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Lawyers Service Newsletter

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Contents

CELEBRATING 40 ★ YEARS ★ 1982-2022

Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

We are cautiously evolving from the difficulties and challenges of the last two years moving towards a new normal of *"Living with Covid"*. We are very much looking forward to welcoming you to our annual clinical negligence conference in Leeds later this month (24-25 March).

Fixed Recoverable Costs: The Department Health and Social Care (DHSC) has now published the long-awaited consultation on FRC in lower value clinical negligence claims. The consultation opened on Monday 31st January and **closes at 11.45 am on 24th April** – please read the consultation and respond: https://www.gov.uk/government/consultations/fixed-recoverable-costs-in-lower-value-clinical-negligence-claims

Clinical Negligence Protocol: I refer to the Lawyer Service circular sent at the beginning of February for more details. In case you missed this, signatories to the Clinical negligence protocol last met on Monday 24th January. I can confirm that currently there are no plans to bring the protocol to an end. Only firms who are members of AvMA's Lawyer Service and/or who are AvMA Panel Members and members of SCIL are entitled to rely on the clinical negligence protocol. Non-members seeking to rely on the terms of the protocol can only do so by separate agreement with NHS Resolution.

The 23th January, saw the Court of Appeal (including Master Rolls, Sir Geoffrey Vos) give judgment on the conjoined appeals of *Paul & another v The Wolverhampton Hospital NHS Foundation Trust*; *Polmear & another v Royal Cornwall Hospital NHS Trust*; *Purchase v Ahmed* [2022] EWCA Civ 12. The effect of the Court of Appeal findings is to severely restrict secondary victim claims from succeeding; an appeal to the Supreme Court is expected. **David Tyack QC** and **Esther Gamble** appeared for the claimant in *Purchase* and **Henry Pitchers QC** with **Oliver May** represented the claimant in *Polmear*, all counsel practise at No 5 Chambers and I am very pleased to feature their jointly written article: ***"The Latest Developments in Secondary Victim Claims"***

Another important case is ***CAM Legal Services Ltd (appellant) v Belsner*** which was heard in the Court of Appeal on 22 – 23rd February. Although this is a PI case involving a few hundred pounds, it has potential implications

for clinical negligence claims especially if a FRC regime is introduced.

Initially, the court of appeal was expected to focus on the question of clients having sufficient information to consent to a CFA which allows a solicitor to recover charges from the client in excess of those recovered from the third party. The court has adjourned to also allow it to consider whether solicitor and client own costs need to be proportionate and at what point non contentious work, is considered contentious. Sir Geoffrey Vos MR, is a member of this court, perhaps signifying the importance of this case. The hearing will continue at the end of July, and we are most grateful to **Ged Courtney** at Kain Knight Costs Lawyers for his article updating us on the key issues in this case.

The Health and Social Care Committee (HSCC) published a report on 06.01.22 entitled *"Clearing the backlog caused by the pandemic"*: **https://committees.parliament.uk/publications/8352/documents/85020/default/** The report acknowledges that there are likely to be a number of cases where there has been a failure to assess, and/or refer for further investigation and therefore a delay in diagnosing conditions.

According to the report, appointments in general practice fell by a third from 24 million in March 2020, to 16 million in April 2020. Further, there were 5.8 million people waiting to start treatment in September 2021. 300,000 of them have been waiting more than one year for treatment, 12,000 have waited more than two years. These figures are conservative. There are no ready answers to how the backlog can and will be tackled, or how the courts will approach cases alleging negligence as a direct or indirect result of coronavirus. **Bella Webb** of Old Square Chambers explores this further in her article: ***"Covid -19 and cancer claims – what lies in store?"***

One of the stated aims of the LS Newsletter is to produce short, pithy articles on issues of importance which are easy for the busy practitioner to digest and consider. Many a clinical negligence practitioner will have faced the conundrum of how to present their client's case or indeed whether the case should even proceed given evidential difficulties posed by missing medical records and/or where instructions conflict with written evidence in the records. **Christopher Barnes**, barrister at Exchange Chambers reviews the recent case of *Freeman v Pennine Acute Hospitals NHS Trust* [2021] EWHC 3378 and summarises the existing caselaw in his article ***"The resolution of factual issues in clinical negligence claims"***.

The Newsletter also aims to share practitioner's experiences. **Robert Rose**, Head of clinical negligence and partner at Lime Solicitors has been generous in sharing his litigation tips, he candidly draws on his own experience of trans vaginal mesh litigation in his article ***"TVT/TOT/TVM mesh implant (consent) litigation – a personal view"***. It includes a particularly helpful section on *"Defendants' strategy – and how to deal with it"*

AvMA continues to put pressure on the government to adopt the recommendations set out by the Justice Committee in their report on the coroner service published in May 2020: **https://publications.parliament.uk/pa/cm5802/cmselect/cmjust/68/6802.htm** Key amongst those recommendations is the need for public funding to be made available to families for representation at inquest. **Bramble Badenach-Nicolson**, counsel from Hailsham Chambers worked with **Dr Charlotte Connor** (who leads AvMA's pro bono inquest team) on the ***Inquest Touching the Death of Catrina Greig***. Catrina had Downs Syndrome, she died from sepsis while she was undergoing treatment for acute lymphoblastic leukaemia. The coroner concluded that Manchester Children's Hospital's collective failures amounted to a gross failure to provide basic medical attention to someone in need and although he found Catrina's death was due to natural causes, he issued a rider of neglect.

AvMA is aware of several cases concerning young children (usually under the age of 4 years) with physical and/or learning difficulties who following admission to Manchester Hospitals have died. Some of the concerns raised by these families are similar, for example, the hospital's lack of communication aids such as Makaton or passports for children with learning disabilities; failures to respond adequately or at all to children's early warning scores; failure to carry out timely observations or undertake pain assessments. While not strictly pertinent to the coroner's enquiry, some families also complain of a lack of compassion during treatment and/or following their child's death. We are interested in hearing from anyone who has or has had conduct of similar cases especially where the death occurred from about 2018 onwards. Please contact **norika@avma.org.uk** if you have any information you can share with us.

Best wishes

The Latest Developments In Secondary Victim Claims

DAVID TYACK QC, HENRY PITCHERS QC AND ESTHER GAMBLE; NO5 CHAMBERS

An analysis of the recent decision of the Court of Appeal in the appeals of *Paul and Another v The Wolverhampton Hospital NHS Foundation Trust; Polmear and Another v Royal Cornwall Hospital NHS Trust; Purchase v Dr Ahmed* [2022] EWCA Civ 12 and discussion of the anticipated appeal to the Supreme Court.

David Tyack QC and Esther Gamble appeared for the Claimant in *Purchase* and Henry Pitchers QC (with Oliver May) appeared for the Claimants in *Polmear* in the Court of Appeal.

Summary

On the 13th of January 2022, the Court of Appeal delivered judgments in the conjoined appeals of *Paul and Another v The Wolverhampton Hospital NHS Foundation Trust; Polmear and Another v Royal Cornwall Hospital NHS Trust; Purchase v Dr Ahmed* [2022] EWCA Civ 12.

The Claimants in all three appeals were unsuccessful, resulting in the strike out of their claims as disclosing no cause of action. However, the Court of Appeal gave the Claimants permission to appeal to the Supreme Court. In its judgment, the Court of Appeal found it was bound by the earlier decision of the Court of Appeal in the case of *Taylor v A. Novo (UK) Ltd* [2013] EWCA Civ 194 but expressed reservations as to the correctness of that authority in light of the leading House of Lords authority of *Alcock and Others v Chief Constable of South Yorkshire Police* [1992] 1 AC 310.

The extant decision of the Court of Appeal in these conjoined appeals is of great significance to secondary victim claims in the clinical negligence setting. If the law as stated in these appeals stands, it will greatly restrict the circumstances in which secondary victim clinical negligence claims succeed. However, if the Supreme Court hold the same reservations regarding *Novo* as the Court of Appeal, an overturn that decision, there will be far greater scope for secondary victims of clinical negligence to recover compensation. It is expected that the decision of the Supreme Court in these appeals will provide much needed clarity.

The Facts

The facts behind the three appeals were analytically similar. In each, alleged or admitted clinical negligence led to the horrifying death of primary victims in front of their loved ones. However, in each there was a lapse of time of varying lengths between the alleged or admitted breach of duty and the horrific event.

In *Paul*, the Deceased (Mr Paul) suffered a heart attack and collapsed in front of his two daughters aged twelve and nine. He died shortly afterwards. It was alleged the Defendant Trust was in breach of duty in failing to perform a coronary angiography around 15 months before Mr Paul's death which if performed would have led to successful treatment. It was alleged that Mr Paul's daughters (the Second and Third Claimants) were entitled as secondary victims to claim for psychiatric injury they sustained through witnessing the death of their father. On the 4th of November 2019 Master Cook, on the application of the Defendant Trust, struck out these claims as disclosing no cause of action. Chamberlain J allowed the Claimants' appeal against the striking out; the claims were reinstated. The Defendants obtained permission to appeal to the Court of Appeal.

In *Polmear*, the Deceased (Esmee Polmear, age 7) was suffering from an underlying abnormality of the small veins in her lungs (pulmonary veno-occlusive disease), a condition that was never diagnosed during her lifetime. The Defendant Trust admitted breach of duty in that her condition should have been diagnosed and treated by mid January 2015. Between then and her death in July 2015 Esmee experienced episodic, transient symptoms from her condition. On the 1st of July 2015, Esmee collapsed and died at school. Her father, the Second Claimant, witnessed the collapse and attempts by members of

staff to give her mouth-to-mouth resuscitation. Esmee's mother, the First Claimant, witnessed the attempts at resuscitation. They sued as secondary victims for their psychiatric injury. The Defendant Trust applied to Master Cook for an order that the claim be struck out. Judgment was given on the 5th of February 2021, after the Claimant's successful appeal before Chamberlain J in *Paul*. Master Cook refused to strike out. The Defendant was given permission to appeal directly to the Court of Appeal.

