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Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

It has been a long year and a particularly long winter! I write this editorial with all the optimism of someone looking forward to the easing of social restrictions, hopefully the end of lockdown and of course, some warmer weather! Whilst this edition of the LS Newsletter cannot begin to offer the level of excitement experienced by many who watched *"The Harry and Meghan Interview"* I can instead offer excellent, relevant, and pertinent articles on real life issues affecting claimant clinical negligence practitioners and their clients.

"Life is a matter of choices, and every choice you make makes you" (John C. Maxwell), so starts Sophie Beesley and Emily Slocombe's article on **"How Bell v Tavistock & Portman NHS Foundation Trust [2020] EWHC 3274 (Admin) is likely to lead to a rise in legal claims".** Sophie and Emily, both of Old Square Chambers look at the role of the Gillick competence test as well as the avenues by which clinical negligence claims are likely to be brought following the court's decision in this case.

Thomas Herbert is a barrister at Ropewalk Chambers in **"Wrongful birth, wrongful life & negligence"** he looks at the decision of Lambert J in *Toombes v Mitchell [2020] EWHC 3506 (QB)* and her analysis and application of Section 1, Congenital Disabilities (Civil Liability) Act 1976. In **"Swift v Carpenter: What to do when there is a short life expectancy"** Christopher Hough, counsel at Serjeants' Inn Chambers gives some pointers on how to approach accommodation claims in cases with a shorter life expectancy.

"A sting in the tail: The court of appeal and cauda equina syndrome" by Jonathan Godfrey of Parklane Plowden Chambers reminds us of the red flag symptoms of cauda equina syndrome and the importance of acting quickly in these cases. Jonathan carefully reviews *Hewes v West Hertfordshire Acute Hospitals Trust & Others [2020] EWCA Civ 1523* where the Court of Appeal re-emphasised that the duty of the judge at first instance is to *"... give reasons for his decision. He need not give reasons for his reasons"* noting that the first instance judge will have heard all the evidence, lay and expert as well as the parties submissions and as such appellants will face an

uphill struggle in trying to persuade the court of Appeal to overturn a first instance decision on a finding of fact.

In **"Do you have an agenda?"**, Hylton Armstrong also practising at Parklane Plowden Chambers observes that there appears to be an increase in the number of clinical negligence claims going to trial or settling closer to it, at the same time courts have a backlog of cases to be listed. This spells delay and continued uncertainty for the claimant. With that in mind, Hylton provides important advice on preparing your experts for pretrial discussions with a view to increasing the likelihood of resolving or narrowing the issues between the parties and avoiding a trial of the action.

"Tomlin Orders: When and how should they be used in personal injury and clinical negligence litigation?" Justin Valentine of St John's Chambers, Bristol, looks at why recording terms of settlement in a Tomlin Order might be preferable to using a consent order especially where there are multiple defendants and settlement is reached with one or more but not all defendants.

Hylton Armstrong's article refers to delays experienced in listing civil cases for trial. Few would deny that even before the pandemic the civil courts were struggling with outdated IT and court closures. The quarterly statistics released by the MoJ for July – September 20 show that 42% fewer fast and multi-track trials were held than in the same period in 2019.

Many predict the backlog of cases in civil courts will get worse before it gets better, so what can be done? Simon Dyer QC of Cloisters Chambers but also a specialist clinical negligence evaluator at Independent Evaluation (IE) looks at the case for **"Independent Evaluation in Clinical Negligence Cases"**. Simon argues that clinical negligence cases are suited to Early Neutral Evaluation (ENE). Apart from the comparative speed of the process, compared to civil litigation, the benefits of ENE can include cost savings, the potential to reduce the stress of the process for both claimant and clinician and resolve costs at the same time. The prospect that parties may also achieve a *"mutually optimised resolution"* makes ENE worth thinking about.

The last twelve months have taught us how quickly things can change and quickly we can all adapt to change. I would not advocate change for the sake of it, but if doing things differently can bring benefits, now is a good time to start thinking outside of the box. We have touched on ENE, but what about **"Before the detailed assessment: the costs mediation"**. Colin Campbell is well known to many of you, a Deputy Costs Judge at the Senior Courts Costs Office (SCCO) and consultant at Kain Knight Costs Lawyers as well as an accredited mediator at Costs ADR, he urges practitioners trying to settle multitrack costs to stop and think about mediation before starting detailed assessment proceedings. Colin's article recognises that mediation is not suitable for all cost disputes but importantly he takes us through the process and introduces us to other possibilities such as Evaluative Mediation.

In *R (Maughan) v HM Senior Coroner for Oxfordshire [2020] UKSC 46*, the Supreme Court determined that the standard of proof for all inquest conclusions would be assessed on the civil standard. The effect of this decision is to lower the standard of proof in conclusions for suicide and unlawful killing from the criminal standard (beyond reasonable doubt) to the civil standard. In **"Supreme Court reduces standard of proof for suicide and unlawful killing in inquest conclusions"**, Kate Wilson, looks at the facts and reasons for the Supreme Court's decision in Maughan.

The decision in Maughan, has significant implications for the coroner's conclusion of unlawful killing which can now be more easily reached. Caroline Wood considers this further in her article **"Unlawful Killing: the new neglect?"** with specific reference to how this may impact on healthcare inquests.

Both Kate Wilson and Caroline Wood are practising barrister at Park Square Chambers, Leeds.

It is with regret that we will not be seeing you in person on 29th and 30th April 2021, when we should have been in Bournemouth for the 32nd Annual Clinical Negligence Conference (ACNC). Nonetheless, AvMA's conference department will be hosting the second online '(Not the) ACNC'. The event will have an obstetrics theme and there will be a live Q&A with the speakers at the end of both mornings. For more details please see:

https://www.avma.org.uk/events/not-the-acnc-29-30-april-2021-online-event/

Best wishes

How *Bell v Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin) is likely to lead to a rise in legal claims

SOPHIE BEESLEY & EMILY SLOCOMBE
OLD SQUARE CHAMBERS

"Life is a matter of choices, and every choice you make makes you" – John C. Maxwell

In law, capacity to make a decision is the ability to use and understand information to make that decision, and communicate any decision made. A person lacks capacity if their mind is impaired or disturbed in some way, which means they are unable to make a decision at that point in time.

Like adults, young people (aged 16 or 17) are presumed to have sufficient capacity to decide their own medical treatment, unless there's significant evidence to suggest otherwise. Children, under the age of 16 years, can consent to their own treatment, if they are believed to have enough intelligence, competence and understanding to fully appreciate what is involved. This is known as being Gillick competent.

The principal issue considered by the court in *Bell v Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin) was whether a child under 16 can achieve *Gillick* competence in respect of a decision to take puberty supressing drugs (PBs) for gender dysphoria.

The case was brought by Keira Bell, a 23-year-old woman who transitioned to male and regretted starting PBs at the age of 15, and the unnamed mother of a 15-year-old autistic girl who is on the waiting list for treatment. The claim was for judicial review of the Defendant's practice of prescribing PBs to persons under the age of 18 who experience gender dysphoria.

Gender dysphoria is a condition where people experience distress because of a mismatch between their perceived identity and their sex at birth and have a strong desire to live according to their perceived identity.

The Defendant, through its Gender Identity Development Service (GIDS), offers a three-stage treatment pathway of physical intervention. Stage 1 is the administration of PBs, which can be prescribed to children as young as 10. Stage 2 is the administration of cross-sex hormones (CSH), which can only be prescribed from around age 16. Stage 3 is gender reassignment surgery, which is only available to those over 18.

The court held that for a child to achieve *Gillick* competence in this context, the child would need to understand not only the implication of PBs, but those of progressing to CSH because the evidence showed that only about 1.9% of children stopped the treatment after stage 1 and did not proceed to CSH. The relevant information that a child would have to understand, retain and weigh up included that CSH could lead to a loss of fertility, the impact of CSH on sexual function, the impact on future and lifelong relationships etc.

The court held that it would be difficult for a child under 16 to understand and weigh up such information: although they might understand the concepts, for example, of a loss of fertility or sexual function, that was not the same as understanding how their adult life would be affected.

The difficulty of obtaining informed consent was exacerbated by the lack of evidence as to the efficacy of PBs in treating gender dysphoria and the long-term consequences of taking the medications.

Gillick makes it clear that any decision is treatment and person specific, however, the court's findings led it to conclude (and issue a declaration) that it was highly unlikely that a child aged 13 or under would ever be *Gillick* competent to give consent to treatment with PBs. It was doubtful that a child aged 14 or 15 could do so either.

In relation to children aged 16 or 17 years, pursuant to section 8 of the Family Law Reform Act 1969, there is a presumption that such children have the capacity to consent to surgical and medical treatment. However, given the long-term consequences of GIDS' clinical interventions and that the treatment was innovative and experimental, the court stated that clinicians *"may well consider"* obtaining court authorisation prior to commencing the clinical treatment.

This is one avenue through which this important case is likely to give rise to an increased number of legal claims, involving children seeking PBs. Following the ruling, the

Defendant suspended referrals for hormone therapy. NHS England has also issued revised rules for the treatment of children and adolescents by GIDS, stipulating that before doctors can prescribe PBs, they need to apply to a court for an order that the treatment is in the child's best interests.

Doctors will also need to review the cases of patients already receiving PBs and potentially apply for court orders to confirm that treatment is in individuals' best interests. NHS England has appointed Dr Hilary Cass to lead a review into GIDS.

To put the issue in context, about 3,000 children are currently being seen by GIDS, of whom several hundred are receiving PBs, and there is a waiting list of almost 5,000.

Another route for a potential increase in legal claims is through clinical negligence claims, brought by people who regret starting the treatment and allege their informed consent to treatment was not obtained, because they were not *Gillick* competent to make a consent decision or because the consent process itself was not *Montgomery* compliant.

In all scenarios, records of the consent process, accounts of pre-treatment consultations and any applicable informed consent guidance are likely to be key in assessing the appropriateness of decisions. Evidence of genuine *"space to think"* being given between stages within the treatment pathway will also be important, as will evidence of alternative treatments being offered (e.g. psychological treatment and support), to ensure the treatment pathway offers true choice rather than generating persistence.

Improving the availability of data to assess the impact and efficacy of the treatment will also be important. The court expressed its surprise that better data was not already available three times within its judgment. The court heard that the Defendant had also not collated data on many other important statistics, such as, the age distribution of those prescribed PBs, the proportion of children referred to the service with an existing autism diagnosis, the number of children (if any) assessed suitable for PBs but not assessed as *Gillick* competent.

Many of the court's findings arguably resonate with the views expressed in *"First Do No Harm"*, the recently published report of the Independent Medicines and Medical Devices Safety Review, which stated:

> *"Innovation in medical care has done wonderful things and saved many lives. But innovation without comprehensive pre-market testing and post-marketing surveillance and long-term monitoring of outcomes is, quite simply, dangerous. Crucial opportunities are lost to learn about what works well, what does not, what needs special measures put around its use, and what should be withdrawn because the risks over time outweigh the benefits. Without such information it is not possible for doctors and patients to understand the risks, and patients cannot make informed choices."*

In relation to the longevity of this decision, the High Court refused the Defendant permission to appeal its decision, however, it is understood that the Defendant will seek leave to appeal directly from the Court of Appeal.

Sophie and Emily are barristers practising at Old Square Chambers within its clinical negligence team. Old Square's team comprises a group of highly regarded specialists whose collective experience enables the team to provide advice and advocacy across the full range of clinical negligence and related disputes. The team, and many of its individual members, are recognised for their expertise in The Legal 500 and Chambers & Partners.

Wrongful Birth, Wrongful Life & Negligence: Considering *Toombes v Mitchell*

THOMAS HERBERT
ROPEWALK CHAMBERS

The Claim

The Claimant in *Toombes v Mitchell* [2020] EWHC 3506 (QB) was born in 2001. She has a congenital developmental defect causing spinal cord tethering. She alleges that the cause of this disability is her mother's failure to take folic acid before her conception and that this failure was due to the Defendant's negligent advice. She commenced proceedings against the Defendant in respect of her *"wrongful conception and birth"* alleging that but for the Defendant's negligence she would never have been conceived. The matter came before Lambert J for trial of a preliminary issue, namely whether, taking her factual case at its highest, the Claimant had a valid cause of action.

The Nomenclature

In simple terms, a *'wrongful birth'* claim is a claim by a mother for the reasonable costs associated with their child's disability together with an award for pain and suffering associated with the pregnancy and childbirth: see *Parkinson v St James and Seacroft University Hospital NHS Trust* [2002] QB 266. On the agreed facts for the preliminary issue trial, it was common ground in Toombes that the Claimant's mother would have had such a claim. For reasons explained by Lambert J at [39], however, no such claim was advanced.

The Defendant in *Toombes* contended that the claim advanced in that case was a *'wrongful life'* claim: a term coined in the United States and adopted by the Law Commission in its Report on Injuries to Unborn Children (Law Com. No. 60) of August 1974: see [3]. As such, the Defendant argued, it was expressly excluded by the Congenital Disabilities (Civil Liability) Act 1976 and, in any event, would not have been recognised at common law even before the introduction of the 1976 Act following *McKay v Essex Area Health Authority* [1982] QB 1166.

