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The charity for patient safety and justice

Lawyers Service Newsletter

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Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

Welcome to the first Lawyer Service Newsletter of 2023. Certainly, for AvMA the New Year has heralded a fresh and positive start, the organisation is now led by our new CEO, Paul Whiteing – Paul, has hit the ground running. A former lead Ombudsman at the Financial Ombudsman Service, Paul is no stranger to a challenge! He is making a point of getting out there to meet as many people as possible, from lawyers to arm's length bodies such as the CQC and others. If you have not yet met Paul, do introduce yourself at the ACNC in Bournemouth 22nd – 24th March.

AvMA has welcomed other changes too. Our new Communications and Fund-Raising Officer, Paula Santos, is no stranger to AvMA or to many of you. Paula was formerly in our conference department but will now be guiding the organisation through the ever-important world of social media. Last, but not least, we welcome Kate Eastmond who is appointed as Events and Webinar Co Ordinator in the Conference department. Paula and Kate will be at our Annual Conference in Bournemouth, they would be pleased if you said hello to them.

Over the years there have repeatedly been calls and suggestions for a no-fault compensation scheme to replace clinical negligence litigation. Other reforms suggested include, tort reform to curb the rising cost of damages; capping loss of earnings to a level equivalent to the average national wage; that there should be defined health and social care packages to avoid the cost of private care; reform of Section 2(4) Law Reform (Personal Injury) Act 1948, so the claimant can no longer recover the cost of private hospital care. Some of these suggestions resurfaced recently when the Rt Hon Jeremy Hunt MP, was Chair of the Health Select Committee.

The Covid pandemic has changed the landscape, backlogs in the NHS are now longer than ever, low staffing levels and moral are a perennial problem for trusts. Many trusts are struggling, and the next healthcare scandal never feels too far away. For all its well-deserved respect it is hard to get away from the fact the NHS haemorrhages public money. Given the general state of the economy and the uncertainty caused by Brexit, it may be that the conditions for a perfect storm are gathering and if that is right, then clinical negligence lawyers need to be prepared to argue that the true cost of such

reforms lie in the additional cost injection required for social care.

A few years ago, we put together a Legal Think Tank, which has met regularly to consider these sorts of issues in more detail. The Legal Think Tank has identified that the most effective way forward is for an independent expert (an academic) to consider social care costs in more detail. The view is that the data and reports obtained on the cost of social care is fair and impartial and can be used to form part of any future discussions on alternatives to litigation. We are inviting you to donate to the cost of the academic researching and reporting on this – we have suggested an initial target figure to cover the cost of two independent reports of **£40,000**. For more information and background on the Legal Think Tank, please do read the article ***"No fault compensation, Tort Reform and Why We are inviting you to donate"*** included in this edition of the Newsletter. We will also be available to discuss this further at the Annual Conference in Bournemouth. SCIL and Legal Think Tank are equally involved in bringing this piece of work together and APIL has been invited too.

Another difficult subject which frequently presents itself is that of material contribution. **Henry F Charles** and **Christopher Fleming** both of 12 Kings Bench Walk, examine the decision in the case of *CNZ (suing by her father and litigation friend MNZ) v Royal Bath Hospitals NHS Foundation Trust (i) and the Secretary of State for Health and Social Care (2)* in their article ***"Material Contribution: The latest but probably not the last chapter"***. In examining this case, both Henry and Christopher identify that the courts approach to material contribution is problematic not least because there are six overlapping principles at play, they helpfully go on to identify each of those principles.

Bramble Badenach-Nicolson of Hailsham Chambers asks, ***"Does the decision in Maguire, mark the beginning of a shift in the application of Article 2 in healthcare inquests?"*** This is an interesting case, not least because the deceased was a particularly vulnerable individual with downs syndrome, living in residential care. Considerations for the Supreme Court – was there a deficiency in the regulatory framework because no care plan had been prepared in advance to identify a way of getting an incapacitated person to hospital, especially where that person was unable to give consent and was known to have a fear of hospitals? If so, did that deficiency operate to the patient's detriment? Or will the SC find this a straightforward case of mere error or medical negligence?

We are only just beginning to charter the real implications of the UKs departure from the European Union. Judge Pinto has sat in the Grand Chamber in leading cases where the European Court has considered in the context of healthcare what a member state's obligations are under Article 2. He has expressed concern that what is driving the decisions in these cases is a *"...strict financial interest in safeguarding the hospital authorities from legal challenges"* and aims at *"...the protection of health professionals in an untouchable legal bubble, shirking State responsibility for health-system and hospital-related death or serious injury under the Convention and consequently limiting the Court's jurisdiction in this area"*. That is indeed quite a portend especially now the UK is going it alone, facing difficult economic times and a potential crisis in the retention of healthcare staff and the delivery of services to the public. We await the Supreme Court's decision in *Maguire*.

In acknowledging the difficulties currently faced by the NHS we also recognise that private healthcare is growing increasingly attractive to members of the public who can afford it. How safe is private healthcare? How much do we really know about what goes wrong? **Arran Macleod**, Senior Associate, Pennington Manches Cooper explores concerns about private healthcare in his article ***"Going private: problem or panacea?"***.

On 24th April 2022, the government closed the consultation on fixed recoverable costs in clinical negligence claims valued up to £25,000 together with its proposals for a new streamlined process. We are still waiting for a response. Compulsory Early Neutral Evaluation (ENE) is integral to this streamlined process, despite the fact neither claimant nor defendant clinical negligence practitioners have any experience of ENE, let alone the effect of making this particular alternative dispute resolution (ADR) process compulsory.

On 14th March, the Law Society Gazette, carried an article entitled *"MoJ expecting sevenfold rise in mediation workload"*, the article attributed Sarah Rose, deputy director of dispute resolution at the MoJ, as saying that *"an integrated system of compulsory dispute resolution was at the forefront of our minds"* for claims valued at under £10,000.

Mediation as a means of ADR has been around for decades. NHS Resolution's commitment to mediation in clinical negligence claims is demonstrated by its contracts with two established ADR providers, CEDR and Trust Mediation. This approach has perhaps contributed to mediation gathering both pace and popularity with practitioners, whilst noting that mediation is not compulsory. **Paul Balen**, has a distinguished career, first as a much-respected claimant clinical negligence specialist

and more recently as Director of Trust Mediation, we are pleased to include Paul's article ***"Kisses, cuddles, and closure – 1000 mediations and counting!"*** With 80% of mediations concluding in settlement, evidence that it can be successful at any stage of the claim whether introduced early or post issue and is flexible enough to achieve resolution on liability only and/or quantum issues, ADR and mediation appear to be here to stay, this article is not to be missed!

Can you donate to AvMA? Conscious that as we draw towards the end of the financial year, firms will be looking to bring their solicitor/client billing up to date. While firms invariably attempt to return money belonging to clients and other third parties promptly, there are on occasions residual balances, perhaps because a client has moved but not provided a forwarding address and can no longer be traced. Firms are allowed to pay residual balances of £500 or less on any one client matter to a charity of the firm's choice provided they comply with prescribed circumstances – R5(1) SRA Account Rules: **https://www.sra.org.uk/solicitors/standards-regulations/withdraw-client-money/**

As you know, AvMA is an independent charity which offers advice and information, through its helpline, written advice and information and inquest services, to the public without charge. We are not in receipt of any government grants or other support. If you have a residual balance on a client account/s, please consider AvMA as your charity of choice, your donations do help us maintain our public facing services and campaign work. If you would like to make a donation in this way please email **Nicky Rushden** for details **nicky@avma.org.uk** – Thank you for considering AvMA and we look forward to welcoming you to the ACNC in Bournemouth, later this month.

Best wishes

No fault compensation, Tort Reform and Why We are inviting you to donate

LISA O'DWYER, DIRECTOR OF MEDICO-LEGAL SERVICES, ACTION AGAINST MEDICAL ACCIDENTS

This is an appeal by the Legal Think Tank, SCIL and AvMA

Doubtless, you will all be familiar with the suggestion that a no fault compensation model would be an appropriate alternative to the current system of compensating a person injured as a result of clinical negligence.

Never mind, that compensation for the clinical negligence claimant is calculated in accordance with the same well-established principles of tort law that a personal injury or any other civil claim is. It is therefore odd that clinical negligence is being singled out for change.

Arguments for a no fault scheme recur periodically, most recently in the Health Select Committee report *"The Safety of maternity services in England"* published 06.07.21 **https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm** The committee's Chair at that time was, Rt Hon Jeremy Hunt MP, he said there was a need to examine *"...how the litigation process should be reformed to save vast sums being spent on compensation, and crucially to promote patient safety in the future"*. The report recommended that rapid resolution and redress scheme should be implemented for maternity claims.

The months following on from the publication of that report have been busy for government: the two metre social distancing rules were phased out, eat out to help out was introduced, a second lockdown was announced on 31st October 2021. In 2022, government was and continues to be, busy firefighting an ailing economy with soaring inflation, rising bank interest rates and combating the effects of Trussonomics, to say nothing of the chaos felt in having three prime ministers in as many months. While the recent focus may not have been on a no fault compensation scheme, or tort reform, it does not mean that this has gone away.