In *Purchase*, the Deceased (Evelyn Purchase, aged 20) visited the Defendant GP with the Claimant (her mother) on the 4th of April 2013. She complained of feeling unwell and amongst other things difficulty in breathing. It is the Claimant's case that her symptoms were indicative of pneumonia and warranted immediate referral to hospital, and the Defendant's management of Evelyn, in failing to refer her, was negligent. She was discharged home. On the evening of the 6th of April, the Claimant and her other daughter went to London – on Evelyn's insistence, and reassured by the medical advice given - for a pre-planned trip. She returned home at 4:50 am on the 7th of April 2013. She found Evelyn very recently deceased in her bed. She attempted in vain to resuscitate her and witnessed horrific events thereafter. The Claimant sued as a secondary victim for her psychiatric injury. On the Defendant's application District Judge Lumb, sitting in the County Court in Birmingham, struck out claim in a judgment given shortly before the decision of Chamberlain J in the case of *Paul*. The Claimant obtained permission to appeal directly to the Court of Appeal.

The Legal Background

The appeals were concerned with so-called secondary victim claims (formerly known as *"nervous shock"* cases). Such claims have been the subject of significant argument and appellate consideration since the last century. The essential characteristics of the tort are that the secondary victim sustains psychiatric injury as a result of witnessing horrific events which imperil the primary victim. Those events must, of course, themselves be a consequence of the defendant's breach of duty.

The law has imposed so-called *"control mechanisms"* on the class of persons entitled to recover as secondary victims. These are designed to restrict the liability of a defendant whose negligence causes events witnessed by, and thereby causing injury to, others. Control mechanisms are the necessary tests that must be satisfied to show that there is sufficient *"legal proximity"* between the secondary victim and the defendant so as to entitle the secondary victim to recover damages.

The speeches of their Lordships in *Alcock* are widely regarded as setting the five control mechanisms which (as well as the requirement of foreseeability of injury) must be satisfied to permit recovery as a secondary victim. Lord Oliver stated:

"[F]irst, that in each case there was a marital or parental relationship between the plaintiff and the primary victim; secondly, that the injury for which damages were claimed arose from the sudden and unexpected shock to the plaintiff's nervous system; thirdly, that the plaintiff in each case was either personally present at the scene of the accident or was in the more or less immediate vicinity and witnessed the aftermath shortly afterwards; and, fourthly, that the injury suffered arose from witnessing the death of, extreme danger to, or injury and discomfort suffered by the primary victim. Lastly, in each case there was not only an element of physical proximity to the event but a close temporal connection between the event and the plaintiff's perception of it combined with a close relationship of affection between the plaintiff and the primary victim"

Of the many authorities since *Alcock*, two assumed particular significance in the conjoined appeals. Both involved lapses of time between the defendant's breach of duty and the events witnessed by the Claimants. In *Taylor v Somerset Health Authority* [1993] PIQR P262, the Claimant's husband died at work of a heart attack as a result of clinical negligence some months before. The Claimant saw her Deceased husband's body in the hospital morgue around an hour after his death. In *Taylor v A. Novo (UK) Ltd* [2014] QB 150, the Claimant's mother suffered apparently minor injuries at work when a fellow employee tipped a stack of boards over. Three weeks later she unexpectedly collapsed and died in front of the Claimant, as a result of a deep vein thrombosis and pulmonary emboli caused by the initial accident. In both cases the Claimants were held not to qualify as secondary victims and their claims failed.

The Arguments Before the Court of Appeal

A specific issue for consideration in the conjoined appeals was whether any events which occurred before those witnessed by the Claimants - whether the earlier alleged or admitted breaches of duty, or earlier injury to the primary victim - could act as a bar to the claims succeeding. The parties advanced three differing arguments in this regard.

The Defendants in all three appeals argued that a defendant to a claim for damages for clinical negligence can be liable to a secondary victim only when the horrific

event witnessed by the claimant occurs before or at the same time as the damage which would complete the primary victim's cause of action in negligence.

The Claimants in the *Paul* appeal argued that such a defendant can be liable to a secondary victim when the horrific event witnessed by the claimant occurs before or at the same time as *"manifest"* damage to the primary victim, defined as damage it was the duty of the defendant to protect the primary victim against.

The Claimants in the *Polmear* and *Purchase* appeals argued that any prior damage to the secondary victim was irrelevant and that so long as a claimant witnesses a horrific event as a result of the defendant's negligence and otherwise satisfies the *Alcock* control mechanisms, they should recover as secondary victims.

The Decision of the Court of Appeal

The Court of Appeal (Sir Geoffrey Vos MR, Lord Justice Underhill, Vice President of the Court of Appeal (Civil Division) and Lady Justice Nicola Davies) were unanimous. It was found that the question of what is a relevant horrific event such as to entitle the secondary victim to recover is not dependent on the completion of the primary victim's cause of action for negligence. Nor is a relevant horrific event dependent on the first manifestation of injury to the primary victim. In so finding the Court of Appeal rejected the respective *"damage"* control mechanisms contended for by the Defendants and the Claimants in the *Paul* appeal.

The Court seemed attracted to the argument of the Claimants in *Polmear* and *Purchase* that damage to the primary victim was irrelevant as a control mechanism and that the claims should not be struck out. Sir Geoffrey Vos MR observed at paragraph 82 that: *"actual injury or damage to the primary victim is not even necessary to found liability to the secondary victim, as Lord Oliver made clear in* Alcock*."* Further Sir Geoffrey Vos said at paragraph 80 that *"Looking at the matter without regard to the authorities, it is hard to see why the gap in time (short or long) between the negligence (whether misdiagnosis or door design) and the horrific event caused by it should affect the defendant's liability to a close relative witnessing the primary victim's death or injury that it caused."* Lord Justice Underhill said at paragraph 103 *".....that if the point were free from authority I would be minded to hold that on the pleaded facts the Claimants in all three cases should be entitled to recover."*

In spite of this, Sir Geoffrey Vos MR and Lord Justice Underhill (with whom Lady Justice Davies agreed) found that the Court of Appeal was bound by the decision in *Novo* and that all three claims should fail because of the lapse of time between the alleged breach of duty and the horrific event that it caused. Sir Geoffrey Vos held at paragraph 96 that *Novo* was *"binding authority for the proposition that no claim can be brought in respect of psychiatric injury caused by a separate horrific event removed in time from the original negligence, accident or a first horrific event."*

However, the Court of Appeal expressed reservations as to whether *Novo* correctly interpreted the *Alcock* control mechanisms and indicated that the issues merited consideration by the Supreme Court. The Claimant's applications for permission to further appeal were granted, despite the Defendants' opposition.

The Effect of the Decision of the Court of Appeal

The law as stated by the Court of Appeal would significantly restrict circumstances in which secondary victim claims in the clinical negligence setting will succeed. The paradigm clinical negligence case involves a patient with an underlying disease or condition, which is diagnosed and treated late, resulting in injury to the primary victim as the condition progresses - with an inevitable lapse of time between a breach of duty and any later horrific event (such as the death of or serious injury to the patient). In such situations, secondary victims would not be able to recover succeed in their claim. In clinical (and indeed other) settings, the secondary victim would only be able to recover where the horrific event is near instantaneous with the breach of duty.

The Court of Appeal suggested that decision in *Novo* was based on an interpretation of the *Alcock* control mechanisms about which the Court of Appeal had reservations (see e.g. the judgment of Sir Geoffrey Vos MR at paragraph 99). Lord Justice Underhill said it was not easy to identify the precise ratio of *Novo* (see paragraph 104). We expect that it will be argued in the Supreme Court that *Novo* was wrongly decided and should not be followed. In any event, it is to be hoped that the Supreme Court will be able to bring clarity to this important area of the law.

CAM Legal Services Limited (appellant) v Belsner

GED COURTNEY
KAIN KNIGHT COSTS LAWYERS

"There is only one good joke in relation to legal costs, and that is that employment tribunal disputes are not contentious" said Ben Williams QC. No one on the Bench laughed. Whilst that could be due to the fact that the topic of legal costs is generally not a typical subject for witty one liners, it is more likely that the matter of *Belsner v Cam Legal Ltd* gave some of the most senior judges in the country a lot to think about.

I wrote an article for this publication last year following the decision of Lavender J where he found that in order for a solicitor to charge their client more than the sums recovered from a third party, they must have that client's *"informed consent"*. The solicitors, Cam Legal Services, were not happy with that outcome and sought permission to have that decision reviewed by the Court of Appeal. In addition to seeking an appeal of Lavender J's findings, the solicitors sought permission to resurrect an argument which was raised at first instance, namely, did s.74(3) of Solicitors Act 1974 even apply? S.74(3) states;

"The amount which may be allowed on the assessment of any costs or bill of costs in respect of any item relating to proceedings in the county court shall not, except in so far as rules of court may otherwise provide, exceed the amount which could have been allowed in respect of that item as between party and party in those proceedings, having regard to the nature of the proceedings and the amount of the claim and of any counterclaim."

It might be easy to dismiss s.74(3) as an artifact of the old county court scale costs, but it is arguable that it survives in some form into the modern regime. CPR 46.9(2) refers to s.74(3), but only to state that it can be disapplied in circumstances where solicitor and client have entered into a written agreement that permits charges greater than the sums recovered from the third party. It was this *"written agreement"* that Lavender J found required the client's *"informed consent"*.