The Claimant, in response, argued that the claim was not one for *'wrongful life'* and was, indeed, permitted by section 1(2)(a) of the 1976 Act, which allows recovery by children born disabled as a consequence of negligence affecting a parent in his or her ability to have a healthy child. The Claimant further argued that the 'wrongful life' label is restricted to cases of tortious acts or omissions following conception but for which the pregnancy would have been terminated (as opposed to cases in which it is alleged that, but for the negligence, the child would not have been conceived at all).

The 1976 Act

Section 1 of the 1976 Act provides as follows:

(1) Civil liability to child born disabled.

(1) If a child is born disabled as the result of such an occurrence before its birth as is mentioned in subsection (2) below, and a person (other than the child's own mother) is under this section answerable to the child in respect of the occurrence, the child's disabilities are to be regarded as damage resulting from the wrongful act of that person and actionable accordingly at the suit of the child.

(2) An occurrence to which this section applies is one which –

(a) affected either parent of the child in his or her ability to have a normal, healthy child; or

(b) affected the mother during her pregnancy, or affected her or the child in the course of its birth, so that the child is born with disabilities which would not otherwise have been present.

(3) Subject to the following subsections, a person here referred to as the defendant is answerable to the child if he was liable in tort to the parent and would, if sued in time, have been so: and it is no answer that there could not have been such liability because the parent suffered no actionable injury, if there was a breach of legal duty which, accompanied by injury, would have given rise to the liability.

(4) In the case of an occurrence preceding the time of conception, the defendant is not answerable to the child if at that time either or both of the parents knew the risk of their child being born disabled (that is to say, the particular risk created by the occurrence); but should it be the child's father who is the defendant, this subsection does not apply if he knew of the risk and the mother did not

(5) The defendant is not answerable to the child, for anything he did or omitted to do when responsible in a professional capacity for treating or advising the parent, if he took reasonable care having due regard to then received professional opinion applicable to the particular class of case; but this does not mean that he is answerable only because he departed from received opinion.

The Act gave effect to the recommendations of the Law Commission's 1974 Report, wherein so-called *'wrongful life' claims were considered. The issue posed was "whether a child should have a right of action when the allegation essentially is that it has suffered harm from being born and the real complaint is that it would have been better not to have been born at all"*. In relation to advice provided to a woman during pregnancy, the Commissioners noted that *"here the negligence did not cause the disability; it caused the birth, but no act or omission of the advisor could have brought about the birth of a normal child"* and concluded that an action for wrongful life *"in the strict sense of the term"* should not be permitted.

The Commissioners went on to consider the American case of *Williams v State of New York* [1966] 18 N Y 2d 481 where, because of a hospital's negligence, a female patient had conceived as a result of rape. The child sued the hospital for damages for the stigma of illegitimacy and the action was dismissed on the ground *(inter alia)* that illegitimacy was not an injury. However, the Commissioners considered that *"if the rapist had been syphilitic, a more sympathetic basis for a claim might have been advanced"*. A second example was given of an intentional wrong by a man suffering from syphilis who had intercourse with a woman without telling her that he was infected. The Commissioners concluded that the child in such cases should have a remedy because *"we do not think that these are really cases of wrongful life. There is we think a difference between a negligent failure to prevent the birth of an already conceived child and negligence which actually causes the intercourse which results in the conception. In the latter case we think that the child should be able to claim damages and that they should be assessed by comparison with the child as he would have been had he not suffered from the disability."*

The Decision in *McKay*

In *McKay*, the claimant was born disabled as a result of rubella suffered by her mother during the course of her pregnancy. She alleged that, but for negligence in managing the pregnancy, her mother would have been informed of the risk that her pregnancy would be affected by rubella and would have terminated the pregnancy. The Court of Appeal held that the claim was one for wrongful life and that it faced two main obstacles: first, a policy objection to permitting a claim which was inconsistent with the concept of the sanctity of human life; and, secondly, the impossibility of evaluating damages.

The Arguments in *Toombes*

The Claimant argued (i) that the label *'wrongful life'* is limited to claims which include the allegation that, but for the negligence, the pregnancy should have been terminated – so-called *'abortion cases'*; (ii) that this narrow definition is demonstrated by the reasoning in *McKay* – in which the court referred to the sanctity of human life – and supported by the Law Commission's analysis in its Report; and (iii) that it is, in any event, unlikely that *McKay* would be decided in a similar way today because popular attitudes towards abortion have changed.

The Defendant argued that, although this was not a case in which the Claimant would have been aborted, it was nonetheless the case that but for the negligence she would never have been conceived – thus raising the same policy and legal objections as in *McKay*. Reliance was placed on *Criminal Injuries Compensation Authority v First-tier Tribunal (Social Entitlement Chamber)* [2017] 4 WLR 60, which concerned a claim brought by a disabled child who was the product of an incestuous rape of his mother by his maternal grandfather and where (at [31]) Henderson LJ stated that *"the real complaint would have to be that he should never have been conceived at all"* before noting that such a claim was for wrongful existence and not personal injury, and that the law did not recognise such a claim following *McKay*.

The Analysis

Against – and somewhat in contrast to – that background, Lambert J's starting point was the Act and its proper interpretation. She considered that a cause of action under section 1 involves three components: (i) a *"wrongful act"*; (ii) an *"occurrence"* as defined in subsections 1(2)(a) or (b); and (iii) a child born disabled.

As to (i), this was accepted on the agreed facts for the purposes of the preliminary issue trial. As to (ii) and (iii), Lambert J decided in the Claimant's favour at [45]-[48]:

> *I accept that the word occurrence means that something happened. This is to give the word its ordinary linguistic meaning. However the Act does not require that the occurrence involve a change or alteration in the mother's physiological state. … To the extent therefore that [the Defendant] submits that an occurrence must be referring to some physical change in the mother's condition before conception, this was considered by the Commissioners only to be excluded as a pre-requisite for liability [by the provision at subsection 1(3)]. It is not necessary for the mother to prove an actionable injury: something may have altered her physical state but equally she may have been physically unaffected.*
>
> *There is however an alternative and more fundamental objection [the Defendant's] case that in this case there was no occurrence. The problem for [the Defendant] is that, depending upon its circumstances, the act of sexual intercourse itself can be a relevant occurrence. In the examples given at [88] of the Report (both variations on the facts of* Williams*), the occurrence is the intercourse with a person affected by a sexually transmitted disease. …*
>
> *Both of the examples given are, to the modern eye, rather archaic but they illustrate the simple point being made by the Commissioners that the circumstances of the intercourse may amount to an occurrence. …*
>
> *With this in mind, I see no reason why, on the agreed facts before me, the Claimant's mother's reliance upon the negligent advice which she was given, that is, having sexual intercourse without the protective benefit of folic acid supplementation is not a relevant occurrence. I find that it was. This deals squarely with [the Defendant's] argument that, on the agreed facts, nothing happened and so there was no occurrence. Something did happen and that something was intercourse when the mother was in a folic acid deficient state.*

Having dealt with the question of construction, Lambert J went on to consider whether the claim was a *'wrongful life'* claim in the *"strict sense"*. At [51]-[53], she held that it was not:

> *The Act draws a distinction between pre-conception occurrences and occurrences which affected the mother during the course of her pregnancy. There is a rider to subsection 1(2)(b) "so that a child is born with disabilities which would not otherwise have been present" which is, according to the Explanatory Note, "… so worded as to import the assumption that, but for the occurrence giving rise to a disabled birth, the child would have been born normal and healthy (not that it would not have been born at all)". That rider has not been added to subsection 1(2)(a) which contains no express prohibition on claims brought by children who, but for the wrongful act, would never have been conceived.*
>
> *The rider was not included in subsection 1(2)(a) and deliberately so. … A negligent failure to prevent the birth of an already conceived child engages a range of social and moral policy issues, not least the imposition upon the medical profession of a duty to advise abortion in possibly dubious circumstances. However, claims based upon a wrongful act before conception which leads to the intercourse and conception raise no such difficulties.*
>
> *The legislation was drafted to make this distinction and to permit certain actions arising from pre-conception occurrences even though, but for the wrongful act, the conception would have not taken place. … Unlike in a post-conception case, there is no need for the claimant to prove that, but for the wrongful act, he or she would still have been born. It is sufficient that the claimant was, in fact, born with a disability resulting from the occurrence.*

On that basis, Lambert J was able to distinguish both *McKay* (where the court was dealing with a claim which, had it been brought under the Act, would have engaged subsection 1(2)(b) and would have been excluded by the rider to that provision) and the *CICA* case (which was concerned with a distinct statutory scheme).

The Result

There was accordingly judgment for the Claimant on the preliminary issue.

It is worth remembering, first, that this was a decision on assumed facts and whether the Claimant ultimately succeeds in her claim will depend on the court's ultimate factual findings at trial. It is also worth recalling what this case is not. It is not a *'wrongful birth'* case. Nor is it a decision about the social and moral considerations that loom large in this area.

This case is a decision on the correct statutory interpretation of section 1 of the 1976 Act. Following Lambert J's clear and logical analysis, the constituent requirements for a cause of action to arise under that

section are now established; and the distinction between section 1(2)(a) cases (which will include pre-conception occurrence cases) and section 1(2)(b) cases (which will include post-conception occurrence cases) has been made clear.

Swift v Carpenter: What to do when there is a short life expectancy?

CHRISTOPHER HOUGH
SERJEANTS' INN CHAMBERS

SERJEANTS' INN

In October 2013, Charlotte Swift had the misfortune to be involved in a serious road traffic accident, in which she suffered the loss of one leg, and serious injuries to the other. As a result of her injuries, she needed to move to bigger, adapted accommodation, costing £900,000 more than her uninjured needs. She faced further misfortune: her claim was heard at a time when no compensation could be awarded to meet these accommodation needs, without her going to the Court of Appeal.

Seven years later, she was awarded slightly more than £800,000 by the Court of Appeal, having originally been refused any award, following Mrs Justice Lambert's (correct) application of the principles of *Roberts v Johnstone*.

The calculation for the award of damages for the cost of purchasing a suitable property in Mrs Swift's case was:

1. Cost of the property now required: £2,350,000
2. Value of the existing property: £1,450,000
3. Capital shortfall: £2,350,000 - £1,450,000 = £900,000
4. Life expectancy per Table 2 Ogden: 45.43 years
5. Value of the reversionary interest: £900,000 x 1.05 -45.43 = £98,087
6. Damages award = £900,000 - £98,087 = £801,913

This calculation was based on a calculation of the present value of the reversionary interest, a little-known aspect of the property market (with a market of about 4 sales per year). As is known, the Court of Appeal heard evidence from a number of experts in their search for a fair way to allow a Claimant to live in suitable accommodation, without presenting them (or, more likely, their heirs) with a large windfall in the form of the capital value of the property.

In fact, the shortfall of £98,087 was made up by Part 36 sanctions (Mrs Swift had made a Part 36 offer to settle and recovered £65,000 by way of enhanced damages and £43,000 penalty interest). In total, Mrs Swift was awarded just over £909,900.

Were it not for this good judgment/fortune, she would probably have used her damages for pain and suffering to make up the difference,

It is clear that this guidance is meant to be of wide application.

"for longer lives, during conditions of negative or low positive discount rates, and subject to particular circumstances, this guidance should be regarded as enduring." [Irwin LJ @ §210].

The caveat of *"for longer lives"* is important. For those with a shorter life expectancy, the calculation produces a significant shortfall. For example, if Mrs Swift had been aged 75 at the date of hearing, the calculation would have been:

1.05 Xy -14.01 = 0.5048

£900,000 x 0.5048 = £454,339.43

Award of damages = £445,660.57

This is obviously wrong. How can the injured Claimant buy a house unless given the means to do so? It is not just the very old: every practitioner will have cases where the injuries lead to a reduction in life expectancy, whether it is children injured at birth who will only just reach adulthood, or those who will die much younger as a result of their injuries (not just in the sense of a capital sum, but to allow for the increase in the value of property).

The Court of Appeal made it clear that, in these circumstances, the court should consider a different approach.

> *"...I am concerned only with a case of the present kind, where the claimant has a long life expectancy. In such a case the application of a discount rate of 5%... will mean that the shortfall between the cost of the additional element and the amount awarded will typically be comparatively small and... the gap between the need and the damages following*

deduction of the present value of reversionary interest should be capable of being bridged without creating substantial difficulties for the claimant. The position will be different in short life-expectancy cases... these may require a different approach" Underhill LJ paragraph 228

What might the alternatives be? Somewhat surprisingly, it is very unclear. Surprising, as the Court of Appeal made it very clear that they felt that they were providing enduring guidance (see above), and that they knew that the parties would want to know what they could expect to receive/pay. Irwin LJ cited *Knauer* [2016] UKSC 9

"... it is important that litigants and their advisers know, as surely as possible, what the law is, particularly at a time when the cost of litigating can be very substantial, certainty and consistency are very precious commodities in the law.

