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Lawyers Service Newsletter

JUNE 2023

Contents

Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

I start by drawing attention to a recent statutory instrument (SI) laid before parliament on 24th May 2023, ***"The Civil Procedure (Amendment No.2) Rules 2023"***. The Rules are due to come into force on 1st October 2023. Amongst other things, it ushers in a new intermediate track, doing away with the proposal to extend the fast track and also unexpectedly, Rule 26 (10) (b) which says *"...a claim must be allocated to the multi-track where that claim is - ... (b) one which includes a claim for clinical negligence, unless ...(ii) both breach of duty and causation have been admitted"*

You will recall that the original MoJ consultation on FRC in civil claims up to £100,000 published in June 2019, said *"clinical negligence cases are generally excluded from the FRC proposals made in this consultation"*. In the response to the consultation (page 73, para 12.4) there was further reassurance in that *"The Government can confirm that the following categories of case will be excluded, categories, from the expanded fast track at this stage: i. Mesothelioma and other asbestos related claims; ii. Clinical negligence cases"*

The SI explanatory note which is not part of the rules says the intention is to extend the application of FRC to most civil proceedings allocated to fast and intermediate tracks. Any claim which *"must"* be allocated to the multi-track is not subject to fixed costs, so it appears that only clinical negligence claims where there is an admission of breach and causation will be assigned to the intermediate track and subject to FRC.

The SI does not contain any detail as to whether the application of fixed costs in eligible clinical negligence cases is intended to be retrospective. Will the work done to secure the admission of liability fall to be costed under a FRC regime, or will the costs be assessed on the usual standard basis? Clarification is being sought. We should also remember that Jackson LJ original proposal was for a FRC regime to be in place for claims up to £250,000.

Apart from updating you generally, the purpose of highlighting this recent development is to draw practitioners' attention to how quickly and easily things can change. While we have been focused on waiting for the government's response to the consultation on FRC in low value Clinical

negligence claims valued up to £25,000, we now find that clinical negligence claims valued at £25,000 - £100,000 will be allocated to the intermediate track if there is an admission of liability.

The Health and Social Care Committee are calling for a no-fault compensation scheme to replace clinical negligence litigation, variations of this scheme have been explored previously in the form of the Rapid Resolution & Redress scheme (RRR). In the **last LS Newsletter** we looked at the government's failure to address the corresponding increase in the cost of social care which must accompany a no fault system. We invited you to contribute to the cost of commissioning an independent expert, Professor Rockey (an academic) to provide an independent report on what the increased cost of social care are likely to be were such a scheme to be introduced.

We thank those firms and individuals who have offered to contribute so far but generally practitioners have been slow to respond either to ourselves or SCIL who are also appealing for donations for the same cause. There is some way to go before we meet our target figure of **£40,000** to cover the cost of these important reports. It will take time for Professor Rockey to research and to report back. We are refreshing the appeal for contributions - please contact Norika by email (**norika@avma.org.uk**) with details of your name, your firm's name and the amount you wish to pledge, please head the email along the lines of ***DONATIONS: Social Care report***. Donations will be paid into SCIL's bank account, Norika will then respond with the details.

CNZ v (1) Royal Bath Hospitals NHS Foundation Trust (2) Secretary of State for Health and Social Care is a case which considers how retrospective *Montgomery* consent should be – *Montgomery* was decided by the Supreme Court in 2015. It also examines causation and material contribution and how the court should approach divisible and indivisible injuries, our thanks to **Marcus Coates-Walker** of 1 Crown Office Row for his succinct summary of the key points in this case.

Staying with the topic of causation, **May Martin** barrister at Parklane Plowden has looked at the case of *Jenkinson v Hertfordshire County Council* [2023] EWHC 872 (KB) in her article ***"Breaking the Chain of causation: no "special rule" for negligent medical treatment"*** and clarifies whether an intervening act, such as negligent medical treatment breaks the chain of causation for the original (non NHS) tortfeasor.

There is a great deal more the NHS needs to do to learn from litigation however the Getting it Right First Time (GIRFT) initiative does appear to have got off to a strong start. The GIRFT strategy in orthopaedics starts by identifying three key factors that give rise to variation in litigation costs, those are noted to be (i) clinical performance of the department involved (ii) performance of the legal or claims handling team and (iii) how well a trust's governance structure allows learning from claims to be shared with front line staff to improve patient care.