It was clear that the Court of Appeal had assumed that the primary focus of the appeal would be the requirements of the written agreement in CPR 46.9(2). Notwithstanding it's prominence in the skeleton arguments, the Court appeared surprised at the force of the submissions made by the appellant on the s.74(3) point generally. Cam Legal argued that s.74(3) was not engaged. If it wasn't, there was no need to even consider the further grounds. The heading for s.74 of the Solicitors Act is *"Special provisions as to contentious business done in county courts"*. The appellant argued that as this matter had not been issued, having settled at stage 2 of the Low Value Personal Injury Portal, that it could not be *"contentious business"* or work done *"in the county court"*. It was this point that prompted the joke from leading counsel referred to in the opening of this article. It was argued for the solicitors that work only becomes contentious when court proceedings are issued. Once issued, all work done prior to proceedings becomes contentious. This was considered by the appellant to be a well established principle. Seemingly this was not a view shared by the bench. Even more strange, was that the Court appeared to suggest that costs payable by clients to their solicitors needed to be proportionate. Since Solicitors Act assessments are conducted on the indemnity basis, it was argued by the solicitors that *"proportionality"* as a concept in legal costs, did not apply.

On the evening of the first day of the appeal the Appellant and the Law Society, who had intervened, lodged further written submissions. At the outset of the second day, the Court explained they'd considered the further material and noted that there was perhaps more to this case than had first been appreciated. The Master of the Rolls noted that the one and half day listing was, on reflection, optimistic and asked the parties to come back for two to three days in the summer. He asked the parties to pay particular attention to the wider issues that may arise as a consequences of the Court of Appeal's decision.

At present, it is difficult to see what those consequences may be. Given the comments of the Master of the Rolls it may be that the biggest consequences could be to reforms that are yet to be made. It is certainly true that the increased scope of fixed recoverable costs in a significant number of matters, including clinical negligence, will likely be impacted by the Court of Appeals findings. If the Court were to find that work done prior to the issue of court proceedings amounted to *"contentious business"*, then this could have a profound impact on the enforceability and future usefulness of contingency fee agreements in matters governed by fixed costs. Contingency fee agreements, save for those as outlined in the Damages Based Agreement Regulations 2013, are currently prohibited in matters relating to contentious business.

If the court accepted the Solicitor's argument that this was indeed non contentious business, there remains the question as to whether or not the Court will find that proportionality is a factor to be considered in solicitor/client costs disputes. S.3(f) of *The Solicitors (Non-contentious Business) Remuneration Order 2009* requires the Court to consider *"the amount of value of any money or property involved"* when deciding whether costs are *"fair and reasonable"*. It is noteworthy that the value of the sums in dispute is acknowledged as a relevant factor in CPR 44.4(3)(b) generally, and there has been no suggestion that this would create a requirement for costs to be proportionate when assessing costs on the indemnity basis. That being said, CPR 44.4 is only talking about the assessment of whether costs are reasonable. Whether costs are *"fair"* may be an entirely different matter. If the Court of Appeal were to find that there was a requirement for costs between solicitor and client to be proportionate, this could further call into question the viability of more modest clinical negligence claims, where substantial time and expertise are brought to bear for relatively small sums.

Although the parties didn't get far enough to address the issue, there is still an ongoing question as to the extent of the fiduciary duties (if any) owed by a solicitor to their client when agreeing the terms of their own remuneration. It was this presumed fiduciary duty that Lavender J felt created the need for informed consent when considering CPR 46.9(2). It is difficult to see how such duties could apply in such circumstances, but as this point was not subject to much in the way of oral argument on first appeal, we are likely to see the point developed further by both sides.

This is a matter which continues to unfold. The inter play between fees charged to clients in areas where costs are fixed is a question that will need to be carefully considered as wider reforms are enacted. For many practitioners, deducting money from their client's damages is the only way to ensure that the work remains viable. For this reason, the content of their retainer documents and advice has never been more important. Precisely what advice the Court of Appeal feels is necessary however remains to be seen.

COVID-19 and Cancer claims – What lies in store?

BELLA WEBB
OLD SQUARE CHAMBERS

None of us need a reminder that COVID-19 is the biggest health crisis to affect the world for decades. It has stolen the lives and livelihoods of many a family and stretched others, including dedicated healthcare and medical professionals to breaking point. However, it has become increasingly clear over the past two years that the indirect death toll and wider health impact of COVID-19 will be felt far beyond those who contract the disease itself. Perhaps one of the most publicised patient groups upon whom COVID-19 has had a disproportionate effect is those with or yet to be diagnosed with cancer. After the first UK lockdown was introduced in March 2020, cancer screening was suspended, routine diagnostic work deferred and only urgent symptomatic cases prioritised for intervention. As the curative timeframe for cancer is frequently analysed in blocks of 5 and 10 years, it will be some time before the full effect of this crisis is truly understood.

Couple the critical overlay of the past two years with the already enormous physical, emotional, societal and legal burden of cancer in the modern world and you have the components of a perfect storm. Sadly, cancer remains the most common cause of death in the UK when assessed on a broad disease group level, with (perhaps of particular poignancy in the current context) lung cancer as one of the biggest killers. Those fundamentals are all the more concerning when one considers that, notwithstanding the relative wealth and position of the UK globally for its respected healthcare systems, we have a reputation as having one of the worst cancer survival rates in Europe. Back in 2014, Cancer Research UK reported that late diagnosis might, at least in part, explain the statistics. By January 2018 when the CONCORD-3 findings were published, whilst the UK's survival rates had improved, it still lagged behind other comparable countries.

Perhaps unsurprisingly, almost as soon as COVID-19 took hold, studies began to emerge analysing the potential impact of the crisis upon (amongst other conditions) cancer. The DATA-CAN study set up by the Health Care Research Hub analysed real time data from March to May 2020 during the first lockdown and predicted that there could be as many as 7,000 – 35,000 excess cancer deaths due to COVID - a frightening figure. Most recently, in January 2022, the CAGE centre at the University of Warwick reported that:

a) From March 2020 to February 2021 alone, there were 4,000 excess deaths for non-Covid reasons in England (including but not limited to cancer).

(b) For every 30 deaths directly caused by Covid-19, at least one non-Covid death could have been avoided (some of which will be cancer related).

(c) The share of patients receiving cancer treatment following urgent referral within the NHS 62 day target dropped from 78% before the pandemic to 71% in 2020 and as low as 67% in recent months.

(d) More than 53,000 people had had their cancer treatment delayed past the NHS set goal.

(e) Currently more than 32,000 cancer patients were missing from the treatment list.

(f) The number of cancer cases receiving urgent first treatment dropped by around 2000 per month during the pandemic.

There can therefore be little doubt that the outlook for cancer over the coming years in the UK looks set to have stalled further, with a corresponding potential and significant increase in legal claims by cancer patients and the families of the bereaved. So great has been the concern over the potential cost to the NHS of an influx of COVID related legal claims that the MDU called in 2020 for a public debate over the need for legal immunity for medics from claims arising in relation to care during the pandemic. It is understood that several US states have already adopted such legislation. Moreover, on 25th March 2020, the Coronavirus Act 2020 became law. Section 11 thereof provides indemnity for the clinical negligence liabilities of healthcare professionals and others arising out of NHS activities undertaken during the coronavirus outbreak, and has been supplemented by a new NHS Resolution scheme *"to provide additional indemnity*

coverage for clinical negligence liabilities that may arise when healthcare workers and others are working as part of the coronavirus response, or undertaking NHS work to backfill others, in the event that existing arrangements (CNST, CNSGP or individual arrangements) do not cover a particular activity." (**https://resolution.nhs.uk/**).

So how does the wider management of cancer during the pandemic impact upon the management of legal claims relating to cancer?

The bulk of cancer related legal claims fall into two categories:

1. Delays in diagnosis, usually due to an alleged failure of the GP in primary care to refer onwards under the two-week wait rule, and;

2. Delays in administering treatment after diagnosis and/or incorrect treatment administration.

There can of course be no legal claim for delayed diagnosis flowing from cases in which patients, frightened of contracting COVID, did not seek medical attention for suspicious symptoms which ultimately prove to have been due to cancer. Moreover, all such claims will likely suffer from two inherent difficulties, namely the reluctance of some patients to pursue medics who have fought hard to save lives under extreme pressure during the pandemic, and the anticipated reluctance of the judiciary either to penalise medics working under such conditions, or to open the floodgates for such claims.

Far apart from those overarching considerations, it can readily be envisaged that claims brought in respect of care received during the pandemic, and certainly within the early stages of it (before effective guidance was published and in the midst of widespread condemnation of the provision of effective PPE, or lack of it) will face the following fundamental defences:

(1) That there has been no breach of duty due to the need to utilise more junior or less experienced staff from other areas of practise to provide cover during the pandemic, and/or;

(2) The lack of resources available to provide such care/the need for redistribution of resources to deal with COVID/the need to protect patients and staff from COVID infection.

(3) That, in respect of factual causation, even with earlier referral the patient would not have been diagnosed and/or treated any earlier, due to a lack of /policy driven redirection of resources, and;

(4) In terms of legal causation, that there may be multiple causes (some potentially negligent and others non-negligent) of any damage sustained.

The existing law of tort has long assessed the standard of care by reference to the post held and not the practitioner's experience within it. One need only look back to every law student's introduction to the case of *Nettleship v Weston* (1971) 2 QB 691, to see that a learner (there driver) was to be held to the standard expected of a reasonably skilled and competent driver.

In *Wilsher v Essex Area Health Authority* (1987) QB 730, Mustill LJ in the Court of Appeal (the case of course later went to the House of Lords on other issues) commented that:

" this notion of a duty tailored to the actor, rather than to the act which he elects to perform, has no place in the law of tort. ..To my mind, it would be a false step to subordinate the legitimate expectation of the patient that he will receive from each person concerned with his care a degree of skill appropriate to the task which he undertakes, to an understandable wish to minimise the psychological and financial pressures on hard-pressed young doctors...."

The principle has since been reaffirmed in cases including *FB v Rana* (2017) PIQR P17 and (albeit in a slightly different context) in *Darnley v Croydon Health Services NHS Trust* (2019) AC 831, (2018) UKSC 50.