Some points can be discerned:

a) it was made clear that the primary aim is provide proper and full compensation, which must mean providing suitable accommodation:

"There are well established examples in the field of tort where a degree of overcompensation has proved unavoidable... If it were to prove impossible here to award a claimant full compensation without a degree of over-compensation, then it seems to me likely that the principle of fair and reasonable compensation for injury would be thought to take precedence". (Irwin LJ paragraph 206)

There are some practitioners who believe that this could mean the full capital cost.

b) Mortgage interest-only product: whilst this was thought unsuitable for longer life cases (a sit produced an award higher than the capital sum) it could, if available work for short-life cases

c) Equity release loans were rejected as there was no suitable product [Irwin LJ pg 9 ß33]

d) Rental was rejected because it would be higher than the capital costs: but this applies in long-life cases and may not in short-life cases. There are obvious difficulties in renting, as many injured people do not wish their families to have to find accommodation when they die (somewhat crudely dismissed as a windfall to be avoided it at all possible). The increased costs of renting a suitable flat was allowed in *Miller v Imperial College NHS Trust* 2015. I have found that *"the City"* will fund the purchase of a suitable property to rent to a person with a short-life expectancy, with a PPO paying the rent (and capital sums to pay for the costs of adaptation and restoration at the end of life).

e) A loan from the defendant to the claimant with a charge was excluded because the NHS Trust was not in a position to offer such a loan and the difficulties of shared ownership were felt to be insuperable.

f) The Claimant should not be expected to use their claim for loss of earnings to subsidise the shortfall (there should be no more robbing Peter to pay Paul).

g) The person with a short-life expectancy may be able to sell their reversionary interest on the open market. It seemed to be accepted that such a market does not now exist. But it might emerge:

"It is entirely possible following this decision ...that an expanded market in the sale of such reversionary interests will develop. Claimants who have sustained a significant limitation of their damages by reference to the windfall, may seek to recoup that shortfall

h) Another argument suggested is possible reconsideration of a claim for loss of earnings for the *"lost years"*.

In other words, the position is very unclear. It will become clearer as cases emerge. It is incredibly unfortunate that the injured person with a very short life expectancy may have to endure Mrs Swift's long wait to find out how they can recover the costs of buying suitable accommodation.

A sting in the tail : The court of appeal and Cauda Equina Syndrome

JONATHAN GODFREY
PARKLANE PLOWDEN CHAMBERS

A review of the Court of Appeal decision in *Hewes v West Hertfordshire Acute Hospitals Trust and Others* [2020] EWCA Civ 1523

The Court of Appeal set out invaluable guidance and practical assistance regarding the evaluation of the trial judge's findings within the boundaries of the appeal process. It re-emphasised that any appellant has a very onerous position to overcome in challenging the findings of a trial judge who has listened to the evidence and resolved the disputes between respective experts. There are significant hurdles to overcome. They are not to be taken lightly.

This case was as far as is known, the first case directly relating to the treatment of cauda equina syndrome (" CES") to come before the Court of Appeal. The Court rejected any notion of providing general guidance on the management of cauda equina cases.

CES Cases

In its publication, *"Did you know? Cauda Equina Syndrome"*, published in July 2020, NHS Resolution reported that as between January 2008 to December 2018, it received 827 claims for incidents of CES. Out of the 827 claims, 340 had been settled with damages, 212 were described as being *"without merit"* and 275 remained open. The cost of the claims was specified as being £186,134,049, including payments for claimant legal costs, NHS legal costs and damages.

The age range of claimants was heavily orientated at those aged between 31-50 years at 65%, and of the others, 23% were aged between 51-85, 8% were aged between 0-30 years and 4% , their age was unknown.

It cites *"red flag"* symptoms of CES that require rapid investigation and treatment as including, sciatica in both legs; anal and/or buttock numbness; loss of feeling between the legs (saddle anaesthesia); motor weakness, sensory loss or pain in both legs ; bladder retention and/ or incontinence and bowel disturbance/incontinence.

Clinical Preamble of CES set out in the Court of Appeal Judgment

CES is commonly caused by the prolapse of a large disc in the spinal canal. It compresses a bundle of nerves which transmit messages to and from the bladder, bowel, genitals, and the saddle area, interfering with sensation and movement. It derives its name from the Latin, cauda equina (or *"horse tail"* in translation), the bundle of nerves which resemble the particular anatomy . Having been diagnosed, CES is seen as a medical emergency, because unless the pressure on the nerves is released quickly, they can be damaged permanently. There are different types of CES depending on the extent of nerve damage that has been caused. These include CES Incomplete ("CESI"), and CES Complete, commonly known as Retention CES ("CES-R"). All patients with CES experience a continuous deterioration, but the rate of the deterioration varies as between patients. Sometime the deterioration is complete within in matter of hours. In other patients CESI never reaches CES-R.In the context of the case it was agreed that, in general, on the balance of probability, the outcome of surgery for patients with CESI tends to be good, whereas it tends to be poor for patients with CES-R. It is vital that once CES is suspected and MRI is undertaken as soon as is reasonably possible, and that if CES is discovered, that the patient undergoes decompression surgery as soon as is reasonably possible.

The Facts

The facts mirrored those often seen in CES cases. The *"red flags"* or the tell-tale symptoms of CES which are often there to be seen.

The Claimant, who was 50 years of age, suffered from a history of low back pain with radiologically confirmed disc protrusions in his lumbar spine at L4/5 and L5/S1. He had been given a caudal epidural on 22nd February 2012.

On 11th March 2012 the Claimant attended an urgent care centre with worsening back pain, where he was

seen by an out of hours GP. He was told to consult his GP if matters worsened, and if he became numb, that immediate hospital treatment was needed.

The matters in issue arose on 12th March 2012.On that day, at about 1.00am the Claimant went to bed. The Claimant awoke at or about 5am in pain and with numbness in the groin area. He called the out of hours service and spoke to Dr Tanna, a GP, at about 6am, and informed him about developing numbness in the bum and leg. Dr Tanna made the realisation that the Claimant had symptoms associated with cauda equina. He recommended that the Claimant visit A&E immediately. They would organise an urgent scan and get him to see an orthopaedic doctor. The Claimant's wife called an ambulance at 6.32am and spoke to a clinician who arranged for an ambulance to be sent. The ambulance arrived at the Claimant's home at 7.21 am and left at 7.38am. He was taken to Watford General Hospital where he arrived at 8.19am.

The Claimant was reviewed and examined by a FY2 doctor (a junior doctor in the 2nd year of his foundation training) in A&E at 9.20am, who referred him onto the orthopaedic team. No negligence was alleged in the claim as against the FY2 doctor. The Claimant was eventually seen by the orthopaedic on call doctor, Dr Kirkby, who was in the first year of her foundation training. Dr Kirkby thought that she examined the Claimant at about 10.40am. She undertook a clinical examination and discussed his case with an orthopaedic registrar "**re cauda equina "**. The plan evaluated was to send the Claimant for an x ray and MRI scan. A spinal x ray was undertaken at 11.23am. At 11.59 am a form requesting an MRI scan was placed into the hospital's Computerised Radiological Information System ("CRIS"). The form made no indication of possible CES and was not marked urgent. The Claimant alleged that this was negligent. A bladder scan was undertaken at 12.03 pm.

The Claimant's details were inputted into CRIS at 1.26pm. An MRI scan was undertaken at between 1.33pm and 1.50pm. This was about 90 minutes post the request placed into the computerised system. The plan was that there should be an urgent discussion with the orthopaedic consultant *"for theatre today impression : cauda equina"*. The scan showed a massive L5/S1 disc herniation occupying the majority of the central canal. A discussion was had with the he National Hospital for Neurology and Neurosurgery in London ("QSH"). A nursing note at 6pm showed that CES having been confirmed, an an urgent transfer was arranged to QSH. The Claimant arrived at QSH at 8.09pm and was taken to theatre at 10.30pm. Surgery was commenced by way of decompression surgery at 11pm. Despite the treating clinicians' best efforts, the Claimant was left with residual symptoms of cauda equina.

It is worth noting in the context of the case that followed, that there was an approximate 17-hour period between when Dr Tanna suspected CES and the surgery being carried out.

The Claimant brought a claim alleging that:

i. Dr Tanna, the GP, should have contacted Watford General Hospital to ensure that the Claimant could bypass A&E and be seen straightway by Orthopaedics;

ii. The Second Defendant, the ambulance service, should have prioritised the need for transfer to hospital, and in not doing so, caused a delay in his transfer of 19 minutes; and

iii. The First Defendant managed his case negligently. He was a potential surgical emergency. He was not seen quickly enough whereby investigation and treatment was delayed. Once Dr Kirkby had suspected CES, she should have called for Consultant opinion, arranged an urgent MRI scan, marked the MRI scan request form as urgent, and mentioned CES or suspected CES. The Claimant's MRI scan should then have interrupted the list of elective scans inputted.

It was alleged that each Defendant had caused the Claimant permanent and unavoidable injury and loss of function. It was the Claimant's case that he had not developed urinary retention, CES-R, at the point which , absent the negligence, he should have been operated upon. Had he been operated on sooner, on the balance of probabilities, it was contended that he would not have suffered the injuries that he did.

The First Instance Judgment

The matter was heard by Anne Whyte QC, sitting as a Deputy Judge of the High Court. The trial lasted some 6 days.

I have not sought to navigate a course in this article setting out the detailed reasoning and assessment of the evidence by the trial judge but suffice to say that the trial judge made no findings of any breach by any of the Defendants, albeit that there was an admitted delay in transfer by 19 minutes by the ambulance service, but which was agreed made no difference causatively to the outcome, if the only avoidable delay, being de minimis.

The trial judge also found that in any event, the decompression surgery could not reasonably have been

undertaken in such time as to make any difference to the eventual outcome.

Appeal

The Claimant appealed on a number of grounds. A precis summary of the grounds upon which permission was granted by McCombe LJ are:

i. The trial judge erred in law and in fact in holding that the GP, Dr Tanna, did not breach his duty of care;

ii. She erred in both respects in deciding that the Claimant had not proved factual causation as against the GP, Dr Tanna;

iii. She erred in both respects in not drawing adverse inferences as against the First Defendant from the absence of any evidence of a discussion between the orthopaedic and radiology departments about the urgency of a MRI scan for the Claimant, or about the priority to be given to patients;

iv. She erred in both respect in her decision on factual causation as regards to the First Defendant; and

v. She erred in both respects in holding that the Claimant had failed to establish legal causation as against any of the Defendants.

In granting permission to appeal on the grounds highlighted, McCombe LJ acknowledged that the judgment of the trial judge was *"carefully reasoned"* and that he had considered whether it was appropriate to give permission to appeal on any grounds, as to a significant degree, they involved challenges to findings of primary fact, and assessment of those facts. The skeleton argument had however convinced him that there was more than a merely fanciful chance of success.

Reasoning in the Court of Appeal

The appeal lasted 3 days. The Court of Appeal soundly rejected the grounds of appeal wholeheartedly endorsing the findings and reasoning of Anne Whyte QC, reached at first instance.

Elisabeth Laing LJ giving the lead judgment identified that *"the question for the court on this appeal is whether the decision of the judge is wrong. Nevertheless, an appellant in an appeal such as this is not free to invite the court to re-visit the whole case, and to stand in the shoes of the first instance judge"*.

It was specified that in *Perry v Raleys Solicitors* [2019] UKSC 19 at Paragraph 52, Lord Briggs JSC, said, that in considering whether the judge at first instance had gone wrong in their decision on the facts to an extent which enabled the Court of Appeal to intervene was *"whether there is no evidence to support a challenged finding of fact, or that the finding was one which no reasonable trial judge could reach"*.

It was noted that the trial had lasted 6 days and that there were pages of pleadings, witness statements, experts' reports, and academic literature for the trial judge to absorb before the trial and to reflect upon having reserved judgment. Laing LJ referred to the fact that *"this appeal is not a wholesale opportunity to revisit in detail, her findings of fact, her evaluative assessments, or her mixed findings of fact and law"*. She went on to emphasise and quote Lewison LJ's *"vivid metaphor"* in *Fage UK Limited v Chobani UK Limited* [2014] ETMR 26, at paragraph 114 *"in making his decisions the trial judge will have regard to the whole sea of evidence presented to him, whereas an appellate court will only be island hopping"*.