GIRFT has recently published a new national pathway for the management and treatment of suspected Cauda Equina syndrome (CES). **Justin Valentine** is a regular and very welcome contributor to the LS Newsletter, a specialist clinical negligence barrister with a special interest in CES cases, he practises out of St John's Chambers, Bristol. Justin has contributed to the GIRFT national pathway for CES which he looks at more closely in ***"New Pathway for Suspected Cauda Equina Syndrome"***. In the article Justin draws attention to when early symptoms such as sciatica require an urgent as opposed to an emergency referral; provision of MRI scanning; when surgery should be considered urgent and concludes that it is likely that deviation from this pathway unless justified will constitute a breach of duty.

Finally, **Tara O'Halloran** of Old Square Chambers considers ***"Are defendants entitled to medically examine claimants prior to pleading a defence?"*** with specific reference to the recent case of *Read v Dorset County Hospital NHS Foundation Trust, University Hospital Southampton NHS Foundation Trust* [2023] EWHC 367 (KB).

We hope you enjoy this edition of the LS Newsletter the next edition is planned for November, we do encourage you to submit titles for publication. The Newsletter is a great way of sharing tips on practice and procedure, your experience of litigated cases and examining the implications of recent case law as they apply to clinical negligence claims. On behalf of AvMA we wish you all a good summer with plenty of sunshine!

Best wishes

CNZ V (1) ROYAL BATH HOSPITALS NHS FOUNDATION TRUST & (2) SECRETARY OF STATE FOR HEALTH & SOCIAL CARE

MARCUS COATES-WALKER
1 CROWN OFFICE ROW

Background

In January 2023, Mr Justice Ritchie handed down an important decision dealing with *Montgomery* and causation in birth injury claims.

The relevant findings of fact:

a. The Claimant was born in a very poor state at 01.03 on 3 February 1996. She was a twin and her sister was born about an hour before her.

b. She had suffered acute profound hypoxic ischaemia (PHI) for between 14 and 18 minutes duration (mid point 16 minutes). 3 minutes of that PHI occurred after her birth until she was resuscitated at around 01.06. The acute PHI caused the Claimant's cerebral palsy.

c. Fetal bradycardia was occurring from around 00.50 (the mid point of 00.48 to 00.52).

The Claimant's case:Her mother requested caesarean section (CS), but her requests were refused or delayed. In addition, her mother was never offered elective caesarean section (ECS) despite it being a reasonable treatment option. When the hospital finally decided to deliver the Claimant by CS, the operation was carried out negligently late. That caused or materially contributed to the development of her acute PHI.

The Defendants' case: In 1996, ECS was not a reasonable treatment option to offer during the antenatal period. Therefore, it was not offered. Offering and advising normal vaginal delivery was the correct practice and the Claimant's mother did not request caesarean section antenatally. There was no negligence during the labour and the parents' requests for CS were granted in a timely way.

Issues

***Montgomery* - The antenatal period**

Given the Claimant's mother's obstetric history, she argued that she did not want either artificial rupture of membranes (ARM) or an epidural. Her case was that she had been refused an ECS in the antenatal clinic. This allegation was defended on the basis that: (a) no such request had been made; and (b) in 1996 the standard management for twins where there had been previous vaginal delivery and no concerns about fetal position was vaginal delivery (NVD). Therefore, it was argued that ECS was not a *'reasonable alternative treatment'*.

The judge queried how far back Montgomery actually applied. Acknowledging that this judgment was based on changing societal attitudes to consent which were premised on greater personal autonomy and access to information (particularly from the internet), he found that it applied as far back as 1996. However, he questioned whether it applied much earlier than about 1993. Ultimately, the judge found that the antenatal consent process was reasonable and lawful for medical practice in 1996. He found that CS was discussed with the parents and they agreed to NVD with IOL and as little intervention as possible. Therefore, the claim failed in this regard.

The delivery of the Claimant

In summary, it was found that:

a. The crucial period relevant to the allegations was between 00.25 and 01.03 (a period of 38 minutes).

b. There was a negligent delay of 6.5 minutes in delivering the Claimant.

c. At 00.25 / 00.26, there was a negligent failure to discuss the necessary reasonable treatment options (including CS and ARM) and the associated risks and benefits with the parents. In short, *Montgomery* applied even in circumstances where the need for treatment was imminent and time was of the essence.

d. At 00.35, a further discussion took place and there were similar failures. It was found that the parents had made a clear choice for CS but this was ignored. There was a failure to act on their decision and to act urgently in taking the Claimant's mother to theatre. The clinician was criticised for taking it *'slowly'*.

e. It was held that the total negligent delay was between 5 and 8 minutes (mid point of 6.5 minutes). The Claimant should have been delivered by 00.55 to 00.58. This would have been within the non-damaging 10 minute period of PHI.