On the contrary, the Health Select Committee's report: *NHS Litigation Reform* **https://committees.parliament.uk/publications/22039/documents/163739/default/** which was published this time last year in April 2022, saw Jeremy Hunt commenting in the following terms:

"The system of compensating patients for negligence in the NHS is long overdue for reform. We're urging the Government to adopt our recommendations to reduce both the number of tragedies and the soaring costs to the NHS"

"It is unsustainable for the NHS in England to pay out more than £2 billion in negligence payments every year – a sum equal to the cost of running four hospitals – a figure that will double in 10 years if left unchecked."

"Under the current system, patients have to fight for compensation, often a bitter, slow and stressful experience with a quarter of the enormous taxpayer-funded sums ending up in the pockets of lawyers."

"We need a better system that learns from mistakes, following the lead of countries like New Zealand and Sweden. We must move away from a culture of blame to one that puts the prevention of future harms at its core."

Steering a course through an ailing UK economy is likely to continue to preoccupy Mr Hunt, who as Chancellor of the Exchequer now holds the purse strings. Still, there is no suggestion that he has changed his views on no fault compensation being a panacea to the rising cost of clinical negligence litigation and the apparent inability of the NHS to learn lessons. This issue is not just about the views of a single politician: the drive to reduce the cost of NHS litigation will be attractive to politicians of all persuasions and at first glance a system that could reduce litigation and improve patient safety has many attractions so is likely to be with us whatever flavour of Government we have.

The Legal Think Tank (LTT)

In 2020, AvMA put together a Legal Think Tank (LTT), comprised of some of the country's most senior and experienced lawyers, including barristers and representatives from SCIL. The LTT was convened for

the purpose of looking at difficult issues such as no-fault compensation, it has met regularly over the years. This has provided an opportunity to discuss challenges to the clinical negligence market, to consider how patient safety might be improved and to look at how clinical negligence claims might be resolved in a more cost effective and beneficial way for the injured patient and/or distressed family.

No Fault Compensation and Tort Reform

The 2021 report: *"The Safety of maternity services in England"*, referred to there being a *"...consensus from our witnesses that the United Kingdom's approach to compensation is not the optimal solution either for families or the healthcare system. A review of compensation schemes around the world found that "a quiet but notable shift has occurred away from adversarial court-based dispute resolution to administrative compensation schemes". The result of that shift has been significantly lower costs."* The report recommended the UK consider a no-fault compensation scheme, drawing on comparisons with the Swedish and New Zealand models.

AvMA is not averse to a no-fault compensation model, providing it is fully funded and can demonstrate increased learning and better patient safety. A no-fault model holds certain attractions, not least the threshold for eligibility will be lower, looking to whether care was provided in accordance with best practice as in Sweden, or injury arising because of treatment as in New Zealand. That means, more people would in theory be eligible for relief.

It goes without saying that any alternative model must be able to provide the injured person with the care and assistance they require, and they must have proper access to the equipment and therapies needed. Funding must be available to adapt properties and homes so the person who has been adversely affected and/or their family are enabled to live life as fully as possible. Read in isolation, there is considerable lure in statements that refer to *"significantly lower costs"*, but that on its own does not necessarily paint a true picture.

It is a well-established fact that social care in the UK has been underfunded for years, the recent pandemic has further highlighted the inadequacies of the system. The lack of funding for social care is said to be responsible for bed blocking which in turn prevents the NHS from reducing its own backlog of patients and waiting lists as efficiently as possible.

The LTT consider that the cost of a no-fault compensation scheme must be looked at within the context of the cost of social care. How much investment is required to make social care, adequate to meet current need? How much more investment would be required to underpin a no fault compensation scheme? What does all of that mean for the UK tax payer?

To compare the UK with Sweden we need to also consider the Swedish demographic, population, and expectation of government – some Swedish citizens pay income tax at 80%. Herein lie clues to the true costs of no-fault compensation.

Repealing Section 2(4) Law Reform (Personal Injury) Act 1948, is a suggestion which has also attracted considerable attention. The effect of this simply prevents claimants from recovering the cost of private medical care. The NHS is in crisis, a shortage of experienced staff, staff recruitment and retention issues, to say nothing of low morale from over work and the ever-growing waiting lists and backlog. Repealing Section 2(4) Law Reform (Personal Injury) Act, 1948 will simply add to the existing NHS waiting lists. That will not help the NHS and it certainly won't help an injured patient and their family, it will only prolong the claimant's pain and suffering. There are no obvious wins here, despite the rhetoric.

These are important questions which government has side stepped but which must be addressed. They are propositions which will not go away, they repeatedly raise their head and are persistently submitted as a panacea for the cost of clinical negligence litigation. There is little evidence that either of these approaches, will change the culture of the NHS or will improve patient safety.

Costing Social Care

It is difficult for claimant lawyers to galvanise themselves in the way in which NHS Panel firms can. Mindful of this, the LTT has endeavoured to consider ways in which the profession, especially those representing claimants might respond to this. It has considered whether anything needs to be done at all but concluded that now is the right time for the profession to be taking these suggestions seriously. That means, being prepared and able to respond with authority by having properly assessed and thought through costings for social care. The recommendation is that the most effective way forward is for claimant lawyers to commission their own independent expert to identify the true cost of repealing Section 2 (4) and introducing a no-fault scheme.

An outline of the brief to the expert

The expert has been directed to the Health and Social Care Committee report on the safety of maternity services in England and their firm recommendation that a no blame compensation scheme be introduced, such as Rapid Resolution & Redress. The expert has been asked to provide:

(i) An analysis of the state of social care within the UK currently and under a no fault compensation scheme.

(ii) A Comparison between the cost of social care in UK and New Zealand and UK and Sweden including highlighting the current difference in per capita tax contributions between the countries.

(iii) To address the costs of introducing a social care system that is fit for current purposes and then identify the cost of a social care system that could adequately support a no fault scheme

(iv) To identify evidence that the no fault compensation schemes operating in Sweden and New Zealand do work for the injured party

(v) What evidence is there that no fault compensation schemes do in fact improve patient safety and learning?

(vi) The expert has been approached on the basis that he will provide two separate reports. One report is to focus on the social care issues associated with a possible no fault compensation scheme in England and Wales. The other report focuses on the implications of capping claimant damages as an alternative to no fault compensation.

The nominated expert

On the back of this recommendation a considerable amount of work has gone into identifying an appropriate expert. Initially whittled down to five possible academics, each with relevant areas of research, such as social justice and social care from a range of universities: Exeter, Cardiff, Birmingham and Leeds.

The expert we recommend to you is Professor James Rockey, Senior Lecturer in Economics with a special interest in political economy and inequality: **https://www.birmingham.ac.uk/staff/profiles/business/rockey-james.aspx**

Professor Rockey has confirmed that the brief falls within his area of expertise.

Cost of an independent expert

Professor Rockey having considered the brief has provided us with his time estimate and the cost of researching and writing the reports as follows:

Report 1:	122 hours x £180 per hour =	£21,960.00
Report 2:	51 hours x £180 per hour =	£9,180
Total:		£31,140.00
VAT:		£ 6,228.00
		£37,368.00

Prof Rockey has discounted his hourly rate from £300/hour to £180/hour.

The brief to Prof Rockey is on the basis that two reports are compiled, the costs reflect this.

The LTT recognises that ideally, we should commission Professor Rockey to survey the claimants' experience in the Swedish and New Zealand systems. At the time of writing this article I do not have a cost estimate for this work, but I am happy to circulate this in due course.

Request for donations

This request goes out from the Legal Think Tank, SCIL and AvMA.

The cost of the reports is significant, it is not appropriate for this to be carried by any one organisation or law firm alone. The reports will undoubtedly benefit all claimant clinical negligence lawyers and their firms, it will also benefit counsel specialising in this work. Given that, we are inviting all lawyers practising in England and Wales to donate to help fund Professor Rockey's fees.

Without the benefit of an evidence-based report, along the lines suggested, it is entirely possible that a no fault scheme could be introduced, it is also entirely possible that were this to happen, government would fail to invest in the social care to a level able to support a no fault scheme. The result of that would be that injured patients will be without access to appropriate funding to cover the cost of basics such as access to therapies, care, and equipment.

Lawyers need to be prepared to tackle proposals of this nature. In laying the groundwork now and obtaining reports from Professor Rockey we are in a stronger and better position to respond to the government's recommendations. As we refer to above, this is not something that is likely to disappear if we have a change of Government. The pressures are real and long term. We encourage you to act now, together.

The figure of £37,368 is an estimate of the costs that are likely to be payable. We encourage you to be as generous as you can be so there is an adequate buffer to cover any actual costs, which are likely to exceed £37,368.

At this stage we have set an initial target figure of £40,000 to cover the cost of both reports.

We are asking each firm to be as generous as possible, as a broad guide, we suggest that firms with 3 or less partners in total (not just clinical negligence partners) donate no less than £400 per firm. We recommend that firms with between 4 – 9 partners donate no less than £600 per firm. Firms with 10 partners or more, should consider contributing more than £600/firm. We encourage an approach which reflects the larger the firm, the greater the donation contributed.

This is only a rough guide; the figures only work if every firm whether they have a panel member or as a Lawyer Service member contributes. It only takes one firm not to contribute and the figures become skewed. We are inviting each firm to contribute what they can, but we encourage you to contribute something along the lines of the minimums set out.