It seems most unlikely that the courts would relax such long established principles in the absence of new legislative intervention. However, the courts frequently take account of the conditions (and resources) within which cases are set. In *Wilsher v Essex AHA* above, Mustill LJ commented obiter that the standard of care may be affected by *"battle conditions"* and that where an emergency overburdens a hospital's resources, mistakes made as a result should not lightly be considered to be negligent. Similarly in *Morrison v Liverpool Womens' NHS Foundation Trust* (2020) 1 WLUK 183, in the context of a case concerning the timing of a caesarean section, Turner J stated that:

"...in the clinical context a balance has to be struck between the needs of any given patient and any other competing professional demands placed upon the clinicians involved. Sometimes...the needs of the patient must be deprioritised to allow the clinicians to attend other demands on their time of as a matter of priority...."

Similar observations were made in the helpful analogous case of *University Hospitals NHS Foundation Trust v MB* (2020) EWHC 882 in which an injunction was granted to require a patient to vacate a hospital bed during the COVID pandemic.

As such, the courts are highly likely to have some real sympathy for defences founded upon the stretched resources and unprecedented circumstances occasioned by the pandemic when assessing breach of duty in cancer (and other) claims dealt with during the pandemic. The existing law plainly provides precisely that defensive avenue.

So - are such claims dead in the water? Probably not. Pandemic or no pandemic, there will inevitably remain cases in which healthcare professionals will have acted negligently and caused avoidable harm to patients, in circumstances which have nothing to do with COVID. It is to be assumed that if, for example, a cancer screening or other diagnostic scan was in fact undertaken, and then misreported, liability ought to follow in the usual way.

Thereafter, there would appear to be three main categories of cancer claim affected by COVID:

1. Delays in accessing treatment;

2. Missed diagnoses due to delayed referral or testing;

3. Confusing cancer with COVID.

When considering the prospect of a successful claim in respect of delays in accessing treatment, regard will probably need to be had to the *Rapid Guidelines for the Delivery of Systemic Anti-Cancer Treatments and for Radiotherapy*, published by NICE in March 2020 and later updated in February 2021 (NG161 and NG162). Those guidelines make provision for minimising face to face contact, communication with patients, discussion of their individual risk factors for becoming severely ill with COVID and of the risks and benefits of starting, continuing or deferring treatment. However, the nub of the guidance is in the form of prioritisation tables for deciding when to give or continue treatment. Prioritisation categories are ultimately determined by the percentage prospect of achieving cure and in the lower rungs of the table, extension of life and temporary tumour control. When using the tables to prioritise treatment, the guidance requires account to be taken of factors including (see section 3.3 of NG161 and 7.1 of NG162) the level of immunosuppression associated with treatment and patient specific factors, balancing the risk of cancer not being optimally treated with the risk of immunosuppression and serious illness from COVID and critically, capacity issues such as limited resources.

The guidance requires a shared decision to be made with the patient, the making of prioritisation decisions as part of an MDT, on an individual patient specific basis and with such decisions to be properly documented. There are also recommendations for considering modifications to the usual treatment regime and retraining of nurses from other areas to provide such treatment.

Any challenge to the guidelines themselves, notwithstanding the public condemnation of the approach taken to deferring cancer care by some prominent medico legal experts through the media, is likely to be fraught with difficulty and would not realistically be achievable through the normal clinical negligence litigation routes. However, that leaves open the very real potential for challenges to be brought upon the basis of incorrect application of those guidelines, with the greatest prospects of success most likely to be reserved for those patients who were or should have been considered high priority with the best chances of cure. Practitioners will need to consider whether the patient was correctly ranked within the table. Were decisions taken on a patient specific basis by the MDT? Were those decisions effectively documented? Was any or any adequate consideration given to the modified provision of treatment? The legal team will need to be astute to the applicable guidance at the material time (there having been several amendments to the same), and to the very extensive disclosure likely to be required to demonstrate that other patients given higher priority did not warrant it, albeit with resources assessments being specific to the particular hospital or ward in issue.

In relation to claim types 2 and 3 above, whilst challenges based upon the suspension of screening programmes will likely be fraught with difficulty, NG12 - the NICE guidelines for *"Suspected cancer: Recognition and Referral"* remained in place throughout. That was emphasised in a useful NHS publication entitled *"Urgent Cancer Diagnostic Services During COVID-19"* published in January 2021. Notwithstanding the fact that most GP appointments were conducted remotely throughout the pandemic, surely if an appointment, remote or otherwise, was given, then there can be no COVID-related justification for failing to take a full and proper history, and specifically one which seeks to examine any non-COVID specific but cancer suspicious features in the case of overlapping symptoms. For example, whilst many lung cancer cases may present with cough and shortness of breath, precisely the symptoms for which patients were told to stay at home for fear of COVID, persistence of symptoms, recurrent

chest infection, smoking history, haemoptysis and weight loss are not understood to be features of COVID. Further, the need for effective communication and safety netting remains wherever a consultation, through whatever medium, takes place. That ought to be the case from the earliest stages of the pandemic but will be all the more pertinent after guidance such as that in January 2021, together with the May 2020 NHS *"Clarification of Cancer Waiting Times guidance during COVID-19 pandemic"* was issued and when testing for COVID became more readily available - such that concerns about a COVID-related cause for symptoms could be excluded by means of a swab test. The further out from the initial acute phases of the pandemic the timeline in issue is, the greater one might anticipate the prospect of success to be.

Interestingly, the January 2021 NHS publication referred to above not only provided for the need to maximise the provision of initial diagnostic testing in primary care or through direct GP access pre-referral, but also provided for flow charts adapting urgent cancer diagnostic pathways for a range of the most common cancer subtypes; detailed consideration of which may well be essential to the assessment of causation in any such claim.

As such, there would appear to remain a number of potential avenues for a finding of breach of duty in such claims, notwithstanding the likely cogent resources and emergency conditions defences. The greater difficulty anticipated is, in the author's view, likely to be in establishing how quickly the patient would have been seen, diagnosed and ultimately treated had early referral taken place. That will in turn require the type of assessment of the guidance and the extensive disclosure requirements previously considered, together with a much greater anticipated role for the often complex application of material contribution arguments to questions of legal causation where negligent and non-negligent (pandemic related) factors intersect. Those issues will require practitioners in this field to be ever more vigilant in their selection of appropriate, persuasive and balanced experts who remain in active clinical practise and have an appreciation of the workings of the NHS in such conditions.

Ultimately just how successful these claims will be, and indeed how well and how quickly the UK manages to make up lost ground in cancer referrals and treatment, remains to be seen!

The resolution of factual issues in clinical negligence claims

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It is commonplace for factual issues to arise in clinical negligence claims. Those issues may relate to the symptoms complained of, the advice given or the consenting process itself. The contemporaneous medical notes may be lost, incomplete or inconsistent. It is vital that practitioners be aware of the approach that the court will likely take to determining the factual issues before considering the fundamental issues of breach, causation and quantum.

In the recent case of *Freeman v Pennine Acute Hospitals NHS Trust* [2021] EWHC 3378 (QB) there is a very helpful discussion and summary of the existing case law. In relation to fact finding generally, the judge commented that (para. 18):

As Lord Browne-Wilkinson said in Bolitho, the Claimant bears the burden of proving her case – including on factual issues - on the balance of probabilities. But I must first make such findings as I can on the evidence elicited rather than too readily resorting to the burden of proof and I must give sufficient reasons for doing so as Irwin LJ stressed in Barnett v Medway NHS *[2017] Med. L. R. 217 (CA) at p.54:*

There is great virtue in writing judgments concisely. However, the parties do need to know sufficiently what led to the conclusions reached. In this instance, the judgment gave only the briefest explanation. The obligation is all the clearer in a case of such complexity, and in a case where a key issue is decided on the basis that a claimant has failed to discharge the burden of proof…."

Missing records

In the *Freeman* case the claimant accepted that the burden fell upon her but argued that the Court could and should draw an inference from the Defendant's poor record keeping – the argument being that if the court accepted that the record-keeping system at the time was substandard in not recording telephone calls, then it should not be able to rely on the absence of the record of such a call. The court noted and endorsed the approach of the Court of Appeal in *McKenzie v Alcoa* [2020] PIQR P6 in which it was said that:

"It seems therefore that it is possible to state the following propositions. First whether it is appropriate to draw an inference, and if it is appropriate to draw an inference the nature and extent of the inference, will depend on the facts of the particular case, see Shawe-Lincoln *at [81]–[82]. Secondly silence or a failure to adduce relevant documents may convert evidence on the other side into proof, but that may depend on the explanation given for the absence of the witness or document, see* Herrington *at 970G;* Keefe *at [19]…."*

The weight to be attached to oral evidence as compared to clinical notes

There have been a number of authorities addressing the weight to be given to oral evidence as against contemporaneous written evidence, albeit not all in the clinical negligence sphere. HHJ Tindall (sitting as a High Court Judge) helpfully reviewed all of the competing decisions (at paras. 23 to 29 of his judgment) before summarising his conclusions on all the factual issues at para 30:

I can perhaps summarise my approach to all these authorities in three short points:

30.1 The burden of proof is on the Claimant, but I should still attempt to make findings on all evidence on the balance of probabilities: Bolitho *and* Medway.

30.2 When assessing allegedly absent clinical records and any disadvantage to the Claimant, I apply the approach in Shawe-Lincoln *as developed in* Mckenzie.

30.3 When assessing the consistency of oral evidence with actual clinical records, I will apply the approach in Synclair *and* Manzi *that I consider consistent with the approach taken on the facts in* CXB, HTR *and* Ismail.