This application of *Montgomery* in the context of an imminent delivery rather than antenatally is different to how previous Courts have dealt with this issue (see *ML v Guy's* [2012] EWHC 2010). Mr Justice Ritchie explained that the difference in this case was that the Claimant's father was in the delivery room at 00.26 and able to speak for the Claimant's mother and they both chose CS which they had made clear. Whether *Montgomery* applies in the context of an imminent birth where a mother gives birth alone in the absence of a birthing partner is therefore unclear.

Causation

In summary, it was found that:

a. On the balance of probabilities, the duration of the acute PHI was 14 to 18 minutes (midpoint 16 minutes). The Claimant was suffering bradycardia during those 16 minutes which is likely to have started between 00.48 to 00.52 (midpoint 00.50).

b. The agreed expert evidence was that the first 10 minutes of acute PHI are not generally damaging. However, the minutes thereafter (minutes 10 to 16 in this case) cause increasing or incremental brain damage. Therefore, it was held that there were around 6 minutes of damaging PHI.

c. Had the 6.5 minutes of negligent delay not occurred, the Claimant would have been born at 00.56 / 00.57 by CS. This would have been within the non-damaging 10 minute window.

d. Therefore, on the findings of fact, *all of the Claimant's brain injury* was caused by the negligence and 'but for' causation was satisfied.

However, at the extreme ends of the range of the factual findings, earlier delivery would have avoided some but not all of the damage. It was here that the judge was troubled most. He conducted a detailed analysis of the authorities concerning *'but for'* causation and material contribution.

The judge held that, in the context of acute profound hypoxic ischaemia, every minute counts. On the basis that there is no linear relationship between minutes of acute PHI and functional outcome, the judge found that medical science was unable to identify with generality, accuracy or detail the functional effect of each minute of brain cell deaths. It was scientifically impossible. Therefore, the Claimant was entitled to recover 100% of the damage caused by the PHI on the basis of the material contribution test.

In doing so, the judge rejected the *'Aliquot theory'* advanced by Dr Lewis Rosenbloom on behalf of the Defendant. In short, Dr Rosenbloom argued that the likely functional outcome caused by acute PHI could be broken down into 5 minute blocks of time (or aliquots). In that way, a Court could assess the level of disability that the Claimant would have had in any event. The judge rejected this theory, partly because there was insufficient evidence to support the proposed distinctions.

However, he considered that, if fairness was the only test, the Court should apportion quantum so that a Defendant is only liable for the brain damage which it caused and not that which would have occurred in any event. He suggested that a fair way to apportion damages would be by way of a percentage based on the relative durations of the PHI caused by the negligent delay compared to the PHI which would have been suffered in any event.

In exploring whether an apportionment was possible in this case, the judge conducted a detailed analysis of how a Court should approach *'indivisible'* vs *'divisible'* injuries. He drew a distinction between: (a) *'trigger'* injuries which can properly be considered *'indivisible'*; and (b) injuries that are *'dose related'* and therefore divisible:

Whilst the judge was clearly attracted to the fairness of an apportionment of quantum based on a percentage tied to the relative duration of acute PHI, he ultimately summarised his analysis of the law as follows:

> *In law I consider that the cases I have reviewed above show that if there is a scientific gap making proof of causation of functional outcome, therefore also quantification, impossible in contra-distinction to merely difficult, then the Claimant will recover 100% of the damage she has suffered due to the acute PHI so long as the Claimant can prove that the breach made a material contribution to the reduced functional outcome which was more than de-minimis.*

However, in cases involving divisible ('*dose related*') injuries where the evidence allows the functional outcome to be attributed in percentage proportions to the negligent and non-negligent causes, the judge's clear view was that there should be an apportionment.

Material contribution is an ever-developing area of clinical negligence work. However, the question of when an apportionment should and should not be applied may well be the next hotly contested chapter in its evolution.