Recommended individual barrister donations

Barristers over 5 years call: £250 + VAT £50.00
Total £300.00

Barristers 1 – 5 years call: £150 + VAT £30.00
Total £180.00

Pupils / Academics: £75.00 + VAT £15.00
Total £90.00

This is simply a suggestion as to the level of donations. All donations are welcome. We do appreciate the challenges firms are facing in the current economic climate with rising costs everywhere, however if we cannot raise the funds that we need to meet the cost, we will not be able to commission this important piece of work which will help us maintain the focus on access to justice and patient safety which is at the forefront of what we are all seeking to achieve.

Material Contribution: the Latest but probably not the last Chapter

HENRY F. CHARLES AND CHRISTOPHER FLEMING
12 KINGS BENCH WALK

12
King's Bench Walk

CNZ (Suing by her father and litigation friend MNZ) v Royal Bath Hospitals NHS Foundation Trust (1) and The Secretary of State for Health and Social Care (2)

Charles Dickens' Great Expectations has 59 chapters, published over the course of nine months to form a classic piece of literature. We may have great expectations that each upcoming material contribution judgment will bring clarity and resolution to what material contribution means, but we seem not far short of 59 cases with no resolution in sight. *CNZ* is the latest instalment, and is another case that is largely obiter in respect of material contribution.

Background

The Claimant was born in 1996 and has cerebral palsy as a result of acute profound hypoxic ischemia (PHI) which she suffered before and for 3 minutes after her birth. The Claimant's case was that her mother requested a caesarean section (CS), but that the CS was delayed or denied.

The Court found that the PHI endured by the Claimant was caused by the delay in offering her mother CS, and that the whole of the Claimant's brain damage was therefore caused by the breach[1]. The experts agreed that brain damage would not have begun to occur until after the first 10 minutes PHI, and the Court found that the total PHI likely lasted 16 minutes, of which 6.5 minutes were due to the negligent delay. The Claimant therefore satisfied the standard *'but for'* test. However, Ritchie J went on to make lengthy obiter comments on the principle of material contribution. In particular, he considered how quantum would have been assessed using material contribution if his factual findings had been different and the brain damage had in fact been caused by 5 minutes of negligent PHI and 1-3 minutes of non-negligent PHI.

1 *The case involved interesting questions relating to consent and the decision in Montgomery which are beyond the scope of this article.*

Material Contribution

The principle of material contribution has developed to allow the law to establish causation where a scientific gap makes it impossible to satisfy the *'but for'* test. In summary, a claimant can establish causation if they can prove that a breach made a material contribution to his/her injury which was more than de minimis. In his review of the authorities on the subject, Ritchie J noted the apparent distinction that had developed between cases involving *'divisible'* and *'indivisible'* injuries[2]. An indivisible (or *'trigger'*) injury is one where the severity of the injury is unaffected by the breach, such as a stroke, cancer, or death. The injury either happens or it does not. A divisible (or *'dose'*) injury is one where the severity of the injury is linked to the quantity or severity of the insult, such as asbestosis or industrial deafness. PHI is a divisible injury, as the more PHI the foetus suffers the greater the brain damage.

Ritchie J summarised the authorities on how to apportion damages when considering divisible injuries as follows (at [391]):

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

The Aliquot Theory

The Court rejected the approach proposed by the first defendant's medical expert for apportionment

2 *There are a growing number of authorities which suggest that material contribution does not apply to indivisible injuries in clinical negligence claims (see for e.g. in Thorley, dealt with below). As the injury in CNZ was divisible this was not an issue addressed by Ritchie J in his judgment.*

of damages. This approach, the Aliquot theory, was a method of determining the disability caused by the PHI using duration as a yardstick. The expert conceded that the theory only worked if the Court considered chunks of 5 minutes. In the first Aliquot between minute 10 and minute 15, mild to moderate disabilities would arise. PHI lasting 15 to 20 minutes would cause severe disabilities. The judge rejected this approach, reasoning that if the damaging PHI lasted 10 minutes, but only 5 minutes of these were negligent, the claimant would be in the moderate category and the damages would be assessed on the difference between the actual symptoms and the symptom pattern set out in the mild category. However, if the negligent PHI lasted only 3 minutes, apportionment would be impossible so recovery would be 100%. This would mean a lesser injury resulting in more damages, which was illogical. Furthermore, the qualification of the disability as *'mild'* required a greater level of detail for the difference to be properly quantified, and the Court was not satisfied that they had sufficiently accurate epidemiological evidence to support the theory.

Perhaps confusingly, the learned judge roundly rejected the Aliquot theory but readily accepted the conventional thesis that brain damage would not start to occur until after 10 minutes of PHI.

The Court's decision

The court considered that evidence would not have permitted an apportionment of quantum based on the relative duration of PHI (i.e. 5min negligent/3min not negligent): in his finding the experts agreed that such proof was scientifically impossible. Therefore, the Claimant would have recovered 100% of her damages.

Commentary

Arguably the learned judge's finding that it would have been *'impossible'* to quantify functional outcome in this matter raises some quite difficult issues.

In *Holtby v Brigham*[3], apportionment in an asbestosis claim (a divisible injury) was considered possible despite the court finding that *'any mathematical approach was clearly unsupported by the evidence'*, and there was *'no mathematical division to be made in medical term.'* Why were the mathematical difficulties arising from the medical evidence a bar to apportionment in *CNZ* but not in *Holtby*? Could the approach suggested at [392] have enabled quantum to be apportioned on the basis of percentage tied to the relative duration of PHI? If industrial disease law and practice is to be imported, then per Stuart-Smith LJ's comments in *Holtby*:

This method of dividing responsibility on a time exposure basis is, I understand, adopted among insurers in such cases as these. In the absence of some unusual feature, such as for example periods of exposure to a particularly dangerous blue asbestos during some periods, that seems to me to be not only the sensible, but correct approach in law. In practice, many years afterwards, such distinctions are likely to be impossible to prove.

The learned judge cited Mustill J's decision in *Thompson v Smiths*[4] that *'justice demands the court make the best estimate it can in light of the evidence'*, and that *'the question of apportionment is a jury question'*. On one view he declined to treat apportionment as a *'jury'* question and instead considered himself bound by what the limits of the medical evidence allowed.

A possible explanation for adopting this approach is provided at [372], in which the learned judge explains that the Court must take into account that the award for potential damages, in being very large, would render a broad-brush approach less relevant. Ascertaining the case law in support of such an approach is difficult. Moreover in public policy terms might a larger award more fairly invite apportionment on a broad-brush basis because of the unfairness of landing a defendant with 100% of a very large bill?

The learned judge's reasoning begs the question of what circumstances in which it is *'difficult'* to apportion damages (as opposed to *'impossible'*) might in fact resemble. In reality, is the proposition not a binary one, i.e. either the medical evidence allows for attribution or it does not? And in turn, if the medical evidence allows for the attribution between a tortious agent and an injury, then is this not simply the standard *'but for'* test?

We would suggest that the problem in all of this is that there are at least six concepts or principles in play, and potentially colliding. It is helpful to list them in no particular order.

(a) Proof of causation on the balance of probabilities – 51% - necessarily a fairly blunt instrument which gives rise to concerns as to injustice

(b) Scientific/medical experts understandably being cautious about engaging with the civil law requirements of proof: scientific proof is a very different beast. The less well known than it should be case of *BAE Systems*

3 *[2000] 3 All E.R. 421 CA*

4 *[1984] Q.B. 405*

(Operations) Ltd v Konczak[5] provides a framework and imposition of *'tough love'* to try and avoid material contribution being deployed.

(c) Conflict as to the applicability of material contribution where the tortfeasor has made a more than minimal contribution to indivisible damage, the extent of which cannot be ascertained. *Thorley* suggests this is not possible in medical negligence claims on the basis of *AB v MoD*[6]. However, *AB v MoD* cannot be readily squared with Lord Toulson's views in *Williams v Bermuda*[7] and *Sienkiewicz v Greif*[8]. In the former, Lord Toulson noted with approval the formulation of Professor Sarah Green[9]:

... It is trite negligence law that, where possible, defendant should only be held liable for that part of the claimant's ultimate damage to which they can because of the linked... It is equally trite that, where a defendant has been found to have caused or contributed to an indivisible injury, she will be held liable for it, even though there may well have been other contributing causes....

(d) Focus on an end point. Death is clearly indivisible – someone is dead or not dead, but death is a state, it is not the injury leading to the state of death. If in *Thorley v Sandwell & West Birmingham Hospital NHS Trust*[10] - concerning hypoxic brain injury – one asks what difference would a capable midwife have made a handful of minutes earlier, the answer would perhaps be a lesser injury and divisible (or scientifically incapable of divisible) injury.

(e) Reaching for the flag of material contribution to cloak a case. *Bailey v MoD*[11] was ostensibly decided on a material contribution basis, but as has been subsequently observed, it is readily amenable to conventional *'but for'* analysis. HH Judge Auerbach in *Davies v Frimley*[12] opined that in fact there is nothing novel in *Bailey* and its antecedents.

