no factual evidence to support such a contention. There was no such contention in the claimant's Protocol letter, in her pleading or in her witness statement. It was not part of her evidence.

This case emphasises the importance of the claimant's factual evidence in a case where reliance is placed upon the ***Chester*** exception. As per Simon LJ in ***Correia***, "if a claimant is to rely on the exceptional principle of causation established by ***Chester v Afshar***, it is necessary to plead the point and support it by evidence."

A free-standing claim?

Recent attempts by claimants to bring a free-standing claim in damages based on a mere failure to warn of risks have been roundly rejected by the courts.

In ***Diamond v Royal Devon & Exeter NHS Foundation Trust*** [2017] EWHC 1495 (QB), the High Court was asked to determine two issues on appeal. Only the second issue is relevant for present purposes, namely the surgeon's alleged failure to ensure that the claimant had given informed consent before proceeding to repair the hernia with a mesh. It was common ground that during the pre-operative consultation, the surgeon did not discuss with the claimant the potential implications of the proposed mesh repair in terms of a pregnancy in the future. On the basis of the expert evidence from both sides, there was general consensus that the claimant should have been counselled about the potentially adverse effects of a mesh being present in pregnancy. In the circumstances, the defendant did not seek to dissuade the court from

its preliminary views, which were that there was a lack of informed consent both by reason of the failure to advise of the risks associated with a mesh repair with regards to future pregnancy, and also by reason of the failure to mention the possibility of a primary suture repair.

Against this background, HHJ Freedman identified the following crucial question: what would the claimant have elected to do armed with the knowledge that a mesh repair carried certain risks in the event of a pregnancy and that a suture repair was a possibility, albeit likely to fail? It was not argued on behalf of the claimant that she would have opted for no treatment. Finding against the claimant on causation, HHJ Freedman held that on the balance of probabilities, even if the claimant had been in a position to give informed consent, exactly the same procedure would have been undertaken.

In response to the claimant's further 'ingenious arguments' in closing submissions, the court had no hesitation in rejecting the first argument, which was that the failure to provide informed consent should give rise to compensation for the 'shock' of discovering that she could not have children. The court also rejected the claimant's second argument, which was that the negligent non-disclosure of information by the doctor should of itself create a right to damages for the patient. Neither ***Montgomery*** nor ***Chester*** lend any support to the proposition that a mere failure to warn of risks, without more, gives rise to a free-standing claim in damages. Furthermore, the claimant did not come within the ***Chester*** exception. Even if it could conceivably be said that she has suffered an *injury* in consequence of the operation, it could not sensibly be argued that the outcome was *intimately connected to the duty to warn* such that it should be regarded as being caused by the breach of that duty.

Less than a month after the decision in ***Diamond***, the Court of Appeal handed down its judgment in the case of ***Shaw v Kovac & Anor*** [2017] EWCA Civ 1028. In ***Shaw***, the claimant brought a claim as the personal representative of her late father, who died following an operation conducted by the first defendant at the second defendant's hospital. The defendants conceded that they had given insufficient information to the claimant's father about the risks of the treatment, and that he would not have undergone the operation had he been aware of the risks.

The claimant argued that the wrongful invasion of her father's personal autonomy represented a separate and free-standing cause of action. Aside from the procedural bar arising from the claimant's failure to plead such a claim, Davis LJ held that the failure to give proper advice so as to obtain informed consent to what would otherwise be an unauthorised invasion of the patient's body should properly be formulated as an action in negligence/breach of duty (***Chester*** and ***Montgomery*** considered). It was accepted by counsel that a "free-standing award of substantial compensatory damages in respect of the invasion of [the patient's] personal autonomy by reason of the surgical procedures being performed in circumstances where his informed consent had not been obtained" has never been expressly awarded or acknowledged in any previous reported authority.

Having considered the decisions in ***Chester*** and ***Montgomery***, Davis LJ went on to say that the existence of a patient's human rights and fundamental rights have always been the foundation of and rationale for the existence of a duty of care on doctors to provide proper information. The additional award of compensatory damages sought by the claimant is therefore unnecessary and unjustified. If, in any particular case, an individual's suffering is increased by his or her knowing that his or her 'personal autonomy' has been invaded through want of informed consent, then that can itself be reflected in the award of general damages. In reality, the claim was for loss of expectation of life, which was precluded by Section 1 of the Administration of Justice Act 1982. The recoverability of vindicatory damages was also precluded for the reasons given in ***R (on the application of Lumba) v Secretary of State for the Home Department*** [2011] UKSC 12.

As the above cases have demonstrated, the claimant's factual evidence is often crucial to a claim founded on an allegation of the defendant's failure to obtain informed consent for a proposed procedure or course of treatment. Such a claim has to be clearly pleaded, both in relation to the nature of the alleged risk/information, of which the defendant has failed to warn/provide, and in relation to the issue of causation, including the decision that the claimant would have made had proper advice been given. The duty to warn only extends to material risks. Further, there must be a close nexus in fact between the initial wrongful advice and the ultimate injury. If the claimant would have suffered the injury in any event, or if there was a break in the chain of causation, the claim will fail.

ARTICLE BY

ROCHELLE RONG
ROPEWALK CHAMBERS

Vaginal mesh: The next clinical scandal?

MARCUS COATES-WALKER
ST JOHN'S CHAMBERS

It has affected hundreds of thousands of women across the world. It has been covered by every major media outlet and has been recently debated in Parliament. But, what is a vaginal mesh implant? And why is it being touted as the next clinical scandal that is set to be bigger than Thalidomide?

The basics

The vaginal mesh implant is designed to help women who suffer from stress incontinence and prolapse usually occurring after childbirth or with age.

The procedure is called trans-vaginal tape (TVT) mesh surgery. Thousands of women have the operation every year. The procedure is considered to be the least invasive surgical option taking no longer than 20-30 minutes. A mesh tape made out of plastic is passed through the vagina and placed round the urethra to form a sling. This is designed to be permanent and to support the bladder like a hammock.