Breaking the chain of causation: no 'special rule' for negligent medical treatment

MAY MARTIN
PARKLANE PLOWDEN

Parklane Plowden

In *Jenkinson v Hertfordshire County Council* [2023] EWHC 872 (KB), the High Court provided guidance as to when negligent medical treatment will break the chain of causation between an earlier tortfeasor and the damage suffered by the Claimant. To sum up the case in a nutshell, the High Court clarified that negligent medical treatment is to be treated exactly the same as any other potential intervening act. There is no special rule (as was previously thought) that the treatment had to be *'so grossly negligent as to be a completely inappropriate response to the injury'* before it would break the chain of causation.

The Facts

The Claimant suffered a bad ankle fracture when his foot entered an uncovered manhole. He brought a claim against the Council, who admitted breach of duty but disputed causation and quantum.

Due to the fracture, the Claimant underwent surgery on his ankle. The surgery was not successful, and the Claimant had to undergo six further surgeries. He was left with a poor prognosis for his ankle, with significant problems in working and carrying out his hobbies.

The Council obtained a report from an orthopaedic expert which expressed the view that the initial surgery performed on the Claimant had been carried out negligently. The report identified a number of failures in relation to the surgical procedure. Had the surgery been carried out properly, the orthopaedic expert gave the view that the Claimant would have been able to return to work 3-6 months after the accident and have minimal restriction in his everyday life.

Following receipt of this orthopaedic report, the Council applied to amend its defence in terms that placed responsibility for the Claimant's injuries with the NHS Trust who had carried out the allegedly negligent operation. The Council's position was that the medical treatment had broken the chain of causation between its tort, and the damage suffered by the Claimant. The Council sought to add the NHS Trust to the claim.

That application was opposed by the Claimant, and subsequently refused by District Judge Vernon. It was that refusal that was appealed by the Defendant.

District Judge Vernon refused to grant permission to amend because he directed himself that *'in cases where alleged negligent medical treatment is given to address injuries sustained as a result of an earlier tort, **only medical treatment so grossly negligent as to be a completely inappropriate response to the injury inflicted by the defendant** should operate to break the chain of causation'*, citing the case of *Webb v Barclays Bank and Portsmouth Hospitals NHS Trust* [2001] EWCA Civ 1141.

Webb was a case that concerned a woman who had tripped on a paving slab, causing her to hyperextend her knee. When receiving treatment for her injury, she was advised by her consultant that an above-knee amputation should be carried out. It was accepted that that was negligent advice and that amputation should only have been a last resort. The Court of Appeal had to determine whether that negligent advice and treatment broke the chain of causation and so absolved the original Defendant of liability. It held that it did not. In reaching that decision, it expressly considered a range of factors, one of which was that the doctor's conduct was negligent but not grossly negligent. It was that reference that seemingly led District Judge Vernon to direct himself that there was a special rule of law applicable to negligent medical treatment in the context of breaking the causal chain.

The High Court in *Jenkinson* reviewed the decision in *Webb* and identified the error in District Judge Vernon's direction. The High Court stated that there was no such special rule that required intervening medical treatment to be so grossly negligent before the chain of causation could be broken. The High Court noted that there was no logical justification for such a rule, and that the rule would be a recipe for litigation over the side-issue of determining if the treatment was sufficiently negligent as to amount to a *'completely inappropriate response'* to the injury.

The High Court therefore granted the Defendant permission to amend its claim and add the NHS Trust into the proceedings.

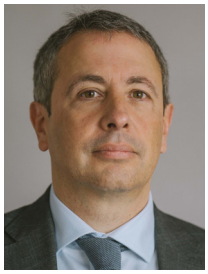
Comment

The High Court decision must be correct. The issue of whether or not an intervening act has broken the chain of causation is one which requires consideration of a multitude of factors. The court has to make an assessment as to whether or not the ultimate damage is damage for which the original tortfeasor should be responsible. It is not a question for which bright-line rules of law are suitable, nor is there any apparent reason why intervening acts performed in the context of medical treatment should form a special category of their own.

The decision should not be seen, however, as making it easier for Defendants to shift responsibility for injuries suffered as a result of their breach of duty onto the NHS. It is unlikely to result in a wholesale change in approach from Defendants. *Jenkinson* is not authority for the proposition that a finding of negligent medical treatment will limit the Defendant's liability to damage suffered up until the negligent treatment. The High Court held only that the Council's causation argument had a real prospect of success; it did not go further than that. The striking facts of *Webb* illustrate the challenges that tortfeasors will have to overcome in order to successfully run an intervening act defence in respect of negligent medical treatment.