(f) Confusion over the inter-relationship of material increase in risk and material contribution to damage. The deployment of material increase to risk is, per *Fairchild v Glenhaven*[13] strictly limited to mesothelioma cases (slightly broadened later in *Heneghan v Manchester Dry Docks Ltd*[14]). The practical problem is that in proving damage for material contribution purposes the link between the damage and the tort is very often going to be derived from the fact that it is a truth universally acknowledged that x or y does lead to damage: so incipiently material contribution to risk is part of the proof of material contribution to damage. See *Drake v Harbour*[15] : "that the loss ensued which was of a kind likely to have resulted from such negligence, this will ordinarily be enough to enable a court to infer that it was probably so caused, even if the claimant is unable to prove positively the precise mechanism ..."

Much of the problem stems from terminology: the indivisible may be indivisible because of lack of proof, the divisible may seem indivisible because of lack of proof (science marches on, *Bonnington Castings v Wardlaw* would now be approached as a classic divisible case). We would suggest that this is where the problem lies: material contribution[16] as a concept (see Lord Toulson above, approving the classic view that material contribution applies to indivisible injury) has been afflicted by a separate issue of how one separates out there or thereabout divisible cases at trial.

In short, we would argue that the classic understanding of material contribution applying to indivisible injuries remains valid, but what needs review is proof of attribution of divisible injuries. *CNZ* is an important step along that road. *Drake v Harbour* may provide a clue to sorting that conundrum: *"... ... If [the Court] concludes that the only alternative suggestions put forward by the defendant are on balance improbable, that is likely to fortify the court's conclusion that it is legitimate to infer that the loss was caused by the proven negligence."* That might amount to a tacit reversal of the tactical burden of proof upon receipt of cogent first base evidence from a claimant. Interestingly shifting of the burden of proof has received formal endorsement in Canada: see *Cook v Lewis*[17], although the Supreme Court of Canada later worked its way to a *"substantial factor"* test – akin to material contribution in *Athey v Leonati*[18].

5 *[2017] EWCA Civ 1188*
6 *[2010] ECCA Civ 1317 Wherein Smith LJ held that material contribution applied to divisible conditions – contrast that with Smith LJ in* Dickins v O2 *where she felt that material contribution applied to indivisible injury*
7 *[2016] UKPC*
8 *[2010] UK SC10*
9 *Causation in Negligence, Hart Publishing, 2015*
10 *[2021] EWHC 2604*
11 *[2009] 1 WLR 1052*
12 *[2021] EWHC 169*
13 *[2002] UK HL 22*
14 *[2016] EWCA Civ 86*
15 *[2008] EWC Civ 25*
16 *Probably a comparatively rare beast*
17 *[1951] SCR 830*
18 *[1996] 3 CR 458*

Will the decision in *Maguire* mark the beginning of a shift in the application of Article 2 in healthcare inquests?

BRAMBLE BADENACH-NICOLSON
HAILSHAM CHAMBERS

hailshamchambers

Eleven years on from Rabone: will the Supreme Court's decision in *Maguire* mark the beginning of a shift in the application of article 2 to inquest healthcare cases, or will it reaffirm the Court of Appeal's warning in *Morahan* that an inquest is a *"relatively summary process"*?

Bramble Badenach-Nicolson provides her views on what we might expect from the anticipated Supreme Court judgment in the matter of *R (on the application of Maguire) v His Majesty's Senior Coroner for Blackpool & Fylde and another*[1]

Lord Dyson remarked in *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2 that *"the court has been tending to expand the categories of circumstances in which the operational duty will be found to exist"* [25].[2] Whether or not that forecast has played out over the intervening decade still remains unclear and the probing questions put by the Supreme Court Justices to Counsel for the Appellant in the hearing of *R (on the application of Maguire) (Appellant) v His Majesty's Senior Coroner for Blackpool & Fylde and another (Respondents)* on 22 and 23 November 2022 would suggest that they will be reluctant to cast the proverbial net any wider.

Whilst the case of *R (Morahan) v HM Assistant Coroner for West London* [2022] EWCA Civ 1410 has not been relied upon by the Appellant in *Maguire*, what can be described as a fairly stern warning by Lord Burnett at paragraph 7 of that judgment[3] will still ring in the ears of those lawyers attempting to advance article 2 arguments and, no doubt, in those of the Supreme Court Justices when considering their decision in *Maguire*:

"An inquest remains an inquisitorial and relatively summary process. It is not a surrogate public inquiry. The range of coroners' cases that have come before the High Court and Court of Appeal in recent years indicate that those features are being lost in some instances and that the expectation of the House of Lords in Middleton of short conclusions in article 2 cases is sometimes overlooked".

Background facts

Readers will be familiar with the facts of Ms Maguire's case: she was born with Down's Syndrome in addition to learning disabilities and in 1993, she moved to live in a residential care home which was managed by a company called United Response. Her placement was paid for and supervised by Blackpool Council.

During her residency at the care home, Ms Maguire was subject to a standard authorisation granted by the Council pursuant to the Deprivation of Liberty Safeguards.

She became ill over the two days before her death. A 111 call made on 21 February 2017 resulted in advice to call an out-of-hours GP. The GP consultation took place over the phone, but continuing concerns led to an ambulance being called later in the evening.

The paramedics who attended the care home on 21 February wished to transfer Ms Maguire to hospital, but she would not co-operate. An out of hours GP was contacted who advised that attempts should be made to persuade Ms Maguire to go to hospital but that if she refused, she should stay in the care home and be monitored overnight, which is what happened.

However, the following morning, 22 February 2017, Ms Maguire's condition had worsened and she was taken to hospital with kidney failure, dehydration and metabolic acidosis. She died following a cardiac arrest later that day.

1 *The recordings from 22-23 November 2022 can be found here:* https://www.supremecourt.uk/cases/uksc-2021-0038.html
2 https://www.supremecourt.uk/cases/docs/uksc-2010-0140-judgment.pdf
3 https://www.bailii.org/ew/cases/EWCA/Civ/2022/1410.html

The inquest

The Coroner initially agreed with Ms Maguire's family that the circumstances of her death warranted an article 2 inquest. As a result, the Coroner called evidence over the course of the inquest which satisfied his procedural duty under article 2.

However, before the jury was asked to perform its section 5 Coroners and Justice Act 2009 (CJA) duty at the conclusion of the inquest, the Coroner decided that the evidence did not suggest that the death might have resulted from a violation of the positive article 2 obligation to protect life and therefore, the coronial procedural duty did not apply and the jury's conclusion was necessarily limited by section 5(1). He made this decision following the authority of *R (Parkinson) v HMSC for Inner London South* [2018] 4 WLR 106.

Of course, had the Coroner decided that the inquest should continue to satisfy the article 2 procedural obligation, the jury would have been asked to record the circumstances in which Ms Maguire came by her death (as per section 5(2)).

The family initially claimed for judicial review of the Coroner's decision in 2019, however that was dismissed on the basis that there was no *"systemic dysfunction arising from a regulatory failure"*, nor was there a *"relevant assumption of responsibility"*.

Court of Appeal 2020 decision

The family advanced three grounds of appeal in 2020:

(i) The Divisional Court erred in concluding that the article 2 obligation did not apply, following *Rabone v Pennine Care NHS Trust* [2012] 2 AC 72;

(ii) If *Parkinson* applied, the Divisional Court was wrong to conclude that the failure to have in place a system for admitting Ms Maguire to hospital did not amount to a systemic failure; and

(iii) The Divisional Court erred in failing to take account of the wider context of premature deaths of people with learning disabilities.

The Court of Appeal held that Ms Maguire's death was related to her seeking *"ordinary medical treatment"* and that therefore the operational article 2 duty of the state to protect life was not engaged in the first place. Accordingly, no further investigation by way of an article 2 inquest was required. The Court also held that the *"very exceptional circumstances"* which would lead to an article 2 inquest in a medical case such as this did not come into place because there was no systemic regulatory failing.

Maguire Supreme Court hearing on 22 and 23 November 2022

An application for permission to appeal to the Supreme Court was lodged in February 2021 and the hearing took place in November 2022. The key question was whether there is a credible suggestion there was a breach of either a systemic or operational duty[4], and therefore whether the Coroner's procedural duty to order an article 2 inquest arose.

It was made clear at the outset of the hearing that the Appellant was not seeking to argue that this was a case where the coronial article 2 procedure automatically arose. Jenni Richards KC, acting for the Appellant, further clarified her position that there had been a breach of either or both systemic or operational duties on the part of the State. Moreover, she argued that there was not necessarily a dividing line between the two obligations (systemic and operational), referring to the Strasbourg case of *Fernandes de Oliveira v Portugal* [2019] ECHR 106.[5]

This case underpinned much of the appeal, paragraph 107 in particular:

"The question whether there has been a failure by the State to comply with its above-mentioned regulatory duties calls for a **concrete rather than an abstract assessment of any alleged deficiency.** *The Court's task is not normally to review the relevant law and practice in abstracto, but to determine whether the manner in which they were applied to, or affected, the applicant or the deceased gave rise to a violation of the Convention (see Lopes de Sousa Fernandes, cited above, § 188). Therefore, the mere fact that the regulatory framework may be deficient in some respects is not sufficient in itself to raise an issue under Article 2 of the Convention.* **It must be shown to have operated to the patient's detriment***" [emphasis added].*

In *Lopes de Sousa Fernandes v Portugal* (2018) 66 EHRR 28, quoted above, the applicant complained that the respondent state had been responsible for breaches of article 2 in relation to the death of her husband. It was reaffirmed in the judgment that within the context of alleged medical negligence, a state's substantive positive obligations relating to medical treatment were limited to

4 *The* 'credible suggestion' *test was established in* R (Skelton) v Senior Coroner for West Sussex and Chief Constable of Sussex Police *[2020] EWHC 2813*

5 **https://www.bailii.org/eu/cases/ECHR/2019/106.html#_ftn90**

a duty to regulate; in other words a duty to put in place an effective regulatory framework compelling hospitals to adopt appropriate measures for the protection of patients' lives.