The complications

However, the complications of this procedure can have a devastating and debilitating impact on those affected. Thousands of women have come forward and said that the implants have perforated organs, caused chronic pain and left them unable to work, walk or have sex.

The official complication rate for mesh procedures has been stated as 1-3%. However, some media outlets have allegedly obtained latest hospital figures which show that almost 10% of women who underwent the procedure are suffering adverse effects.

One of the key problems is that mesh can apparently change once inside the body. Urogynaecologists have said the mesh can shrink and become brittle. It then erodes and slices through nerve endings, tissue and organs like the bladder.

One option for women affected is to have the mesh removed. Reports suggest that one in fifteen women fitted with the most common type of mesh later require surgery to have it extracted due to its complications. However, as the mesh is designed to be permanent, this has been described as a highly dangerous procedure.

The major difficulty affected women face is that, unlike the consequences of Thalidomide, you are unable to see the extent of the injuries caused by vaginal mesh. The pain is hidden.

The fall out

Many medical experts have described this as a health scandal bigger than Thalidomide because the scale of the numbers of those affected is far greater. Some of the main issues appear to be that mesh implants were introduced 20 years ago without clinical trial evidence looking at the long-term effects. Experts have commented that most short-term trials have found high efficacy and low complication rates for the most common mesh implants used for incontinence. However, it seems that there is a growing body of evidence that efficacy is lower and complication rates are higher for pelvic organ prolapse. Further, there also appears to be a lack of robust information on the success of the procedures in the long term. However indications suggest that complication rates could be significantly higher than officially reported.

Thousands of injured women have called for vaginal mesh procedures to be suspended and a review to be undertaken into their safety. These calls have been backed by a number of Labour MPs who have called for a public inquiry.

NHS England and various clinical bodies (including the Royal College of Obstetricians and Gynaecologists) maintain that, for many patients the mesh is a safe and effective option that greatly helps with conditions which can be distressing for those affected. They support the position taken by the regulatory body responsible for ensuring medical devices are safe in the UK (the Medicines and Healthcare Products Regulatory Agency (MHRA)) which states that there is insufficient evidence to justify a ban on the product. The MHRA's director stated: "*There is no regulatory reason to take the product off the market because if it is used in the right circumstances with the*

right patients, appropriately consented and aware of the risks, then we have no evidence that the product should be taken off the market."

In July 2017, the Mesh Oversight Group (NHS England), published its report into the issues surrounding vaginal mesh implants. It states that: *"The use of mesh to treat women with stress urinary incontinence (SUI) and pelvic organ prolapse (POP) is a safe option for women. However, the diligent campaigning of some women who experienced complications from mesh surgery has highlighted the need for better information for women experiencing SUI and POP, better data and a multi-disciplinary approach to caring for women."*

The Mesh Oversight Group report then sets out the actions that have been taken to fulfil those recommendations including improvements to:

(a) The clinical quality of the care women receive including improvements to surgical practice and training, updating of clinical guidance and standards, raising awareness of post-operative problems amongst GPs and offering improved and swifter access to clinical expertise for women with post-operative problems.

(b) The quality and amount of data and information available to support informed decision making by patients and clinicians. This includes improving the reporting of adverse incidents and improving procedure coding in Hospital Episode Statistics so that a more complete picture of the level and seriousness of complications is established.

(c) The consent process so women are more aware of the pros and cons of the treatment option they have chosen or agreed to. For example through the provision of high quality standardised information for patients and a more consistent consent process.

The issue has recently been debated in Parliament. The debate was initiated by a combination of Emma Hardy (MP for Kingston upon Hull West and Hessle) and the 'Sling the Mesh' campaign set up by Kath Samson (one of the women affected by the procedure).

During the debate, Health Minister (Jackie Doyle-Price) stated the priority is to look into the treatment of women and the recording of complications. She announced that an update to national clinical guidelines by the National Institute for Health and Care Excellence (NICE) on the use of vaginal mesh will be brought forward and be published by the end of the year (18 months earlier than planned). During the debate she stated that *"From my perspective, the issue is not with the product but with clinical practice. That is what is going wrong. That is where we need to be much clearer, ensuring that women are treated properly by their clinicians, given proper advice and risk assessments, and given the opportunity to report any complications and the ability to complain and challenge. The Government also need to ensure that all clinicians have the most up-to-date and appropriate advice."*

If you want to see what reaction those comments received you can find the video online. Needless to say her decision was met with gasps from women listening to the debate in Parliament and shock from fellow MPs. Further, it appears that the Government has refused to hold a public inquiry into the use of vaginal mesh implants. This approach is put into some context when compared with that taken by the Scottish Health Secretary who wrote to health boards requesting the suspension of mesh devices in 2014.

So what next?

As a result of the debilitating effects experienced by thousands of women, mesh implants are now the subject of group action litigation across the world (including in the US and Australia). Media sources suggest that over 50,000 women are suing one manufacturer of the mesh, Johnson & Johnson. In September, Johnson & Johnson's Ethicon unit was ordered to pay a record $57 million in damages to a Pennsylvania woman who had undergone the procedure.

Many women in the UK are now either taking, or considering taking, legal action against: (a) NHS Trusts; and (b) the manufacturers of the mesh itself. Reports earlier this year suggested that damages payouts for women affected in the UK have already reached approximately £500,000. Solicitors firms representing affected women have said that compensation could *"run into the billions"*.

Moving forward, crucial questions are likely to focus on the following:

(a) First, whether the companies that manufacture the vaginal mesh responsibly brought this product onto the market. The clinical research, trialling and development into the long-term risks of this product will be fundamental to the understanding of this issue.

(b) Second, whether patients properly consented to an accurate representation of the risks involved in the procedure. To understand this question it is crucial to undertake a proper and full analysis of the materiality of the risks involved, the significance attributed to those risks by the patient and the decisions that particular patients would have made in any event.