Laing LJ emphasised that the appellate court is not in the same position as the trial judge was for many reasons, namely:

i. She was able to evaluate the witnesses as they gave their evidence. There are many aspects of a witness's responses to questions, such as evasiveness, that are not visible from the court transcript;

ii. She was entrusted with making findings of primary fact, both where there was a dispute about the evidence, and where there was a gap in the evidence;

iii. Her job was to make findings on the balance of probability, which is not a precise science, and which involves an assessment of the relative likelihood of events;

iv. She had to make several evaluative judgments;

v. She was required to make mixed findings of fact and law, not least, the application of the Bolam/ Bolitho test;

vi. The premise of the Bolam test is that there may not be one right answer upon which the facts are found, but a range of reasonable answers;

vii. It was obvious from the significant dispute on causation, that there was a sharp difference of view as between the experts, all of whom the trial judge found gave their evidence in good faith. It was her decision to decide which evidence, on the dispute, she preferred;

viii. The Claimants case on the appeal was that the dispute about causation was binary and to be resolved

by assigning his case to one of two categories, CESI, or CES-R. The distinction between the two is imprecise in the literature. There are different definitions making categorisation difficult. The real question, which the trial judge addressed, was what were the outward signs, on the balance or probability, which showed the progress of the Claimant's underlying pathology, and at which point, on the balance of probability, he had reached a position where functional recovery was no longer likely.

Accordingly, as was emphasised by Laing LJ:

> *"The Claimant therefore has significant obstacles to surmount in this case. It is not enough to persuade the court that a different view of the evidence was possible. The Claimant has to persuade the court that the only possible view was that advocated by the Claimant at first instance".*

It was also recognised by Laing LJ that it is trite that a first instance judge has to decide the principal issues as between the parties and give reasons for their decision which are detailed enough so as to enable the parties to know why they have fared so in their case. A judge is not obliged to decide every single issue in dispute, or to give reasons for their reasons. This re-iterates the position set out by Lewison LJ in *Steachilin & Ors v ACLBDD Holdings Ltd & Ors* [2019] EWCA CIV 817, where he stated *"the principle is clear. The judge must give reasons in sufficient detail to show the parties, and if need be, the Court of Appeal the principles on which he has acted and the reasons that have led to his decision. They need not be elaborate. The judge's duty is to give reasons for his decision. He need not give reasons for his reasons".*

Laing LJ concluded by saying that *"the judge was given many building blocks for her judgment, that is all the evidence, lay and expert, and the parties submissions. The agreed issues were the framework of the judgment. But they did not dictate its overall structure, or its details. Those were for the judge to decide as a cumulative series of assessments which it was for her to make; not for this court..... The tight stricture of the judgment, and its succinctness , are signs that the judge had carefully navigated the sea of evidence and analysed its essential components into a coherent whole".*

On a further aspect, Davis LJ at Paragraph 96 of the judgment recognised that this was probably the first case of CES that had come before the Court of Appeal, but in doing so, spelt out that it did not mean that it raised issues of principle of general application. In fact, an appellate court, often needs to be careful to avoid making generalised pronouncements on the obligations of doctors in medical situations and *"what is ordinarily required, in each case, is consideration of whether the responses and procedures actually undertaken in a given medical situation fall out with the range of reasonably and logically justifiable responses and procedures, applying the Bolam/Bolitho principles, on the facts of the individual case".*

Davis LJ recognised that the grounds of appeal were directed at the trial judge's primary findings of fact and that her evaluation of the facts and that regrettably the criticisms fell foul of virtually all the warnings and caveats in the authorities, and most recently summarised in the Perry decision. The criticisms of the trial judge in her judgment were demonstrably not made out and Davis LJ spoke of being troubled in that *"the appellant's submissions at stages seemed to come close to advocating an approach in effect requiring a counsel of perfection, bordering on strict liability; a long way from the yardstick of reasonableness".*

To affirm the maritime theme that purveyed throughout the Court of Appeal's judgment Davis LJ conveyed the wonderment that at stages of the case it felt as though one counsel was sailing in the Pacific Ocean whilst the other counsel were sailing a parallel course in the Atlantic Ocean.

Reflections

The Court of Appeal did not accede to the suggestion that it should give guidelines in relation to the management of CES cases. Each CES case is to be considered on its individual facts and not placed in the constraint of appellate guidelines.

In terms of focusing in on the appeal based on the trial judge's finding of facts at first instance, the Court of Appeal has shorn up the already almost insurmountable. Any appeal on the findings of facts and their assessment will be a truly gargantuan struggle. Indeed, in the instant case, Laing LJ considered not only that *"the decision which she made [the trial judge] was one which was open to the judge, but it was the right decision".*

Whilst the instant case is believed to be the first case of CES to have been considered by the Court of Appeal, it is unlikely to be the last. The problem posed by CES is primarily its recognition and detection at an early stage of development in order to enable a better outcome to be achieved.

Do you have an agenda?

HYLTON ARMSTRONG
PARKLANE PLOWDEN CHAMBERS

Anecdotally it seems an increasing proportion of clinical negligence cases are going to (or at least closer to) a trial. At the same time, as a result of the pandemic and its impact on the courts, getting to an effective trial is not as easy as it used to be. Some courts have a significant backlog or find it difficult to find a room or judge, and many trials are having to be conducted either completely or partly remotely – which is probably not ideal for the majority of clinical negligence cases. In the circumstances, now is probably as good a time as any, to offer some advice about how to prepare for pre-trial discussions between experts, which by definition are partly designed to avoid avoidable trials.

The power to order a direct discussion between experts comes from CPR 35.12. It states the underlying purpose of a discussion between experts is to identify the issues, discuss them, and where possible reach an agreed opinion. The rules state that the court can (and usually do) direct that after the discussion the experts prepare a joint statement. The court also has the power to make an order about what issues the experts discuss. The content of the discussion must then not be discussed at trial unless the parties agree, and any agreement does not bind parties unless they agree to be bound by it. Paragraph 9 of the Practice Direction adds that the purpose of a discussion is not for the experts to settle cases. Instead, the central purpose is to narrow issues.

Whilst it is now effectively standard practice to require all experts of like discipline to hold joint discussions, the use of agendas is not mandatory. The Practice Direction states that the parties *'must discuss and if possible agree whether an agenda is necessary...'* and if so attempt to agree one that *'helps the experts to focus on the issues which need to be discussed'*. In a simple case or on a simple issue, it may not be necessary to prepare an agenda. It's quite common for example for experts to have to give evidence on liability as well condition & prognosis, in circumstances where isn't much of a dispute, if any, about condition & prognosis. In those circumstances it may not be *'necessary'* to draft an agenda in relation to condition & prognosis. Similarly, I sometimes find that some disciplines or reports lend themselves to a discussion not based on an agenda e.g. care experts reports. The truth is experts are often highly experienced and more than capable of conferring without a template for their discussion. When left to their own devices experts can often prepare something genuinely helpful, like a table or schedule of setting out their respective positions. Moreover, it's arguable that without an agenda, and therefore without the lawyers effectively setting them up for a debate, experts might even stand a better chance of reaching an agreement.

That said, in most cases the joint discussion will probably be better organised and ultimately more helpful to the parties if there is a well drafted agenda. What counts as a well drafted agenda is open to debate, but in my experience, there are a few simple rules you ought to follow.

Firstly, start early. As counsel, I have something of a love-hate relationship with agendas. I know how important they are and enjoy the process of trying to distil a case into a list of simple issues. However, I also often only have a few days to do it! My advice would be to start the process as soon as the evidence is exchanged. By doing this you'll keep your barrister happy, but more importantly the issues should be relatively fresh in the minds of the experts, you'll have a chance to consult with your expert before circulating a draft, and there will be time to go back and forth between the parties if necessary. If you leave it until the last minute, and have to skip one of these steps, you'll probably increase the risk of problems later down the line.

Secondly, do a good preamble. This isn't complicated, but it's important to get it right. Most examples I've seen include something about the purpose of the joint meeting, the role of the experts, a request for reasons, and the relevant tests. In relation to the tests, I'd suggest you fine tune every preamble so that you only deal with the tests applicable to that case. For example, there's no point including generic guidance about *Bolam* in an informed consent case, or something complicated about

material contribution if it's a but-for case. In addition, paragraph 76 of the 2014 Civil Justice Council document entitled *'Guidance for the Instruction of Experts in Civil Cases'* suggests the agenda should indicate what has been agreed and summarise concisely the matters that are in dispute. I find this helps focus my mind on drafting a succinct and simple agenda, and suspect it helps give the experts some insight into what the litigation as a whole is about, so that they can see what their role is in that context. More recently I've started to suggest (or even just prepare myself) a small e-bundle of relevant documents or records. With the software we're now all using, it really doesn't take any time, and hopefully helps the experts focus on what matters. Also, on the subject of technology, I have wondered whether we ought to start including something about how the experts can or should meet by video, on the basis a video meeting might increase the prospect of the experts not falling out.

Thirdly, and on the subject of not falling out, as lawyers, try to be reasonable and constructive. If nothing else, the correspondence between the parties might turn into important evidence in the event there are any applications or costs arguments. However more fundamentally than that, the whole purpose of the joint meeting is to narrow the issues. If the lawyers can't agree about the agendas, the experts might be influenced by that. In the now famous words of Mrs Justice Yip in *Saunders v Central Manchester University Hospitals NHS Foundation Trust* [2018] EWHC 343 (QB) we should aim to adopt a *'common sense and collaborative'* approach, and not a tactical one. That means don't take an issue on a point of semantics unless it affects the substance, and when it comes to the substance don't focus on trying to frame the question to suit the answer you want to achieve. There's no point *'winning'* the joint statement phase, if you only *'won'* because of the question, and then find the evidence unravels at trial. Similarly, you don't want to find the experts disagreed on paper because of the nature of the question, to then find out they probably agreed with each other all along.

Fourthly, and again to avoid any unnecessary arguments, keep questions simple, objective, and neutral. The Practice Direction states agendas *'must not be in the form of leading questions or hostile in tone'*. As a general rule of thumb, start by trying to draft non-leading closed questions i.e., questions that require a yes or no answer. *'Do you agree the Defendant was negligent?'* is not suitable. *'Was the Defendant negligent?'* is fine. That said, every case and issue is different, and there's nothing fundamentally wrong with a simple, neutral, and objective open question. The main point is that the questions should never be leading. In *Cara v Ignotus* [2015] 10 WLUK 170 Master Yoxall reinforced this point, and also confirmed that if a party formulated an agenda using leading questions, it ran the risk of being required by the court to reformulate it so as to comply with the Practice Direction.

Fifthly, and in default of agreement between the parties, think carefully about how you manage any disagreement. There's no need (and rarely enough time) to keep going back and forth. Some model directions suggest having 2 agendas, numbered sequentially. However, Mrs Justice Yip (this time in *Saunders v Central Manchester University Hospitals NHS Foundation Trust* [2018] EWHC 343) didn't agree with this, on the basis it tested the patience of the expert (and court), produced a lengthier joint statement, and potentially increased costs. Instead, she recommended simply inserting some additional questions into a single agenda, and also raised the prospect of the court considering cost consequences in the future.

Sixthly and finally, be creative. We are governed by the rules, but the rules are also reasonably flexible. For example, the rules don't say when a joint meeting has to happen, instead, it can be ordered *'at any stage'*. The notes in the White Book at CPR 35.12.1 confirm that discussions between experts may be directed at any stage and either before or after the disclosure of their reports, and that it is important that experts should communicate at the earliest possible stage to establish that they are answering the same questions or addressing the same issues. In cases that are bound to be resolved by the evidence, there's no reason why parties can't expedite process. It's now quite common to exchange expert evidence on a without prejudice basis pre-issue, and there's nothing to stop you organising a discussion after that, or at least before being positively required to do so by the court. If you chose to do that make sure it's clear whether or not that meeting is also being conducted on a without prejudice basis. The rules also don't say anything about how to structure an agenda. In some cases, it may be sensible to draft questions based on the allegations as they appear in the pleadings. In other cases, often more complex cases, you might prefer the experts deal with the issues of medical principle, so that the parties can then apply those principles to the allegations. The rules also don't say anything about how many times the experts can meet to prepare a joint report. In fact, the notes in the White Book at CPR 35.12.2 do say that in some exceptional circumstances *'it may be apparent to the parties or their lawyers that the experts' views set out in a joint statement are based on a material misunderstanding of law or fact. In such a situation this should be drawn to the experts'*

attention so they may consider the point before trial'. It seems to me that a good way to resolve this sort of problem would be to arrange for a second joint meeting, but clearly that should, as the notes warn, *'not be used by way of an inappropriate attempt to reopen the experts' discussion by a party dissatisfied with its result of the first one'*.

In summary, in the current climate agendas for joint discussions are likely to be a crucially important step in the process of litigating a claim. Whilst joint meetings are usually effectively obligatory, agendas aren't. If an agenda is *'necessary'* do it early, get the pre-amble right, and approach the process collaboratively. The best way to do that is to keep the agenda short and sweet, and the questions simple, neutral, and closed if possible. If there is a dispute about the content of an agenda, try not to fall out, and if you have to, manage that disagreement fairly and proportionately. In addition, in the right set of circumstances, think creatively about when you time the joint meeting, what goes in the agenda, and whether you might need a second meeting. In the end we are just aiming to produce, as Mrs Justice Yip said, a document to help us *'understand the key issues and each expert's position on those issues'*.

Tomlin Orders: When and How Should They be Used in Personal Injury and Clinical Negligence Litigation?