New Pathway for Suspected Cauda Equina Syndrome

JUSTIN VALENTINE
ST JOHN'S CHAMBERS



St John's CHAMBERS

In a major development for the management and treatment of suspected Cauda Equina Syndrome ("CES"), Getting it Right First Time ("GIRFT") has published a new national pathway; **Spinal Surgery: National Suspected Cauda Equina Syndrome (CES) Pathway**.

In this article, Justin Valentine, who has a speciality in CES cases and is listed as a contributor to the pathway, reviews and analyses the recommendations from a legal perspective. He provided a brief legal analysis of the pathway in an NHS England webinar which was held on 2nd March 2023.

Cauda equina syndrome ("*CES*") is a serious neurological condition which can result in life-changing injuries. The cauda equina is a bundle of nerves at the end of the spinal cord. These nerves provide motor and sensory function to the legs, the bladder and the bowel. CES can be caused by trauma, infection or tumour. However, the chief cause is degenerative disc herniation causing compression of the cauda equina and this is the focus of the pathway. CES requires prompt surgical decompression because if the compression is not relieved swiftly permanent disability may result, in particularly paralysis and permanent loss of bowel, bladder and sexual function. According to "**Spinal Surgery: National Suspected Cauda Equina Syndrome (CES) Pathway**" ("*the Pathway*") published in February 2023, 23% of litigated claims for spinal surgery in England relate to CES.

There is a variation in response by practitioners and by trusts to suspected CES both in relation to what signs and symptoms should trigger investigation and as to the urgency of that investigation. This makes the field prone to differing opinions by expert neurosurgeons, spinal surgeons and general practitioners (to whom many patients initially present) and, accordingly, susceptible to litigation where there is an adverse outcome.

The Pathway provides a national framework for the diagnosis and treatment of suspected CES with the aim to diminish unwarranted variation in treatment, improve outcomes and reduce litigation.

One area particularly prone to dispute is the urgency with which patients with bilateral sciatica should be referred. According to *"GP Notebook"*, used in many GP practices, evidence of bilateral nerve root involvement (typically sciatica) requires immediate (or emergency) referral. However, this is disputed by many practitioners and the NICE guidance only added bilateral symptoms as indicative of impending nerve damage (CES) in 2018.

The **Management page of the NICE guidance** in relation to sciatica, suggests emergency referral, ie immediate, to a spinal surgery service if there is suspicion of CES or urgent referral (within 2 weeks) if *"Red flags are present in the absence of neurological dysfunction"*. Neurological dysfunction is described as *"Severe or progressive neurological deficit of the legs, such as major motor weakness with knee extension, ankle eversion, or foot dorsiflexion"*.

The Pathway recommends that sudden onset bilateral radicular pain (sciatica) **without** CES symptoms should lead to *"urgent"* referral ie within two weeks rather than *"emergency"* referral albeit that safety netting for red flags should be provided and if there is a deterioration or new CES symptoms, then an emergency referral should be made.

According to the Pathway emergency referral is warranted where there is leg pain and/or back pain with recent onset (within 2 weeks) of other neurological symptoms which it identifies as:

- *difficulty initiating micturition or impaired sensation of urinary flow;*
- *altered perianal, perineal or genital sensation S2-S5 dermatomes – the area may be small or as big as a horse's saddle (subjectively reported or objectively tested);*
- *severe or progressive neurological deficit of both legs, such as major motor weakness with knee extension, ankle eversion or foot dorsiflexion;*

• *loss of sensation of rectal fullness;*

• *sexual dysfunction – inability to achieve erection or to ejaculate, or loss of vaginal sensation.*

A further area of contention in many litigated cases is, where there is sudden onset of CES symptoms, how quickly an MRI should be undertaken subsequent to emergency referral. The Pathway recommends that a bladder scan be performed and that an MRI be undertaken *"as soon as possible, and certainly within four hours of request to radiology"*.

There are many cases where despite a request for an MRI, it is not undertaken for considerably longer (12 or more hours). If there is neurological deterioration during this period, it is often irreversible establishing causation in any subsequent litigation. The Pathway proposes an approach whereby local provision for a 24 hour MRI facility should be in place by June 2024 and *"Where this is not possible currently, a standard operating procedure in conjunction with local spinal and radiology services should be in place describing the local pathway for urgent out of hours scanning"*.