Where a contracting state had made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as an error of judgment on the part of a health professional or a negligent coordination among health professionals in the treatment of a particular person could not be considered sufficient to call a contracting state to account in relation to its positive article 2 obligations. The fact that the regulatory framework might be deficient in some respect would not be sufficient in and of itself to engage article 2 concerns; it had to be shown to have operated to the patient's detriment.

Alleged systemic breaches

Ms Richards argued that there were a number of different systemic breaches, the primary concern being that there should have been in place a system which would have produced in advance a care plan ensuring that there was a pre-identified means of getting an incapacitated patient to hospital, when they were known to be unable to consent and had a fear of going to hospital.

As expected, there was considerable judicial intervention on this point. Lord Reed queried whether there was any point in the ambulance being sent for on the evening of 21 February 2017, if the crew were unable to administer sedatives. This gave rise to a series of questions as to whether there was in fact a systemic failing, or whether there was a series of poor judgment calls over the course of the evening which did not amount to a failing on the part of the State.

Ms Richards referred to Mr Maguire's own written case (as he was another Interested Party) where he provided the Court with references of instances where a different course of action may have made a difference to Ms Maguire's case and would ultimately have prevented her death. One such instance was sending a different ambulance crew: one of the key alleged failings was that a crew was sent, none of the members of which were qualified to administer sedatives. Ms Richards suggested that there should have been a policy in place where the crew are duty bound to radio back to ambulance control, asking for an advanced paramedic to attend. However, that point was tested again: the ambulance crew could have taken such action in any event, regardless of whether there was a policy in place. That much was *"obvious"*. Lord Stephens queried whether any systemic or operational breach had taken place on the part of the State in a situation where the ambulance crew and the GP had the authority to request sedation as a matter of urgency but no such action was taken.

Ms Richards emphasised that the key consideration was that no exercise of judgment was carried out on the evening of 21 February 2017, either by the attending paramedic who gave evidence to that effect at the inquest or by the out of hours GP, who had accepted that her own triage of Ms Maguire had been poor and she could have sent a doctor to the care home equipped with sedatives.

To illustrate this point further, Ms Richards referred to the fact that the next morning, ambulance staff attended and they were able to extract Ms Maguire from the home by way of a carry chair with her limbs tied to the legs of the chair. Therefore, whilst the Mental Capacity Act 2005 gave the home the power to sedate or manhandle Ms Maguire, it was an act of broad terms and did not deal with specificities which may have made a difference in this case. Assessing the Act on a regulatory level, it was submitted by Ms Richards that there was no process which compelled the production of a protocol which might have applied here, and that could be characterised as a systemic failure.

Lady Rose asked Ms Richards to clarify whether her case was either that a) a protocol should have been prepared in advance to deal with a case such as Ms Maguire's or b) whether a regulation should exist which would have compelled the production of a protocol in advance. Lady Rose observed that had there been a protocol in place and everyone had just ignored it, there would not have been a regulatory breach. Ms Richards confirmed that she was running both arguments.

Again, the discussion turned to the question of whether it would have been *"obvious"* to the ambulance crew that they should consider sedation and Lord Sales queried whether a plan or protocol would have been ignored on the night of 21 February by this specific group of practitioners and that in itself would not have constituted a systemic or operational breach. Ms Richards' argument was that whilst such a consideration was indeed *"obvious"*, there should be plans in place to enable practitioners to deal with situations such as Ms Maguire's. However, again, Lord Sales made the point that if the practitioners in question should have been thinking about sedation and other means of conveying Ms Maguire to hospital by means of basic common sense, that detracted from the need to have a protocol in the first place.

Alleged operational breach

This part of the hearing was shaped by the definition of an operational breach by the Court in *Osman v UK* [1998] 10 WLUK 513[6]: a duty by the State to take reasonable measures would arise where there was a real and immediate risk to life.

A number of Strasbourg cases were examined in detail, such as *Traskunova v Russia* [2022] ECHR 631[7], where the deceased participated in a clinical trial and it was held that there was deficient implementation of a regulatory framework, and UK prison death cases such as *Keenan v UK* [2001] 33 EHRR 38[8] and *Edwards v UK* [2002] ECHR 303[9]. In all three cases it was held that there was a range of healthcare shortcomings and those failures amounted to a breach of the States' operational obligations.

The Justices considered whether *Traskunova* was an *'outlier'* in the body of cases explored as the judgment appeared to draw a fairly rigid line between systemic and operational duties. This question was examined within the context of the principles set out in *R (Humberstone) v Legal Services Commission* [2010] EWCA Civ 1479: namely that article 2 would be engaged in hospital settings in limited circumstances where allegations were systemic in nature. They did not include cases where the only allegations were of *'simple'* medical negligence.

After some lengthy consideration of the above issue, Lady Rose re-centred the discussion on paragraph 107 of *Fernandes de Olivera v Portugal*: the Applicant must show that a deficiency, whether systemic or operational, had some quantitative effect on the death. As Lady Rose put it, one has to descend from the abstract consideration of the regulatory framework to show it made some difference in the instant case. It was on this basis that the Justices had trouble in squaring *Traskunova* with the general principles discussed: in *Traskunova* the systemic regime was held to be satisfactory but there was a failure in implementation. Ms Richards' proposed solution to this mis-fit between the authorities was to decide that there was an overlap between the systemic and operational duties owed by the State.

However, the Justices again voiced their concerns that *Traskunova* did appear to cast the net very wide. Another suggestion by the Appellant was that the errors of judgment in that case could be characterised as a series of failures which amounted to a systemic breach. This prompted a reassessment of *Lopes de Sousa Fernandes v Portugal* [186]:

"The Court reaffirms that in the context of alleged medical negligence, the States' substantive positive obligations relating to medical treatment are limited to a duty to regulate, that is to say, a duty to put in place an effective regulatory framework compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients' lives".

Paragraph 186 above was further elaborated upon in paragraph 191 of *Lopes de Sousa* where it was clarified that the State's responsibility under article 2 would only really be engaged in exceptional circumstances. The first type of exceptional circumstance

"concerns a specific situation where an individual's life is knowingly put in danger by denial of access to life-saving emergency treatment [...] it does not extend to circumstances where a patient is considered to have received deficient, incorrect or delayed treatment".

The second type of exceptional circumstances illustrated by the Court in *Lopes de Sousa* arises where:

"a systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving emergency treatment and the authorities knew about or ought to have known about that risk and failed to undertake the necessary measures to prevent that risk from materialising, thus putting the patients' lives, including the life of the particular patient concerned, in danger".

It was emphasised at paragraph 195 of *Lopes de Sousa* that:

"the dysfunction at issue must be objectively and genuinely identifiable as systemic or structural in order to be attributable to the State authorities, and must not merely comprise individual instances where something may have been dysfunctional in the sense of going wrong or functioning badly".

Comment

Returning to the two Portuguese cases: the obstacle the Appellant faces in this case is that even if there had been a policy in place to cater for situations such as the one in which Ms Maguire found herself on the evening of 21 February 2017, it seems the outcome would most likely (and very sadly) not have been any different. To quote the above Strasbourg authorities: the mere fact

6 https://www.bailii.org/eu/cases/ECHR/1998/101.html
7 https://hudoc.echr.coe.int/fre#{%22tabview%22:[%22document%22]
8 https://hudoc.echr.coe.int/fre#{%22itemid%22:[%22001-59365%22]}
9 https://hudoc.echr.coe.int/fre#{%22itemid%22:[%22002-5416%22]}

that the regulatory framework (systemic or operational) may well have been deficient in some respect will not be sufficient to raise an issue under article 2. Moreover, the regulatory deficiency must be shown to have operated to Ms Maguire's detriment.

An important feature of the oral evidence at the inquest was that neither the out of hours GP nor the paramedic attending the home considered the potential issue of extracting Ms Maguire from the home, either by sedation or manhandling. On the face of this evidence, it is not only most unfortunate but also deeply concerning that two different practitioners failed to carry out the same judgment exercise. That in itself will most likely be considered to be symptomatic of a serious regulatory failing.

Nevertheless, the fact that the care home staff, with the help of a different ambulance crew, were able to safely convey Ms Maguire to hospital with physical restraint on the morning of 22 February 2017 does not sit easily with the argument that Ms Maguire suffered detriment as a result of deficiencies in the regulatory framework. On the contrary, that Ms Maguire was safely take to hospital on the morning of 22 February 2017 indicates that the ambulance crew and out of hours GP involved in her care (or lack thereof) on the evening of 21 February 2017 were negligent and would most likely not have followed protocol in any event.