In *Synclair v East Lancs NHS* [2015] EWCA Civ 1283 the Court of Appeal upheld the trial judge's acceptance

of a claimant's account of his condition, rejecting contemporaneous clinical notes, with Tomlinson LJ holding, at paras. 10 to 15:

"10. [Counsel] reminded us of some of the classical learning on the nature of the judicial fact-finding function. We were shown, in chronological order: the well-known remarks of Lord Pearce in his dissenting speech in Onassis & Calogeropoulos v Vergottis *[1968] 2 Lloyds Rep 403 at p 431; the guidance given by Lord Goff of Chieveley giving the opinion of the Judicial Committee of the Privy Council in* Grace Shipping v Sharp & Co *[1987] 1 Lloyd's Rep 207 at 215-6, in particular founding upon his own judgment in the earlier decision of the Court of Appeal in* Armagas Ltd v Mundogas SA (The Ocean Frost) *[1985] 1 Lloyd's Rep 1 when he said, at page 57:-* "Speaking from my own experience, I have found it essential in cases of fraud, when considering the credibility of witnesses, always to test their veracity by reference to the objective facts proved independently of their testimony, in particular by reference to the documents in the case, and also to pay particular regard to their motives and to the overall probabilities. It is frequently very difficult to tell whether a witness is telling the truth or not; and where there is a conflict of evidence such as there was in the present case, reference to the objective facts and documents, to the witnesses' motives, and to the overall probabilities, can be of very great assistance to a Judge in ascertaining the truth."

In Grace Shipping *Lord Goff noted that his earlier observation was, in their Lordships' opinion* "equally apposite in a case where the evidence of the witnesses is likely to be unreliable; and it is to be remembered that in commercial cases, such as the present, there is usually a substantial body of contemporary documentary evidence." *We were reminded that in "*The Business of Judging*", Oxford, 2000, Lord Bingham of Cornhill observed that:-* "In many cases, letters or minutes written well before there was any breath of dispute between parties may throw a very clear light on their knowledge and intentions at a particular time." *11. The essential thrust of this learning is the unsurprising proposition that when assessing the evidence of witnesses about what they said, or what was said to them, or what they saw or heard, it is essential to test their veracity or reliability by reference to the objective facts proved independently of their testimony, in particular by reference to contemporary documentary evidence.*

12. However it is too obvious to need stating that simply because a document is apparently contemporary does not absolve the court of deciding whether it is a reliable record and what weight can be given to it. Some documents are by their nature likely to be reliable, and medical records ordinarily fall into that category. Other documents may be less obviously reliable, as when written by a person with imperfect understanding of the issues under discussion, or with an axe to grind....I would commend the approach of His Honour Judge Collender QC, sitting as a judge of the High Court, in EW v Johnson *[2015] EWHC 276 (QB) where he said, at paragraph 71 of his judgment:-*

"I turn to the evidence of Dr Johnson. He did not purport to have a clear recollection of the consultation but depended heavily upon his clinical note of the consultation, and his standard practice. As a contemporaneous record that Dr Johnson was duty bound to make, that record is obviously worthy of careful consideration. However, that record must be judged alongside the other evidence in the action. The circumstances in which it was created do not of themselves prevent it being established by other evidence that that record is in fact inaccurate. Dr Johnson, a GP, had made his own note of a consultation at an out of hours walk-in centre at a hospital. After a careful evaluation of all the evidence in the case, the judge found that Dr Johnson's oral account in evidence, based on his contemporaneous note, was reliable. In *Welch v Waterworth* [2015] EWCA Civ 11 a surgeon was unsuccessful in persuading the court that his own notes of a surgical procedure...one a manuscript note written very shortly after the operation and another a typewritten note made later in the day at home, did not accurately record the order in which he had carried out the constituent parts of the relevant procedure.

...14. With those observations in mind, I turn to Mr Colin's detailed criticism of the judge's approach here. His three principal points were:- i) Clinical records are made pursuant to a clear professional duty, serious failure in which could put at risk a practitioner's registration. Moreover, they are not compiled simply as a historical record, they fulfil an essential and ongoing purpose in informing the care and treatment of a patient. Contemporaneous records are for these reasons alone inherently likely to be accurate. No doctor would have any reason to produce a note which misrepresented clinical observations or the patient's concerns. Something more than a patient's assertions to the contrary is required to displace the sanctity, my word...of the notes."

Those propositions were accepted by Tomlinson LJ and was noted as doing so by Sir Ernest Ryder SPT in *Manzi v King's College NHS* [2018] EWCA 1882, at para 18, who added (at para 25):

"The proposition that a contemporaneous clinical record is inherently likely to be accurate does not create a presumption in law that has to be rebutted.... It is an important factor in evaluating materials of that kind so that reasoning is necessary to explain how records (or their absence) are being treated on the facts of a particular case. To raise the bar so high that an analysis of what might be sufficient to displace inherent reliability is needed in every case is to make the process of fact finding too onerous and mechanistic."

It follows, and this will be of little surprise to those practicing in clinical negligence claims, that the contemporaneous medical notes may be persuasive but they are not and should not necessarily be determinative.

TVT/TOT/TVM mesh implant (consent) litigation – A personal view

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Having been involved with the tension-free vaginal tape (TVT) mesh (consent) litigation for the last five years or so, I wanted to take this opportunity to bring together some of my experiences, and the experiences of my colleagues, which I hope will be helpful for other claimant lawyers fighting on behalf of their clients. I am going to refer to one of my cases directly and draw from that case a number of conclusions.

This article is not meant to be a detailed analysis of the legal or medical issues, but rather a practical account of what steps should be taken to protect our clients' positions and to deal with the defendant's strategy, which is entirely encompassed by the phrase *"deny, defend and delay"*. The views expressed are purely my own.

Background

Pelvic mesh implants are used as a surgical option to treat prolapse and incontinence. As we now know, these devices can lead to internal damage and agonising, chronic pain.

Over 100,000 women in the United Kingdom have had a mesh fitted. It amounts to a net-like fabric (made of polypropylene), which can be attached to the walls of the vagina, acting as a *'scaffold'* to support organs – essentially keeping them in the right place to help manage incontinence or prolapse.

The device is used for pelvic organ prolapse (POP) and stress urinary incontinence (SUI). Complications include bleeding, pelvic/abdominal pain, chronic infections, recurrent UTIs, dyspareunia (pain during intercourse), worsening bowel/bladder injuries and chronic pain. In addition, it can cause mesh extrusion (protrudes through the skin) or mesh erosion (erosion into the vaginal tissues/organs).

Part, or all, of the device can be removed, but it becomes far more difficult to do so the longer time goes on. Vaginal mesh has effectively been suspended for the last three years or so.

Baroness Julie Cumberlege (Chair of the Independent Medicine and Medical Devices Safety Review – *'Do No Harm'*) issued a report in July 2020. She noted that women who had suffered mesh-related problems often did complain, but those complaints and worries were dismissed as *"women's problems"*, often leaving victims traumatised, intimidated and confused.

She found that much of the suffering was *"...entirely avoidable, caused and compounded by failings in the health system itself"*, as well as a culture of denial lead by a disjointed and defensive health care system that failed to listen to patient's concerns. She went further and suggested that we have a health care system entrenched in institutional denial and misogyny. It ignored patients when complaints were made of debilitating and life-altering, irreversible, pain.

The Baroness applauded the victims of mesh for their bravery, dignity and tenacity. She went on to say that the first duty of any health system is to do no harm to those in its care. Sadly, that duty was breached by a number of healthcare providers, not least the NHS.

Common threads

I have noticed throughout the TVT/TOT mesh cases that there are a number of common threads, which include:

(i) Alternatives to surgery not being explored (despite sometimes relatively minor symptoms of prolapse/stress incontinence);

(ii) Failure to perform tests prior to surgery (in order to determine the extent of the prolapse or urodynamic studies to determine the extent of the incontinence);

(iii) Conservative measures often not offered – for example, supervised pelvic floor exercises or pessaries;

(iv) Substandard surgery – mesh placed too loosely or sometimes in the wrong place;

(v) A failure to warn of the risks and, in particular, a failure to obtain proper, informed consent.

(vi) A failure to refer to other specialists, including to the fields of pain management or urology.

What also became apparent during our investigations into these cases was that, during the decades 2000 to 2020, many urologists and urogynaecologists became deskilled in open surgical interventions for the management of stress urinary incontinence. Market forces caused a circumstance where patients were encouraged by the promise of minimally invasive interventions and clinicians were either incapable or unwilling to offer open surgery (such as colposuspension and autologous rectus fascia slings). Despite (NICE) guidelines that all the alternatives and their benefit/risk profiles should be discussed, many patients, as Baroness Cumberlege found, were not offered these options.

Following the recommendation by the Independent Medicines and Medical Devices Safety review, the DOH paused the use of mesh in July 2018 and the Cumberlege review led to the National Commissioning of Complex Mesh Centres, although these were not up and running until last year.

There is now a substantial body of scientific evidence that supports fears that the TVT procedure causes chronic pain, particularly in the suprapubic area. Non-surgical treatments are often overlooked, including supervised pelvic floor muscle treatment, advice on weight loss, duloxetine therapy or a continence pessary, which may have avoided any surgery for SUI at all.

Talbot -v- Torbay and South Devon NHS Foundation Trust QB-2019-000604

The background to this case will be familiar to those involved in this litigation. The claim related to the consent process for two gynaecological surgeries, which my client underwent for vaginal prolapse and urinary symptoms. We alleged on her behalf that the defendant trust failed to advise her as to alternative treatment options, and to adequately discuss with her all her options and the potential risks in connection with an anterior repair, which took place on 30th September 2011, and an uphold procedure (insertion of mesh) on 22nd March 2012.

It was alleged that, had she been properly advised, she would not have consented to these procedures – instead, she would have continued to use pessaries and physiotherapy/bladder retraining, which would have improved, or alleviated, her urinary symptoms. If necessary, she would have undergone non mesh surgery some time in the future.

The defendant denied any breach of duty, despite admitting that the consent form for the uphold procedure did not document the risks of the procedure and the claimant was not advised of alternative conservative options/non-mesh options.