(c) Finally, whether the mesh was implanted using substandard technique.

It is likely that Parliament will revisit this matter in the New Year once the updated NICE guidelines are published by the end of 2017. This is a serious issue. It appears to have now achieved proper recognition on a national level. However, it is the response to this issue by the government, NHS Trusts and manufacturers that those affected will be most concerned with. Only time will tell how this litigation develops. However, it is clear that the weight of the evidence against vaginal mesh implants and their surgical implementation is growing stronger as the more women that have experienced complications come forward.

ARTICLE BY

MARCUS COATES-WALKER
ST JOHN'S CHAMBERS

How to get the best from your medical expert in clinical negligence cases

JUSTIN VALENTINE
ST JOHN'S CHAMBERS

> *He was very free with his allegations of professional negligence against a number of doctors and surgeons, all of which have been shown to be without foundation. These allegations were based upon a superficial reading of the relevant notes and records and a totally inadequate appreciation of matters which were well-known to those who have up to date responsibility for the day to day care of spinal injuries but which were unknown to him...*[1]

An expert's *"overriding duty"* is, according to CPR 35.3, to the Court. This is a somewhat optimistic statement of the expert's duty. After all, in clinical negligence cases each party has their own breach of duty and causation experts whose evidence is being relied upon precisely to support the party's case. However, as the quotation above demonstrates failure to pay adequate attention to the logic of the expert's opinion, to the thoroughness of the analysis and to the qualifications of the expert will prove fatal to the case as well, possibly, to the expert's future flow of medico-legal work. Credibility is paramount.

Experts must be persuasive

In ***Morwenna Ganz v Dr Amanda Jillian Childs, Dr John Lloyd, Kingston Hospital NHS Trust*** [2011] EWHC 13 (QB), the Claimant, 14 at the time, alleged that the Defendants had been negligent in their treatment of her so that they were liable for permanent brain damage sustained through her developing mycoplasma pneumonia.

What is of interest in Foskett J's judgment is his focus not only on Professor Kirkham's expertise (the Claimant's neurological expert) but on her presentation as a witness. It is suggested that if an expert does not present as someone who could potentially be *"authoritative", "cautious", "thoughtful", "well-balanced"* and *"non-partisan"*, then they should not be instructed. Foskett J, in dealing with Professor Kirkham, stated:

> *197. I will deal with Professor Kirkham first. Her CV demonstrates that she is a highly qualified and highly distinguished paediatric neurologist who has been a Consultant for about 20 years with clinical experience at Great Ormond Street Hospital and Southampton General Hospital. She was a senior lecturer in Paediatric Neurology at the Institute of Child Health for approximately 16 years prior to her appointment as Professor of Paediatric Neurology at the Institute in October 2006. Her written contributions to medical literature, both in textbook form and article form, is very extensive and her particular research interest has been in the detection and prevention of brain damage in acutely sick children. Her recent Doctor of Medicine thesis at the University of Cambridge was entitled 'Cerebral Haemodynamics in Normal Subjects and Children in Coma'. She was eminently well-qualified to offer an opinion on relevant issues in this case.* ***So far as her presentation as a witness was concerned, I thought she was authoritative when she felt she could be, cautious when she felt she had to be and entirely thoughtful and well-balanced in her approach. She was, in my view, an extremely impressive witness upon whom I felt I could place reliance. I detected no basis for thinking that she was partisan or that she was attaching herself to some document or piece of information "because it suited her case" ...*** *[emphasis added].*

Consider, by way of further example ***Williams v Jervis*** [2008] EWHC 2346 QB where Roderick Evans J had this to say about Dr Gross, the Defendant's neurological expert:

> *119 ... In my judgment the criticisms made of him on behalf of the claimant are justified. Although Dr Gross has dealt with the claimant's case voluminously there are clear indications of a lack of thoroughness and a failure to spend adequate time in properly analysing the case. It may be that his heavy workload and high documentary output has prevented this. It is equally likely in my judgment that he approached the case with a set view of the claimant and looked at the claimant and her claimed symptomology through the prism of his own disbelief. From that unsatisfactory standpoint he unfortunately lost the focus of an expert witness and sought to argue a case. I am driven*

1 *Scott v Bloomsbury Health Authority [1990] 1 Med LR 214*

to the conclusion that I am unable to place reliance on Dr Gross's evidence in this case.

Williams v Jervis illustrates an all-too-common problem, that of producing reports of huge length often at high cost but without sufficient analysis. This is often achieved via typesetting means, ie large font, double spacing and wide margins. It is suggested that such an approach is indicative, albeit not determinative, of a reluctance to analyse.

Rather, what is required is a succinct report that summarises relevant material in a sophisticated way and reaches comprehensible and clear conclusions. Voluminous reports often bat off conclusions to a further report pending further investigation or review of further records. In such cases the experts themselves may lose the thread of the material.

Experts will be assisted by a comprehensive set of well-ordered and indexed medical records and should be referred to relevant entries. Specific issues which the expert should address should be raised in the letter of instruction albeit with the proviso that the expert need not limit themselves to those issues. Similarly, if there are issues which the expert should not address, eg breach of duty if that is admitted, then this should be made clear.

Clear analysis of the material is often demonstrated by an expert's willingness to include a summary of the key views at the commencement of the report. After all, if an expert demonstrates by such means an interest in communicating then that suggests an intention to analyse.

The key to a good report is that it must be persuasive, both to the parties and, if the case gets that far, to the judge. This requires close examination of the logic of the position held and condescension to and examination of the details of the case. Lawyers are adept at these skills and should assist the expert in the furtherance of this aim. As set out in the Protocol:

> *15.2 Experts should not be asked to, and should not, amend, expand or alter any parts of reports in a manner which distorts their true opinion, but may be invited to amend or expand reports to ensure accuracy, internal consistency, completeness and relevance to the issues and clarity. ...*

Being involved in this process will significantly enhance the ability to assess the opposing party's expert evidence and to put informed questions to the experts. What is required is a clear reasoning within the report, backed up, where appropriate, with reference to medical literature. Bald assertion is of little assistance.