Of course, one of the main motivations for families making article 2 arguments is that it gets them one step closer to the possibility of legal aid funding and until that position changes, the article 2 inquest scene will continue to develop and those family members unable to afford legal representation will be overwhelmed by the sea of authorities through which Ms Richards waded in this appeal. It seems unlikely that the judgment will mark a dramatic change in the way courts determine article 2 healthcare cases. However, it will hopefully break new ground in providing relative clarity to families and practitioners alike in otherwise murky waters.

Going private: problem or panacea?

ARRAN MACLEOD, SENIOR ASSOCIATE
PENNINGTONS MANCHES COOPER

PENNINGTONS MANCHES COOPER

With increased waiting times reported in NHS hospitals for elective and non-urgent procedures, more people are turning to treatment in private hospitals. Currently there are estimated to be over 180,000 private patient admissions every year. However, despite an increase in patient numbers, choosing private healthcare does not guarantee optimum results.

There is still relatively little known about the quality and safety of care provided to patients in a private hospital setting. This lack of reliable data and information prevents patients from being able to assess the nature of risk properly, which should be possible in order to make an informed choice about where and whether to receive treatment in a private healthcare environment. Potential concerns include:

Not enough is known about adverse events and hospital outcomes and there is insufficient transparency as to how private hospitals are rated

The majority of patients treated in private hospitals are *'low risk'* – i.e., they are, ostensibly, less likely to develop complications following surgery. Despite their low risk status, the Centre for Health and the Public Interest has previously suggested that the number of unexpected deaths and serious injuries may be higher than anticipated for low-risk patients. In 2017 a private hospital was awarded an *'Outstanding'* rating by the Care Quality Commission a few weeks after a coroner found that a patient's unexpected death had been caused by the *'neglect'* of its nursing staff.

The size and limited facilities of private hospitals pose problems and facilitate increased levels of risk

Most private hospitals are significantly smaller than their NHS counterparts. This means that they do not offer the same number and standard of facilities or departments as NHS hospitals and, importantly, do not have the facilities to deal with complications and emergency situations in the same way. This often means that patients who experience complications during treatment in a private hospital need to be transferred for further management and care in an NHS hospital.

Staffing arrangements in private hospitals may not be satisfactory

The consultant surgeons and anaesthetists who work at private hospitals are *'self employed'*. Once they have completed the procedure which they were contracted to undertake, they very often leave the hospital and the patient is left in the hands of relatively junior doctors – often locum doctors, known as resident medical officers (RMOs). The RMOs may not have worked in the hospital before or may not have expert medical training that aligns with the patients they are responsible for looking after in the post-operative period. The RMOs may be unfamiliar with the consultants' procedures and processes – all consultants in private hospitals have a number of procedures that junior doctors are expected to understand and follow in order to ensure continuity of care - and this level of unfamiliarity can lead to failures in patient safety.

These are all areas of concern that members of our team come across regularly when advising claimants on whether or not there have been failures in their care at a private hospital. A client for whom we acted recently encountered a number of such issues during her elective treatment at a private hospital in Buckinghamshire.

Factual background

Our client was admitted to the Shelburne Hospital for private elective eye surgery. The procedure – known as an epiretinal membrane peel – was straightforward and was performed without complication.

Post-operatively, however, at around 5pm, she was transferred from theatre to the recovery room. The consultant surgeon and consultant anaesthetist, who

had been responsible for her care, went home, and our client's post-operative care was handed over to hospital nurses, overseen by a mid-grade RMO. The RMO was not employed by the hospital but had been provided by an agency.

At around 6pm, our client was transferred from recovery to her private hospital room. It was around this time that she began to feel unwell. She felt nauseous and sick. Her symptoms gradually worsened and, at just before 9pm, she experienced a wave of nausea and told the nurse who had been visiting her in her room that she needed to be sick. The nurse spoke with the RMO, who attended our client's hospital room but did not examine her. She prescribed a weak anti-sickness drug, which is normally used to treat patients who suffer movement induced nausea (such as car sickness) and was not appropriate for treating nausea and sickness induced by anaesthetic drugs.

Our client's symptoms were not resolved with the anti-sickness tablet that the RMO prescribed. She told the nurse that she still felt unwell but, instead of being re-examined, she was informed that she needed to start getting ready to go home. It transpired after the event that the Shelburne Hospital had made a decision to stop offering inpatient stays, and it was clearly lacking in sufficient facilities for our client to remain in hospital for ongoing monitoring and management.

Her husband arrived to collect her from hospital but immediately complained to the nurse that she was clearly in an unfit state to go home. His concerns were rebuffed and the RMO gave our client an anti-sickness tablet for her ongoing symptoms. This was clearly insufficient; she was, by now, retching and unable to swallow oral medication.

Despite her husband's complaints, our client was discharged. She was so unwell that she was not able to stand and walk independently and had to be wheeled out of the hospital in a wheelchair. When she arrived home, she continued to experience nausea and sickness and one episode of retching during the evening caused her to suffer a haemorrhage in the eye that had been operated on earlier in the day. That haemorrhage caused our client to suffer a retinal detachment and, despite the efforts of her eye surgeon, she was informed that the sight from her left eye was permanently impaired and was unlikely ever to recover.

As part of the clinical negligence claim, expert evidence was obtained from specialists in anaesthetics, ophthalmology, nursing and general medicine. Their opinion was that the RMO had been negligent for:

i) not following the consultant anaesthetist's procedure of contacting him in the event of any complication arising from the anaesthetic;

ii) not prescribing an appropriate anti-sickness drug when he first learned of our client's symptoms, indicating a lack of experience in treating ophthalmic patients; and

iii) for discharging our client home when it was not safe to do so.

It was the opinion of the experts that had our client's symptoms been properly managed, her nausea and vomiting would have resolved within 30 minutes, she would have avoided the retching episode that caused her to suffer the retinal detachment and she would have retained the sight from her right eye.

Despite the allegations of negligence being formally denied, the RMO ultimately agreed to compensate our client for her injuries and the claim settled for six figures.

Summary

This case demonstrates a number of the familiar risks of obtaining treatment in a private hospital setting.

While there will inevitably be positive reasons for seeking private healthcare, not least the option of receiving treatment more quickly, we remain uneasy about the lack of senior supervision of junior doctors who are unfamiliar with the hospital and its procedures but are expected to provide good quality medical care to private patients. This is ultimately putting patient safety at risk.

Kisses, cuddles, and closure - 1000 mediations and counting!

PAUL BALEN, DIRECTOR
TRUST MEDIATION

Trust Mediation
specialist personal injury and clinical negligence mediation

At the beginning of December 2022 Trust Mediation mediated its 1000th mediation under the NHS Resolution Mediation Scheme almost exactly to the day 6 years after the first contracts for mediation providers under the Scheme were awarded.

It therefore appears to be a good time to see how mediation in clinical negligence cases has evolved over this time and to consider the scope for further evolution and uptake as dispute resolution is now recognised to be a key part of the claims process and no longer *"Alternative"*.

What cases are suitable for mediation?

The two early pilot schemes run by NHSLA (as it then was) with CEDR concentrated on small value claims. When the current Scheme was introduced most commentators felt that it was these type of cases that were best suited for mediation as a cost effective method of resolution. Instead it quickly became clear that claims of all values could be and were being successfully mediated to great satisfaction to the extent that now over 40% of our recent mediations have involved claims with a value claimed to exceed £750k.

It was also widely believed that mediation would only be suitable for quantum only claims. Far from it. Experience has shown that open and flexible discussions under the guise of mediation privilege can successfully resolve cases where breach, factual and medical causation and even contributory negligence can be explored, issues narrowed and risk evaluated.

At what stage in the process is mediation most effective?

Again, to the surprise of some sceptics, the answer is that in our experience the resolution rates do not vary whether the mediation is held early or late in the litigation cycle. Not unnaturally in the early days of the scheme the vast majority of cases mediated were post CCMC and immediately before trial echoing the historic *"door of the court"* settlement practice. 6 years later 70% of our cases are pre-CCMC the overwhelming majority being pre-issue. Whenever held, the mediation resolution rate on the day or immediately thereafter sticks at around 80%, itself probably an underestimate as often parties do not let us mediators know what actually happens after the mediation has concluded.

Why can't we just have a settlement meeting?

All our mediators at Trust Mediation have a specialist background in conducting clinical negligence and personal injury claims or defences. We are entirely familiar with joint settlement meetings and of course on many occasions they work well. Putting as it does the claimant at the centre of the process, the mediation scheme empowers the claimant and allows for exploration of whatever issues the claimant seeks to help him/her to come to terms with what happened.

This discussion can involve the claimant as much or as little as he or she requires and can deal with extra judicial matters such as apologies and lessons learnt in a far more relaxed an collaborative manner than possible at most settlement meetings, which tend to an adversarial discussion between lawyers, often with claimant confined to the proverbial broom cupboard.

Even in a dispute being hard fought at the adversarial level, the introduction of an independent neutral encouraging the parties to work out how best the matter-an issue or the entire claim -can be resolved invariably produces dividends for the parties and most importantly satisfaction and at least a degree of closure for the claimant.