My client developed a horrendous combination of symptoms as a result of these procedures. These included a shortened/narrowed vagina, fibromyalgia, suprapubic pain, significantly limited mobility, wholly unable to have an intimate relationship with her partner, and bladder irritability/overactivity with severe urinary frequency, urgency and nocturia. In addition, she suffered generalised weakness and chronic, persistent pain. Not surprisingly, she developed a depressive disorder.

Her care needs were extensive, requiring assistance because of her continuing/disabling pain. She struggles with mobility and transfers, she cannot put on her own shoes, she is unable to undertake domestic chores, she cannot enjoy her time with her grandchildren and requires over twenty seven hours of care per week.

A Letter of Claim was served on 22nd February 2018, with a Letter of Response served July 2018 denying all allegations and raising a limitation defence. Proceedings were served in March 2019. Allegations included that she was not told the September 2011 procedure (anterior wall repair) would not cure her urinary symptoms and there were alternative treatments.

Had she been properly advised, she would not have consented and she would have undergone conservative measures (ring pessary/physiotherapy/bladder retraining). Likewise, prior to the uphold procedure (insertion of mesh), she was not advised of alternatives options (despite support for those alternatives in the medical literature). Had she known of them, she would not have consented to the surgery.

A defence served in July 2019 argued that, even if the claimant had been *'properly consented'* and given the correct information, she would have still proceeded with the operations and the outcome would have been the same. They also alleged that all appropriate alternatives had been provided.

Covid-19 impacted on both parties' ability to obtain their evidence, but we were hopeful when a mediation took place in December 2020. The defendants, however, attended and indicated they had no offers to make.

Following exchange of lay witness and expert evidence, the defendants made two offers; £101,000 in March 2021 and then just under £187,000 in August 2021.

The case eventually settled at a round table meeting in October 2021 for £575,000. No apology or explanation was offered.

I set out below some of the main learning points I have taken from this case and others similar to it.

The claimant's statement

Taking detailed statements from claimants is, of course, vital in any clinical negligence case. For the TVT mesh cases there are particular issues that must be dealt with in detail as early as possible. Not only must the statement set out your client's recollection of the events, particularly around the issue of consent, it must also set out her case on causation; what would she have done had she been given the proper information (avoiding, of course, the risk of hindsight).

Sadly, most of our clients have only become aware of the alternatives to mesh when an expert medico-legal report has been obtained. In Mrs Talbot's case, she was not warned of the significant risk of deterioration in her overactive bladder following an anterior repair.

At her pre-operative assessment in relation to a vault prolapse, the defendant failed to discuss alternatives to mesh surgery and the issue of mesh erosion. Despite also facing her third prolapse repair in less than a year, no offer of a second opinion was made. The consultant failed to inform her that there was no long-term data on the safety of mesh repair and failed to discuss her individual circumstances as to which vault prolapse operation would suit her best.

On the consent form, he failed to mention the specific risks of mesh. His operation note lacked any detail and was substandard. Further, there was no evidence that he tried to remove the mesh once her complaints began.

What we have found to be helpful is to have the client and medical expert (preferably an urogynaecologist) to go through the consent process properly and to see what our client's response to that would be. At that point, we would discover whether we have a case on causation.

Also, in these *'early days'* of mesh litigation, defendants routinely pleaded limitation as a defence – that appears to be changing. But, if they do raise it as an issue, you must take careful instructions as to date of knowledge and ideally a separate limitation statement should be prepared (and consider without prejudice disclosure of that statement should limitation be raised in the defendants' Letter of Response, or in the defence). In Talbot, such a statement was obtained and summarised in an open letter to the defendant. They subsequently withdrew limitation from their defence.

Use the Clinical Negligence Protocol if you are able to, otherwise agree an amnesty as to limitation. Consider the client's actual and constructive knowledge (review the medical records, see how many caring medical professionals dismissed her concerns, and spot, if you can, the reluctance to refer to pain management, and if it happened, the one or two appointments she had with that specialist). Also set out in detail when your client contacted you, what her instructions were, and what advice you gave.

My experience so far is that even if your client fails on the date of knowledge (Section 11(4) of the Limitation Act), she will nevertheless succeed on the discretion to exceed in Section 33. Anyway, why shouldn't she? The medical records will be available, the consultant and his/her team are likely to still be alive, and the Trust is likely to have been pretty dismissive of her complaints for some time.

Any statement should, of course, also refer to the nature and extent of the claimant's losses, and provide a reasonable indication as to the nature and extent of her injuries. These conversations are highly sensitive – many of my clients have complained of how their femininity has been taken from them, as well as destroyed their hopes for an engaging and fulfilling life towards the end of their careers/beginning of their retirement. Relationships are ruined and the joy of grandchildren lessened by chronic pain and mobility issues. Financial insecurity dominates our client's lives towards the end of their working careers.

Experts

Clinical negligence cases are fought and won through the medium of expert evidence. The defendants and the court will try and limit your choice and number of experts. Proportionality will be raised in a misguided attempt to save *'resources'* and court time. That will, of course, again be judged on a unfounded basis that invariably your client's claim is of a *'modest value'* and that the threshold for instructing a number of experts has not been reached (because either your client has not obtained any psychological support, seen a pain consultant before, or as her care needs can easily be quantified by solicitors who, without any nursing experience, are able to look into the crystal ball and determine what the future is likely to hold for her).

With Ms Talbot's case, we were initially unable to persuade the court to allow us to instruct a care or psychological expert. The defendant successfully argued that it was

simply a matter for a uorgynaecologist to deal with breach, causation, condition and prognosis. Despite this failure at the CCMC, we did make a successful application to introduce care and psychological evidence – but took the risk of obtaining that evidence, serving it and then seeking retrospective permission.

I and the team here have decided that now, all cases must be front-loaded. By the time you issue, you should have sufficient expert evidence not only to justify all the allegations relating to breach and causation, but almost the entire case on quantum – with a fully-pleaded schedule. The experts should, in a sense, justify each other's position.

The experts listed below should certainly be considered in respect of all TVT claims, although of course, this will be dependent upon the nature and extent of your client's symptoms.

Gynaecologist/urogynaecologist – in many ways, the critical starting point for expert evidence. Their remit is wide. They will be dealing with breach of duty, so should have a thorough knowledge and understanding of the Montgomery ruling. They should have had experience of fitting (and ideally removing) tapes, as well as an understanding of the symptoms that can flow from such devices above and beyond immediate surgical pain. They need to balance a good understanding of the medical literature, with hands-on experience of what a reasonable practioner would have advised at the appropriate time, (guard against hindsight). This, of course, feeds into causation and they must be able to deal with the variety of health issues in this area. Importantly, they need to understand what is outside their expertise and defer to other experts when appropriate. Finally, for condition and prognosis reports, they must be able to sign-post other experts (care, pain management, occupational therapy, psychiatry), because the chances of you being able to rely on other key areas of expertise will be dependant on this disclosed report persuading a judge that additional experts are required.

Urologist – required if there are complex urinary issues, above and beyond the experience listed previously. Their evidence is likely to be focussed on causation, condition and prognosis, with the interpretation of urodynamic studies being of critical importance.

Pain management – experience in one of the mesh removal centres is a must. Too many specialists in this field claim expertise, but can become hopelessly exposed in joint expert meetings when it becomes apparent they have little or no experience in pelvic-related pain issues. Causation, condition and prognosis all need to be commented on, and they must have a thorough understanding regarding the breaches of duty relied upon. Pre-existing co-morbidities are common place, and in terms of understanding a client's pain, must be carefully untangled. Such an expert will have to be thoroughly versed in issues relating to fibromyalgia, arthritis and other underlying disorders, and be clear on what has caused/exacerbated/accelerated various chronic symptoms.

Care – this is where the largest aspect in terms of quantum lies. Empathy and sensitivity are just as important as a knowledge of which care rates to utilise. This expert needs to very much rely on both urogynaecology and pain management reports, but will also have the chance to properly assess a client in a home environment, where so many more difficulties will be noticed above and beyond what would have been seen in a clinical setting. It is essential that this expert has access to the DWP records (with appropriate commentary from both gynaecological and pain management experts). If needs be, a separate statement from the claimant dealing with any inconsistencies within the records will be required.

Psychiatric or psychological – anxiety, adjustment disorders and depression are sadly common features in these cases. Chronic pain and/or ongoing incontinence have a profound impact on a client's well-being, and should not be relegated to either a joint experts approach or indeed left out altogether.

Accommodation – the use of such an expert may be dependent on the evidence of your care expert. If adaptations to the home are required, do not rely on builders' quotes. The evidence from someone who understands the utility of such adaptations is important. The courts can be hostile to the inclusion of such experts and in this field, it may be wise to instruct an expert on joint basis.

Pension loss – very useful where there has been a substantial reduction or loss of earnings. Such reports are ideally obtained on a *'white-label'* basis, meaning you don't specifically have to obtain permission to rely on their expertise, but can rely on their work within your schedule of loss.

Neurophysiologist – defendants are beginning to suggest the use of this expert to objectively assess damage to the nerves, usually through the use of invasive nerve conduction studies. We have recently successfully argued against a defendant being given leave to rely on such evidence (and indeed seeking to vacate the trial and stay the action pending our client undertaking such tests). Mandating uncomfortable and invasive tests such as these is clearly unacceptable in the medical legal field.

Costs budgeting and case management

There is no doubt that in these cases you need to *'front load'* them in terms of breach, causation, condition and prognosis evidence. To do otherwise will risk what we encountered in the Talbot case – a simple refusal by the court to allow experts in care, psychiatry and accommodation, despite an indication in the condition and prognosis evidence from the gynaecologists/pain management experts that this was required.

At that stage, quantum was unclear, and the court felt that the *'threshold'* for allowing such evidence to be adduced was not reached. Later in the case we did instruct a care expert and made an application for leave to rely on that report, together with psychiatric and joint accommodation experts. With a schedule of loss amounting to over £1 million at this stage, the court felt it was appropriate and clearly proportionate for the parties to rely on such evidence. Had leave not be given then this would have been catastrophic from the perspective of properly valuing our client's claim.