JUSTIN VALENTINE
ST JOHN'S CHAMBERS

There is, in general, no need to use a Tomlin order where all that is required is an order that one party shall pay money to another. However, one party may request that the terms of settlement be recorded in a Tomlin order rather than an ordinary consent order. This article reviews the reasons that may be suggested for using a Tomlin order, examines the validity of such reasons, sets out the advantages and disadvantages of such a procedural step and discusses the safeguards which should be employed if a Tomlin order is used.

After trial in which the claimant has been successful, there will be judgment for the claimant and an order for costs in the claimant's favour. An ordinary consent order follows this format, is entitled *"Consent Order"* and, in its simplest form could be as follows:

> 1. Judgment for the Claimant in the sum of £x [or *"The Defendant shall pay to the Claimant £x"*] in full and final settlement of the claim, such sum to be paid to the Claimant's solicitors by [14 days].
>
> 2. The Defendant do pay the Claimant's costs of the action to be subject to detailed assessment if not agreed.

A Tomlin order is a form of consent order which avoids the entering of judgment. It takes its name from a Practice Note issued by Tomlin J in 1927 though it was in use well before that date.

A Tomlin order is in two parts. The first part is the court order proper which stays the proceedings on agreed terms contained in the second part, the schedule. The schedule records the terms of settlement agreed between the parties and amounts to a binding contract. The contract set out in the second part cannot be directly enforced as an order of the court but requires an application to carry the terms into effect in the case of breach, ie failure to pay the agreed damages. In its simplest form in the personal injury/clinical negligence context it is headed "Tomlin Order" and is in the following format:

Court Order

1. The claimant and the defendant having agreed to the terms set out in the schedule hereto, it is ordered that all further proceedings in this claim be stayed except for the purpose of carrying such terms into effect. Permission to apply as to carrying such terms into effect.

2. The Defendant do pay the Claimant's costs of the action to be subject to detailed assessment if not agreed.

Schedule

1. The Defendant shall pay to the Claimant's solicitors the sum of £x in full and final settlement of his claim in this action by [14 days].

The *"Permission to apply"* provision at paragraph 1 of the court order is the mechanism by which breach, ie failure to pay, can be enforced.

The order for costs, paragraph 2, must be in the court order proper otherwise the court will not be able to exercise the judicial function of the detailed assessment process.

Absence of Judgment

As is apparent, there is no judgment in the sum of £x in a Tomlin order. This has a number of important implications.

Interest

In the absence of a judgment the settlement sum will not attract statutory interest (currently 8% per annum). Although late payment of damages is rare, it can happen. Accordingly, this is not a theoretical but an actual risk which may prejudice a claimant. This can be remedied by the inclusion of an interest provision in the schedule.

Enforceability

Similarly, as the terms of settlement are not in the court order proper, they cannot be directly enforced as an order of the court but by lifting of the stay and application for breach of contract. The usual remedies for enforcement set out in the CPR do not apply. This carries a time and cost repercussion for the claimant. Inclusion of an interest provision will go some way to ensuring payment is made. However, it may also be sensible to include in the schedule a term that the defendant shall be liable for costs of enforcement on an indemnity basis.

Amending the Tomlin order set out above to include interest and costs of enforcement yields the following suggested order (additional paragraph in bold).

Court Order

1. The claimant and the defendant having agreed to the terms set out in the schedule hereto, IT IS ORDERED THAT all further proceedings in this claim be stayed except for the purpose of carrying such terms into effect. Permission to apply as to carrying such terms into effect.

2. The Defendant do pay the Claimant's costs of the action to be subject to detailed assessment if not agreed.

Schedule

1. The Defendant shall pay to the Claimant's solicitors the sum of £x in full and final settlement of his claim in this action by [14 days].

2. If payment is not made by [14 days] then the settlement sum shall attract interest of 8% per annum and the Defendant shall be liable on an indemnity basis for the Claimant's costs in setting aside the stay to seek enforcement of the compromise including the interest payable as a consequence of late payment.

Defendant Reluctant for Judgment to be Entered

The lack of a judgment against the defendant is the main reason given by defendants for use of a Tomlin order.

This is sometimes expressed as a *"psychological"* or emotional reluctance which may be relevant where the lay client, usually a small company or individual in such cases, is unhappy at the settlement reached but has been persuaded by the legal team that settlement is commercially sensible. It will be a matter for the parties as to whether this wish is catered for. As long as the safeguards above are taken, then the risk of using a Tomlin order is minimised.

More often, the reason for wishing to avoid judgment is said to be the concern that there will then be a judgment debt which may have relevance to credit worthiness or generally to the standing of the company involved. This rationale cannot withstand legal scrutiny for the following reasons.

Section 98 of the Courts Act 2003 provides that a register is to be kept, in accordance with regulations, of judgments entered in the High Court and the County Court. Those regulations are the Register of Judgments, Orders and Fines Regulations 2005/3595.

Regulation 8(1)(a) provides that the appropriate officer shall send to the registrar a return, subject to regulation 9, of every judgment entered in the High Court and a County Court. Banks and loan companies use the register to decide whether to give credit or loans.

However, regulation 9(c) provides that regulation 8(1)(a) does not apply to any judgment until:

i. an order is made for payment by instalments following an application by the judgment creditor;

ii. an application is made for payment by instalments by the judgment debtor;

iii. the judgment creditor takes any step to enforce the judgment under Part 70 of the 1998 Rules (general rules about enforcement of judgments and orders);

iv. the judgment creditor applies for an order under Part 71 of the 1998 Rules (orders to obtain information from judgment debtors);

v. the judgment creditor applies for a certificate of judgment under rule 8 of CCR Order 22 in Schedule 2 to the 1998 Rules;

Pursuant to the above provision, if payment is made on time, then the judgment will not be registered. Moreover, regulation 11 provides that where it comes to the attention of the appropriate officer that the debt to which the entry relates has been satisfied one month or less from the date of the judgment, that officer shall send a request to the registrar to cancel the entry and where it has been satisfied after more than one month, the officer shall send a request to endorse the entry as to the satisfaction of the debt.

It is therefore apparent that if payment is made on time of the judgment sum, then the debt will not be registered

and there can be no issue of credit worthiness or of the standing of the company.

Qualified One-Way Costs Shifting ("QOCS")

There is one situation where the use of a Tomlin order for a claimant is highly advisable, namely where there are multiple defendants and settlement is reached with one, some but not all of those defendants.

Cartwright v Venduct Engineering Limited [2018] EWCA Civ 165 is authority for the proposition that a winning defendant in a QOCS case may recover its costs from damages ordered against a losing defendant. In that case the claimant sought damages for noise-induced hearing loss against 6 defendants. The claims against D4, D5 and D6 were compromised by way of a Tomlin order with a schedule attached which provided that the claimant accept £20,000 in full and final settlement of his claim. The claims against the other defendants were discontinued. D3 sought its costs arguing that they could be enforced against the claimant out of the £20,000. Judge Hale held that as they had been paid pursuant to a Tomlin order there had been no *"order for damages and interest made in favour of the claimant"* within the meaning of CPR 44.14(1). D3 appealed and the matter was leap-frogged to the Court of Appeal.

The Court of Appeal dismissed the appeal. It held that there was nothing in CPR 44.14(1) to suggest that the fund out of which a costs order against a claimant would be met was limited to damages paid by the defendant who sought to enforce the costs order. However, the judge was right that a Tomlin order was a record of a settlement reached between the parties and since the payment of damages was within the schedule, it was not an order to which CPR 44.14(1) applied.

This is clearly a very compelling reason for a claimant, in the case of multiple defendants, to compromise a claim by way of a Tomlin order. Similarly, defendants would be wise to reach agreement between themselves not to compromise claims by way of Tomlin orders.

Confidentiality

One of the reasons offered by defendants for the use of a Tomlin order is confidentiality. This may be relevant in commercial litigation but is rarely an issue in personal injury and clinical negligence litigation. Confidentiality in relation to a settlement is a serious matter which requires the nature of the confidentiality sought to be set out in the clearest terms, for example, who can the agreement be disclosed to, is the confidentiality term a condition of the agreement and what are the repercussions if there is a breach. It would, it is suggested, be very unwise to agree to confidentiality in the personal injury context if breach may result in the repudiation of the agreement.

Moreover, it is suggested it would be inappropriate for any public authority (eg the NHS) to request confidentiality of the terms of compromise.

Variation of Periodical Payments

According to the White Book at note 40.6.2, where a claimant is *"pressing for a provisional damages award and an order permitting variation of the periodical payments, should the contingency arise, a Tomlin order may prove to be a useful device for settling quantum on a conditional basis"*. The same would hold for a defendant seeking variation of periodical payments. The latter may arise, for example, where a defendant has a certain scepticism that a claimant will move to, or stay within, his own private accommodation as opposed to statutory-funded residential care.

The terms of CPR 41.8 and the Practice Direction will not permit a variable periodical payments order where the dates on which and the amount of increase or decrease is uncertain. Such order was sought in *AA v CC and MIB* [2013] EWHC 3679 (QB) where Swift J held that the court did not have power under CPR 41 to make an order for periodical payments which would start and end on dates which were uncertain. Further, the court found that the Damages (Variation of Periodical Payments) Order 2005 did not assist the parties in the circumstances. Nevertheless, a solution presented itself in the form of making this part of the agreement subject to a Tomlin order. Swift J was then content to approve the Tomlin order.

However, as is made clear in a useful discussion of Tomlin orders by Warby J in *Zenith Logistics Services (UK) Ltd and others v Keates* [2020] 1 WLR 2982 the schedule to a Tomlin order merely records the terms of settlement agreed between the parties. Therefore, the court cannot *"approve"* those terms for the purposes of CPR 21.10, ie where the claimant is a child or protected party. Approval is an exercise of judicial function representing an external check on the propriety of the settlement; *Dunhill v Burgin* (Nos 1 & 2) [2014] UKSC 18; [2014] 1 WLR 933.

Accordingly, a Tomlin order is not an appropriate mechanism where a party lacks capacity (as he did in *AA v CC* and MIB).

In any event, attempts to sidestep the clear provisions of periodical payment legislation, both procedural and substantive, are unwise. Although it may allow agreement to be reached by the respective legal teams in relation to the instant claim, it risks dispute by funders and deputies in the future. Such risks do materialise and will be associated with significant costs which will be borne by the funder and by the claimant out of the settlement sums.

The note in the White Book referred to above should therefore be treated with considerable caution.

Effect of Tomlin Order on Future Claims

In *Vanden Recycling Limited v Kras Recycling Ltd* [2017] EWCA Civ 354 the court of Appeal gave guidance on the differences between a consent order and a Tomlin order. It held that a consent order was, in substance and effect, the same as an order following judgment. Accordingly, with reference to *Jameson v CEGB* [1998] 1 AC 455 a satisfied judgment ordinarily bars claims against other tortfeasors who are liable for the same damage.

This could be relevant, for example, in a case where an accident at work is followed by potential clinical negligence, a claim is brought against the employer tortfeasor which is then compromised on a commercial basis. If a consent order is utilised, there may be, depending on the parties' intention as to whether the full measure of the claimant's loss had been fixed, no further permissible claim against the provider of medical treatment. The better option in this case would be to use a Tomlin order and expressly reserve the right to bring proceedings against other defendants.

Conclusion

Tomlin orders are used too often in personal injury and clinical negligence claims. Outside the very specific and defined circumstances above, their use cannot be logically justified. If they are used then the safeguards mentioned above as to interest and enforcement should be included within the schedule.

Independent Evaluation in Clinical Negligence Cases

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Optimal dispute resolution

As a silk in clinical negligence cases, it seems to me that clients are often best served by early resolution of their clinical negligence claims. However, except in the simplest of matters, cases take significant time to prepare. There are often lengthy waits whilst expert evidence is collected, due to the availability of experts, the best of whom have substantial waiting lists. There then comes a long delay whilst the defendant carries out a similar exercise. Assuming matters remain in dispute there is the court process itself, from issue to trial takes 18 months to 2 years, even in non-COVID times. Add this all up and it is rare that a case will be resolved at a trial in less than 4 years from the date of alleged negligence. This is a sizeable portion of anyone's life, but perhaps particularly for those suffering the continuing effects of medical negligence. I have been involved in a number of cases where a seriously injured claimant has tragically died before their case has resolved. Importantly the case hangs over the heads of the clinicians involved too. The Court backlog and impact of COVID are well-publicised, and there is reason to fear the situation will become even more sub-optimal in future.

In addition to the delay and stress, there is the cost. A fully prepared clinical negligence case fought to trial is expensive, and the defendant's costs are now usually irrecoverable.

If everyone agrees, as I think they do, that speeding things up would be beneficial, not just to the claimant and their family, but also to the impugned clinicians and their employers, how can his be done without compromising justice to either party?