The experienced mediator steeped in the dynamics of these type of claims, often involving high emotion, anxiety and grief, is used to reading the room even in the online world, deflecting pressure and antagonism and, hopefully in a relaxed way, getting to the issues and their resolution.

Do I need to instruct counsel?

In the early days of the scheme most cases mediated involved counsel usually for both sides. Fee earners at panel firms tell us that NHS Resolution encourages them in appropriate cases act as mediation advocate themselves or if the fee earner is relatively inexperienced with more senior input. Some lawyers in claimant firms are now feeling confident enough to act as mediation advocate themselves with conspicuous success.

Research published by NHS Resolution in 2021 suggested that when both sides used counsel the resolution rate actually dropped. Although early in the scheme some counsel did indeed find difficulty in adapting from adversarial to collaboration/resolution but now most are seasoned performers fully understanding of both the mediation process and the role of the mediator, even to the extent of repeating unconsciously guidance/ suggestions made by mediators in previous mediations.

Does not mediation simply mean compromise and accepting less than the claim is worth?

In court generally the position is black or white. You win and the other side loses. In a mediated settlement there is likely to be compromise by both sides but the overall value to a claimant of the certainty of settlement, especially one at an early stage, as well as the provision of extra judicial remedies if appropriate, cannot simply be measured in pounds.

Much the same applies to the defence. Faced with the lottery and irrecoverable expense of courts, the value of offsetting the risk with a settlement can be calculated from costs (of both sides) saved even if at first sight the compensation paid might be higher than originally envisaged. It is often said that a mediation is a success if both sides go away with settlement but slightly dissatisfied. The NHS Scheme process can and does allow both parties to leave the mediation room absolutely satisfied with the resolution achieved. More than one claimant has said to me at the conclusion -even one where there had been no admission but settlement achieved - *"the mere fact that payment was agreed shows my claim was justified"* and *"it was never about the money anyway"*.

How should you prepare for mediation?

Our experience is that those cases which fail to be resolved at mediation are usually those where one of both parties have failed to prepare for resolution rather than trial. We have also come to realise that the pre-mediation call our mediators make to the individual parties is key and must be taken seriously by the parties' solicitors. We have now produced a check list[1] available to help the parties plan but the essence is to start thinking resolution at an early stage asking yourself what do I need to do to help my opponent help me resolve the case. What are the key issues/stumbling blocks and how might we work through or round them? What do I have or know that my opponent may not have or know? How best can I use mediation confidentiality and privilege to advance the prospects of resolution?

Above all take the mediator into your confidence and discuss how he or she can help you and your client. Put your thoughts into a Position Statement. In the online world (and 95% of our mediations have remained online since Covid) we routinely offer to meet the claimant and any other person from either side who wishes to meet and experience our online platform. Do encourage your client to take advantage of this. It reduces apprehension about the technology and meeting this stranger who has been parachuted into the claim.

What is a position statement?

In the early days position statements were rarely used but the importance of their role is increasingly being recognised by those more experienced in the use of mediations. A position statement is not a pleading. Think of it as a cross between a case summary and a plan as to how resolution either of individual issues or the whole case can be achieved. Provide concessions or further information hopefully to advance both the mediator's and your opponent's understanding. If you have not already done so (hopefully not leaving it to the last minute!) use its preparation as a prompt to produce to your opponent information or documents not necessarily prepared to trial standard that you believe will advance your client's prospects of achieving resolution.

Our experience is that the mere fact of looking at your client's case in this way should prompt your and your opponent's thoughts on resolution/settlement and increase the likelihood of that being achieved. If your schedule does not include figures delete the hated letters TBA and put in a figure for mediation purposes. If there has been a joint meeting of experts indicate how you now see resolution in the light of any agreement reached by

1 https://www.trustmediation.org.uk/wp-content/uploads/2023/02/TM-Mediation-Preparation-Checklist.pdf

those experts. If there remain differences explain how you see them being reconciled.

Ideally send the position statement to your opponent once you are happy with it. There is no need to get precious about exchange. This is not an adversarial issue. If it is going to help your client by advancing the prospects of a satisfactory resolution just do it! If there are matters it would help the mediator to know that are not for the opponent's eyes provide that orally or in writing in a confidential position statement for the mediator only. That might include issues on how to deal with, for example, life expectancy, expectations or family relationships etc.

Experience again shows that the more you take the mediator into your confidence the greater the prospects of resolution. If extra judicial remedies are important to your client warn the mediator and ask him to raise them with your opponent if not already done so and choreograph their presentation.

Schedules!

Most mediations one way or another revolve around schedules even where liability and causation are also in dispute. Mediation works best when during preparation each party realises the importance of a mediation schedule. For the claimant that means the original schedule being brought up to date and revised as a confidential mediation schedule, clarifying points known to be in issue and taking a more realistic view of certain items where applicable. Not only does that help with managing your client's aspirations it also helps remove tension points if you know in advance that an item is unsustainable.

Similar comments apply to those advising defendants. If a counter-schedule is served just before the mediation it should be for the mediation and not the trial. The language sometimes used by defendants in such counter schedules can unnecessarily produce very marked adverse responses from claimants which handicap resolution. As mediators with the privilege of observing reactions in both private rooms, we know that mediation works so much better if such documents come across as considered, realistic and not antagonistic. Such documents show that the process of mediation is being taken seriously and that creates a good atmosphere for the start of the mediation day itself.

It also helps the mediator if someone has taken it upon themselves to match the two mediation schedules in a summary. All too often a mediator is faced in preparation with comparing apples and pears!

Preparing the Claimant

The vast majority of Claimants will not have experienced mediation before. Preparation should, as well as the opportunity to meet the mediator beforehand, include an explanation of the process and the mediator's role. Often this can be included in the introductory meeting or if there has not been one at the start of the day when the mediator can have a private session with you and your client. In the online world there is a lot to be said for checking the technology being used by the claimant. Making sure his or her correct name is displayed and he or she is sitting in a suitable and comfortable location with the best view. If there is someone else going to be present ,whether the mediation is in person or online, it is necessary for that person also to sign the mediation agreement's confidentiality page.

If extra judicial remedies are going to be involved explore your client's requirements and discuss them with the mediator and if appropriate your opponent. If your client is prepared to provide an impact statement or some kind of update orally at the start of the mediation our experience is that this is incredibly useful. Many claimants welcome the opportunity to share their personal thoughts. Some find it cathartic, even life changing, in itself. Defendants' representatives who up to then may simply have seen the claimant as a name or number invariably welcome the opportunity to see, and, if practical listen, to the real person behind the story. The impact of such a statement on a defendant team and on the whole atmosphere at a mediation should not be under-estimated. Do consider this in advance and not spring it on your client on the day. There is of course no requirement for the claimant to participate at all and no pressure to do so.

Even if the claimant does not want to participate actively find out if he or she would participate in a session at the start of the day when everyone present can introduce themselves and explain their roles. Like everything else in mediation (except for confidentiality) such a session is optional but again simply identifying who the participants are represents a human touch vastly different from the formalities, gowns and wigs etc of the oppressive court process.

Also ensure that you and your client understand the role of the mediator -independent and neutral; there to help but not judge; there to listen and if necessary provoke discussion and debate on relevant issues, but if asking questions -usually of the lawyers – there to reality test strengths, weaknesses and risk and in doing so not to be taken as a reflection of partiality but simply seeking to help the parties themselves to narrow areas of dispute

and aid resolution; and, finally, if passing messages between breakout rooms whether face to face or online doing so as messenger released to that extent from the confidentiality binding him over the discussions taking place in each room and not as that party's advocate.

Most memorable experiences

Mediation is a confidential process. Each case involves different personalities and for a mediator different challenges. In an area where emotions often run high the opportunity for parties to release emotions, recreate trust and resolve their differences or achieve a better understanding is for a mediator the most rewarding element.

The good:

In face to face mediations pre-Covid hugs and kisses from satisfied claimants which often replaced the more formal handshakes -even hard bitten defendant counsel receiving a hug from a claimant on revealing he had already asked for a written apology to be supplied; tears welling up from both parties representatives as a claimant recounts the impact of the event (and the delay in dealing with the consequences); a defendant counsel tearing up her schedule in the privacy of her breakout room having realised (like me) hat the real person she had just met was not the person that appeared to be described in the papers; the claimant accepting with alacrity an offer by a Trust representative to go into the hospital and repeat her description of her experience at one of their future in-house training sessions; the email received from a leading counsel who had opened the mediation by bemoaning the fact that it was not a JSM recanting his view having experienced mediation for the first time; the insistence of a young man on giving an oral impact statement against his mother's and his lawyer's wishes, providing an amazing insight on what had happened to him and then after the claim had settled telling me he felt now for the first time in years that he could deal with people and, he now realised, looking forward to finding employment doing so.

The bad:

Five lever arch files of medical and employment records; schedules full of *"to be advised"*; parties holding back relevant statements and reports *"we have not got to that stage in directions yet!"*; PSLA claim by mother of £475k following a still birth (when asked where in the JC Guidelines that figure could be found being asked by counsel asking what they were!); D turning up on the day and revealing for the first time that this was a *"no offers"* mediation; asking a non-specialist solicitor (in private) why he had chosen a particular counsel to be told it was because he was a doctor (unfortunately it transpired not of medicine!).