Again, you must ensure that each and every expert instructed is supported by your key breach/causation experts. Where possible, disclose your quantum evidence in good time for the CCMC. This will assist in terms of costs budgeting, and of course will enable you to make an early, targeted and effective Part 36 offer on quantum.

This will also impact on the directions you request. Defendant behaviour in these cases has already been characterised earlier (!). By early preparation, you will be able to put the claimant in the *'driving seat'*. Request a tight timetable, do not routinely agree extensions of time – particularly when this could impact upon the trial date – and open the door to defendants attempting to vacate trial dates.

Costs budgets must anticipate, sadly, the war of attrition that is currently being encountered. Conferences with experts must include meetings post-service of the defence, post-exchange of lay witness evidence, pre-exchange of reports, pre-experts meetings (where the agenda can be agreed with your own expert team), and finally pre-trial. As the case progresses and phases within the budget become exhausted, consider making an application to the court to increase the level of costs allowable. At the very least, put the defendant on notice that you will, at detailed assessment, seek to recover costs above and beyond those allowed within the budget because of their conduct (in Talbot, one mediation was allowed for within the budget. We then had to proceed to a RTM towards the conclusion of the case because of the lack of proper engagement by the defendants in the mediation process).

Take into account the vulnerability of your client – reflect that in the budget, and claim time and enhanced client care where necessary.

Defendants' strategy, and how to deal with it

Their strategy is clear and simple – they will deny everything and no admissions will be made at any stage. Sadly, to date, mediation has been misused by them. In two of our cases, we were lectured by their Counsel, which helpfully set out why we had instructed the wrong experts, how our client couldn't possibly have been misled at the point of consent, and that inevitably, her case would fail on causation (including of the factual variety).

Pleading limitation is no longer a tactic, but relentless delay and refusal to engage in any meaningful dialogue appears to be the defendant's overwhelming objective. It is not clear if their intention is to *'grind down'* our clients, with small offers being made just before trial preparation. There certainly does does appear a concerted effort to treat these claims almost as a class action, fighting every issue, and trying to seize control of the litigation by constant applications for extensions, and mind-numbing amendments to expert agendas (which go backwards and forwards with depressing regularity, as they seek to amend your own questions, and raise their leading questions as substitutes).

Our response now is to take great care in considering all aspects of the defendant's behaviour. Applications to extend time for exchange of lay witness evidence should be considered sparingly. While we are all too aware of the pressure clinicians are facing due to Covid pressures, it is always worthwhile asking the defendants what is causing the delay. Any response leaning towards Covid pressures must be explained – in what way has their practice areas been impacted? Are gynaecologists/pain management clinicians really at the forefront of Covid (say compared to intensivists or A&E)? Ask your own expert – they will have views. Take into account clinical statements which will have been obtained before the drafting of the defence – do they need more time to refine, edit and massage their lay witness evidence (often trying to bring secondary *'expert evidence'* via lay statements)?

The same applies to medical reports. Tell the defendant early on (preferably at the CCMC) whether your client will have difficulty in attending in-person medical appointments and ask them to consider virtual appointments (works well for psychiatric and to an extent,

pain management), or appointments geographically close to your client (do our Yorkshire or Devon clients really need to attend a rush-hour appointment at Harley Street?). If you don't, expect the defendants to make applications extending time for exchange on the basis your client is *'unreasonably'* refusing to travel and that there is no reason for them to fund a friend/relative to accompany client (who invariably is suffering from incontinence, could be in chronic pain, likely to have mobility problems, and could have a depressive/anxiety disorder, making a six-hour or so round trip daunting).

As mentioned above, the defendant's sense of control (or losing it) is particularly heightened during the experts meeting phase. My suggestion is send a draft agenda to them, making it clear you will not countenance any changes to your own questions, but you will accept additional questions raised by them. They will of course do both, at which point, sadly, the default positon is two agendas. The agenda process has become an industry in itself – leading not to a narrowing of issues, but rather an obfuscation of what needs to be discussed.

Ultimately, the defendant will only ever respond if placed under suitable pressure. From the claimant's perspective, this means making early, sensible Part 36 offers on liability and quantum. To front-load your cases and not take such steps is bordering on the negligent – none of our clients want the litigation to go on for longer than it needs to, and this is one of the few tools available to us to get the other side to focus on their own position. Calderbank offers also have a role to play – time limit them, and indicate once they have expired you will be replacing it with a Part 36 offer pitched at a higher amount.

While I am less optimistic about the role of mediation in these cases than I once was, there is an argument that this should be pursued once the claimant's expert evidence is finalised. That can be shortly before or after issue of proceedings, rather than the more common scenario of a couple of weeks before trial. At the very least, a mediation should be able to narrow the issues between the parties, and hopefully, quantum discussions can take place thereafter.

Conclusions

Ms Talbot was pleased with the settlement we achieved for her, but what troubled me and her legal team was that the defendant in this case gave every impression that this was all a *'numbers game'* and that their sights were very much on the several hundred other cases currently making their way individually through the High Court in London and various other district registries.

Despite the agony of the *'agenda wars'*, there were some important break-throughs from the claimant's perspective.

In relation to the breach/causation experts, it appeared to be accepted that our client could have undergone treatment with pessary, physiotherapy and medication, and that the defendant's lay witness evidence clearly confirmed no such options had been offered. On the issue of factual causation, our client made it clear that had she been given the option of non-surgical techniques, why wouldn't she have taken them?

The nature and extent of the medical guidance at the time was noted and agreed, and in terms of consent, the experts agreed that our client should have been informed of the material risks and benefits of the procedure, its likely outcome, and all reasonable surgical and non-surgical treatment options. The defendants did push for generalising what *'most patients would have done'* in Ms Talbot's position had she been properly consented, only to see their own experts accept that most would try conservative measures first.

The discussions between the pain experts became unnecessarily complicated, with the defendant expert arguing that our client was suffering from a chronic post-surgical pain syndrome, which she would have suffered with any form of vaginal surgery. While conceding this had led to *'some'* vaginal discomfort, the expert opined that all her continuing difficulties were unrelated to the index event.

The claimant's pain expert argued that our client's pain started with the insertion of the mesh, which led to irritation of the tissues leading to secondary hyperalgesia/pelvic floor dysfunction/pudendal nerve irritation. Taking into her account her pre-index health, he ascribed 75% of her ongoing problems to the defendant's negligence.

Ms Talbot's case was pleaded on the basis that the breaches of duty caused or materially contributed to her present condition. So, even if she failed the *'but for test'*, she would succeed on the contribution point. This didn't always appear to be understood by our opponents, who kept re-iterating that Ms Talbot's claim was *'all or nothing'*, a view that sadly informed their degree of engagement with us throughout the case. What was clear, particularly to the pain management experts on both sides, was that there was a significant difference between the pain symptoms she had before and after the index surgery – in

a sense factually, the case for a material contribution had been made.

The urologists were unable to meet before the RTM, but again, there was clear evidence Ms Talbot's symptoms had deteriorated following the uphold surgery, causing urgency, stress and urge urinary incontinence. It was also apparent that but for their negligence, her bladder symptoms would have improved or been cured by physiotherapy and/or medication.

Finally, the psychiatrists did agree that but for the defendant's breaches of duty, Ms Talbot would not have suffered her depressive condition, which, in turn, had been increased by her perception of pain.

In summary, Ms Talbot's case confirmed to me and my colleagues that these cases should be pursued. The importance of getting the right team around you (experts, counsel and your own colleagues) cannot be underestimated.

It does, in some ways, feel as if I have been transported back, to a certain extent, to the bad old days of litigation where mediation was largely ignored, blanket denials were common place, and delay became one of the central weapons employed by the defence.

I do not know if NHS Resolution has an agenda with these cases. To my knowledge, none have yet proceeded to trial. Cases worth less than £50k in quantum are attracting offers, but the rest of the cohort are subject to a tough and lengthy litigation process, culminating in very late offers/settlements being achieved.

Baroness Cumberlege's observations concerning a culture of institutional denial and misogyny appear, sadly, reflected in this ongoing litigation.

Inquest touching the death of Catrina Greig

BRAMBLE BADENACH-NICOLSON
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Background

Catrina Greig was born on 21 October 2014 and died on 7 September 2018. Catrina was born with Down's Syndrome and battled against poor health for most of her childhood. Catrina's Down's Syndrome made her more susceptible to infections and it would take her longer than the average child to recover.

On 14 August 2018, Catrina's parents took her to a hospital in Wigan as they were concerned that they had given her doses of child Calpol, as opposed to infant Calpol, to treat her for a chest infection. There were no issues relating to the Calpol, however, when Catrina was sent for blood tests, the doctors found evidence of blasts. Concerned that Catrina might have leukaemia, the doctors recommended that she and her parents go to the Royal Manchester Children's Hospital [RMCH].

The family arrived at the RMCH on 15 August 2018 and Catrina was diagnosed with acute lymphoblastic leukaemia [ALL]. A key factor in this case is that Catrina's parents wanted to take her back home for treatment at a local hospital. They had been in Manchester visiting family. However, the staff at the RMCH persuaded them that Catrina would receive the best treatment there.

UKALL 2011 Protocol

Another key issue in this case, and one of the family's concerns, was that they were not adequately informed about Regimen A of the UKALL 2011 Protocol. In short, the Protocol recommends that prophylactic antibiotics are given to children with Down's Syndrome before induction chemotherapy is administered to treat ALL [this is set out within Appendix 5 of the Protocol]. Appendix 5 recommends Ciprofloxacin but acknowledges that individual centres may wish to use alternative antibiotics based on local infection and resistance patterns.