In relation to imaging, the Pathway is published on the same day as the Clinical Imaging Board's guidance *"MRI Provision for Cauda Equina Syndrome"* which is to like effect.

If imaging establishes cauda equina compression, then surgery should be undertaken on an emergency basis. Again, in many civil claims a patient is diagnosed with cauda equina compression but not operated upon until the following day during which time irreversible neurological deterioration may have occurred. The Pathway notes that surgery for patients with incomplete CES should be treated as a NCEPOD (National Confidential Enquiry into Patient Outcome and Death) E1/E2 emergency[1] *"as it is time-sensitive and life-changing, but not life-threating"* and that *"Any reason for delay should be documented"*. Practitioners should ensure that any documented reasons for delay are disclosed.

The Pathway also makes specific provision for catheterisation of the patient prior to surgery and a trial without catheterisation post-operatively with pre/post void bladder scans. Again, there are civil claims where assessment of bladder function is inadequately performed and there is urine retention which can lead to permanent bladder damage in and of itself (bladder volume greater than 1,000ml for several hours will lead to permanent bladder distension injury).

The Pathway provides an advance in the treatment for patients with suspected CES and clarification for those involved in litigation of CES cases where there has been a failure of management.

The courts must still apply the *Bolam* test as amended by *Bolitho v City and Hackney Health Authority* [1998] AC 232. As noted in *C v North Cumbria University Hospitals NHS Trust* [2014] EWHC 61 (QB) when discussing the *Bolitho* test:

> *A Judge should not simply accept an expert opinion; it should be tested both against the other evidence tendered during the course of a trial, and, against its internal consistency. For example, a judge will consider whether the expert opinion accords with the inferences properly to be drawn from the Clinical Notes or the CTG. A judge will ask whether the expert has addressed all the relevant considerations which applied at the time of the alleged negligent act or omission.* ***If there are manufacturer's or clinical guidelines, a Court will consider whether the expert has addressed these and placed the defendant's conduct in their context.***

In light of this legal principle, it is suggested that deviations from the Pathway, unless justified on a sound basis, will prima facia constitute breach of duty.

On 2nd March 2023 at 1pm there was an NHS England webinar at which **Mike Hutton**, the GIRFT clinical lead for spinal surgery and lead author of the Pathway, was joined by a number of speakers to discuss best practice in light of the Pathway's recommendations. **Justin Valentine** provided a brief legal view of the Pathway during the webinar. The webinar is accessible from *Future NHS* but a login is required.

1 *For explanation of this categorisation see:* **https://www.ncepod.org.uk/classification.html**

Are defendants entitled to medically examine claimants prior to pleading a defence?

TARA O'HALLORAN
OLD SQUARE CHAMBERS

OLD SQUARE CHAMBERS

Read v Dorset County Hospital NHS Foundation Trust, University Hospital Southampton NHS Foundation Trust [2023] EWHC 367 (KB)

Summary

The Defendants said they could not plead a full defence until their expert had examined the Claimant and finalised his opinion on causation. The Court, in dismissing their application to stay proceedings, said there would need to be something *"exceptional"* to depart from standard clinical negligence directions, which provides for examination after the exchange of liability witness evidence.

Background

The Claimant brought a high value claim relating to the development of cauda equina syndrome. The Defendants admitted breach of duty but denied causation. The Defendants expert said he could not finalise his view on causation without examination: he needed to assess her pre-injury and post-injury condition (including her co-morbidities), and there were internal inconsistencies in some of the measurements taken by her condition and prognosis expert that could only be verified by examination and assessment.

Application

The Defendants made an application to stay proceedings under CPR 3.1(2)(f) following service of the Particulars of Claim, so their expert could finalise his opinion and the Defences be drafted. The Defendant said causation was key to the claim, and that it was a waste of costs to serve a holding defence, which they would need to amend later. This was also likely to result in a delay narrowing the issues between the parties and could disrupt standard directions given at CCMC.

The Claimant's position

The Letter of Responses pleaded a causation defence to the level of detail not uncommon in these types of proceedings. Claimants very frequently have comorbidities, but this should not take the case out of the normal pathway. The Claimant's vulnerable mental health would be prejudiced by the delay, and the Defendants may well require the examination to be repeated at a later stage in proceedings. She was not refusing to have an examination but wanted it to take place after the exchange of liability witness evidence, as was the normal course of events.