Appropriate expertise

If an expert is to be credible then they must have appropriate expertise. In a recent case in which I was involved the central allegation was of negligent failure to undertaken initial hip replacement surgery after the Claimant had sustained a serious fracture to her leg rather than fixation of the fracture which fixation subsequently failed requiring revision hip replacement surgery. The expert stated that he had *"relevant"* experience when in fact he was a general orthopaedic surgeon with only minimal experience in hip surgery. This was clearly insufficient, the expert was swiftly and forcefully out-ranked and the case dropped.

Experts should be asked to specify exactly what experience they have. Assertions as to expertise should not be taken at face value but should be probed before instruction.

Caution should be exercised in relation to professional experts, ie experts who spend more time working as experts than in practice. Such experts may demonstrate less independence (since their income depends largely on medico-legal work) and will likely possess a less firm grasp on current practice; see, for example ***Melhuish v Mid-Glamorgan Health Authority*** [1999] MLC 00145 where the Claimant suffered amniotic fluid embolism in the womb just before birth resulting in hypoxia and acute brain damage. Thomas J assessed the medical experts (and preferred the defendants') as follows:

> *Although Professor Rubin [consultant physician] and Professor Halligan [consultant obstetrician and gynaecologist] were younger than Mr Clements [consultant obstetrician and gynaecologist] and Professor Rosen [consultant physician] and thus had less experience, I do not consider that that relative lack of experience in any way counted against them. Although Professor Rosen and Mr Clements had considerable medico-legal experience, Professor Rubin and Professor Halligan had the advantage of being at the front line of current medical practice and did not spend an undue amount of their time in medico-legal work. In contrast, Professor Rosen had retired and Mr Clements spent a considerable portion of his time away in risk management and medico-legal work. It was somewhat surprising that both Professor Rosen and Mr Clements had been ignorant of the seminal work of Professor Clark on AFE until their involvement in this case.*
>
> *I preferred the evidence of Professor Rubin and Professor Halligan to that of Mr Clements and Professor Rosen wherever it conflicted;*

Caution should also be exercised where an expert has retired from clinical practice or, if a case is likely to take a number of years to conclude, where the expert may retire in the interim and become unavailable. Consider, for example, ***Toth v Jarman*** [2006] EWCA Civ 1028, CA where the Defendant GP attended the Claimant's five year old son who had suffered a hypoglycaemic attack at home. Rather than administering an intravenous glucose injection immediately the Defendant sent him to hospital. The issue was one of causation and the nature of the respective experts' clinical experience proved pivotal:

> *In our view the judge was plainly entitled to prefer the evidence of Professor Hull [retired paediatric specialist] over that of Professor Marks [largely retired consultant and lecturer in clinical pathology], based on his experience and the substance of his evidence, as well as the manner in which he gave it. Despite his eminence as a clinician and an expert on hypoglycaemia, Professor Marks had limited experience and, as he accepted, little expertise in treating children and in particular any with glycogen storage disease, in contrast with the considerable experience of Professor Hull in treating children generally and some experience in caring for children with glycogen storage disease. Professor Marks conceded that he was rarely concerned with day to day management of patients but, when he was, he had treated adults rather than children and had in any event retired from clinical practice in 1995. His involvement in treating children had ceased 35 years previously and he had never had any day to day responsibility for the management of children such as Wilfred with GSD. He had only ever seen 3 or 4 cases of GSD (and then not as the treating doctor) and had no personal experience of the death of a child with GSD from hypoglycaemia. He conceded that he would not be competent to address the question of irreversible brain damage occurring in a 5 year old child in the absence of fitting. Professor Hull on the other hand, was an experienced paediatrician who had had consultants' responsibility for children with hypoglycaemia and with GSD. He did not accept that Professor Marks was an expert on treating children with hypoglycaemia, describing him as a distinguished chemical pathologist. Given that the experts were not of the same discipline, and given their differences in experiences and expertise, the judge was entitled to reach the conclusions he did in assessing their evidence.*

Citation of literature

The Oxford Centre for Evidence-Based Medicine provides a table setting out levels of evidence.[2] The highest level of evidence consists of systematic reviews ("SR") of randomised-control trials ("RCT") (an analysis of many separate RCTs), then come RCTs with narrow confidence intervals, followed by all or none studies,[3] then SR of cohort studies (which link risk factors with health outcomes), then individual cohort studies and so on.

The very lowest level of evidence of the 10 identified is that which the legal profession largely rely upon.

> *Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"*

Accordingly, any additional factor which an expert may contribute to their opinion will be of significant value. This may include:

(a) Citing peer-reviewed literature in support of the opinion reached. In this regard experts should be instructed to undertake literature searches on medical databases.

(b) Citing international, national or local guidelines as to the practice adopted and referring to their applicability within the relevant clinical setting.

(c) Appending literature and guidelines cited to the report or otherwise making them available; see CPR 35 PD 3.2(2). In ***Breeze v Ahmad*** [2005] EWCA Civ 223, the defendant's expert cited literature but did not provide it. On appeal, the claimant contended that the literature had been misinterpreted. The appeal was allowed.