Alternative Dispute Resolution (ADR) has long been encouraged by the Courts. It is now 15 years since Lord Dyson's judgment in *Halsey v Milton Keynes NHS Trust* [2004] EWCA Civ 267, supposedly changed the game:

> *"All members of the legal profession should routinely consider whether their clients' disputes are suitable for ADR. Acting in a client's best interests includes... advice on resolving disputes by all appropriate means of ADR as well as litigation."*

Nearly a decade after *Halsey*, the judiciary's frustration was evident in *Oliver & Anor v Symons & Anor* [2012] EWCA Civ 267:

> *"It depresses me that solicitors cannot at the very first interview persuade their clients to put their faith in the hands of an experienced practitioner...to guide them to a fair and sensible compromise of an unseemly battle which will otherwise blight their lives for years."*

Since 2013, parties in personal injury disputes in England & Wales have been able to utilise a form of Early Neutral Evaluation (ENE), where the focus is on getting to the answer that would be given at trial. There is no reason why ENE cannot be deployed in clinical negligence disputes.

In the case of *Seals & Anor v Williams* [2015] EWHC 1829, Norris J neatly encapsulated matters:

> *"The advantage of an Evaluation process over Mediation is that a person with subject matter expertise evaluates the parties' cases in a direct way, and provides an authoritative view of the legal issues of the case and an experienced evaluation of the strength of the evidence. The process is particularly useful where the parties have very differing views of the prospect of success and perhaps an inadequate understanding of the risks of litigation itself."*

The Civil Procedure Rules were specifically amended to recognise the role of ENE. CPR: 3.1(2) provides that the Court may:

> *"(m) take any other step to make any other order for the purpose of managing the case and furthering the overriding objective, including hearing an Early Neutral Evaluation with the aim of helping the parties settle the case."*

In *Lomax v Lomax* [2019] EWCA 1467, ENE was ordered despite one party not consenting and not wanting to engage. It was held that to impose a limitation to the effect CPR 3.1(2)(m) required the consent of all parties would be contrary to the overriding objective. In *Laporte and Christian v Commissioner of Police of the Metropolis*

[2015] EWHC 371 (QB), Turner J found that the Defendant's belief in having a cast-iron defence (which was proved correct at trial) could not justify their refusal to engage in ADR and must be reflected in a punitive costs order.

In *Marsh v Ministry of Defence* [2017] EWHC 3185 (QB) Thirlwall LJ made it plain that if public bodies sought to avoid engaging in ADR *"for public policy reasons"*, then they have to be prepared to take the costs consequences.

It is worth explaining how ENE works and how it differs from other forms of ADR. In a mediation the mediator is not supposed to express any view on likely outcome, unlike in an evaluation, and so provides no evaluation of the strengths and weaknesses of either side's case. In a JSM of course the parties have their own positions to try to thrash out, but with no independent guidance and assistance as to likely outcome of any dispute or disputes. Parties perhaps unwilling to recognise the strengths of the opposing party's case overall, or on particular issues, during a mediation or in an RTM, may find it easier to accept an impartial evaluation of the merits of both their own and their opponent's positions by an independent practitioner.

The process is this:

Step 1:

One party suggests, or both parties agree, referral to Independent Evaluation. This can be at any stage from pre-issue and even occurs after first instance decisions when permission to appeal has been granted.

Step 2:

An Evaluator with relevant expertise is appointed for the entire duration of the process. Contact is established with both parties' representatives. Assistance is provided in identifying the legal and factual issues.

Step 3: Directions

Replicating the Court's functions in terms of evidence gathering, Interim Payments, etc. Exploring the strengths and weaknesses of positions. Guiding the management of expectations. Helping the parties make decisions and optimising resolution of the dispute. Approximately 75% of disputes resolve by the end of or shortly after the Directions phase.

Ensuring that sufficient evidence is available to enable a forensic analysis of the probable outcome at trial and avoiding unnecessary and irrelevant evidence. Ensuring that the parties lodge Position Statements and costs estimates not less than 7 days ahead of the Evaluation day.

Step 4: Evaluation

Less formal than a trial and without cross-examination. Evaluations were undertaken in person but adapted quickly to the COVID-era and are now being done remotely. On complex issues, it is possible that certain experts will be involved in the day and questioned by the Evaluator. The Evaluator informs the parties of the likely outcome at trial ('*the evaluation*'); helps the parties achieve a mutually optimal settlement ('*facilitation*'); and resolves costs on the same day (except for Appeal cases).

Step 5: Facilitation & Costs

The Evaluator then performs a facilitative mediation to ensure that the parties achieve a mutually optimised resolution. The parties having been required to provide costs information prior to the Evaluation day, every effort is made to resolve costs and thereby avoid those matters remaining a source of ongoing dispute.

The advantages of this process may be significant. Including a settlement protecting any ongoing therapeutic relationship; greatly reduced stress and strain to those involved; and much quicker resolution of the dispute, particularly if trials are listed years away. The parties should feel that they have seen the likely outcome at trial without the delay and cost of a trial.

Before the Detailed Assessment: The Costs Mediation

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Case over. What next?

The answer depends upon how the case came to be over (we are talking here about multi-track costs). If at trial, the likelihood is that the Judge will not only have given a judgment, but also decided who should pay the costs. Usually that means that the loser will be ordered to pay the winner's cost with the order continuing that these must be *"assessed if not agreed"*. It follows that in the absence of agreement, the court will decide by detailed assessment under Civil Procedure Rule (CPR) 47 what is due.

The position is different if an offer under CPR Part 36 is accepted within time. In that eventuality, there is a deemed costs order for standard costs in favour of the party accepting the offer -see CPR 36.13(1) and CPR 44.9. Likewise, where a party discontinues an action and serves notice under CPR 38, a costs order eventuates in favour of the discontinued-against-party (see CPR 38.6) carrying an entitlement to have those costs assessed under CPR 47.

Finally, the case can end on terms being agreed between the parties. In those circumstances, they can strike their own bargain about the costs, but often the settlement will provide for the loser to pay the winner their costs, or at least a proportion them, again with the entitlement to have them assessed by the court if they cannot be agreed.

Let us suppose that the case has been concluded in one of the ways described above. If it has not been possible to agree the costs, is the next step to start detailed assessment proceedings, pay a court fee and ask the court to decide what they should be?

No, it is not. Stage one ought to be to consider whether there is another way in which the costs can be resolved. Do that and quickly, and the words *"Alternative Dispute Resolution"* (ADR) will spring to mind, the best-known form of which is Mediation.

The first thing to note about Mediation is that it is not a judicial process at which binding decisions are taken but one where the involvement of a neutral third party is used to break the deadlock. An excellent description is that given by Catherine Newman QC in *Burgess v Penney* [2019] Costs LR 1453.

> *"Mediation should not be about one side getting what they want. That is a misconception of the purpose of mediation. Mediation should be about attempting to reach a solution which both parties can live with as a better alternative to litigation...."*

Having said *"think Mediation"*, it is only fair to CPR 47 to say why detailed assessment should not be the first and only port of call after negotiations have broken down. The reason is that Mediation, when successful, is quicker, cheaper and delivers a result that is risk free. If it does not result in a settlement, those costs will be additional to those of the detailed assessment, but as the success rate at mediation is high, it is a chance that parties ought to be prepared to take.

The starting point is to look at what happens when receiving parties obtain their costs orders. There is no chance that the paying party will sign a cheque payable to bearer, leaving the amount blank. In all matters, some form of costs breakdown will be needed and that is also the case where the parties agree to mediate. In an action which has been budgeted under section II of CPR 3, a schedule for the pre-budget costs plus the last agreed or approved budget might suffice. If not, a more detailed schedule may be needed. Failing that, a full bill will be required, but if the matter is not going to proceed to a detailed assessment, this need only be a paper bill, rather than the cumbersome electronic monster which requires the bill detail section to list everything down to the last one-line e-mail.

Once the bill, breakdown or schedule has been served and the paying party has had an opportunity to consider the claim for costs, that is the moment that thought should be given to Mediation, but it takes two to tango. All parties must agree to mediate and no one, not least the court, can bring an unwilling participant kicking and screaming, to the Mediation table.

That said, *Refuseniks* beware. In an action, those who unreasonably refuse an offer of ADR, and Mediation in particular, have long since been subject to penalties. These are likely to include the disallowance of costs to which they would otherwise be entitled, or to costs being awarded against them on the indemnity rather the standard basis -see for example *Wales (t/a Selective Investment Services v CBRE Managed Services Ltd* [2020] Costs LR 603. Similarly, in detailed assessment proceedings, Costs Judges have expressed judicial disapproval by similar means where paying parties have unilaterally refused a reasonable offer by the receiving party to mediate – see *Reid v Buckinghamshire Healthcare NHS Trust* [2015] WLUK 752.

Let us assume, however, that the case has ended and rather than go directly to the expense of a detailed assessment, the parties have decided to give Mediation a try. To that end, they have engaged the services of a Costs Mediation Services Provider and signed a Mediation Agreement containing the terms upon which each side has agreed to mediate. They have done that for the following reasons: -

- They can choose the Mediator from an experienced panel offered by the Mediation Services Provider. Contrast the court, which appoints the judge without reference to the parties.
- They can decide when, where and for how long the Mediation will last. Contrast the court which sets the timetable and may involve the hearing not being listed for at least six months hence, or longer.
- They decide what they want to spend as the Mediator's fee will be agreed in advance and usually split 50/50.Contrast the court where the costs of assessment are uncapped and open ended.
- They choose the documents which they wish the mediator to see. Contrast the court which mandates everything which must be uploaded onto the court file under CPR 47.13 PD 13.12.
- They agree that the Mediation is to be confidential and that nothing said can subsequently be disclosed or used against them. Contrast the court, where everything is tape recorded and can be transcribed at the request of any member of the public.
- They are in control of their destiny at all times in the sense that the Mediator cannot impose a solution or settlement. Contrast the court, where, like it or loathe it, what the judge says, goes.
- With Mediation, there is no such thing as a bad day in court, where the parties are at risk of being at the wrong end of a Part 36 offer which may have an enormous financial impact on the outcome. Likewise, the loose cannon proportionality test under CPR 44.3(5). At a Mediation, it is irrelevant.
- The costs themselves: settle these at the Mediation, and it is cash in the bank for the receiving party and an end to the paying party's liability to pay interest at the best deposit rate around -8% on yet-to-be-ascertained costs.
- Finally, finality. Agree the costs at Mediation and the case is over. No more days in court. No appeals. Time to get on with the next case without the cloud hanging over the parties of having to argue about whether work done on a matter that might have started five years ago or more, was reasonably undertaken.

If this sounds like a panacea, why has Mediation not replaced detailed assessment as the means by which all costs are resolved at the end of the case?

The answer to that is that Mediation is not suitable for all types of dispute, as will be seen shortly. That said, there are two principal reasons why parties are reluctant to mediate. The first is that it is believed that Mediation adds another layer to the overall costs which will be wasted if the process fails. Mostly wrong. Even if the Mediation does not work on the day, in all likelihood it will resolve some of the *"Big Ticket"* issues and parties who keep on talking often find that they are be able to reach an agreement within the following week or two.

The second reason is ignorance about the process. Mediation is not about trying to persuade a judge to your point of view through advocacy and the successful deployment of legal arguments. Instead, it is about getting a conversation going which has broken down by talking through those issues which have prevented settlement, in the presence of a neutral third party, called a Mediator.

How does the Mediator go about doing that? The Mediation will start with a facilitative stage. That will involve all parties being in the same room (whether that is in-person or in a remote Zoom or Teams room, matters not) so that the parties can chat across the table and identify the sticking points which hitherto have prevented a settlement. Often that will involve the hourly expense rates, the indemnity principle or the *"Wild West"* proportionality test under CPR 44.3(5). In this context, short Position Statements setting out each party's stance, are useful. Sometimes, with the help of the Mediator, issues such as these can be resolved, but if not, the Mediation can go into *"Private Session"*. By this is meant that the Mediator will have a confidential discussion with each party in a private room (easily set up

where the Mediation is being conducted remotely) when the party in question can talk in complete confidence about the case. Any offers can be communicated by the Mediator to the other party, in total contrast to the court where the Judge cannot know anything about offers and what has been going on behind the scenes. By using Shuttle Diplomacy in this way, very often an agreement can be brokered.

If not, what next?

Absent agreement at the facilitative stage, the Mediation will not have worked, but that does not mean that it has failed. If (and only if) the parties agree and sign a piece of paper evidencing that fact, the Mediator can be invited to undertake an Evaluative Mediation. That is an entirely different process under which the Mediator ceases to be neutral, but instead expresses a view about the merits of the issues which are dividing the parties. Put differently, if asked, the Mediator will give an opinion as if he or she were sitting in the Costs Judge's chair, which may include (if requested) a basis for settlement. Contrary to the court, however, where the judge's decision is final, a Mediator's evaluation is *"Take it or Leave it"*. The parties will be invited to consider the evaluation, but the Mediator has no power to impose it. Whether or not the parties wish to settle is up to them. If they do, and most Mediations work at this stage, it is for the parties to draft a simple settlement agreement which is binding on both. At that point, the Mediator's job is done.