Appendix 5 unambiguously sets out that all febrile neutropenia should be treated as high risk, and that Down's Syndrome patients may not present with classic signs of sepsis, such as pyrexia. Therefore, non-specifically unwell patients should be treated as septic until proven otherwise. The Appendix also warns: *"be alert to early signs of shock in septic patients and refer promptly for intensive care"*.

The evening before Catrina started chemotherapy, her parents were given a plastic bag-full of information on the Protocol. Crucially, they were never told that the RMCH had a policy in place according to which children being treated for ALL were not to be given any prophylactic antibiotics at all. This was because of an increasing resistance to antibiotics within the local area. Catrina's parents were very clear that had they been made aware of this deviation from the Protocol, they would not have consented to Catrina's treatment at RMCH.

Catrina commenced chemotherapy on 17 August 2018. She did well for the first week of treatment, but rapidly declined on 24 August 2018. Her abdomen was visibly distended; she was crying constantly; she refused to eat; and was generally in a lot of pain. At this stage, Catrina's parents were providing most of her personal care; the nurses carried out checks at regular intervals but failed to undertake a proper pain assessment throughout her stay. These symptoms continued for four days, over the August Bank Holiday weekend. Her heart rate was increasing day by day, as was her temperature. It was on 29 August 2018 that sepsis was first mentioned by the medical team. Catrina triggered Amber on the Early Warning Score at 18:06pm. She then triggered Red at 20:38pm, but, contrary to the local policy, further observations were not repeated within the hour. The medical records show that there was a *"plan to treat as sepsis"* at 21:37pm. Catrina did not commence antibiotics until 22:30pm.

Catrina's condition did not improve. She was admitted to PICU where she arrested three times. An X-ray conducted on 30 August revealed likely neutropenic colitis and a further ultra-sound confirmed that Catrina had thickened bowel loops and pneumatosis. Catrina fought the infection for another eight days, following which her parents agreed to compassionate extubation. She died on

7 September 2018 and the medical cause of death was sepsis.

The Inquest

The inquest was heard in Manchester Coroner's Court before Area Coroner Zak Golombeck. Evidence was heard from Catrina's mother, Clare Greig, and two medical witnesses.

The two key questions to be addressed at the Inquest were:

a) had Catrina been given prophylactic antibiotics, would she have survived?

b) had Catrina's sepsis been diagnosed and antibiotics administered sooner, would Catrina have survived?

We heard evidence from Catrina's mother, Dr E who wrote a Level 2 Investigation Report and a causation expert, as requested by the Coroner.

Mrs Greig gave evidence and, as a practising nurse, was able to assist the Coroner with more complex issues than might be expected from a lay witness. She described Catrina's personality and emphasised how she still found it difficult to come to terms with the fact that Catrina may not have died had she and her husband taken Catrina to another hospital, albeit contrary to the advice they were given by the medical team at RMCH. She voiced her concerns about the fact that the nursing staff did not tend to Catrina's personal care, they did not communicate with her (or Catrina), and they did not undertake any pain assessments.

Dr E then gave evidence. In his report, he concluded that there were issues in Catrina's care. Whilst it is likely the outcome would have been the same, given Catrina's disease and comorbidities, the optimum treatment was not provided and it could not be determined with certainty that this would not have changed the outcome. During the Inquest, Dr E concluded that Catrina should have been given prophylactic antibiotics, unless there was a strong reason to the contrary. As for the delay in administering antibiotics, Dr E concluded that, had the sepsis been recognised earlier and antibiotics started 12 hours earlier, Catrina might have survived.

In his witness statement, the causation expert concluded that, since Catrina had lived a further 8 days following her commencement on antibiotics, the delay would not have been causative of death. During evidence, however, he agreed that commencing antibiotics within the 12 hours prior to the actual administration at 22:30pm would have more than minimally improved Catrina's chances of survival.

The Coroner finally admitted the Level 2 Investigation Report, a rule 23 witness statement and correspondence between the family and the Trust into evidence.

The conclusion

The Coroner summed up the evidence and returned a hybrid conclusion (short-form and narrative), finding natural causes with a rider of neglect. He was highly critical of the RMCH and found that there was no clear explanation as to why the hospital's position was to go against the Protocol. He found that the decision to provide no antibiotics at all was a failure in the care provided to Catrina, and concluded that it would have been imperative for a family, such as Catrina's, to be made aware of a local decision to go against a national protocol.

As for the delay in administering antibiotics, the Coroner found that the treating clinicians did not appreciate the severity of Catrina's condition and did not recognise that her health was deteriorating.

One issue the Coroner was keen to address was communication between Catrina and the medical staff. He expressed his concern about the fact that there was not a clinician available to communicate with Catrina in Makaton, a sign language programme which she used with her parents. He drew a comparison with a child without Down's Syndrome and concluded that the clinicians would be expected to communicate with them on a basic level to see how they felt. He found that the care, or lack thereof, Catrina received in that regard was *"unacceptable"*.

In relation to his finding of neglect, the Coroner made three interesting comments: firstly, he concluded that Catrina was a dependent person, first and foremost as a result of the fact that she was a patient in hospital and was dependent on clinicians to provide her with a basic level of care. He then held that the RMCH's policy to deliver care contrary to the UKALL Protocol and the delay in treating Catrina with antibiotics both amounted to a failure to provide basic medical attention.

Lastly, he turned to consider whether such failures were *"gross"* within the meaning of *R v North Humberside Coroner Ex p. Jamieson* [1995] Q.B. 1, CA. He concluded: *"In my judgment, taken in isolation, neither failure was a gross failure to provide basic medical attention to a person in a dependent position. However, when taken collectively, there was a gross failure to provide basic*

medical attention to Catrina. I therefore will add the rider of neglect [...]". Causation was not an issue in so far as neglect was concerned, because both experts agreed that the failures set out above more than minimally contributed to Catrina's death.

Written submissions were requested by the Coroner in relation to issuing any preventing future death reports. At the time of writing the Coroner is yet to make his final decision.

Comment

Whilst the narrative conclusion allowed for comment by the Coroner and the rider of neglect reflected (to a degree) the poor treatment Catrina received, inquests into hospital deaths rarely afford families any real sense of closure. The overarching grievance Catrina's family had was that no one at the hospital had answered their questions or treated them with compassion, when Catrina was being treated or in the aftermath of her death. Catrina's family understood that such grievances were beyond the remit of the Coroner, but that does not make the process any easier. Those representing families should prioritise managing their expectations.

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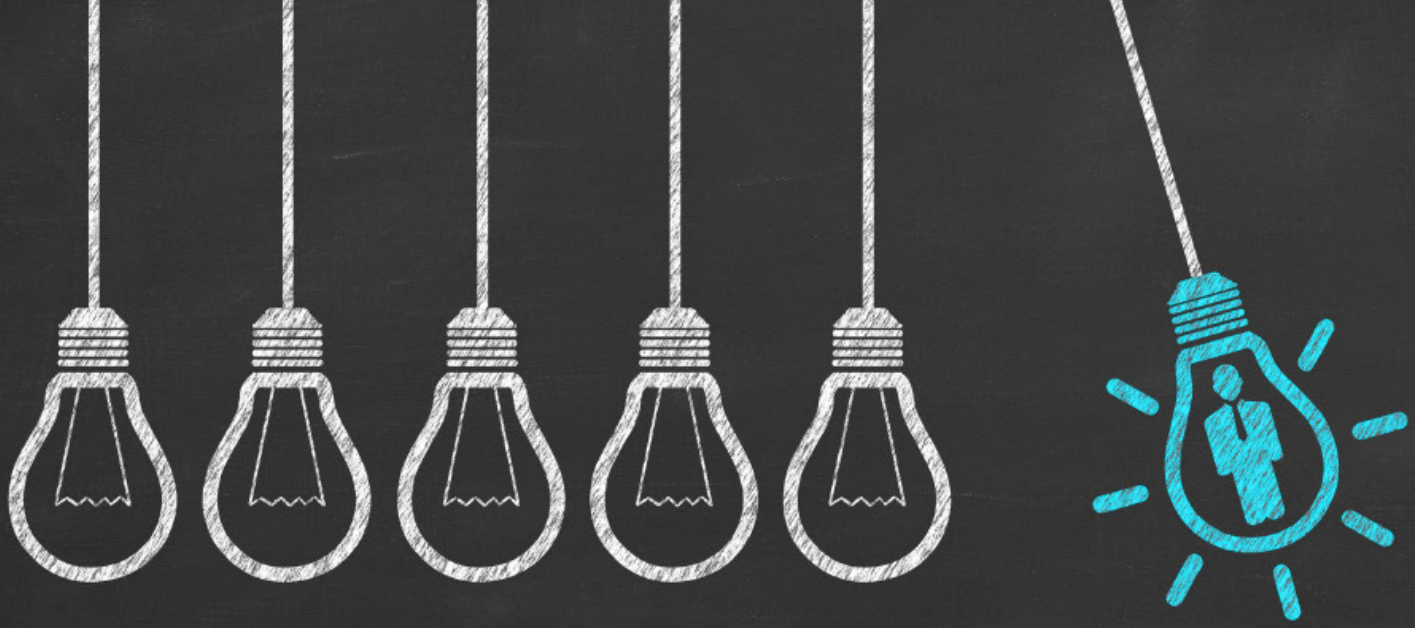

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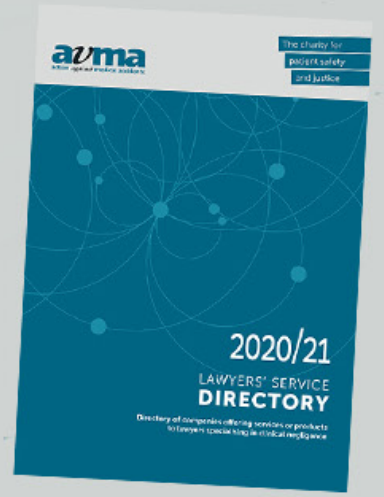

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