Consider ***Nasir Hussain v (1)Bradford Teaching Hospital NHS Foundation Trust and (2) Doctor Keith Jepson*** [2011] EWHC 2914 (QB) in which the Claimant suffered Cauda Equina Syndrome ("CES") whilst a patient in the Bradford Royal Infirmary. The central question for Coulson J was the issue of causation. The judge attacked the Claimant's orthopaedic expert's credibility, his reasoning and his failure to review relevant literature:

> *66. Unhappily, for a number of reasons, I found Mr McLaren to be an unsatisfactory expert witness, and I could not conclude that his minority view should prevail over that of the majority.*

2 *http://www.cebm.net/oxford-centre-evidence-based-medicine-levels-evidence-march-2009/*

3 *For an explanation see http://www.bmj.com/rapid-response/2011/11/01/all-or-none-studies*

67. First, there was his unsatisfactory evidence relating to the Second Defendant (paragraph 22 above). Secondly, there was his (only) report of 12 November 2010, which I consider to be a superficial examination of the Claimant's claim which does not address, except in very general terms, the critical causation issue.

...

71. The third difficulty with Mr McLaren's evidence on this point was that, although there was a good deal of literature on the subject of CES, and a number of papers dealing with when surgery should be performed, Mr McLaren did not rely on any of that published material in his report. He only referred to it to dismiss the literature altogether. Although in his oral evidence he attempted to suggest that reference to those papers was implicit in his report, I do not accept that: he deliberately did not seek to rely on the literature in his report. Instead, he sought to rely on his own experience which, because it was both contradictory and undocumented, could not be the subject of meaningful research or comment by the defendant's experts. Neither the number (15 or 40), nor the precise condition of his former patients at the time of surgery, could possibly be verified by anyone else.

Publications may also be helpful in relation to whether your expert really is an expert. Inevitably, an expert who has published in the area will have greater authority in Court.

Expert evidence is pivotal in clinical negligence cases. Although lawyers are not experts in any field aside the law they do possess the key analytical skills necessary to assess expert evidence and can avoid, with reasonable diligence, the situation faced by ***Leggatt J in Hirtenstein and Another v Hill Dickinson LLP*** [2014] EWHC 2711 (Comm) (a commercial case):

Mr Chettleborough's valuation approach effectively involved putting the available information into a black box from which a figure emerged based entirely on his gut feel. The problem with a valuation pronounced ex cathedra in this way is that it is not capable of being tested or subjected to any rational scrutiny. It amounts to saying "trust me, I am an expert valuer". However, unless the expert is able to point to some objective evidence to demonstrate the reliability of his judgment – which Mr Chettleborough was not – it is not acceptable in the context of litigation to be asked to take an expert's opinion on trust. Experts' opinions, if they are to be accorded any weight, need to be supported by a transparent process of reasoning.

ARTICLE BY

JUSTIN VALENTINE
ST JOHN'S CHAMBERS

14 edition of the Judicial College Guidelines – what's changed?

BRUNO GILL
OLD SQUARE

Having had the 13th edition for 2 years, most of us have become very familiar with its contents. This year, the 14th edition has been published.

Although there are no sweeping changes, and the guidance is largely unchanged, there have been a few alterations which practitioners involved with medical accidents may wish to note.

A general increase in damages

All awards have been increased by almost 5%, rounded to the nearest £10, to reflect the general increase in RPI since the last edition.

Equal treatment for genders

One significant change, reflecting a continuing march towards equality, is that awards for facial injuries (chapter 9) and scarring to other body parts (chapter 10) will no longer differ according to gender. The old-fashioned view that a scar would be more injurious to a female than a male has been consigned to the dustbin. The level of award will be influenced by the subjective impact on the victim, including the extent to which they valued their appearance, not by assumptions based on gender.

This change has required a broadening of the bracket to take account of a wide range of views. It is anticipated that the brackets will narrow with time as more information on judicial decisions becomes available.

Further factors to be taken into consideration in cases of very severe brain damage

Under chapter 3(A)(a) – very severe brain damage, the level of award is to be affected by four new factors in addition to the previous three (which were (i) the degree of insight, (ii) life expectancy, and (iii) the extent of physical limitations). These new factors are (iv) the requirement for gastrostomy for feeding (v) sensory impairment, (vi) ability to communicate with or without assistive technology, and (vii) the extent of any behavioural problems.

The bracket explicitly now also covers cases of 'locked in' syndrome.

Advances in technology reducing pain and suffering

Another change one might spot are the brackets under chapter 1 (injuries resulting in death). Some brackets remain the same, subject to the generalised uplift (e.g. (D) and (E)), while the others have altered quite radically, for example (A) has gone from £17,550-£19,910 to £11,000-£20,880. It appears that this is to reflect advances in technologies and medicine which, on the one hand, can increase life-span but, on the other, are able to reduce pain and suffering, thereby lowering the sums awarded for PSLA.

Minor injuries – representatives taking the wrong approach

In respect of minor injuries, it has apparently been noted by District Judges that representatives often submit that the length of time of any symptoms is what matters when assessing damages. This, according to the Judicial College, is incorrect. It needs to be recognised that recovery is often not linear and can largely occur in the early days. Accordingly, those brackets dealing with soft tissue injuries (e.g. 7(A)(c) - neck, 7(B)(c) - back, 7(C)(d) –shoulder) now include a new factor which is 'the extent to which ongoing symptoms are of a minor nature only'. Three months of neck pain, therefore, would not permit an award at the top of bracket 7(A)(c)(iii) if the symptoms in months two and three are of a minor nature only.

The same logic applies to injuries under chapter 13.

Injuries to male reproductive system

Previously, the Guidelines just recognised a total loss of reproductive organs within chapter 6(E)(a). In the 14th edition, there is now a distinction between total loss and orchidectomy without loss of sexual function or impotence. Cases of orchidectomy, perhaps

understandably, attract a significantly smaller award than cases of total loss.

Sexual function a relevant factor for cases of paraplegia

The level of award for injuries resulting in paraplegia (2(b)) are now expressly to take into account impact on sexual function in addition to the previous factors.

More skin conditions now covered by chapter 12

Chapter 12, previously just dermatitis, now expressly also includes other skin conditions including (but presumably not limited to) eczema and psoriasis.