In fairness to detailed assessment, it must be acknowledged that Mediation is not suitable for all costs disputes. Where the receiving party is a Protected Party, court approval will be required if the instructed solicitors wish to use any of the damages to pay their costs beyond the level of those agreed with the paying party, whether at a Mediation or otherwise. Likewise, where one party is a litigant in person, Mediation may not lend itself to a fair result since the Mediator cannot prevent an unjust settlement if that is what the LIP is determined to have, whereas at court, the judge decides who gets what. Beyond that, however, it is hard to think of circumstances in which a costs Mediation will not be suitable, *a fortiori* in matters under the Solicitors Act 1974. Such disputes invariably involve bad blood between solicitor and ex-client, whose dirty laundry will be hung out to dry at a detailed assessment in the glare of publicity. Contrast Mediation where everything said and done is in private and even disputes which appear to be intractable, can end up being settled without rancour.

Having decided to go to a costs Mediation, what are the ingredients which are necessary if it is to succeed?

First and foremost, the parties must have a willingness to compromise and those with authority to do that must attend the Mediation or be available by direct telephone contact. There is no point in going through the motions just to avoid the risk of an adverse costs order being made. Do that, and the miscreant will be found out and penalised – see judgment of Jack J in *Malmesbury v Strutt & Parker* [2008] 5 Costs LR 736. at paragraph 72.

Second, the parties must be able to feel and absorb pain. As Catherine Newman QC recognised, Mediation is not about winning or losing. If a party wishes to win, they should go to detailed assessment, but if they do that, they should remember that there is no such thing as a watertight case. Things can go wrong on the day. Should that happen (for example by coming a cropper under Part 36 .7(4)), they will end up as the loser. With Mediation, there are no losers, because the parties decide for themselves whether they wish to settle or not. If they do, the likelihood is that the paying party will believe that too much is being paid, whereas the receiving party will reckon that they have settled for not enough, but that is the nature of Mediation. To get a result you can live with, you must be able to take and absorb pain but the prize for doing that is in the elimination of risk and the achievement of certainty.

What price that certainty? Settle at Mediation and that is the end of the litigation. Battle on through detailed assessment and there is no such end because there can be an appeal. Much better to clinch the deal, close the book and get on with the next case.

Supreme Court reduces standard of proof for suicide and unlawful killing in inquest conclusions

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R (on the application of Maughan) (Appellant) v Senior Coroner for Oxfordshire [2020] UKSC 46

The Supreme Court has on 13 November 2020 handed down the judgment in this case concerning the appropriate standard of proof for conclusions at inquests.

Facts

The inquest concerned the death of Mr. James Maughan ("JM") who died whilst in custody at HMP Bullingdon. He was found in his prison cell hanging by a ligature from his bedframe. He had a history of mental health issues and was agitated on the previous evening and threatened self-harm. At the inquest, the Senior Coroner for Oxfordshire decided that a jury could not safely reach a short form conclusion of suicide. This was because the jury could not be sure beyond reasonable doubt that JM had intended to kill himself. The Senior Coroner invited the jury to return a narrative statement of the circumstances of JM's death on the balance of probabilities. The appellant, JM's brother, began judicial review proceedings to establish that the jury's conclusion was unlawful. He argued that the Senior Coroner was wrong to instruct the jury to apply the civil standard of proof when considering whether JM had committed suicide (as part of the narrative conclusion). Both the Divisional Court and the Court of Appeal had dismissed the application, concluding that the standard of proof for short form and narrative conclusions of suicide was the civil standard.

The Decision

By a majority, the Supreme Court decided that the appropriate standard of proof for the short form conclusion of suicide is the balance of probabilities – the civil standard. Lord Kerr and Lord Reed dissented.

Importantly, the Supreme Court went further, and determined that the standard of proof for *all short form conclusions at inquest is the balance of probabilities*. This includes the short form conclusion of unlawful killing.

Conclusions at inquest can be given by way of a short form (often the use of a single word e.g. suicide) or a narrative conclusion (a brief factual statement). The standard of proof is now the same in both.

Reasons for the decision

The Supreme Court noted the *"recent transformation"* of many inquests from a traditional inquiry into a suspicious death into an investigation which is to elicit the facts about what happened and in appropriate cases identify lessons to be learnt for the future. The changing social attitudes and the changing scope of inquests was a significant factor in the decision of the majority.

The Coroners and Justice Act 2009 does not state the standard of proof for conclusions at the end of an inquest. The Coroners (Inquests) Rules 2013 (produced pursuant to section 45 of the 2009 Act) contains a note within the Record of Inquest (which is a prescribed form referred to in rule 34) that *"the standard of proof for the short form conclusions of 'unlawful killing' and 'suicide' is the criminal standard of proof. For all other short form conclusions and a narrative statement the standard of proof is the civil standard of proof"*. The majority considered that this note amounts to a matter of procedure and effectively represented the law as it stood at that time.

Criticism for the standard of proof for suicide (beyond reasonable doubt, at that time) was not new in 2013 however those drafting the 2013 rules did not consider that it was appropriate to evoke a change in the law via that secondary legislation.

However, the majority in this case found that the Note (iii) does not take away the role of the courts in reviewing the common law.

Lady Arden noted, as had the Court of Appeal, that the provision in the 2013 Rules allowed for the possibility of different standards of proof in the same inquest i.e.

beyond reasonable doubt in the short form conclusions of either suicide or unlawful killing but the civil standard in any narrative conclusion. Whilst in many inquests a narrative is often used as an alternative to a short form conclusion, it is possible for both to be used.

Lady Arden, providing the leading judgment, considered that the civil standard should apply for the following reasons:

- The common law does not demonstrate any cogent reason for not applying that standard.
- Inconsistent conclusions could be reached in the same inquest if the law remained as it was. A system of fact-finding on that basis is internally inconsistent and unprincipled and does not meet the standards of a modern, principled legal system.
- The civil standard still results in safeguarding the interests of those adversely affected by the conclusion. It still requires a finding that the deceased took his own life and intended to do so, on the balance of probabilities. It is not enough for the coroner or jury to think that because certain possibilities (e.g. unlawful killing by an unknown person) can be discounted, that suicide must have occurred.
- The criminal standard of proof may lead to suicides being under-recorded and to lessons not being learnt. There is a considerable public interest in accurate suicide statistics as they may reveal a need for social and medical care in areas not previously regarded as significant.
- There has been significant changes in societal attitudes and expectations over recent years, in particular to suicide. Suicide used to be a crime, however it is not any more. Now, the bereaved are awarded in cases where proper precautions have not been taken when a person was at risk of suicide.
- Whist the views of some with certain religious beliefs consider that suicide is a moral sin, this could not be described as the generally prevailing attitude of society.
- The purpose of inquests has changed.
- Other leading commonwealth jurisdictions have also taken this course.

The Supreme Court went further, however, and confirmed that the lower civil standard of proof would apply for the short form conclusion of unlawful killing. This view had been rejected by the Court of Appeal for a number of reasons including a concern about the protection for a person implicated in any conclusion of unlawful killing. It was noted that that person might be less able to enjoy the protection conferred by s10(2) of the 2009 Act (the determination at an inquest may not answer any question of criminal liability on the part of a named person) if the standard of proof was lower.

The Chief Coroner provided arguments before the Supreme Court both for and against the lower standard of proof. The Chief Coroner explained that the application of the criminal standard in unlawful killing cases derives from the fact that coronial proceedings used to be a means for finding criminal liability. It used to be the duty of the coroner's jury to record the name of the person considered to have committed the offence of murder, manslaughter or infanticide. However, section 56(1) of the Criminal Justice Act 1977 removed this duty.

Lady Arden concluded that the civil standard applied for unlawful killing for the following reasons:

- There is no principled basis for distinguishing the standard of proof of unlawful killing and suicide. A different standard of proof for a short form and a narrative is likely to give rise to confusion and inconsistency. Furthermore, The person implicated is equally liable to suffer prejudice from the findings of a narrative statement, which can be found on the balance of probabilities.
- The Court rejected the argument that public confidence would be lost if an inquest concluded a person was unlawfully killed and yet the criminal prosecution failed. The public are likely to understand there is a difference between an inquest and a criminal trial.
- If there appears to be a risk that criminal proceedings will be brought before an inquest has been completed, the inquest can be adjourned and in some circumstances set out in Schedule 1 to the 2009 Act must be adjourned. This affords some protection to a person who is at risk of prosecution.

Dissenting Judgments

Lord Kerr dissented and Lord Reed agreed with his decision.

Lord Kerr concluded that the criminal standard of proof should remain for both suicide and unlawful killing. He rejected arguments as to any inconsistency between short form and narrative conclusions. There is a clear distinction between a narrative and short form conclusion. A narrative statement recounts the salient evidence and circumstances. In the case of unlawful killing and suicide,

it should not constitute a final conclusion on that evidence unless the coroner or jury has become convinced beyond reasonable doubt that it is justified.

Lord Kerr considered that the Note (iii) in the 2013 rules confirmed the existing common law (which was unquestionably that the appropriate standard of proof was beyond reasonable doubt) and it became a statutory rule. It can only cease to have effect if Parliament enacts legislation to amend or abolish it.

Conclusion

Whilst the application of the civil standard of proof to the conclusion of suicide is unlikely to be a surprise, the application of the lower standard of proof in relation to the conclusion of unlawful killing represents a seismic shift in coronial law and procedure.

Unlawful killing includes all unlawful homicide such as murder, manslaughter and infanticide. Death by bad driving cases may only be regarded as *'unlawful killing'* if they satisfy the ingredients of manslaughter (i.e. gross negligence manslaughter). Although the purpose of an inquest is to record in a judgment-neutral factual way how the deceased came by their death, in cases where there is a possibility of an unlawful killing conclusion appropriate facts may have to be explored which have some bearing on civil and criminal liability. Although pursuant to section 10(2) the identity of the perpetrators should not be given in the determination, there will be some cases where it will be obvious that a particular person is responsible for death. Whilst some will welcome the consistency now between short form and narrative conclusion, this decision will be of concern to others, given that the conclusion of unlawful killing will now be far more easily reached. The Chief Coroner may provide further useful guidance when Guidance Note 17 is updated to reflect this judgment.

Unlawful Killing: The new neglect?

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On 13 November 2020, the Supreme court in *R (Maughan) v. HM Senior Coroner for Oxfordshire* [2020] UKSC 46 determined that the civil standard of proof, balance of probability, applies to all inquest conclusions both short - form and narrative. Previously, the criminal standard of proof of beyond reasonable doubt applied to the short-form conclusions of unlawful killing and suicide.

In Maughan, the Senior Coroner decided it was not safe to leave a short - form of suicide to the jury because they could not be sure beyond reasonable doubt that the Deceased had intended to kill himself. The jury returned a narrative conclusion, based on questions from the Coroner referring to the civil standard of proof, including finding, *"We believe James deliberately tied a ligature made of sheets around his neck and suspended himself from the bedframe..."* and *"We find that on the balance of probabilities it is more likely than not that James intended to fatally hang himself that night"*. Thus, effectively, a conclusion of suicide on balance of probability was reached by a narrative without using the word *"suicide"*. Such a narrative conclusion accords with the guidance in Form 2, note (iii) on the Record of Inquest which reads, *"The standard of proof required for the short form conclusions of* "unlawful killing" *and* "suicide" *is the criminal standard of proof. For all other short-form conclusions and a narrative statement the standard of proof is the civil standard of proof"*. Accordingly, a Coroner could always have come to a narrative conclusion which implicitly found unlawful killing or suicide on balance of probability. Following Maughan, the standard of proof of balance of probability also applies to the short -form conclusions of *"unlawful killing"* and *"suicide"*.

On 13th January 2021, the Chief Coroner provided guidance on Maughan in Law Sheet 6, which notes that the law has not changed in relation to the elements of the offence of unlawful killing which need to be made out, albeit following Maughan, to the civil standard, on balance of probability. The guidance also notes that where a Coroner or Coroner's jury comes to a conclusion of unlawful killing, that finding has no bearing on criminal proceedings, which are subject to a materially higher standard of proof (as well as entirely different procedural rules).

No conclusion of unlawful killing may name the person responsible, otherwise there will be a breach of section 10(2), Coroners and Justice Act 2009. A conclusion must not be framed so as to appear to determine any question of criminal liability *on the part of a named person*, thereby legitimating a conclusion of unlawful killing provided no one is named. That person must still be capable of being identified (in the mind of the decision maker), whether by name, description or otherwise, as the person who caused the death.

What will be the consequence on healthcare inquests of the lowering of the standard of proof to balance of probability in relation to short - form unlawful killing conclusions?

Unlawful killing comprises more than one offence. Of relevance to healthcare inquests, unlawful killing includes unlawful act manslaughter, corporate manslaughter, and gross negligence manslaughter. This article considers gross negligence manslaughter, the most common form of manslaughter in the Coroners' courts.

Gross negligence manslaughter

The 6 elements of the offence of gross negligence manslaughter are: -

1) The defendant owed an existing duty of care to the victim. There will almost certainly be a duty owed by the medical practitioner to a patient.