Correct Test

Both parties agreed that the correct test was set out in *Laycock v Lagoe* [1997] P.I.Q.R. p 518 CA. It is a two-stage test. First, the Court must decide if the interests of justice require the examination sought. Only if it finds that they do, the Court must then consider stage two which is whether the party opposing the examination has a substantial reason for the test not being undertaken. It must not be an imaginary or illusory reason.

Judgment

Master Stevens dismissed the application. He found that it was not in the interests of justice to direct the case from the usual order of play; the court was very familiar with litigation involving the development of cauda equina and issues of comorbidity such that the present case was not unusual enough to require a different approach. The Letter of Reponses showed that the Defendants could form a view on causation, and the unfairness in the Claimant having the benefit of examination before the pleading was hardwired into the CPR by the requirement to have

a condition and prognosis report with the Particulars of Claim. He also observed that the case law relied upon by the Defendants referenced absolute refusals to undergo an examination, which was not the case here.

Master Stevens said there would need to be something *"exceptional"* to depart from the normal standard directions, as those have been designed to accord with the overriding objective.

Costs were unlikely to be saved by granting the application since the Defendants may well require a further examination at a later stage, and multiple examinations should be avoided where one will suffice. As for amending the defences at a later stage, he acknowledged this may create some delay but said amendments may be needed for any number of reasons following the exchange of expert evidence. He was not therefore required to engage with stage two but considered that the Claimant had demonstrated a substantial reason for delaying the examination including her psychiatric vulnerability, the likelihood she would end up having to repeat the examination, and the fact there was no proven timed saved overall.

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

Court of Protection conference

9 November 2023, Hilton Leeds City Hotel

AvMA's Court of Protection conference returns to examine the current state of litigation and the challenges and responsibilities facing those who work in this important area. Booking now open.

AvMA Specialist Clinical Negligence Meeting

Afternoon of 1 December 2023, Grand Connaught Rooms, London

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

AvMA Holly Jolly Christmas!

Evening of 1 December 2023, Grand Connaught Rooms, London

The success of our anniversary celebrations every fifth year has encouraged us to make it an annual event! The evening will commence with a drinks reception followed by a fantastic three-course meal with wine, live music and dancing. It will be the perfect event to entertain clients, network with your peers and reward staff. Booking now open.

Clinical Negligence: Law Practice & Procedure

12-13 December 2023, Shoosmiths LLP, Birmingham

This is the course for those who are new to the specialist field of clinical negligence. The event is particularly 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. Full details available soon.

Cerebral Palsy & Brain Injury Cases – Ensuring you do the best for your client

1 February 2024, Hilton Leeds City Hotel

This popular AvMA conference is returning on 1 February 2024 in Leeds, to 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. Booking will open in the Autumn.

34th Annual Clinical Negligence Conference (ACNC)

21-22 March 2024 (Golf Day & Welcome Event 20 March) 2024, Royal Armouries Museum, Leeds

Join us in Leeds for the 34th AvMA Annual Clinical Negligence Conference (ACNC), the event for clinical negligence specialists! The very best medical and legal experts will ensure that you stay up to date with all the key issues, developments and policies in clinical negligence and medical law, whilst enjoying great networking opportunities with your peers. Early bird booking will open in September.

Look out for details on more AvMA events coming soon! For further information on our events:

www.avma.org.uk/events

e-mail conferences@avma.org.uk

AvMA Medico-Legal Webinars

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

Working on a client file and looking for more information to assist you with your case?

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For more information, please contact

Kate Eastmond (**kate@avma.org.uk**)

or call 02030961126.

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Help support AvMA while raising goodwill and awareness for your organisation

From golf days and bike rides to curry nights and quiz nights, holding an event on behalf of AvMA can bring great benefits to both you and us. And we are on hand to offer advice and support to help your event run smoothly. So whether your focus is on business objectives (networking with clients and colleagues, reaching a new audience, building customer loyalty) or purely philanthropic, we can help you to make your event a real success.

OR CHOOSE YOUR OWN EVENT...

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We can promote your event to our clients and lawyer service members through dedicated mailings, social media posts and word of mouth recommendations, helping you to reach a wide audience of potential guests.