A new category of minor finger injuries

Within hand injuries, what used to be 'fracture of one finger' (t) has now become 'minor finger injuries' to cover not only fractures, but scarring, tenderness and reaction to cold where there is a full recovery. It may be the case that this bracket now becomes of more assistance in cases of negligent surgery to the finger/hand.

ARTICLE BY

BRUNO GILL
OLD SQUARE

continued on page 27

In the South Yorkshire Coroners Court Inquest touching the death of LH

ANDREW WILSON
PARK SQUARE CHAMBERS

LH was a 35 year old woman who was 37 weeks pregnant. She died in the early hours of the morning on 4th April 2016. The post mortem listed the cause of death as:

1A) Shock & Haemorrhage

1B) Perforated gastric ulcer

2) Codeine dependency and emergency caesarean hysterectomy

I was instructed by the family who had a number of concerns about the circumstances surrounding LH's death and the conclusions drawn by the Consultant Histopathologist who performed the autopsy.

LH had a history of codeine dependency and for that she had been prescribed methadone in 2011; the family had always disagreed with this prescription.

On 3rd April 2016, LH had been at a family member's house and had not complained of any pain or discomfort other than severe varicose veins. She collapsed at just before 7pm. An ambulance was called.

The first responder from Yorkshire Ambulance Service attended at 7pm. The ambulance arrived shortly afterwards.

LH had no pulse and she was shutting down. The paramedic was unable to find a vein; an attempt at intraosseous (bone marrow) access also failed because the paramedic chose the wrong needle. CPR was being given.

LH was transported to the ambulance. A further attempt to find venous access failed and intraosseous access could not be re-attempted because the equipment had been left at the house.

LH's mother was present; she had concerns with the manner in which the YAS conducted themselves.

YAS failed to place a pre-alert to the hospital. The effect of that was that the hospital did not know that LH was on her way. On arrival at the hospital, the emergency button needed to be pushed to call the A&E crew.

There were no surgeons present on arrival. There was therefore a delay between arrival at the hospital and the necessary emergency C-section. The baby did not survive that operation.

As soon as LH was opened up, it became obvious that she was bleeding significantly from her stomach cavity; 2-3 litres of blood were present. The cause and source of the bleeding were not obvious; preliminary thoughts were that it was coming from the uterus. The massive haemorrhage protocol was instigated. LH had been asytolic since she was found with only a brief period of cardiac output. At 8:16pm, the decision was made to cease resuscitation; the source of the bleeding had still not been found.

LH then spontaneously had a cardiac output.

At 9:00pm LH was transferred to the operating theatre. The surgical team re-commenced treatment. A splenectomy was performed and the cause of the bleeding was still unknown. A hysterectomy was performed but the cause of the bleeding was still unknown.

The abdominal bleeding could not be controlled surgically.

By 11:00pm, LH had been given 16 units of blood and 4 units of plasma. She received a further 14 units of blood, 6 units of platelets, 4 units of fresh frozen plasma and other substances to support the circulatory system before her death. This was a massive amount.

Treatment ceased at 3:30 am on 4th April and LH dies at 4:30 am.

Overall, the general presentation of this case was of a massive, uncontrollable bleed in the abdominal cavity.

Called to give evidence Dr Richmond, Consultant Histopthologist, Dr Morely, Forensic Toxicologist, Dr Almeda General Practitioner, Matt Pollard, Substance Misuse Service, Dr Rutter, Consultant Obstetrician and Gynaecologist Mr Loftfallah, Consultant Obstetrician and Gynaecologist, Mr Went, Consultant Haematologist, Dr Hartog, Consultant Anaesthetist, members of LH's family, the first responder and the paramedics.

Families' concerns:

1) The cause of death being linked to codeine dependency;
2) Was the ulcer caused by use of codeine;
3) Why was LH prescribed Methadone and could the methadone have masked initial symptoms?

4) Did members of YAS jump to conclusions about LH, considering the methadone prescription? Did they act differently as a result?
5) Were the actions of the paramedics appropriate?
6) Did the fact that the intraosseous equipment was left behind effect LH's chances?
7) Did the fact that the pre-alert was not given affect LH's chances?
8) Why was the source of the bleed not found?

The inquest occurred over two days.

The staff from the YAS was called first. Notwithstanding the family's concerns the overwhelming evidence was that the treatment given at the scene was as would be expected. LH was in a terrible situation by the time that YAS staff attended; there was some evidence that the staff had panicked slightly. This was unsurprising considering the readings that they were seeing.

The pre- alert should have been given. It was not. There was a systemic failure. This was to be reviewed.

There were 2 outstanding concerns:

1. Whether the lack of intraosseous access was causative of death;
2. Whether the lack of pre-alert (and therefore the hospital not being ready) was causative of death.

The Consultant Histopathologist confirmed in evidence that in actual fact, he had no real evidence to link the codeine dependency to the ulcer. It is known that non-steroidal anti inflammatories can cause stomach ulcers; codeine on its own does not.

The evidence from LH's family is that she did not take NSAI and codeine mix. Only prescribed codeine which she would obtain alternatively and not regularly.

The dependency was effectively ruled out as contributing.

The coroner had allowed LH's GP to be called. She has prescribed the methadone to LH in order to treat her codeine addiction a number of years before. Dr Almeda's evidence revealed that the prescription was provided without a face to face meeting and without any reliable information as to the extent of LH's addiction. LH had attempted to come off the methadone on a number of occasions but struggled with addiction to it. She always used it at safe levels when pregnant.

The evidence from Dr Rutter and Dr Hartog was convincing and reliable. Following questions, it became clear that LH had likely suffered a massive haemorrhage before the ambulance arrived. That there would have been a drastic lack of oxygenation to major organs and that brain damage would have begun to occur within 2- 5 minutes. It was also clear that a woman in late stage pregnancy who suffered such a haemorrhage would require an emergency C-section within 2 minutes of suffering it to provide any realistic chance of survival. This had not been clear in the written evidence.