2) The defendant negligently breached that duty of care (by an act or omission): No responsible body of doctors would regard the treatment as acceptable.

3) At the time of the breach there was a serious and obvious risk of death. Serious, in this context, qualifies the nature of the risk of death as something much more than minimal or remote. Risk of injury or illness, even serious injury or illness, is not enough. An obvious

risk is one that is present, clear, and unambiguous. It is immediately apparent, striking and glaring rather than something that might become apparent on further investigation.

4) It was reasonably foreseeable at the time of the breach of the duty that the breach gave rise to a serious and obvious risk of death.

5) The breach of the duty caused or made a significant (i.e. more than minimal, trivial or negligible) contribution to the death of the victim.

For causation of death to be proved (as with all homicide offences), the actions or omissions of the identifiable person must cause death but need not be the sole or main cause provided that they contribute significantly to it: *R v Cheshire* [1991] 1 WLR 844

If based on an omission, causation will be established only if the evidence shows that, at the time when the deceased's condition was such that there was a serious and obvious risk of death, such assistance would have saved the deceased person's life. see, for example, *Ceon Broughton v R* [2020] EWCA Crim 1093.

6) In the view of the jury, the circumstances of the breach are so reprehensible as to justify the conclusion that it amounts to gross negligence and requires Criminal sanction.

Elements 2 and 3 will not need separate consideration or articulation in many cases. The Chief Coroner's Guidance note 1 on unlawful killing combines the two.

In relation to the 6th element, *R v Adomako* [1995] 1 AC 171 (HL) indicates that a breach of duty should only be categorised as gross when it involves *'such disregard for the life and safety of others as to amount to a crime against the state and conduct deserving punishment'*. In a medical context, the *Court of Appeal in R v Misra* [2004] EWCA Crim 2375 cited, with approval, the following passages from the trial judges summing up: *"Mistakes, even very serious mistakes, and errors of judgment, even very serious errors of judgment, and the like, are nowhere near enough for a crime as serious as manslaughter to be committed"* and in *Bawa-Garba v R* [2016] EWCA Crim 1841 at 36, *"Suffice to say that this jury was (and all juries considering this offence should be) left in no doubt as to the truly exceptional degree of negligence which must be established if it is to be made out"*.

A Coroner will have to grapple with formulating the correct application of the civil standard of proof to the test that the misconduct should be condemned as the *crime* of gross negligence manslaughter.

I anticipate that the 6th element of the test is likely to be applied as a value judgment of the conduct, similar to the test for a finding of neglect. Neglect is limited in a medical context to a gross failure to provide basic medical attention. There must be *"A sufficient level of fault"*, to justify a finding of neglect. *R (Khan) v HM Coroner for West Hertfordshire* [2002] EWHC 302 (Admin) at 44. Coroners have, therefore, been applying a similar, but not identical, value judgment in relation to a finding of neglect.

Aside from differing tests relating to the *"level of fault"*, how else does gross negligence manslaughter differ from neglect?

1. The misconduct must relate to one identifiable person, whereas neglect may apply to a death arising from the combined conduct of different medical practitioners.

2. The risk of death (and nothing less) being a reasonably foreseeable consequence of the misconduct is explicitly incorporated as one element of the test for gross negligence manslaughter.

3. Neglect applies to omissions, although it does not matter if some actions were taken, provided the omissions on the part of medical practitioners are capable of forming part of the total picture which amounts to neglect. In *Cleo Scott v HM Coroner for Inner West London* [2001] EWHC Admin 105 at [28] – [29] Keene LJ said, *"There have been a number of cases where there had been medical attention but where neglect remained a possible element in a verdict … Omissions on the part of medical practitioners are capable of forming part of the total picture which amounts to neglect"*. Gross negligence manslaughter can apply to acts and/or omissions.

Implications

Where previously a family would have sought a conclusion of neglect, if the misconduct complained of can be attributed to an individual and is *"truly, exceptionally bad"*, a family may now seek a conclusion of unlawful killing.

Similarly, where the misconduct complained of is attributable to acts of an individual rather than an omission, such that neglect would not be an appropriate finding, there may be scope for a conclusion of gross negligence manslaughter, subject to satisfying the test.

An employee may need separate representation from their employing organisation because of potential conflicts of interest.

As a consequence, there may be an increased use of lawyers where unlawful killing is a possible conclusion.

Pre - action admissions of negligence may be less forthcoming given the increased possibility of a conclusion of unlawful killing.

Recently, requests were made on behalf of medical practitioners for legal protection from prosecution for healthcare professionals who may have to decide on allocation of limited resources during Covid 19. The protection sought was intended to apply where the decisions were made in good faith, in circumstances beyond the healthcare practitioners' control and in compliance with relevant guidance. Insofar as that legal protection was intended to relate to prosecutions for unlawful killing, decisions made in those circumstances of good faith seem unlikely to satisfy the test for a conviction or conclusion of gross negligence manslaughter.

Following from Maughan, it appears likely that a short form of conclusion of unlawful killing will be made more frequently in an inquest, in particular in circumstances where previously a family may have sought a finding of neglect or in circumstances where the total picture comprises acts rather than omissions such that neglect would not apply.

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On the mornings of 29th and 30th April 2021 – when we should have been in Bournemouth for the 32nd Annual Clinical Negligence Conference (ACNC) – we will bring some of the excellent speakers who were due to present at the conference directly to your computer by hosting the second online '(Not the) ACNC'. The event will have an obstetrics theme and there will be a live Q&A with the speakers at the end of both mornings. Online booking is now open and we very much hope that you will join us on the 29th and 30th April.

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Since its inception in 2007, the Court of Protection has made crucial decisions to try to protect the well-being of vulnerable individuals. In a rapidly-evolving legal environment, AvMA's third annual Court of Protection conference will examine the current state of litigation and the challenges and responsibilities facing those who work in this important area.

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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 Wednesday 1st December. Registration and a networking lunch will commence at 12.30, with the meeting starting at 13.30 and closing at approximately 17.15.

AvMA's Christmas Drinks Reception, which is also open to non-panel members, will take place immediately after the meeting. The event provides an excellent opportunity to catch up with friends, contacts and colleagues for some festive cheer! Booking will open in September but put this date in your diary now!

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24-25 March 2022 (Welcome Event 23rd March), Royal Armouries Museum, Leeds

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Early bird booking will open in September 2021, with the programme available in December 2021. 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 patient safety and justice.

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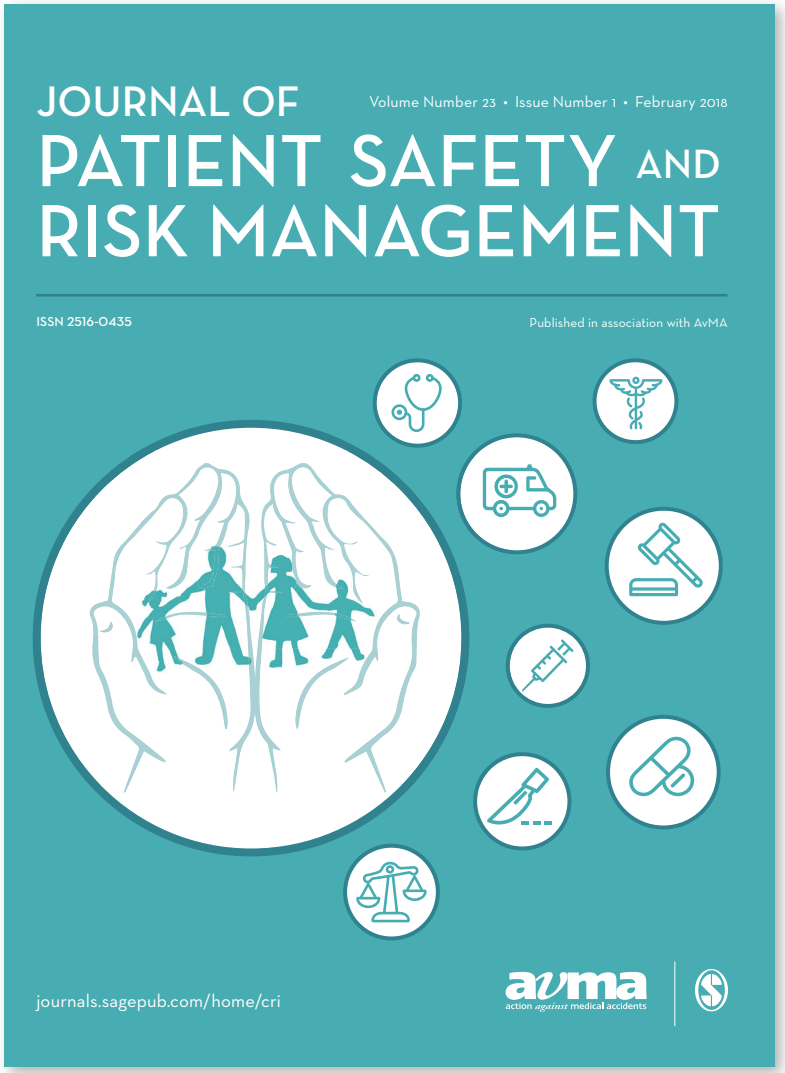

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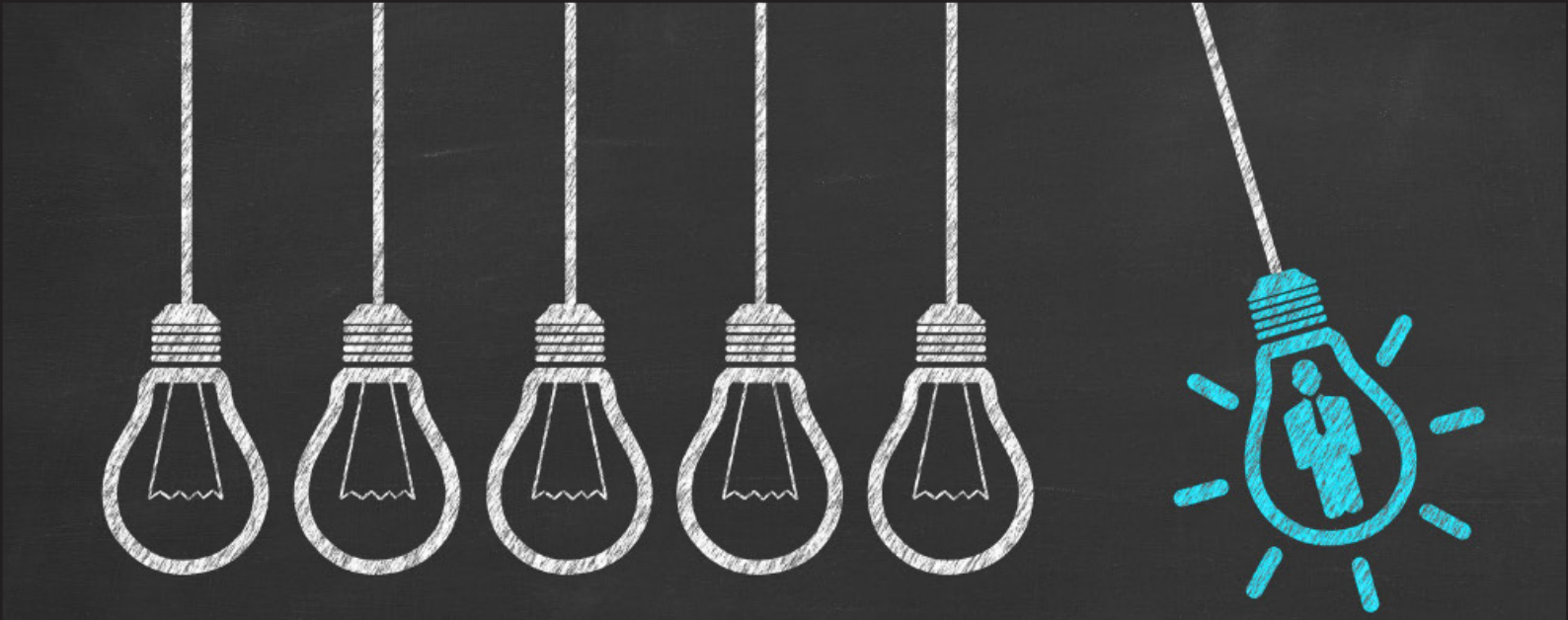

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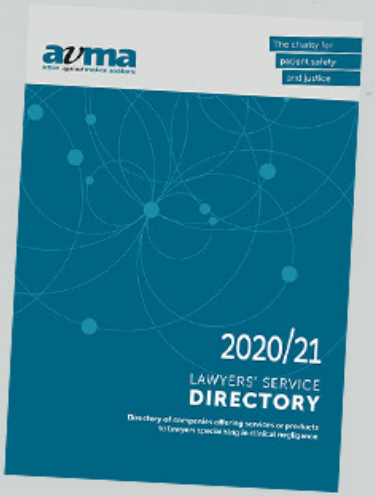

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