Use of the AvMA brand

We can provide logos, banners, presentations and other marketing materials to promote the charitable aims of your event and encourage more people to attend and support AvMA

Expert speakers

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Get in touch

To find out more about how AvMA can work with you to create a really exciting event for your firm, please contact Paula Santos for an informal chat.

Email: fundraising@avma.org.uk **Tel:** 020 8688 9555

Action against Medical Accidents, Freedman House, Christopher Wren Yard, 117 High Street, Croydon CR0 1QG
Tel: **020 8688 9555** Fax: **020 8667 9065** Email: **fundraising@avma.org.uk** **www.avma.org.uk**

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Get in touch

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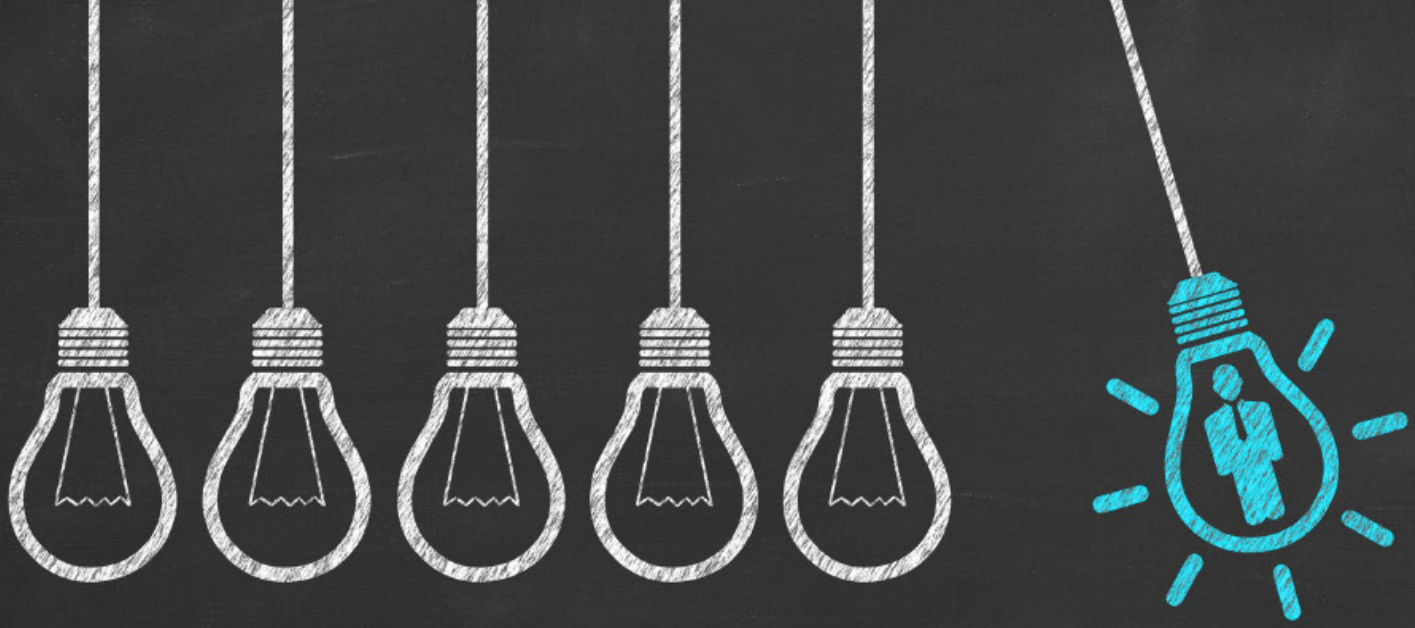

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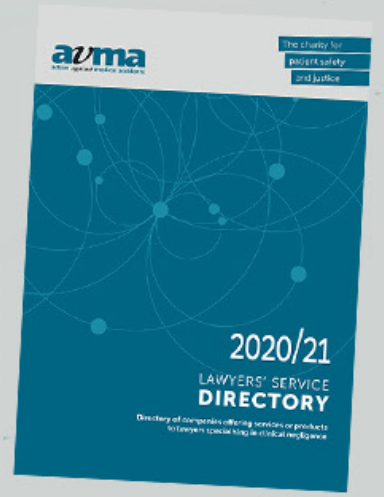
The AvMA Lawyers' Service Directory provides listings of key service providers geared to the clinical negligence solicitor, including:



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- Rehabilitation consultants
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- Counselling
- Mediators
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