Verdict

Codeine dependency and emergency C-section were removed as causes of death.

Cause of death: Shock and haemorrhage as a result of the perforated ulcer.

The Coroner came to some conclusions:

1. Drugs played no part in LH's death or ulcer development;
2. Medical mismanagement played no part in LH's death;
3. The failure to pre alert played no part in LH's death;
4. Ulcer development is rare but a well recognised complication of pregnancy. On balance that was the reason.

The coroner ordered 2 Regulation 28 reports in relation to prevention of future deaths. She set out to the recipients, the nature of her concerns.

1. The first: Dinnington Group practice. The coroner had concerns about the procedures in place when the methadone was prescribed and more concerned that those procedures had not changed. LH was prescribed a 7 day course of methadone without being seen by the GP and without ever having been on it before.
2. Second YAS regarding the pre alert system. The evidence was that there had never been a failure of the pre-alert system. However, the witness from YAS who had responsibility for checking that such systems worked had inly found out about its failure in the days before the inquest. Not at the time. There was an absence of an audit system to track whether they were being made at all.

ARTICLE BY

ANDREW WILSON
PARK SQUARE CHAMBERS

Inquest touching the death of Mrs X

ALEX WILLIAMS
EXCHANGE CHAMBERS

EXCHANGE CHAMBERS

Earlier this year in the Manchester town hall, the area coroner, Mrs Fiona Borrill, concluded the inquest touching upon the death of Mrs X, who died on 15th January 2016 when she was aged 64 years. AvMA instructed Alex G. Williams of Exchange Chambers to represent the family.

In November 2015, Mrs X began to complain of painful haemorrhoids and consulted her general practitioner. Initial treatment appeared to be successful but in December she had to attend Salford Royal Infirmary due to the intense pain. In January 2016, Mrs X was seen at the Trafford General Hospital, following a referral by her general practitioner, where examination identified a possible malignancy whereupon she was admitted to Manchester Royal Infirmary. On arrival, Mrs X was referred for an urgent CT investigation, which revealed marked colonic thickening and a colonoscopy was recommended. By this stage, Mrs X had been suffering with pain for almost 2 months. Treatment had not resolved Mrs X's condition and in that same period, she had lost 1½ stone in weight.

In the early hours of 15th January 2016, Mrs X deteriorated rapidly and unusually. Her early warning score fluctuated, she was described as being more unwell and her peripheries were cooler, which suggested a septic process. Antibiotics and fluids were administered and her clinical position did improve. When the surgical trainee saw Mrs X at 6.20am, he was surprised by the observations, given that Mrs X advised him that the pain had improved. He suspected some ongoing internal abdominal pathology and decided to involve the intensive care unit. The consultant colorectal surgeon on call attended and found the large bowel necrotic with multiple perforations and faecal peritonitis. She elected to call a consultant gynaecologist and vascular consultant to assist with the surgery. The large bowel, fallopian tubes, ovaries and uterus were removed. The consultant colorectal surgeon was surprised at how rapidly Mrs X's condition had deteriorated since having the CT scan and suspected that either a significant embolic event had occurred or that there was an overwhelming systemic inflammatory response to sepsis. Mrs X's small bowel was left inside and, in accordance with usual practice, the intention was that she would be brought back the following day when more definitive surgery would occur. Mrs X was taken to intensive care after the operation and despite steps being taken, Mrs X developed multi-organ failure and sadly died at 10.20pm on the same day.

The family had a number of concerns, including the management that had been undertaken, however; an independent expert instructed by the coroner made no criticisms. There were equally other non-causative areas of concern raised by the family. The patient track system, which records and evaluates patients' vital signs, appears not to have been working on one occasion and repeat observations were not always uploaded onto the system. The family was also concerned at the apparent lack of observations, including hydration levels and the absence of any meaningful clinical review the day before Mrs X died. The trust indicated that their policies were due to be reviewed shortly and agreed that the information elicited at the inquest would be taken into account and the amended policies forwarded to the coroner for her consideration. To date, this does not appear to have happened and we are continuing to follow up with the coroner's office.

ARTICLE BY

ALEX WILLIAMS
EXCHANGE CHAMBERS

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 Panel Meeting

1 December 2017, 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. This year's meeting will take place on the afternoon of Friday 1st December - registration and a networking lunch will commence at 12.30, with the meeting starting at 13.30 and closing at approximately 17.00, prior to AvMA's 35th Anniversary Gala Celebration at the same venue that evening.

35 YEARS avma action against medical accidents

AvMA 35th Anniversary Gala Celebration

1 December 2017 (evening), Grand Connaught Rooms, London

Booking now open!

Join us on the evening of Friday 1 December 2017 to celebrate AvMA's 35th anniversary and to mark the progress that has been made in patient safety and justice since AvMA was formed in 1982.

The evening will be one of celebration, with a drinks reception followed by a fantastic three course meal with wine, live entertainment, dancing and some special surprises!

It will be the perfect event to entertain clients / contacts or reward staff, on an evening that will bring together the key people from the patient safety and medico-legal worlds. AvMA's Specialist Clinical Negligence Panel Meeting will take place that afternoon at the same venue - the Grand Connaught Rooms - a short walk from Covent Garden and Holborn underground stations.

Make sure you're there on AvMA's big night! It promises to be the most memorable of occasions and we look forward to seeing you there.

Experts and Lawyers - Effective Team Working: Legal Instructions and Report Writing

Evening of 24 January 2018, Exchange Chambers, Liverpool

Lawyers and experts are on the same team – lawyers need to learn to instruct properly; experts need to report in a focused and timely manner. By training lawyers and experts together we can provide both essential learning and an important opportunity to network together and discuss issues and concerns.