The ugly:

Travelling to a relatively remote location for an all-day mediation only told that the claimant would not be participating because they had a Pt 36 offer to consider and there were still 2 weeks left for him to accept and needed expert advice before doing so; being told that I as mediator could not speak to the claimant; claimant in the opening session (for the first time) being accused of dishonesty and being threatened with sanctions;). Fortunately these are rare circumstances - none beating the personal injury mediation in which two senior junior counsel actually fought -but that's another story (with a happy ending!)...

What does the future hold for mediation?

Particularly in clinical negligence claims the empowerment of both parties to make decisions dispositive of the issues arising is in itself an important part of the resolution process, whether in the eyes of the claimant or the medical defendant. Both seek resolution and closure. The fact that parties volunteer to mediate, albeit these days under a degree of judicial pressure, is important to the healing/resolution process. If mediation became compulsory the question then is how many turn up simply to tick the box.

Mediation can also sit well with other forms of dispute resolution such as neutral evaluation. All the mediations conducted under the NHS Resolution Scheme are facilitative mediations. Evaluation can, however, easily be incorporated into mediation process, either before or after, or if the parties agree, the mediation itself can switch from facilitative to evaluative if the mediator is prepared to evaluate a particular issue or indeed all issues but only if the parties consent.

The pre-action procedure naturally lends itself to a stocktake at the end prior to issue of court proceedings. With large fees and delays court should become the last rather than the first resort as a result of which an even greater number of mediations could and should be held at the stock taking stage. Lawyers should be increasingly solution providers rather than generals in battle.

The NHS Resolution Scheme is designed to place the claimant/patient at the centre. The patient's lawyers owe their duty to patient/client. Few such clients want to go to court. Fewer still want a long-drawn-out process. For the claimant lawyer, whose duty to the patient is paramount, early resolution means a more satisfied client (and bank manager as a result of better cash flow!).

Finally, on-line mediations forced on the parties originally as a result of Covid but now in the majority of cases the preferred option, are particularly liked by claimants who can participate from home but also by all parties as avoiding time/travel pressures and noticeably increasing collaboration. Adversarial dialogue simply does not work well on-line! The flexibility and adaptability of the on-line process leads to a willingness to adjourn if necessary to consider new points and makes it much easier to resume rather than dump the whole process as a failure. Familiarity now with the on-line process naturally leads to greater use of other resolution techniques such as settlement days; evaluation, and arbitration all of which can successfully be provided online and are part of Trust Mediation's menu of specialist assistance to parties in this field.

Trust Mediation offers free in person or online mediation training and runs quarterly online clinics dealing with mediation tips. Do contact **registrar@trustmediation.org.uk** for all your mediation related queries and drop into our stall in Bournemouth at the annual conference.

Paul has practised as a solicitor in the clinical negligence field for over 40 years. Although now a very part time consultant to his old firm Freeths he remains an AVMA specialist panel member.

Paul qualified as a mediator in 2004 and has conducted approaching 300 mediations mostly, but not exclusively, clinical negligence cases. He is a director of Trust Mediation one of the two mediator providers contracted to NHS Resolution. He has also mediated cases involving NHS Wales, the MDU, MPS and in Jersey.

He was awarded Mediator Achiever of the year at Personal Injury Awards ceremony in 2018.

Golf enthusiasts, join us for the 2023 charity golf day at **Meyrick Park Golf Club**, Bournemouth! Enjoy a unique 18-hole course with stunning views, and compete for prizes with the best individual score, best team score, nearest the pin and longest drive - all kindly sponsored by VFS Legal Funding. Show your support for AvMA and have a great day - just £75 per person or £300 for a team of four!

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23-24 March 2023 (Golf Day & Welcome Event 22 March) 2023, Bournemouth International Centre

If you've not already booked your places, join us in Bournemouth on 23-24 March 2023 for the 33rd AvMA Annual Clinical Negligence Conference (ACNC), the event for clinical negligence specialists! The very best medical and legal experts will ensure that you stay up to date with all the key issues, developments and policies in clinical negligence and medical law, whilst enjoying great networking opportunities with your peers.

Representing Families at Inquests: A Practical Guide

26-27 April 2023, Gatehouse Chambers, London

This conference presents a comprehensive guide to the practice and procedures when representing a family at an inquest. You will hear from an excellent programme of speakers, all experienced in their involvement in inquests, who will provide you with case examples to help you to put the theory into practice. You will also learn more about AvMA's important role in representing families.

Court of Protection conference

9 November 2023, Hilton Leeds City Hotel

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

AvMA Specialist Clinical Negligence Meeting

Afternoon of 1 December 2023, Grand Connaught Rooms, London

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

AvMA's Christmas Soirée

Evening of 1 December 2023, Grand Connaught Rooms, London

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

Clinical Negligence: Law Practice & Procedure

12-13 December 2023, Shoosmiths LLP, Birmingham

This is ***the*** course for those who are new to the specialist field of clinical negligence. The event is particularly suitable for trainee and newly qualified solicitors, paralegals, legal executives and medico-legal advisors, and will provide the fundamental knowledge necessary to develop a career in clinical negligence. Expert speakers with a wealth of experience will cover all stages of the investigative and litigation process relating to clinical negligence claims from the claimants' perspective. Full details available soon.

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

1 February 2024, Hilton Leeds City Hotel

This popular AvMA conference is returning on 1 February 2024 in Leeds, to discuss and analyse the key areas currently under the spotlight in Cerebral Palsy and Brain Injury Cases so that lawyers are aware of the challenges required to best represent their clients. Booking will open in the Autumn.

34th Annual Clinical Negligence Conference (ACNC)

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

Get the 2024 ACNC dates in your diary!

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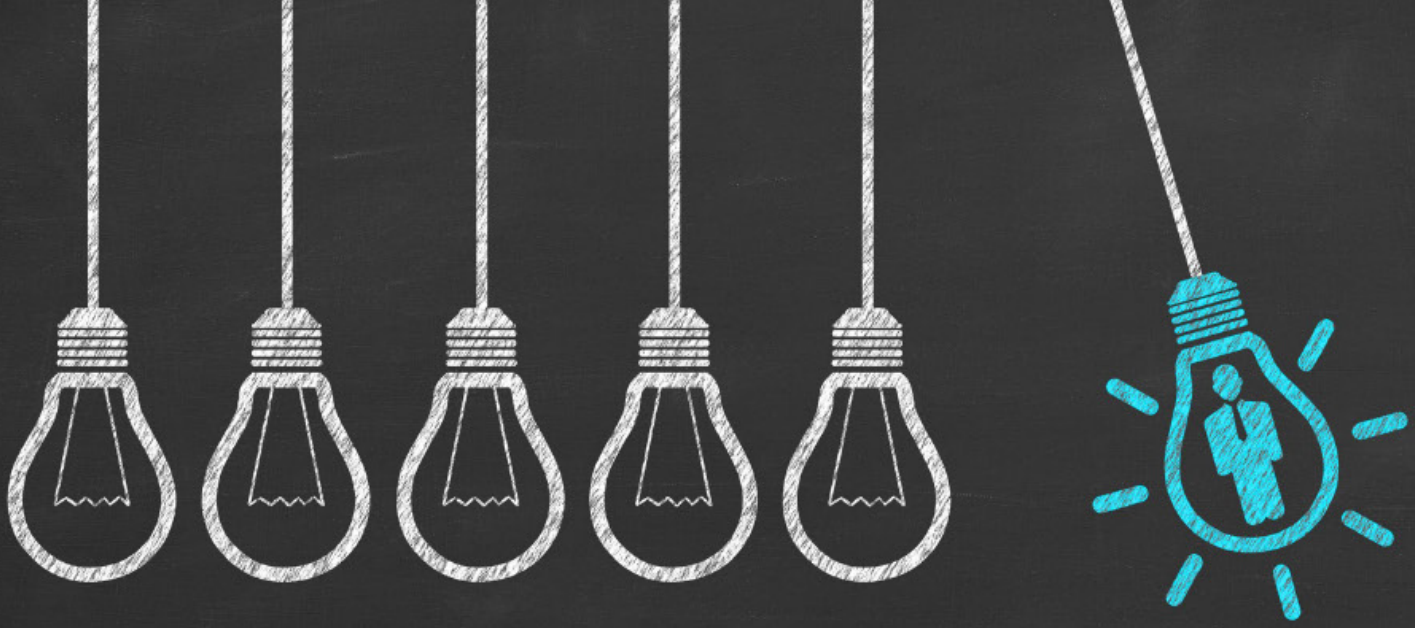

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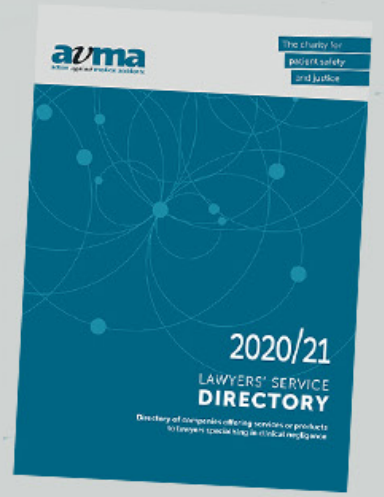

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