Under the Fixed Recoverable Costs proposals there could be changes to the way in which experts prepare reports, including a capping of experts fees at about £1,200 for ALL reports! Preparing the best report possible on a budget will be an essential skill. Solicitors will have to help experts achieve this, the quality of the lawyers instructions to the expert will be more important than ever, you need to be able to identify how to strip down the medical notes to make sure the expert has the minimum amount of documentation which is of maximum importance, every page of the enclosures will need to be relevant, this will be a new skill for many solicitors.

This seminar is the first expert and solicitor training event in what we plan to be a series of nationwide events, and will focus on Legal Instructions, Report Writing and the importance of working together. This is intended to be an interactive session where the views of lawyers and experts are encouraged and welcomed. Booking now open – the fee to attend is just £75 + VAT for AvMA Lawyers' Service members and Medical Experts.

Clinical Negligence: Law Practice and Procedure

25-26 January 2018, Anthony Collins Solicitors, Birmingham

This is the course for those who are new to the specialist field of clinical negligence. The event is especially suitable for trainee and newly qualified solicitors, paralegals, legal executives and medico-legal advisors, and will provide the fundamental knowledge necessary to develop a career in clinical negligence.

Expert speakers with a wealth of experience will cover all stages of the investigative and litigation process relating to clinical negligence claims from the claimants' perspective. Places are limited to ensure a focused working group. Booking opens in November.

Medico-Legal Issues in Neurosurgery and Neurological Disease

28 February 2018, 7 Bedford Row, London

Leading experts will highlight the medico-legal issues surrounding cranial surgery, stroke medicine, spinal surgery, neuroradiology and issues arising in neuro-intensive care. Quantum in neurosurgery and neurological disease will also be covered. This conference is for clinical negligence solicitors and barristers at all levels, as well as healthcare professionals involved in clinical governance and patient safety. The programme will be available and booking will open in December.

Cerebral Palsy and Brain Injury Cases

8 March 2018, Doubletree by Hilton Bristol

This popular AvMA conference returns to Bristol on 8th March and will discuss and analyse the key areas currently under the spotlight in Cerebral Palsy and Brain Injury Cases so that lawyers are aware of the challenges required to best represent their clients. Determining causation, neonatal risk factors and intrapartum fetal distress and surveillance focusing on CTGs will be covered by leading medical experts. Guidance will also be provided on alternative and augmentative communication and assistive technology for children with brain damage, as well as looking at case management, tactical budgeting and the current issues in CP and brain injury claims. The programme will be available and booking will open in December.

Medico-Legal Issues in Oncology

22 March 2018, Slater & Gordon, Manchester

This vital course will provide in-depth knowledge and understanding of Oncology in a medico-legal context relevant to your case load. The day will feature presentations from leading experts on medical treatment of breast tumours; abdominal tumours focusing on cancer of the colon; breast surgery; gynaecological surgery; and an orthopaedic persepctive on oncology. A barrister will also examine causation issues arising in cancer claims. The programme will be available and booking will open in December.

AvMA Annual Charity Golf Day

28 June 2018, Singing Hills Golf Course, West Sussex

The fourteenth AvMA Charity Golf Day will take place on Thursday 28 June 2018 at a new course – the beautiful Singing Hills Golf Course in Albourne, West Sussex (www.singinghillsgolfcourse.co.uk), set in an area of outstanding natural beauty with the South Downs as the backdrop. The Welcome Event for the Annual Clinical Negligence Conference will take place later that evening at the Hilton Brighton Metropole (25 minutes' drive away), so the Golf Day offers the perfect start to the essential event for clinical negligence specialists.

We will be playing Stableford Rules in teams of four and you are invited to either enter your own team or we will be happy to form a team for you with other individuals. The cost is only £98 + VAT per golfer, which includes breakfast rolls on arrival, 18 holes of golf and a buffet and prize-giving at the end of the day. All profits go directly to AvMA's charitable work. Booking will open in early 2018.

30th Annual Clinical Negligence Conference

29-30 June 2018, Hilton Brighton Metropole

Join us in Brighton for the 30th ACNC! The Annual Clinical Negligence Conference (ACNC) is the event that brings the clinical negligence community together to learn and discuss the latest developments, policies and strategies in clinical negligence and medical law.

As ever, it will be an event not to be missed, with the usual high standard of plenary presentations and focused breakout sessions that you would expect from this event, ensuring that you stay up to date with all the key issues. As well as providing you with a top quality, thought provoking, learning and networking experience, the success of the conference helps AvMA to maintain its position as an essential force in promoting justice.

The programme will be available and booking will open in February.

Sponsorship and exhibition opportunities at ACNC2018

The unique environment of the ACNC offers companies the ideal opportunity to focus their marketing activity by gaining exposure and access to a highly targeted group of delegates and experts. Contact us for further details on the exciting opportunities available to promote your organisation at ACNC2018.

Details of further events for 2018 available soon.

Tel: **0203 096 1140**
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The webinars can be watched at a time convenient to you. On average they last approximately 60 minutes and can be accessed on any device with an internet connection. You can watch the video as many times as you want.

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Coming soon!

- **The New NHS – Where Responsibility Lies**
  available from 27 November 2017
- **The Duty to Disclose in Clinical Negligence**
  available from 16 December 2017
- **Consent in Clinical Negligence**
  available from 8 January 2018
- **Medico-Legal Issues in Critical Limb Ischemi**
  available from 5 February 2018
- **Dentistry: Medico-Legal Issues**
  available from 5 March 2018

Current webinar titles include:

- **Medico-Legal Issues in Obstetric Emergencies**
  preview
- **Cerebral Palsy – Understanding Your Clients' Needs**
  preview
- **How to Became a Panel Member**
  preview
- **Medico-Legal Issues in Orthopaedics: a Paediatric Focus**
  preview
- **Medico-Legal Issues in Pain Management**
  preview
- **Medico-Legal Issues in Diabetes**
  preview
- **Medico-legal issues in meningitis and septicaemia**
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